

SOME MOTIVATIONAL, ABILITY, AND OPPORTUNITY  
DETERMINANTS OF REFERRAL FOLLOW THROUGH

by

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## CHAPTER I

### Introduction

A problem confronting any mental health agency involved in screening is how to refer patients more successfully. Whether the source of the referral is an emergency room, hotline, or social agency, the rate of successful referral, according to Craig, Huffine, and Brooks, is generally less than 50% (1974). While working in the emergency room, the researcher noticed that most patients were referred to other agencies for out-patient treatment and that many of these same patients contacted the emergency room at a later date, again in a state of crisis. Usually these patients had not followed through with the first referral. It would seem necessary, in order to provide more appropriate service, aimed at primary or secondary versus tertiary prevention, that the health care delivery system should take a closer look at the factors influencing completed and uncompleted referrals.

Chafetz (1965) describes the role of the emergency room as one of assessment, crisis intervention, and coordination of care. Satloff and Worby (1970) add that the emergency room offers the general population contact with psychiatric emergency services in the least restrictive, most readily available format. Therefore, the crisis service has the first and best opportunity to get people into treatment where their long-term, recurrently acute problems can be brought under control. Both agree that appropriate inter-agency patient referral is an important factor in referral completion.

The University of Oregon Health Sciences Center Emergency Room sees approximately 4,300 patients a year with a diagnosis that is

psychiatric in nature. Twenty-five to 33% of these patients are referred to other resources for out-patient treatment within the community. The referral process is an attempt to coordinate care, offering the patient a treatment option available in the community that meets his/her needs, and which will preclude further emergencies and E.R. visits.

Tischler (1966) describes four choices that the clinician in the E.R. has when assessing a patient; namely, admit the patient to an in-patient service, provide additional services personally, tell the patient that no additional treatment is needed, or refer the patient to another agency for out-patient treatment. In admitting the patient to an in-patient setting, the clinician has the assurance that the patient will receive further evaluation and care. The problems with this option are expense and often, the inability of an in-patient unit to deal with the factors which instigate and maintain the problem. With the decision to personally see the patient again, the clinician is showing an interest, acknowledging the need for a more complete assessment, and accepting the responsibility for follow up. The problem with this solution is that the E.R. worker already has a job and the follow up responsibilities grow exponentially. In deciding that no further intervention is needed, the clinician makes the judgement that the patient has little psychiatric morbidity, that treatment is unlikely to have any effect, or that periodic crisis intervention is the most effective approach to the patient's problems. The decision to refer the patient to another out-patient setting, however, is different from the other three possibilities, in that the patient requires active intervention but is referred outside the clinician's system into a larger, more specialized community referral

network. In this choice, the patient is effectively "lost" to that clinician.

In summary, all patients who are admitted to an in-patient service, seen in the E.R. for follow up, or require no further care, complete a process or choice of care, either obtaining specific treatment or having an end-point to treatment in the case of no referral. Only the referred patient is left with the treatment process incomplete, floating between the E.R. system and the community treatment system.

Referral outcome can be viewed as a behavioral choice that the referred individual makes. In other words, he chooses whether or not to follow through with treatment. Rotter, 1954, states that human behavior is purposeful and that people make choices based on what they want and what they think is the best way to get there. Mathematically this is represented by the formula

$$RV + FM \longrightarrow BP$$

(motivation + freedom of movement or opportunity leads to behavior).

Freedom of movement or opportunity can be defined as any factor external from the individual which strengthens or diminishes the tendency to perform the outcome behavior. In other words, opportunity variables are those which arise out of the situation and affect outcome behavior. Outcome behavior is defined here as the completion or non-completion of the referral (choosing to follow through or not to follow through with the first appointment). Some of the opportunity variables as defined in the literature are, appointment type, number of days until the appointment, whether or not the patient has the name of the referred-to therapist, and whether he/she has a specific appointment time for the

first appointment. All of these variables are external to, and out of control of the patient, who ultimately performs the outcome behavior. Yet, according to the literature, they can greatly affect whether or not the referral process is completed.

Motivation can be defined as any thought or feeling within the patient that leads to behavior. The motivational variables that affect this behavioral outcome are four; patient agreement with the referral, understanding why he/she was referred, knowing what the E.R. clinician had in mind when he/she referred the patient, and previous contact with the referred-to agency. Rotter would say all of these variables strengthen or diminish the perceived reinforcement the patient would receive as a result of the outcome behavior; that of following through with the referral, or not following through.

In the case of the mentally ill patient, particularly, it would seem necessary to add a third dimension to the formula, that of abilities. It then reads,

$$RV + FM + A \rightarrow BP$$

(motivation + opportunity + ability leads to behavior). Both diagnosis and psychiatric treatment history imply abilities. An individual's abilities may or may not meet the demands of the referral process, and we therefore see a difference in follow through performance. A psychotic patient often has problems with confusion and can not figure out how to follow through on a referral; or even why he should follow through. His/her ability to even remember the appointment may even be impaired. Frequently a depressed patient has little confidence that he can feel better and little confidence that treatment will make any difference. His

ability to view his disturbance objectively and take action to improve it is impaired. The neurotic may see psychiatric treatment as a blow to his/her self-esteem and uses defenses to see less and less of a reason to proceed with the referral. Also, his/her anxiety often decreases over time and treatment does not seem necessary. In all cases, the individual's ability to view the disturbance objectively may be impaired. In addition, the psychotic patient may be confused about how to follow through, the depressed patient does not think he can, or perhaps even care about feeling better, and the neurotic may not see the need to complete the referral.

The literature indicates that it would be important to investigate all three groups of variables which affect referral outcome; opportunity, motivational, and ability variables. Those patients less likely to follow up may require a more thorough contact or evaluation while in the E.R. in order to minimize further visits. More attention to all of the variables included in the referral process would insure a higher rate of completed referrals for those groups of patients identified as less apt to follow through with treatment.

The purpose of this study was to identify characteristics of patients more and less likely to complete the referral process, more specifically, to find out which factors within the patient and within the referral system lead the patient to choose or not to choose to complete the referral. More clearly identifying these variables and their interactions can enable us to better help patients complete the referral process.

### Statement of the Problem

As a result of a number of investigations, data are now available that identify some of the variables within the opportunity structure, motivational structure and abilities of the patient which affect referral outcome. It is not understood how these variables interact or contribute to the behavior of follow through, as they have never been used to explain the phenomenon of whether or not the patient chooses to follow through. It is not clear why some patients complete referrals and others do not. To understand this, it is necessary to look at the motivators and opportunities involved with the referral process as well as the abilities of the patients themselves to determine how they affect referral outcome.

### Review of the Literature

Little work has been reported in the literature on referral outcomes or factors that affect these outcomes. It is known that a 50% completed referral rate is considered about average for most out-patient settings. Paykel (1974) studying suicide attempters, 29 of whom were referred for out-patient follow up, found that thirteen or 45% appeared for the first appointment. On the other hand, Bogard (1970), also studied suicide attempters and found that only five of 44 patients (11%) specifically referred to the out-patient department showed up for their appointment. Examining more closely what happened to non-completers, Chameides (1973) did a one year follow up of 51 patients who had failed to keep one out-patient appointment following a visit to the psychiatric emergency room. He found that 40% had received some type of psychiatric care during the year that followed the initial emergency room visit. According to the results of this study, at least

half of E.R. patients choose one-visit, stop-gap emergency treatment, rather than completing the referral and entering into active treatment.

#### Opportunity Structure Variables

Confirmed versus steered appointments - One variable reported in the literature is confirmed versus steered appointments. Kogan (1957) was one of the first researchers to evaluate this aspect of referrals. He found that 37% of the patients who were steered (given a name or phone number to call), completed the referral. Eighty-two percent of the cases in which the patient had a specific appointment time, made contact with the referred-to resource.

Results of a 1971 study clearly supported the superiority of confirmed versus steered appointments for the authors, Rogawski and Edmundson. An analysis of 334 patients referred from an E.R. to out-patient resources, showed that 46% completed the referral. In this study, referrals were defined as completed only if the patient kept at least two appointments with the referred-to facility. When the therapist confirmed the appointment, 63% completed the referral, whereas, when the patient was expected to make his/her own appointment, only 31% followed through with treatment.

More recently, Sudak, Sawyer, Spring, and Coakwell (1977) increased successful referrals to 69% by confirming appointments before the patient left the emergency room. Referrals were 97.2% effective if a patient had been active with a therapist or agency and returned to that same resource.

Length of time until appointment - Raynes and Warren (1971), evaluating 267 referrals to an out-patient psychiatric clinic, found that if

the out-patient appointment was scheduled for more than six days from the initial assessment, 50% of the patients failed to keep the appointment, whereas, if the appointment was scheduled for less than six days, there was only a 13% failure rate. In this particular study, sex was not found to be a significant factor in non-attendance.

Similarly, results of a study conducted in a large Los Angeles public hospital where patients were referred for aftercare in the community, indicated that patients were most likely to keep the appointment if it was within three days of release from the hospital and if it was confirmed before discharge, (Wolkon, Peterson, and Rogawski, 1978). In addition, when an appointment could not be arranged, a phone call to the patient improved the referral completion rate. Ninety percent of the patients with appointments in three days or less kept the appointments. If the appointment was later than three days, but less than seven, 72% of the patient kept it. In these studies, neither the type of transportation used to get to the appointment, nor the type of agency (public or private) seemed to affect the outcome.

#### Motivational Variables

Patient agreement (congruence) with the referral - Koumans (1971) states that in order for the patient to follow through with treatment, he/she must first share the clinician's wish that the patient "get better". In fact, the patient must agree that he/she does have a problem and then agree that the referred-to agency is the appropriate mode of treatment. Rotter would say that only if the individual perceives the choice as beneficial or meeting his/her needs will he/she make that choice. When Bauer and Balter (1971) asked 217 patients how long

they had been ill before their visit to the E.R., 16.1% of them stated that they were not ill at all, thus implying that no further treatment would be necessary. One wouldn't expect these patients to follow through with the referral.

Jellinek defines the idea of patient-clinician congruence as a similarity between the patient's request at the time of the E.R. visit and the patient's perception of the referring clinician's goal. His research findings indicate that patients who completed the referral demonstrated congruence significantly more than the non-completers. Jellinek (1978) used two questions in the follow-up interview to ascertain congruence; namely, "What did you have in mind when you came to the clinic," and "What did you think the doctor had in mind when he/she referred you?" (p. 210). When asked the patients if they still suffered from the original problem, 96% of the completers and 85% of the non-completers stated they were still disturbed by the problem that had brought them to the E.R. originally. He then asked the non-completers why they did not follow through with the referral. Fifteen percent of them did not agree with the disposition; 31% had changed their minds about needing treatment; 10% felt the treatment was too costly; and 34% were unable to give a reason for non-completion.

Patient-clinician relationship - Lazare, Eisenthal and Wasserman (1975) state that patients frequently have goals and expectations of treatment that differ from the therapist who treats them. Coleman and Dumas (1962) studied 24 patients who failed to keep their initial appointment with a mental health clinic. While results indicated that about half (13) of the patients did not follow through because of

adverse reactions to the referring clinician or to the proposed treatment, it is unclear what percentage did not follow through due to problems in the relationship with the referring clinician as opposed to disagreement with the proposed treatment. Those patients who were dissatisfied with the relationship stated that they disliked the therapist or his/her comments. They added that the clinician did not understand them and was not interested in their problems.

Heine and Trosman (1960), Eisenthal and Lazare (1976), and J. A. Hill (1969), all agree the patient-clinician relationship is of import in patient improvement and satisfaction with treatment. For example, Erickson (1975) found that the interest of the therapist in patients is the strongest and most consistent predictor of successful treatment. Other authors, Clemes and D'Andrea (1965), Garfield and Wolpin (1963), and Imber, Nash and Stone (1955) link the initial interview to issues in subsequent treatment, i.e.: predicting early treatment termination on the basis of discrepancies between patient and therapist expectations following the initial interview. No literature has been found on the relationship of the initial interview and referral outcome, with the exception of the Coleman and Dumas study (1962).

#### Ability Variables

Diagnosis - Diagnosis of the patient and its correlation with referral outcome is the most widely reported variable in the literature. Wilder, Plutchnik, and Conte (1977) found that older, Puerto Rican and Caucasian women with the diagnosis of depression had the highest rate of referral completion. Women with the diagnosis of neurotic depression had the highest probability of follow through, 75%. Schizophrenics

followed through 27% of the time. The lowest probability of completion was that of men diagnosed as psychotically depressed, (14%). Del Gaudio, Carpenter, and Stein agreed that neurotic patients were more likely to follow through than those with a psychoses and added that these psychotic patients would most likely contact another agency within one year, again in need of treatment.

Other authors suggest that diagnosis in conjunction with type of appointment is important when viewing referral outcome. Craig, Huffine, and Brooks examined diagnosis as it relates to confirmed versus steered appointments. While they found no difference in completion rates for psychotic patients whether or not the appointment was confirmed or steered, the completion rate was tripled for depressed patients when they received a confirmed appointment. It may be that depressed patients are particularly sensitive to appointment type because of their doubts that treatment will help. Appointment confirmation might remove some of these doubts. Patients with diagnoses of neuroses or character disturbances showed no improvement in confirmed versus steered appointments but were particularly sensitive to the waiting period. This may be due to the fact that their anxiety decreases over time and they do not then see the need for treatment. If the waiting period was greater than one week, the completion rate was one third to one half that of those patients who waited less than a week for their appointment, (1974).

In summary, it is apparent from a review of the literature that about one half of all referrals of psychiatric patients made to out-patient treatment agencies are not completed. It can be conjectured that the majority of these non-completers will continue to experience problems

and will again seek treatment, particularly if their's is a psychotic diagnosis.

The variables which affect patient choice can be divided into three groups; opportunity variables (variables surrounding the actual appointment, which make it more or less easy for the patient to follow through), motivational variables (those variables which help the patient perceive a reward if he/she performs the behavior), and ability variables (those cognitive and affective variables which enable the patient to complete the follow through tasks). These variables all affect the patient's choice to follow through with the referral. Variables such as sex, distance to the referred-to agency, type of transportation used, and type of agency are not clearly correlated with successful or unsuccessful referrals.

#### Hypothesis

It is hypothesized that there are significant differences between the opportunity, motivational and ability variables of patients who complete referrals and those who do not. More specifically, patients with a non-psychotic diagnosis, confirmed appointments within three to six days of the visit to the E.R. with a positive perception of the patient-clinician relationship and who are in agreement with the referral will be most apt to complete the referral process.

## CHAPTER II

### Methodology

#### Setting

The study was conducted at the University of Oregon Health Sciences Center Emergency Room, which is the only E.R. in the City of Portland that has personnel who can evaluate patient's psychiatric problems. All of the patients were seen by psychiatric residents in their second or third year of residency or by a nurse with a clinical specialty in psychiatric nursing. The clinician provided as much immediate assistance as possible using a broad range of treatment modalities. In this setting, approximately 340 psychiatric patients are seen in a month, about a third of whom are referred to other resources for out-patient care.

#### Subjects

The population from which the sample was drawn consisted of patients who came to the E.R. for help with a psychiatric problem, and were referred to other agencies for out-patient treatment. All patients who fit the stated criteria were asked to participate in the study. Patients over eighteen years of age, consenting to participate were included. Patients with a diagnosis of substance abuse, including alcohol, were excluded. Subjects were selected from June to September, 1979.

#### Design

This study was descriptive in nature and correlational in design. The independent variables included appointment type, length of time until appointment, whether the patient had the name of the referred-to clinician, whether or not the patient had a specific appointment time,

understanding why he/she was referred, agreement with the referral, how well their problems were understood, how well their feelings were understood, diagnosis and previous psychiatric treatment. Referral outcome, that is whether the referral was completed or not, was the dependent variable.

#### Data Collecting Instruments

The instrument used in the E.R. included such information as diagnosis, length of time until appointment, and whether the appointment was confirmed or steered. Also included was the patient's age, sex, and previous psychiatric treatment. (See Appendix A for complete instrument).

The instrument used during the follow-up interview by the researcher consisted of six items. (See Appendix B for complete questionnaire). The first item dealt with whether or not the referral was completed, and if not, why the patient did not keep the appointment. The second item asked the patient what outcome he/she expected from the visit to the E.R. The third question had to do with congruence and asked the patient what he thought the clinician had in mind when he/she referred him/her. Items 4 and 5 were used by Eisenthal and Lazare (1976) to evaluate patient-clinician understanding. The two items correlated significantly,  $r = .38, p < .01$ . Item six asked the patient if the reason he went to the E.R. was still a problem. The items contained in both instruments were chosen in order to gain information regarding the opportunity, motivational and ability variables.

#### Procedure

As stated earlier, there were two data collecting instruments, one to be used at the time of the E.R. visit, the other administered during

the follow-up interview. The first was filled out by the referring clinician during or immediately following the interview with the patient in the E.R. The researcher checked on this procedure each morning, examining the E.R. records in order to identify any missed subjects. If subjects were omitted, the researcher contacted the appropriate clinician to obtain the relevant information. The researcher instructed the interviewing clinicians in filling out the initial questionnaire.

Included with the initial patient questionnaire was an informed consent form. Patients were given assurances that anonymity would be preserved and that failure to participate would not jeopardize their treatment at the University of Oregon Health Sciences Center.

Three to four weeks after the E.R. visit, each patient was contacted via phone and asked the six items on the second instrument.

#### Analysis of Data

This study compared the characteristics of patients who did and did not complete the referral process. Percentages were used to compute the frequencies of the variables. Chi-square was utilized to determine the significant differences between the variables, and between the completers and non-completers.

## CHAPTER III

### Results

In this section, the subject population is described first and then opportunity structure variables, motivational variables, and ability variables are related to follow through with the initial appointment. In addition, there will be a section on subjects' comments obtained during the follow-up interview.

#### Study Population

During the period of data collection, 46 individuals evaluated in the E.R. were referred to the study. Of these, one was deleted because of a primary diagnosis of mental retardation, and one was omitted because of an overlying Organic Brain Syndrome. An additional subject was omitted because he was underage. Twelve of the remaining subjects were unavailable for follow-up interviews. Six had moved and six were without phones and did not respond to the follow-up letter requesting an appointment time. Actual follow-up interviews were obtained on 31 subjects.

#### Opportunity Structure Data

Of the four opportunity structure variables -- type of appointment, number of days until appointment, whether or not the subject had the name of the referred-to therapist, and whether the subject had a specific appointment time -- only specific appointment time significantly affected follow through.

Only four subjects received confirmed appointments in the E.R., 75% of whom then kept the appointment (Table 1). The bulk of appointment types were patients calling the referred-to agency in order to receive an appointment (n = 20 of 31 subjects). A total of 25 of the 31

Table 1  
Comparison of Type of Appointment With Follow Through

Type of Appointment	Count Percent	(n) (%)	Follow Through		Row Total
			Yes	No	
Made in E.R.	3	9.7	1	3.2	4 12.9
Patient to call	7	22.6	13	41.9	20 64.5
Patient to confirm	2	6.5	3	9.7	5 16.1
Existing	2	6.5	0	0.0	2 6.5
Total	14	45.2	17	54.8	31 100.0

$$\chi^2 = 4.75420$$

Significance = 0.1907

subjects then were required to make a phone call to set up or to confirm appointments -- in order to begin the referral process. Only nine (29%) of these subjects then kept the appointment.

Unlike the results reported by Raynes and Warren (1971), the number of days until the appointment did not predict follow through, (Table 2). Of the 31 subjects, only nine subjects knew when their appointment would be when they left the E.R., 66% of whom then kept their appointments.

Having the name of the specific therapist the patient was to see in the first appointment also was not a predictor of referral completion (Table 3). Only nine of the subjects had the name of their contact at the referred-to agency, 56% of whom then kept their appointments.

The only significant variable within the opportunity structure was having a specific appointment time for the first appointment (Table 4). Specific appointment time included appointments made in the E.R. and existing appointments with the referred-to agency. Having a specific appointment time resulted in more follow throughs.

It seems from these data that few patients were given the opportunities presumed to increase follow through -- i.e., confirmed appointments in the E.R., with a short wait, and with specific names of referred-to clinicians. Of those that did have these opportunities, the majority followed through, although some of these results are not statistically significant. It was found, however, that having a specific appointment time improved follow through.

#### Motivational Variables

Of the five motivational variables, three were found to significantly effect follow through, one appeared to affect follow through but was not

Table 2

Number of Days Until Appointment as Compared to Follow Through

Days Until Appointment	Count (n) Percent (%)	Follow Through		Row Total
		Yes	No	
Unknown	8 25.8	14 45.2		22 71.0
1-3	2 6.5	1 3.2		3 9.7
4-6	1 3.2	0 0.0		1 3.2
7-9	2 6.5	2 6.5		4 12.9
9 +	1 3.2	0 0.0		1 3.2
Total		14 45.2	17 54.8	31 100.0

$$\chi^2 = 3.71416$$

Significance = 0.4461

Table 3

Comparison of Having Name of Therapist to Follow Through

	Count (n) Percent (%)	Follow Through		Row Total
		Yes	No	
Name of Therapist				
Yes	5 16.1	4 12.9	9 29.0	
No	9 29.0	13 41.9	22 71.0	
Total		14 45.2	17 54.8	31 100.0

$$\chi^2 = 0.5532$$

Significance = 0.4570

Table 4

Comparison of Specific Appointment Time to Follow Through

	Count (n) Percent (%)	Follow Through		Row Total
		Yes	No	
Specific Appointment				
Yes	5 16.1	1 3.2	6 19.4	
No	9 29.0	16 51.6	25 80.6	
Total	14 45.2	17 54.8	31 100.0	

$$\chi^2 = 4.3773$$

Significance = 0.0364

significant, and one variable had no affect on outcome.

The comparison of whether or not the subject knew why he was referred to the referral outcome was significant at the .05 level (Table 5). Of the 31 people studied, 21 could not state why they had been referred for out-patient treatment. Fourteen (67%) of these subjects did not follow through with the referral, and 70% of the subjects who knew why, did follow through.

Agreement with the referral was highly correlated ( $p = .002$ ) with whether or not the subject followed through with the first appointment (Table 6). All eight of the subjects who disagreed with the referral did not complete the referral process.

Patient-clinician relationship was divided into two categories; how well the patient felt his problems were understood, and secondly, how well he/she felt his/her feelings were understood. How well the subject felt his problems were understood was not related to follow through (Table 7). Over half of the subjects reporting their problems were understood "well" or "very well" did not follow through with the first appointment. On the other hand, the subjects' report of the E.R. clinician's understanding of their feelings was significant at the .02 level (Table 8). Of the fourteen subjects who completed the referral, all who felt they were understood very well ( $n = 4$ ), followed through with the referral.

Whether or not the subject had previous contact with the referred-to agency appeared to affect follow through (Table 9) but was not significant ( $p = .12$ ).

Table 5

Comparison of Patient Knowing Why He Was Referred to Follow Through

	Count (n) Percent (%)	Follow Through		Row Total
		Yes	No	
Know Why Referred				
Yes	7 22.6	3 9.7	10 32.2	
No	7 22.6	14 45.2	21 67.7	
Total	14 45.2	17 54.8	31 100.0	

$$\chi^2 = 3.67745$$

Significance = 0.0552

Table 6

Comparison of Agreement with Referral to Follow Through

	Count (n) Percent (%)	Follow Through		Row Total
		Yes	No	
Agreement with Referral				
Yes	14 45.2	9 29.0	23 74.2	
No	0 0.0	8 25.8	8 25.8	
Total	14 45.2	17 54.8	31 100.0	

$$\chi^2 = 8.87979$$

Significance = 0.0029

Table 7

Comparison of Clinician's Understanding of Problem to Follow Through

Clinician's Understanding	Count (n) Percent (%)	Follow Through		Row Total
		Yes	No	
A Little	1 3.2	2 6.5	3 9.7	
Somewhat	7 22.6	8 25.8	15 48.4	
Well	3 9.7	5 16.1	8 25.8	
Very Well	3 9.7	2 6.5	5 16.1	
Total	14 45.2	17 54.8	31 100.0	

$$\chi^2 = 0.81733$$

Significance = 0.8453

Table 8

Comparison of Clinician's Understanding of Feelings to Follow Through

	Count (n) Percent (%)	Follow Through		Row Total
		Yes	No	
Clinician's Understanding of Feelings				
Not at all	1 3.2	0 0.0	1 3.2	
A little	1 3.2	5 16.1	6 19.4	
Somewhat	3 9.7	9 29.0	12 38.7	
Well	5 16.1	3 9.7	8 25.8	
Very well	4 12.9	0 0.0	4 12.9	
Total		14 45.2	17 54.8	31 100.0

$$\chi^2 = 10.9791$$

Significance = 0.0268

Table 9

Comparison of Previous Contact with Agency to Follow Through

	Count (n) Percent (%)	Follow Through		Row Total
		Yes	No	
Previous Contact				
Yes	6 19.4	3 9.7	9 29.0	
No	8 25.8	14 45.2	22 71.0	
Total	14 45.2	17 54.8	31 100.0	

$$\chi^2 = 2.36822$$

Significance = 0.1238

It seems that if the subject understands why the referral is given, agrees with it, and knows the clinician understand his/her feelings, follow through is more likely.

#### Ability Variables

The ability variables are diagnosis and history of psychiatric treatment. History of treatment included whether or not the subject had received any psychiatric treatment in the past, more specifically, history of in-patient treatment, number of hospitalizations, history of out-patient treatment, and history of court commitment to psychiatric treatment.

Diagnosis came close to predicting follow through (Table 10). The largest number of subjects received a diagnosis of neuroses ( $n = 17$ ), thirteen were diagnosed as depressed and only seven as psychotic. Those diagnosed as neurotic were the most apt to follow through (69%), psychotics (29%), and those who were diagnosed as depressed were the least likely to follow through (27%). It may be that depressed patients are without the emotional ability, and psychotics, without the cognitive ability to follow through.

As can be seen in Table 11, previous psychiatric treatment was related with follow through at the .0004 level. Only one out of thirteen subjects who had never had psychiatric treatment completed the referral. Five of the eighteen subjects with a history of psychiatric treatment did not follow through with the referral. Perhaps experience motivated them to seek relief or taught them how to seek it.

This category was further defined into three areas; history of in-patient treatment (Table 12), history of out-patient treatment (Table 13),

Table 10  
Comparison of Diagnosis to Follow Through

Diagnosis	Count (n) Percent (%)	Follow Through		Row Total
		Yes	No	
Psychosis	2 6.5	5 16.1	7 22.6	
Neurosis	9 29.0	4 12.9	13 41.9	
Depression	3 9.7	8 25.8	11 35.5	
Total		14 45.2	17 54.8	31 100.0

$$\chi^2 = 5.2402$$

Significance = 0.0728

Table 11

Comparison of a History of Previous Treatment to Follow Through

	Count (n) Percent (%)	Follow Through		Row Total
		Yes	No	
Previous Treatment				
No		1 3.2	12 38.7	13 41.9
Yes		13 41.9	5 16.1	18 58.1
Total		14 45.2	17 54.8	31 100.0

$$\chi^2 = 12.6917$$

Significance = 0.0004

Table 12

Comparison of a History of In-Patient Treatment to Follow Through

	Count (n) Percent (%)	Follow Through		Row Total
		Yes	No	
In-Patient Treatment				
Yes	12 38.7	3 9.7	15 48.4	
No	2 6.5	14 45.2	16 51.6	
Total	14 45.2	17 54.8	31 100.0	

$$\chi^2 = 14.243$$

Significance = 0.0002

Table 13

Comparison of a History of Out-Patient Treatment to Follow Through

	Count (n) Percent (%)	Follow Through		Row Total
		Yes	No	
Out-Patient Treatment				
Yes	10 32.3	4 12.9	14 45.2	
No	4 12.9	13 41.9	17 54.8	
Total	14 45.2	17 54.8	31 100.0	

$$\chi^2 = 7.1124$$

Significance = 0.0077

and history of court commitment (Table 14). All of these were statistically significant; court committed treatment being the least so at  $p = .04$ . A history of in-patient treatment was highly significant at the  $p = .0002$  level. In-patient treatment reflects familiarity with and dependency upon the treatment system; court commitment may be associated with resistance.

It seems that subjects with severe emotional (depression) or cognitive (psychosis) impairments were less likely to follow through. Further, those subjects who had previous, intensive (but not compulsory) treatment were more likely to follow through.

#### Subjects' Comments

During the follow-up interview, 26 of the 31 subjects stated they were still having the same problems that took them to the E.R. in the first place. Complaints about the E.R. service were infrequent. Two patients complained they had to wait too long and two complained of the bill they received, expressing surprise that it was so large. Three other patients felt the interviewing clinician was "unfeeling" and just interested in getting the interview over with. The majority stated that they received help from the E.R. visit.

Overall, most patients expressed interest in the follow-up interview and remembered when contacted, the purpose of the interview. About a third of the subjects did express some suspiciousness when asked to participate in the study. When assured that their name and situation would be kept confidential and not appear in print, they agreed to participate.

Table 14

Comparison of a History of Court Commitment to Follow Through

	Count (n) Percent (%)	Follow Through		Row Total
		Yes	No	
Court Committed				
Yes	3 9.7	0 0.0	3 9.7	
No	11 35.5	17 54.8	28 90.3	
Total	14 45.2	17 54.8	31 100.0	

$$\chi^2 = 4.03316$$

Significance = 0.0446

## CHAPTER IV

### Discussion

In this chapter, the results will be discussed according to the three main categories of variables; opportunity structure variables, motivation variables, and ability variables.

#### Opportunity Structure

The literature supports the superiority of the confirmed appointment, particularly for those patients who are depressed. It is interesting to note that only five of the 31 patients received confirmed appointments while in the E.R. The others had to call and make an appointment, call and confirm an appointment or to choose between two or three out-patient facilities from which to receive treatment and then call to schedule an appointment. The low number receiving confirmed appointments is, in part, due to the fact that some of the subjects were seen in the E.R. after 5:00 P.M. when most out-patient facilities were closed; thus making it impossible to confirm an appointment. Secondly, the psychiatric residents who often saw the patients had been heavily involved in in-patient settings for the most part and had little exposure to referral resources within the community. Thirdly, some of the out-patient settings were not accepting new clients and placed all intakes on a waiting list, making it impossible for them to receive confirmed appointments. If more subjects had received confirmed appointments, this variable might have related significantly with follow through.

The same principle may be operating in the variable of number of days until the appointment. Only four subjects were seen in six days or less, the majority having unconfirmed appointments and therefore an

unknown number of days until the appointment. It seems that the restricted opportunities for treatment in the community limit the success of referral from the E.R. and may thereby ensure that patients come back again and again to the E.R.

Having a specific appointment time was the only variable in this category which significantly affected follow through. Those patients with confirmed or existing appointments all had a specific appointment time and were most likely to keep the appointment. This may be due to the fact that once an appointment is set up and arranged with both the patient and the referred-to facility, the patient feels an obligation to keep the appointment. In fact it assumes that the patient has chosen to be treated. In having the appointment time specific, the opportunity structure is concretized, thus allowing a more definite opportunity for follow through, assuming motivation and ability exist.

Having the name of the referred-to therapist also concretizes the opportunity structure but does not imply that the patient has chosen or committed himself to seeing this therapist. This may explain why this variable did not affect follow through significantly.

#### Motivation Variables

It is interesting to note that only ten of the 31 subjects knew why they were referred for further treatment. These ten, then were more apt to follow through with the referral. Those who did not understand why they were referred, were very likely not to follow through. Understanding why one is referred, may be seen as a precondition to the operation of the other variables which positively influence follow through. In other words, understanding why a certain choice is desirable is a

precursor to making that choice.

Closely related with this variable is that of congruence or agreement with the referral. Those who disagreed with the referral did not complete their appointment, regardless of what opportunity or ability variables were present. This finding agrees with Jellinek's (1978) and emphasizes the importance of a mutual understanding of the patient's needs and choices between the E.R. clinician and the patient. It seems very unlikely a patient will complete a referral, regardless of how much ability he/she possesses or how good the opportunity structure, if he/she does not perceive the result of following through as something he/she needs or wants.

Patient-clinician relationship was evaluated using two questions; How well the clinician understood the patient's problems and how well the clinician understood the patient's feelings. Eisenthal and Lazare (1976) found in their study that clinician understanding correlated with a positive evaluation of the E.R. interview by the patient. This researcher expected that clinician understanding would increase motivation to follow through with the referral. Yet, those patients reporting that their problems were understood "well" or "very well" were just as likely not to complete the referral process as to complete it. In contrast, all of the patients who felt that their feelings were understood very well, completed the referral. Izard (1960) and Newcombe (1956) see acceptance and understanding of feelings as significant motivators of individual behavior. So, if the patient thinks his/her feelings are understood and feels an alliance with the therapist, he/she will be more likely to agree with the therapist's assessment that he/she needs further treatment.

The final variable in the motivation category, was whether or not the patient had previous contact with the referred-to agency. Presumably, those patients with previous contact with the agency would be more apt to follow through because they were familiar with the choice they were making. The findings in this area, however, were not significant, although those with previous contact did tend to follow through more (66%), compared with those without previous contact (36%).

#### Ability Variables

The last category of variables are abilities; these include diagnosis and treatment history.

Diagnosis did not significantly affect outcome, but did tend towards significance. Considering the fact that very few patients received confirmed appointments, the tendency is of interest. Those patients with the diagnosis of neurosis would be expected to be the most likely to follow through because their emotional and cognitive abilities are relatively good. The results here, agree with Craig, Huffine and Brooks in this aspect.

The researcher suspects that this variable had poor inter-rater reliability. There were six clinicians assigning diagnoses to the patients, two psychiatric nurses and four residents in psychiatry. It is known that different clinicians use different criteria in the diagnosing of patients and it is very probable that this would reduce the power of diagnosis to predict follow through. Furthermore, it is not entirely clear how diagnosis reflects impairment of abilities which are required to follow through. A patient with a long history of psychosis may in fact be more able to complete a referral than someone who is

severely depressed and virtually immobilized by their depression.

Along similar lines, a history of previous treatment, here used as a measure of chronicity, was not expected to correlate positively with follow through. It was assumed that the more chronic a patient was (the greater the number of hospitalizations or contacts with psychiatric treatment), the less apt he/she would be to follow through with the referral, and in fact the less ability he/she had to follow through. Despite expectations, it was found that those with previous histories were much more likely to complete the referral. It would seem then, that chronicity is not a measure of lack of ability, rather that the chronic patient has more ability to follow through. Several things may contribute to this result. First, patients with an extended psychiatric history may have learned the importance of out-patient follow through in the prevention of hospitalization. Second, these patients may well be socialized into the care system. That is, they are familiar with out-patient treatment and the community mental health system and as such have increased motivation to follow through due to familiarity with the system. The choice to follow through does not include as much risk-taking as it does for the patient who has no history of psychiatric treatment. The more chronic patient knows that the choice to follow through will meet some of his/her needs, because it has in the past.

## CHAPTER V

### Summary, Conclusions, Recommendations

#### Summary

Forty-six patients who were evaluated in the E.R. and referred for out-patient treatment were referred to the study. Of these 46, 31 participated in follow up interviews, the others were deleted for various reasons or were unreachable by phone or mail. Patients' responses to the follow up questionnaire items were examined in order to determine the influence of various opportunity, motivation, and ability variables upon performance.

Results of this study, as those of Craig, Huffine and Brooks (1974) and Paykel (1974) found that about 45% of those referred for out-patient treatment followed through. Follow through seemed to be explained by specific variables using Rotter's Social Learning Theory of performance. In the opportunity category, patients were much more likely to complete the referral if they had a specific appointment time arranged, before leaving the E.R. The number of days until the appointment and having the name of the referred-to therapist did not seem to affect follow through.

The motivational variables -- agreement with the referral and understanding why the referral was made -- significantly affected outcome and agreed with Jellinek's concept of congruence. That is to say, patients will be more likely to complete the referral if they and the referring clinician reach a common understanding of what needs to be done. If this happens, the referral becomes the patient's own motive. Another

aspect of the patient-clinician relationship, that of how well the clinician understood the patient's feelings, affected outcome. This may be considered emotional support which is motivating. Interestingly, how well the clinician understood the patients' problems did not appear to influence outcome. Last, previous contact with the referred-to agency, did not affect outcome significantly.

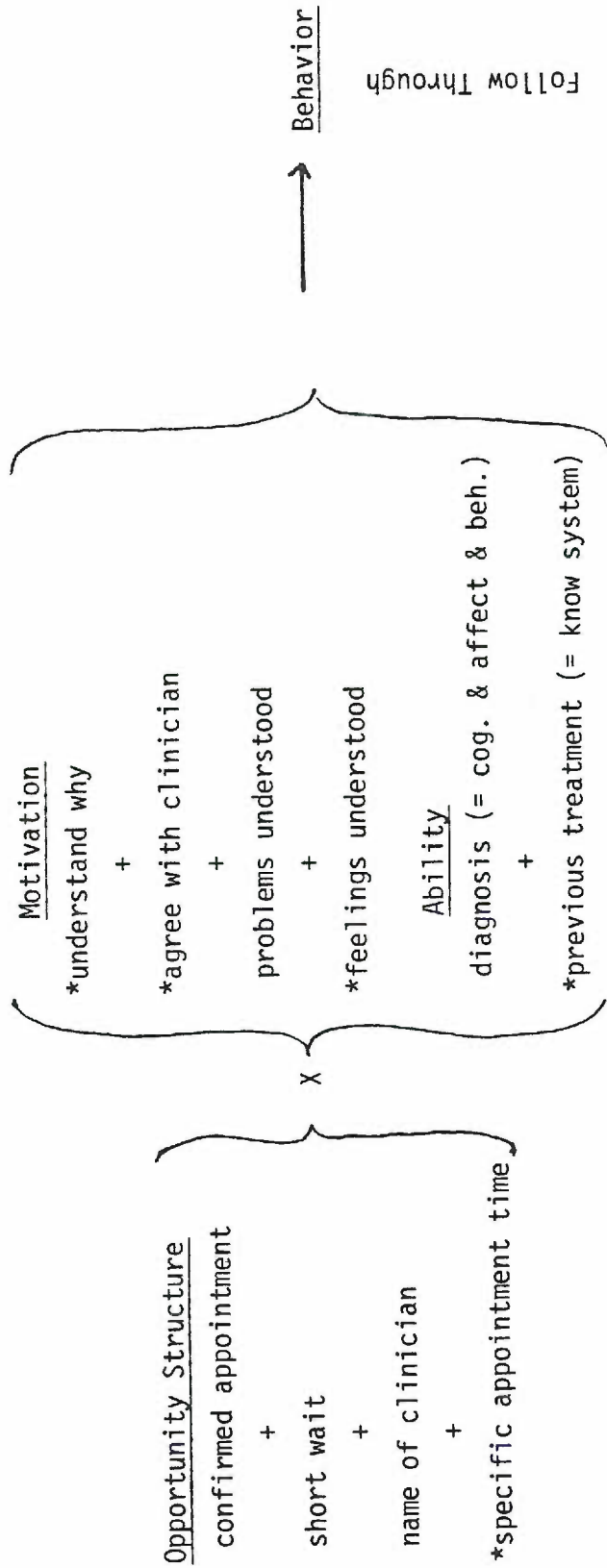
The two ability variables were those of diagnosis and treatment history. Both were thought to imply ability to follow through; the more chronic, disturbed patient being less able to complete the referral process. Diagnosis did not affect referral outcome per se as it probably was not a true measure of abilities. Chronicity or previous experience with psychiatric treatment, did positively affect outcome, suggesting that patients familiar with out-patient treatment and aware of its role in the prevention of in-patient hospitalization will be more likely to keep the first out-patient appointment. Figure 1 summarizes the results and shows the relationship between the variables.

### Conclusions

The response of patients to the follow up interview indicate that agreement with the referral and patient understanding of why the referral was made, are motivating factors as described in Rotter's conceptualization of performance. The patient must agree with the referral and understand why it is an appropriate choice before he/she is likely to follow through. In addition, a positive relationship between the referring clinician and the patient will increase the patient's motivation to complete the referral. Concretizing the opportunity which the referral presents, e.g., by giving specific appointment times, will increase the

Figure 1

Determinants of Follow Through on Referrals from the Emergency Room



\*confirmed predictions

chances of follow through. Finally, ability to follow through is necessary to compliance and is heightened by previous experience with psychiatric treatment.

There is a common desire among clinicians to help the patient and a belief that referral is critical to resolving problems which bring them to the E.R. However, the clinician's efforts must extend beyond the assignment of a diagnosis or the writing of two referral agencies on a slip of paper. The patient's expectations of both the E.R. interview and the referral must be explored, with an eye to motivating the patient sufficiently. Also, his/her ability to follow through must be assessed, independently of diagnosis and the preconceptions commonly held when viewing patients in this way.

Those patients identified as less likely to follow through, i.e. those without previous treatment history or perceived as having limited ability or motivation to complete the referral process, need special attention when receiving a referral. The referral, as an opportunity, must be very concrete. Every attempt should be made to obtain confirmed appointments, as well as a verbalization from the patient that he/she sees the need for further treatment. These high risk patients would also warrant a phone call in several days, reminding them of the outpatient referral. This method was used with some success by Koumans et al in 1967.

#### Recommendations

Despite its interesting results, were this study re-done, there would be a number of areas which could be re-designed. These include:

1. Replication of this study in the fall and winter months when it would be possible to obtain a larger sample due to the increased activity in the E.R.
2. Replication of this study using a measure of ability or level of functioning as opposed to the assignment of diagnoses.
3. Exploring with the patient whether or not previous experience with the referred-to agency was positive or negative.
4. Expanding the questions regarding clinician understanding of problems and feelings.

Treatment recommendations would include:

1. Developing a positive alliance with the patient during the E.R. interview.
2. Negotiating with the patient about what follow up treatment is necessary and why.
3. Giving confirmed appointments whenever possible.
4. If it is not possible to confirm the follow up appointment, calling the patient in several days, reminding him/her of the out-patient referral.
5. Identifying high-risk non-completers, i.e.: those with no previous psychiatric history and taking particular care with the referral process.

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APPENDIX A  
Consent Form

## OUT-PATIENT FOLLOW UP STUDY CONSENT FORM

I, \_\_\_\_\_, herewith agree to serve as a subject in the investigation named, "Investigation of Patient and System Variables as They Affect Referral Outcome" by Beverly Lauck under the supervision of Marie Berger, M.S. (thesis advisor). The investigation is aimed at evaluating emergency referral systems.

The procedures to which I will be subjected are: a phone call and home visit for data collection purposes within one month of being seen in the Emergency Room. The home visit will last about twenty minutes and includes questions regarding the factors that influenced me to complete or not complete the referral process. I may benefit from these procedures by helping health care delivery personnel evaluate the referral process. There are no expected risks involved for me.

The information obtained will be kept confidential. My name will not appear on the records and anonymity will be insured by the use of code numbers.

Beverly Lauck, R.N. has offered to answer any questions that I might have about my participation in this study. I understand I am free to refuse to participate or to withdraw from participation in the study at any time without effect on my relationship with or treatment at the University of Oregon Health Sciences Center.

It is not the policy of the Department of Health, Education and Welfare, or any other agency funding the research project in which you are participating, to compensate or provide medical treatment for human subjects in the event the research results in physical injury. The

Consent Form continued

University of Oregon Health Sciences Center, as an agency of the state, is covered by the State Liability Fund. If you suffer any injury from the research, compensation would be available to you only if you establish that the injury occurred through the fault of the Center, or employees.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Subject's Signature

\_\_\_\_\_  
Witness's Signature

APPENDIX B  
Out-Patient Follow Up Study

OUT-PATIENT FOLLOW UP STUDY  
(For all non-admitted patients)

Patient Name \_\_\_\_\_ # \_\_\_\_\_ Date \_\_\_\_\_

How can patient be reached? \_\_\_\_\_ Phone \_\_\_\_\_

Age \_\_\_\_\_ Sex \_\_\_\_\_ E.R. Clinician \_\_\_\_\_

Referred to: \_\_\_\_\_

Why referred? \_\_\_\_\_

Diagnosis (Circle One)

Psychosis  
Neurosis  
Depression

How was appointment obtained? (Circle One)

Appt. made in E.R.  
Pt. to call & make appt.  
Pt. to call & confirm appt.  
Has existing appt.

Number of days until appointment? (Circle One)

Unknown  
1-3  
4-6  
7-9  
More than 9

Does patient have specific time of appointment?

Yes  
No

Does patient have the name of his therapist?

Yes  
No

Has patient had previous contact with referred-  
to agency?

Yes  
No

Previous psychiatric treatment?  
(Circle as many as applicable)

None  
Court Committed  
In-patient  
Out-patient

Number of psychiatric hospitalizations? \_\_\_\_\_

Total length of time in treatment.

None  
6 months to 1 year  
1-3 years  
3-6 years  
More than 6 years

Any risks involved in clinician making home visit to patient \_\_\_\_\_

Comments:

APPENDIX C  
Follow Up Questionnaire

## FOLLOW UP QUESTIONNAIRE

1. Did you visit the clinic to which you were referred? Had you been there before? (If the patient did not complete the referral, the interviewer will ask why not.)
2. What did you have in mind when you went to the emergency room?
3. What do you think the doctor/nurse had in mind when he/she referred you?
4. To what extent do you think the clinician understood your problems? (5-point response format: Very well to not at all.)
5. To what extent do you think the clinician understood your feelings? (5-point response format: Very well to not at all.)
6. Is the reason you went to the emergency room still a problem for you?

AN ABSTRACT OF THE THESIS OF

BEVERLY WOLF LAUCK

For the MASTER OF NURSING

Date of Receiving this Degree: June, 1980

Title: SOME MOTIVATIONAL, ABILITY, AND OPPORTUNITY DETERMINANTS OF  
REFERRAL FOLLOW THROUGH

Approved:

  
Marie G. Berger, M.S., Thesis Advisor

One of the problems confronting any mental health agency or professional is how to refer patients more successfully. Referral outcome was viewed as a behavioral choice the referred individual makes, based on the opportunity presented, motivation, and ability he/she has. Opportunities were defined as variables regarding the first appointment. Motivational variables were agreement with the referral, understanding why the referral was made, and previous contact with the referral agency. Ability variables were diagnosis and history of previous treatment.

The University of Oregon Health Sciences Center Emergency Room was used as the setting of the study. All patients who were over 18 and not admitted to an in-patient service were asked to participate. Demographic data and consent were gained at the time of the E.R. interview. A follow up phone call to the patient was used to get the

information on referral completion.

Thirty-one subjects participated in the study, 14 of whom followed through with their first appointment. The only opportunity variable of significance was that of having a specific appointment time. Those patients that understood why they were referred, agreed with the referral and felt their feelings were understood by the E.R. clinician were more motivated to follow through with the referral. The ability variable of diagnosis did not correlate with follow through, although a history of previous psychiatric treatment strongly indicated the patient would follow through.