PSYCHOSOCIAL PROBLEMS

The development of a district community psychology service

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SUMMARY. A survey was carried out to assess the difficulties encountered by general practitioners within a health district in the management of patients with emotional problems, and their attitudes to the involvement of clinical psychologists in primary health care.

Based on the response to this survey a district community psychology service has been established. This is an adjunct to hospital-based services and attempts to overcome some of the shortcomings of traditional psychotherapeutic services.

Introduction

THE increase in psychosocial stress, and a shift in emphasis in health care policy towards the treatment of patients with emotional disorders in the community, have contributed to an increase in the general practitioner's burden of care. There are, however, wide variations between practices in the recognized incidence of emotional disorder, estimates ranging from 14 per cent (Shepherd *et al.*, 1966) to 32 per cent (Johnson and Goldberg, 1976). Whilst most of those with severe psychiatric disorders (e.g. psychotic, suicidal, or severely depressed patients) are referred to psychiatric services (Robertson, 1979), the majority of those with less severe emotional disorders (i.e. neurotic patients) are treated by the general practitioners themselves (Brook, 1978). Two of the main reasons given for the low referral rate of the latter group of patients are delay in obtaining an initial appointment (Shepherd *et al.*, 1966; Robertson, 1979) and the patient's reluctance to be stigmatized as 'psychiatric'. It could also be said that specialized outpatient psychotherapeutic services have limited facilities, and far too often are influenced by various theoretical biases, so that they are able to cater for only a very narrow band of the population in need of help.

An important development which has helped to bridge the gap in services for patients with less severe emotional disorders is the involvement of various non-medical professionals such as nurses, social workers, psychologists and marriage guidance counsellors in the primary care setting. Indeed, published reports (Forman and Fairbairn, 1968; McAllister and Philip, 1975) have demonstrated that such involvements can make a positive contribution and improve the overall standard of care. However, in most cases, these involvements have been limited to attachments to one or two practices within a given health district which, despite the known advantages, can have only a limited impact on the district as a whole.

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Aim

In an attempt to develop a comprehensive and equitable plan for a district community psychology service, a survey was carried out to assess the problems related to the management of emotionally disturbed patients and the general practitioners' interest in a direct service from clinical psychologists. This paper presents a brief summary of the survey results and an outline of the organization of a service to all interested general practitioners within a health district.

Survey

Following discussions with the local medical committee, a postal survey was initiated in June 1979 of all 85 general practices in the West Roding District of the Redbridge and Waltham Forest Area Health Authority, in the North-East Thames Metropolitan Region. Each practice was sent a questionnaire and an outline of the possible contribution clinical psychologists might make to primary health care.

Results

The results are based on all questionnaires completed and returned by 30 August 1979. Fifty-six per cent of practices, comprising 67 per cent of the general practitioners in the district, with about 200,000 registered patients, returned the questionnaire.

The important findings have been abstracted from the survey report (Wijesinghe, 1979) and are given below:

1. Overall, the management of patients with emotional problems, as estimated by the general practitioners, is very largely in their own hands. In 60 per cent of the practices, 90 per cent or more of such patients are managed by the general practitioners themselves. In only two per cent of the practices is the same proportion of patients referred to psychiatrists for treatment. As far as the management of these patients is concerned, the specialized psychiatric services appear to be used only slightly more than other agencies (e.g. social services).

2. General practitioners from only five (10·4 per cent) of the 48 practices responding to the survey were satisfied with existing services for the management of patients with emotional problems. Delay in obtaining an initial outpatient psychiatric consultation and the lack of help during crises were the most common causes of dissatisfaction. The next group of factors which appear to cause dissatisfaction relates to the type and quality of services available, where the problem arises of specific client groups such as the elderly, ethnic minorities and alcoholics not being catered for through the outpatient services.

3. The general practitioners from 46 (95·7 per cent) of the practices responding to the survey indicated a positive interest in a direct service from clinical psychologists. In just over half of these cases the general practitioners showed a preference for the psychologist to provide a service on their own premises. The remainder were prepared to refer patients to premises in the community such as a health centre.

Taking note of the survey results a community psychology service was planned and established as an adjunct to already existing hospital services. The essential features of this service are outlined below.

A district community psychology service

Aims

The service was organized for the assessment and treatment in the community of patients with less severe emotional disorders (i.e. neurotic patients). The specific aims of the service were as follows:

1. To provide an easily accessible service, free from long delays for assessment and treatment.

2. To help general practitioners in crisis intervention and preventive work.

3. To help client groups that have not been catered for by the psychotherapeutic services.

Framework

The service was offered to all interested general practitioners in the district, 84 in all, from 46 practices, with a total registered patient population of 203,504. For the purpose of providing the service the district was divided into five geographically defined sectors. These service sectors carried loads which ranged from six to 14 practices, with 17 to 23 general practitioners, and registered patient populations of 36,640 to 50,600.

The service for each sector is based at two or three community centres, which are either health centres or general practitioners' surgeries that are easily accessible to patients in that part of the district.

A trained clinical psychologist is responsible for co-ordinating the service within each sector. This includes assessing and accepting patients for psychological treatment, supervising trainees and volunteers working in that sector, providing feedback to general practitioners on all patients referred, and helping general practitioners in crisis work and with patients that the general practitioners themselves are seeing.

All referrals are accepted for treatment on the understanding that the patient's general practitioner takes medical responsibility. The clinical or professional responsibility for the patient's treatment is taken by the psychologist. The level of responsibility taken by service staff is commensurate with their training and experience.

A broadly eclectic, patient-orientated service is offered, which attempts to cover both remedial and preventive aspects of psychological health care. Based on the initial assessment, an attempt is made to differentiate between those patients who may require short- to medium-term help, and those in need of more long-term help. Short- to medium-term work includes crisis intervention, support and reassurance, psychotherapy and behaviour therapy for focalized problems, and marital, sex and family therapy on the basis of time-limited contracts.

The long-term community work includes groups for agoraphobics run on combined behavioural and insight-orientated lines, psychotherapy groups for adolescents and young adults, and support groups for elderly patients and those with middle life adjustment problems.

Conclusions

The survey results have highlighted some of the major deficiencies in the traditional organization of services for patients with less severe emotional disorders. This is particularly compelling when one takes into account the fact that the district has a psychotherapy service which caters for nearly 300 outpatients on a weekly basis—one of the largest outpatient treatment facilities in the region. The service outlined above has attempted to overcome some of the constraints traditionally associated with psychotherapeutic services. The optimum use of available manpower resources and the organization of the service in terms of small geographically defined sectors has had the following advantages:

1. It has increased the number of access channels for treatment, thus reducing waiting time.

2. It has organized services with respect to particular local needs.

3. Patients are drawn from a number of general practices, so that group treatment is made possible for a variety of client problems.

4. Increased liaison between general practitioners and those responsible for assessment and treatment has taken place.

5. The service is more accessible to patients and free from the psychiatric stigma.

In the short space of six months over 250 new patients have been seen through this service, and it has been extremely well received by both general practitioners and patients. It nevertheless requires careful monitoring, and current research is directed at evaluating several aspects of the service.

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Fractures and postmenopausal oestrogen

Three hundred and twenty-seven women aged 50 to 74 who had had a fracture of the hip or lower forearm were compared with 567 of a random sample of women of similar age. The risk of fracture was 50 to 60 per cent lower in women taking oestrogen preparations for six years or more, but not in those taking them for shorter periods. The decreased risk was clearly evident only in those still taking oestrogens, but both common doses (0.625 and 1.25 mg) seemed to be protective. Although there were epidemiological limitations to the study, the authors argue that these do not invalidate their results, which are the same as a previous similar study.

Source: Weiss, N. S., Ure, C. L., *et al.* (1980). Decreased risk of fractures of the hip and lower forearm with postmenopausal use of oestrogen. *New England Journal of Medicine,* **303**, 1195-1198.

Prescriptions

Dr Vaughan, in reply to a question in the House of Commons, stated that the total number of prescriptions dispensed by chemists and appliance contractors in the United Kingdom in each year since 1970 is as shown in Table 1.

Dr Vaughan explained that a doctor's terms of service require him to prescribe whatever he considers is appropriate for the proper treatment of his patient, and it would be wrong to seek to impose formal restrictions on the quantity of drugs a doctor may prescribe. However, to promote the interests of both economy and safety in the prescribing of drugs, the Department does, with the support of the British Medical Association, encourage doctors to restrict the amount they prescribe on any one occasion to no more than is considered reasonable, having regard to all the circumstances of the patient concerned.

The total number of prescription items dispensed in England in 1979 was 304·6 million (Table 2).

Table 1. Total number of prescriptions dispensed in the United Kingdom, 1970 to 1979.

Year	Number of prescriptions (thousands)
1970	305,995
1971	304,537
1972	315,448
1973	324,557
1974	337,226
1975	346,077
1976	360,476
1977	363,493
1978	378,088
1979	375,072

Table 2. Total number of prescriptions dispensed in England in 1979.

	Percentage	Millions
Dispensed free of charge within the exempted categories	*60.89*	185.5
Dispensed free of charge to holders of 'season tickets'	*3.41*	10.4
Prescription charge paid	*35.70*	108.7

Source: *Family Practitioner Services* (1980). Prescriptions. In Parliament. 7, 134.