

# Does providing more accessible primary care psychology services lower the clinical threshold for referrals?

PHILIP TATA

ANDREW EAGLE

JOHN GREEN

## SUMMARY

**Background.** The growing number of specialist services being provided within primary care has led to the argument that this will reduce the clinical threshold for referrals to these clinics.

**Aim.** The possibility that increasing the accessibility of primary care psychology services will reduce the threshold for referral was examined by comparing levels of psychological disturbance among patients seen by practice-based clinical psychologists with those attending outpatient clinics.

**Method.** Psychological symptoms, distress, disruption in daily life and satisfaction with life were assessed using a questionnaire-based methodology. A consecutive series of 177 patients, assessed in a local general practice or an outpatient department across a wide range of urban locations, was studied over a fixed period.

**Results.** The study revealed equivalent levels of psychopathology within both specialist and primary care clinics. Of the overall sample, 79% were likely to merit a formal psychiatric diagnosis, relating primarily to mood disorder. Levels of subjective distress and life satisfaction were also equivalent at both service locations.

**Conclusion.** The lack of evidence for a reduction in clinical threshold for referral within the primary care sample suggests that general practitioners' referral rates are similar regardless of whether practice-based clinical psychology services are available. This has implications for primary-care-led commissioning of mental health services.

**Keywords:** primary care; mental health; severity; neuroses.

## Introduction

ONE of the commonly cited advantages of a primary care-based psychology service is its accessibility and user-friendliness. General practitioners value the ease of the referral process and the potential for informal contact and discussion with the psychologist about their patients. Patients feel comfortable attending sessions at a familiar local venue, which avoids the potential stigma of attending a mental health unit or a hospital-based service. This service operates as a direct-access 'low-threshold' service, easily used by doctor and patient alike. It is consistent with current health care philosophy of devolving services within a primary-care-led National Health Service (NHS) which is sensitive to the needs of the local population.<sup>1</sup>

However, one of the concerns of potential purchasers such as

health commissioning agencies and the public health departments that advise them is that such a service runs the risk of encouraging general practitioners to refer 'subclinical cases' or the 'worried well', who would recover spontaneously without specialist assistance or whose problems are so minor that no specialist treatment would otherwise be offered. Thus, 'referral drift' could occur as general practitioners refer increasingly less severe cases. Alternatively, the inconvenience and effort of referring to a specialist hospital service may result in more careful consideration of patients' psychological problems and more select referring of cases. Furthermore, self-selection by severity may occur, only the more emotionally distressed and severely suffering patients being inclined to overcome the inconvenience and potential stigma of attending a mental health unit.

In a resource-limited NHS, purchasers and providers of mental health services are understandably concerned with patterns of referral. Recent studies have shown variation in the patients seen by different professionals. Burton *et al* discovered that counsellors in general practice saw patients with characteristics very different from those of patients seen by clinical psychologists, who may be better placed to offer treatment for more disturbed patients with more complicated, long-standing problems.<sup>2</sup> Similarly, Sibbald and colleagues found that general practitioners were more likely to refer patients with more serious emotional problems to clinical psychologists than to counsellors.<sup>3</sup> It has also been shown that general practitioners differ in the ways they refer patients to specialist centres and in their preference of discipline or institution chosen.<sup>4</sup>

The main aim of the present study was to investigate whether patients referred to clinical psychologists working in hospital outpatient departments differ from those referred to clinical psychologists based in general practices. A secondary aim was to establish the levels of severity of psychological disturbance in patients referred, using questionnaires to estimate the prevalence of 'psychiatric caseness' in the two service locations.

## Method

The study took the form of prospective recruitment, over a period of 8 weeks, of patients presenting to a range of primary care and adult outpatient clinical psychology clinics across four London boroughs. The practices referring to outpatient departments were not apparently different from those with a practice-based psychologist in terms of numbers of partners, list size or broad socioeconomic factors. However, those practices with a practice-based service were not randomly chosen since, prior to the study starting, they had indicated specifically an interest in an attached psychologist and subsequently accepted an offer of a particular individual. No attempt was made to balance numbers of patients seen in general practice or outpatient departments, although numbers were broadly similar. Only those patients who actually attended for their first appointment were included in the study, 10–30% of referred patients failing to attend (it was not possible to assess accurately the rates of patients who did not attend but there was no evidence that the two locations differed significantly). The general practitioners involved were aware that

P Tata, BA, MPhil, CCLin Psychol; A Eagle, BA, MSc, CCLin Psychol; and J Green, BSc, MSc, PhD, Departments of Psychology, St Mary's and St Charles' Hospitals, London.

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their patients were completing questionnaires for audit purposes, but were blind to the exact nature of the instruments and the comparison between the two service locations.

The assessing psychologist asked patients to complete a battery of questionnaires at the start of the first consultation, before the formal clinical interview, and remained present to help with any queries. The psychologist also provided a written explanation of the purpose of the study, and reassured patients that their treatment would not be affected by their decision to participate. The following questionnaires were used.

#### *Patient information sheet and clinical ratings*

This questionnaire included items regarding sociodemographic factors. A general set of questions and ratings about the problems for which patients were seeking treatment, and the levels of associated distress and disruption of daily living they encountered, was also included. Levels of distress and disruption were scored on a scale of 0 ('not at all') to 3 ('very much so'). Self-reports were also obtained of treatment motivation using this scale, as were subjective estimates of rates of consultation with the general practitioner in the past year.

#### *The Hospital Anxiety and Depression Scale (HADS)*

This 14-item questionnaire is designed to detect anxiety and depression in outpatient populations.<sup>5</sup> It is also intended to measure the severity of emotional disorder. Scores for each sub-scale range from 0 to 21. A cut-off score of 11 and above is recommended for identifying probable psychiatric diagnosis, whether anxiety or depression; scores of 9 or 10 represent 'borderline' cases.

#### *The General Health Questionnaire (GHQ)*

This is a widely used 12-item instrument spanning a range of items related to psychiatric symptomatology.<sup>6</sup> It provides both a dimensional measure of psychological distress (when scored 0–36) and an index related to the probability that a respondent is suffering from a formal psychiatric disorder (when scored 0–12). Several investigators have employed a cut-off of 2 or 3, above which an individual is deemed to merit a psychiatric diagnosis, albeit of an unspecified nature.<sup>7,8</sup>

#### *The life satisfaction questionnaire (LSQ)*

A measure developed locally at St Mary's Hospital, London, as encouraged by Firth-Cozens,<sup>9</sup> the LSQ is a 14-item instrument with each item scored on a five-point scale (0–4). The total score on this questionnaire may range from 0 to 56. A recent principal components analysis employing a Varimax rotation and the extraction of orthogonal factors identified four main factors that could be classified as relating to the following areas of life satisfaction: general life and self; relationships; domestic issues; and work. (A report on the psychometric properties of the LSQ is currently in preparation.)

#### *Sample*

A total of 177 patients took part in the study. Approximately 12% refused or were unable to complete the tests (e.g. for language reasons). The sample represents a wide range of patients drawn from inner and outer London boroughs. The assessment battery was completed by 99 primary care patients and 78 outpatients over the predetermined recruitment phase.

#### *Data analysis*

The data were analysed using the SPSS-PC+ package. In order to examine whether symptoms and mood levels were equivalent in

the two groups, separate *t*-tests were conducted for the GHQ and HADS (anxiety and depression) scores, as well as for the subjective ratings of the daily distress and disruptiveness of psychological problems and motivation for treatment. Non-parametric (chi-squared) tests were used to evaluate the distributions of the categorical variables (the sociodemographic data), statistical significance being established at  $P < 0.05$ .

## Results

### *Mental state and subjective ratings*

The distribution of GHQ scores for the patients before treatment appeared normally distributed over the full range of scores. The average for the overall sample (21.7, SD = 7.4) was high and comparable to results from other surveys.<sup>7,10</sup> Similarly, the overall HADS anxiety (mean 12.5, SD = 4.2) and depression (mean 7.94, SD = 4.4) scores were normally distributed across the full range of scores. A considerable number of patients were reporting high levels of anxiety, including associated somatic symptoms, and although more patients reported severe anxiety symptoms, a sizeable proportion complained of clinical levels of mood disorder. Comparison of primary care and outpatient means for these variables and the subjective ratings of problem distress, disruption and treatment motivation (Table 1) revealed no significant differences ( $t < 1.0$ ) across service locations.

Employing conservative recommended GHQ (0–12) cut-off scores<sup>8</sup> (see Table 1), it is possible to classify the present sample in terms of psychiatric 'caseness'. A cut-off score of 4 and above was used to optimize the correct classification of 'cases': 79% scored above this cut-off score, and therefore would be likely to receive a formal psychiatric diagnosis. Most of the 'cases' above the cut-off scored within the upper range of the transformed score (10–12), with 34% receiving a score of 11 or 12. The rates of 'cases' across the two service locations were very similar and did not differ statistically ( $\chi^2 = 0.08$ ).

The distribution of individuals meeting the 'caseness' criteria for HADS anxiety and depression scores did not differ significantly between primary care and outpatient locations: anxiety ( $\chi^2 = 0.00$ ); depression ( $\chi^2 = 0.22$ ). In the case of anxiety, a clear majority (67%) of patients were identified as likely to be suffering a formal anxiety disorder, with 13% of the sample falling in the borderline range. About 33% were likely to merit a formal diagnosis for depression, with 12% of the patients in the borderline range complaining of both affective and biological symptoms.

### *Sociodemographic variables*

The data for these variables are shown in Table 2. The overall

**Table 1.** Mean mental state data and subjective ratings by service location.\*

	Primary care sample (n = 99)	Outpatient sample (n = 78)
GHQ score: 0–12	7.54 (3.99)	7.70 (3.64)
0–36	21.70 (7.00)	21.80 (7.16)
HAD-anxiety	12.60 (4.25)	12.40 (4.27)
HAD-depression	8.28 (4.57)	8.99 (4.54)
Distress	2.57 (0.69)	2.60 (0.65)
Disruptiveness	2.14 (0.93)	2.35 (0.74)
Treatment motivation	2.62 (0.78)	2.56 (0.77)

\*Values in parenthesis are SD.

**Table 2.** Sociodemographic data by service location.

		Primary care sample (n = 99)	Outpatient sample (n = 78)
Age		36.0 (12.9)	37.7 (12.1)
Sex ratio (M:F)		1:1.54	1:1.05
Marital status: <sup>b</sup>			
	single	43.4	49.4
	married	7.1	13.0
	cohabiting	35.4	23.4
	divorced/ widowed	14.1	14.3
Educational status: <sup>b</sup>			
	no qualification	20.5	26.4
	O-level/HND	42.1	29.1
	A-level	14.5	16.7
	degree/diploma	22.9	27.8
Occupational status: <sup>b</sup>			
	employed	52.8	43.7
	unemployed	20.2	36.6
	childcare/ housework	12.4	8.5
	other	14.6	11.2

<sup>a</sup>Mean (SD). <sup>b</sup>Figures represent proportions (%) for each sample.

age range was 12–73 years. Individuals under 18 and over 65 years of age were under-represented because outpatient departments have cut-offs at these ages and very few younger or older patients were referred to the primary care clinics. The age difference across locations was not significant ( $t = 0.9$ ). The distributions of sex, marital status, educational attainments and occupational status were comparable in both groups.

### Life satisfaction

The absence of suitable normative control scores makes it difficult to comment on the 'abnormality', if any, of the observed levels of life satisfaction. Total LSQ scores appeared normally distributed, with no significant differences ( $t = 0.31$ ) before treatment between primary care (mean 25.1, SD = 8.91) and outpatient (mean 25.5, SD = 9.33) clinics. None of the above LSQ factor sub-scales differed significantly ( $t < 1.13$ ).

### General practitioner consultation rates

Robson and colleagues suggested that a useful indicator of psychological distress can be found in general practitioner consultation rates.<sup>11</sup> Although base rates of matched non-distressed individuals attending their general practitioner in the areas sampled were not available, self-reported levels of consultation appeared quite high, in that 65% of the sample had consulted their general practitioner four or more times in the last year, and 18% reported attending their doctor ten or more times. Interestingly, the mean rates of consultation in the primary care (mean 5.06, SD = 2.99) and outpatient (mean 5.82, SD = 3.38) groups did not differ statistically ( $t = 1.58$ ). However, these rates do appear higher than those reported in a recent national survey,<sup>12</sup> which (albeit using a different methodology) revealed a mean yearly consultation rate of 3.25 visits.

### Discussion

This study reveals a striking absence of differences between the patients seen by psychologists across primary care locations and

specialist units, despite a wide variation in geographical factors and clinicians involved. The lack of evidence for a 'referral drift' within the primary care sample, as well as the similarity of patient symptoms with those of other studies such as Milne's,<sup>10</sup> suggest that general practitioners have a consistent model of the kinds of patients and problems they refer to clinical psychologists. Providing a more accessible and user-friendly primary care psychology service does not appear to lower the clinical threshold for referrals.

Although some caution must be exercised in interpreting results from questionnaires such as the GHQ and HADS, the present samples' GHQ symptom levels were significantly higher than 'healthy' samples such as those reported by Banks and colleagues.<sup>7</sup> This was also the case when 'psychiatric caseness' was examined: in Milne's sample, 53% at referral and 47% at assessment were so classified on the basis of their GHQ scores,<sup>10</sup> compared with 79% in the present study. With regard to mood disorder, as reflected by the HADS scores, 67% and 33% of our patients were classified as suffering from clinical anxiety and depression, respectively, with 31% of the overall sample classified as likely to be suffering from both types of disorder. A recent study undertaken by the World Health Organization found social and occupational disability to be most prominent among patients with depression and panic disorder.<sup>13</sup> Therefore, it is perhaps unsurprising that such disorders account for a substantial proportion of patients referred by general practitioners to psychologists in either primary care or outpatient clinics.

One strength of the naturalistic assessment of an unselected consecutive series of patients is that the results are likely to be applicable to routine clinical practice. However, logistical and resource constraints made evaluation of the characteristics of those patients who were referred but did not attend for assessment, and any differences from those who did attend, difficult. No detailed assessment of the chronicity of patients' problems was made, nor were formal diagnoses available on a routine or reliable basis. These and other study limitations make it difficult to generalize the results to other practice-based mental health services such as those provided by counsellors or community psychiatric nurses. Finally, differences in referral patterns over time or across certain types of practice might have emerged with a longitudinal and/or more fine grain assessment.

In the context of the current debate about rationing in the health service, it is important to recognize the value of treating potentially economically active individuals with disabling and distressing psychological conditions amenable to psychological treatment. A long-term follow-up study is currently in progress and will be reported in the future. The concept of primary care-led commissioning of mental health services is based on the idea that general practitioners are able to make sensible decisions about the services their patients require, regardless of treatment location. This study provides no reason to question this idea.

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**Address for correspondence**

Philip Tata, Department of Psychology, Paterson Centre for Mental Health, St Mary's Hospital, 20 South Wharf Road, London W2 1PD.



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