Adult Community Psychology Services: Tiering and its seams

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Stratification and hierarchical arrangements are ubiquitous aspects of societal organisation, sometimes welcome, sometimes less so. They may both facilitate a good life and psychological well-being and contribute to human unhappiness and everyday psychological problems. As counselling psychologists this is familiar to us, both from our everyday work with people in distress and closer to home in struggling for our own professional recognition and a niche within the market, especially the NHS. Tiering, as one form of stratification, has served to order services, supposedly distinguishing clients according to needs and marshalling human resources in turn, through skill-mix for example. Knowledge of such boundaries, together with an informed view on their validity or otherwise, is important in attempting to match specific clients to the most appropriate workers and in clarifying and developing professional roles.

Introduction

WITHIN COMMUNITY PSYCHOLOGICAL services primary and secondary care tiers have generally been differentiated by a variety of staff, organisational and client dimensions. Among the latter, chronicity and severity of psychopathology have been regarded as primary distinguishing characteristics, with clients experiencing more severe difficulties clustering in Secondary mental health services and those in Primary Care generally exhibiting lesser morbidity (Goldberg & Huxley, 1980, 1992; Cheston & Cone, 1999). Goldberg and Huxley (1992) situate GPs as the traditional gatekeepers between the two tiers, managing the bulk of psychological presentations within their own practices and identifying and facilitating the onward referral of those clients who require more specialist mental health services. These functions have been frequently highlighted for their variable quality (Goldberg & Huxley, 1980, 1992) and consequently as an area for professional or organisational development (Sartorius *et al.*, 1990). Decentralising policies promulgated by the Department of Health have led to a refocused emphasis on Primary Care, with some specialist services being increasingly provided there, including dedicated mental health input. As part of this trend counselling and counselling psychology in Primary Care has proliferated, and its results favourably evaluated, at least when the services have been appropriately targeted and quality controlled (Rowan & Chandrakumar, 1996; Bellamy & Adams, 2000). Such developments have tended to blur the traditional distinctions between tiers, which, while increasing the possibilities for a more seamless community provision, problematise professional identity and role clarity and demand a more comprehensive approach to service planning. Cheston and Cone (1999) found that the differences between clients at the two levels were quantitative rather than qualitative, with for instance intensity and frequency of distress rather than diagnosis differentiating clients at one or other tier. The emphasis on research and development in the NHS (Milne, 1999), together with the advocacy of evidence-based practice, has resulted in efforts to systematically measure and evaluate psychological services for clinical effectiveness, using standardised outcome measures wherever possible

(Barkham *et al.*, 1998). The present paper sets out to delineate further the seams, especially in terms of the commonalities and differences, between community psychological services for adults at the Primary and Secondary Care tiers and their respective recipients within one Trust area using common measures. This may then act as a comparator to others developing and benchmarking comprehensive community adult psychological services.

The service

The Trust area (East Kent) is semi-rural, covering approximately 750 square miles with a population of 592,603. The area is subdivided into five localities, divided between three Primary Care Trusts, and has some 106 GP practices.

The Adult Community Psychology Service (ACPS), catering to adults 16–65, is a multi-professional service, which at the time of study comprised of clinical psychologists (5wte), counselling psychologists (2wte), counsellors (2.2wte) and psychotherapists (2wte), who are based at centralised locality sites. Referrals are primarily from psychiatrists and other Secondary level services, with GP and Primary Care referrals accepted in all localities except one. The Service organises and manages the Primary Care Counselling Service (PCCS) which comprises 10 (3.3 wte) counsellors and psychotherapists, working in a total of 24 GP surgeries across the Trust, with clients aged 16 years and upwards, including a small number of older adults aged 66 and over. The PCCS operates within a seven session intervention frame, whilst the ACPS offers more medium term interventions, typically of between 10 and 40 sessions. All staff hold a pertinent professional registration, either BPS Chartership, or UKCP or BACP accreditation.

Method

The sample was made up of all client audit and evaluation forms returned by clinicians in both services (397 in the ACPS and 1079 in the PCCS) during the 12-month period of the study. Routine audit and evaluation forms were developed based on the model proposed by Berger (1996). Data collected included client demographics (sex, age, marital status, occupation, ethnicity, number of children) and clinical characteristics (such as primary presenting problems (as described by the clinician), previous contact with mental health services and whether clients referred were using psychotropic medication at the time of referral). In addition Service administration details were collected (response times) as well as treatment and outcome data (such as the number of sessions attended, cancellations, DNAs, discontinuation rates, and clinician ratings of improvement). The CORE outcome measure (Barkham *et al.*, 1998) was used to further evaluate clinical effectiveness, this instrument being given to clients prior to assessment and again following the intervention stage. Barkham *et al.* (1998) developed this for use in routine clinical practice, with 'widespread utilisation' and the intention of creating an 'anonymised UK national database' (Barkham *et al.*, 1998). The questionnaire comprises 34 items, tapping the domains of well-being, symptomatology, functioning and risk to self or others, which when combined yield a global measure of distress.

Data was analysed for statistical significance using non-parametric tests as it was found to be not normally distributed; chi-square analysis, and the Mann-Whitney U test for unrelated samples was used to look at means and CORE scores.

Results

Demographic data is presented in Table 1. Statistically significant differences were found between clients at the two tiers in terms of sex, age, marital status, occupation and the prevalence of parenthood.

Table 2 shows the data for the clients' basic clinical characteristics and highlights significant differences between those at the Primary and Secondary Care tiers regarding previous contact with services, the use of psychotropic medication at the time of referral and the kind of primary presenting problem or diagnosis.

Table 3 summarises the treatment and outcome data. Statistically significant differences were found between the Primary and Secondary Care services in terms of average waiting times between referral and offer of a first appointment (waiting times were reported

Table 1: A comparison of primary and secondary care client socio-demographic data.

Category		Primary Care %: *N=1079*	Secondary Care %: *N=397*	Statistical Significance
Sex:	Male	27	33.3	P = <0.05
	Female	73	66.7	
Age:	<19	5.8	6.7	P = <0.001
	20–29	23.3	27.9	
	30–39	28.2	35.4	
	40–49	21.4	16.7	
	50–59	14.7	12.3	
	60–65	2.6	1.1	
	>66	4.0	–	
Marital Status:	Single	18.8	29.7	P = <0.001
	Married	48.6	40	
	Cohabiting	9.9	15.9	
	Divorced	10.7	10	
	Separated	6.4	3.4	
	Widowed	5.6	1.0	
Ethnicity:	White	98.6	98	NS
	Non-white	1.4	2	
Occupation:	Full-time	35.3	22.1	P = <0.001
	Part-time	13.9	17.5	
	Housewife	21.1	13.0	
	Unemployed	9.7	22.1	
	Retired	7.3	4.2	
	Sick / Disabled	8.1	12.7	
	Student	3.2	5.8	
	Other	1.1	1.9	
	Voluntary	0.2	0.6	
Children:	Yes	74.3	66.4	P = <0.02

Table 2: A comparison of basic clinical characteristics between groups.

Category		Primary Care	Secondary Care	Statistical Significance
Previous service utilisation (%)		30.6	78.7	P = <0.001
Previous services used:	Counselling Services	41.4	15.3	P = <0.001
	Psychiatric out-patient	23.6	42.7	
	Psychiatric in-patient	5.9	11.6	
	Psychology Services	13.2	15.1	
	Private Therapy	3.6	1.1	
	Psychotherapy	4.5	5.1	
	Voluntary / Self-help	0.5	1.3	
	Social Services	5.5	3.8	
Primary problem:	Anxiety	39.1	28.3	P = <0.001
	Sexual Dysfunction	0.6	2.4	
	Psychotic Disorders	0	2.4	
	Mood Disorders	40.2	39.4	
	Eating Disorders	0.5	5.4	
	Personality Disorder	0.9	6.7	
	Neurological	–	1.3	
	Other	18.8	14.1	
Psychotropic Medication (%)		37.2	55.8	P = <0.001

Table 3: A between groups comparison of mean treatment and outcome data.

Category	Primary Care	Secondary Care	Statistical Significance
Waiting time:	50.8 days (SD 49.83)	86.85 days (SD 102.76)	P = <0.001
Sessions attended:	3.83 (SD 2.62)	7.64 (SD 6.84)	P = <0.02
DNAs	0.44 (SD 0.68)	0.89 (SD 1.39)	**P = <0.02**
Cancellations	0.35 (SD 0.68)	1.03 (SD 1.30)	**P = <0.001**
Discontinuation (%)	56.8 43.2	54.0 46.0	
Clinical rated improvement (%):			
Much Improvement	26.7	29.2	NS
Moderate Improvement	29.3	23.1	
Slight Improvement	20.5	14.0	
No change	22.7	32.3	
Slight Deterioration	0.9	1.5	
Moderate Deterioration	0	0	
Much Deterioration	0	0	

Table 4: A comparison of men's and women's pre- and post-therapy CORE scores by tier.

	Pre-therapy				Post-therapy			
Domain	**Primary care** *N*=137	**SD**	**Secondary care** *N*=93	**SD**	**Primary care** *N*=30	**SD**	**Secondary care** *N*=8	**SD**
Men: well-being	2.22	*1.00*	2.29	*0.98*	1.17	*0.99*	1.22	*0.82*
Men: problem	2.23	*0.95*	2.40	*0.91*	0.91	*0.17*	1.48	*0.76*
Men: functioning	1.71	*0.87*	1.92	*0.86*	1.07	*0.80*	1.05	*0.73*
Men: risk	0.62	*0.83*	0.77	*0.84*	0.30	*0.63*	0.16	*0.25*
Men: total scores	1.76	*0.78*	1.93	*0.79*	1.05	*0.76*	1.07	*0.63*
Men: total scores (minus risk)	2.01	*0.84*	2.19	*0.84*	1.21	*0.83*	1.08	*0.81*
Domain	**Primary care** *N*=368	**SD**	**Secondary care** *N*=162	**SD**	**Primary care** *N*=78	**SD**	**Secondary care** *N*=28	**SD**
Women: well-being	2.46	*0.89*	2.61	*0.85*	1.37	*1.15*	1.36	*1.21*
Women: problem	2.33	*0.80*	2.56	*0.78*	1.47	*1.02*	1.41	*1.05*
Women: functioning	1.78	*0.76*	2.05	*0.79*	1.08	*0.89*	1.03	*0.97*
Women: risk	0.41	*0.56*	0.67	*0.72*	0.21	*0.51*	0.36	*0.64*
Women: total scores	1.82	*0.65*	2.04	*0.67*	1.10	*0.83*	1.08	*0.91*
Women: total scores (minus risk)	2.11	*0.72*	2.35	*0.71*	1.29	*0.94*	1.23	*1.01*

using the seven-day week), the average number of sessions attended, cancelled or DNAs. Clinician ratings of improvement were not significantly different between the two services. Nor were significant differences found for discontinuation rates between services.

Table 4 shows mean CORE scores for males and females at the Primary and Secondary Care tiers, pre- and post-therapy. No significant differences were found between men's scores in Primary and Secondary Care on all domains at pre and post therapy. By contrast, women's scores revealed a strongly significant difference between those at the Primary and Secondary Care tiers at the pre-therapy stage in all domains except well-being: Mann-Whitney Test, p=<0.005. By the post-therapy stage women's CORE scores at both tiers had evened out, inter-group differences at that point being statistically non-significant.

Discussion

The present study indicates that both the client populations and the clinical services at Primary and Secondary Care tiers are distinctive, being distinguishable on a wide range of variables chiefly associated with complexity and chronicity of client psychopathology. Thus clients at the Secondary Care tier, although tending to be younger (Fylkesnes, Johnsen & Forde, 1992), have had substantially more past contact with mental health services, particularly as psychiatric outpatients or in-patients. More intractable problems, such as psychosis, sexual dysfunction, personality disorders and eating disorders, clearly contributed to this trend and mark some categorical differences. Corresponding levels of self-reported distress, as reflected in the CORE scores, tallied with this picture, with higher symptom levels being reported at the Secondary Care tier (Goldberg & Huxley, 1980, 1992), a finding supportive of the tier seams as described by Cheston & Cone (1999). The waiting time for Secondary tier psychology was significantly longer as was the subsequent intervention. Cancellations and non-attendance were also markedly higher, indicative perhaps of a more volatile psychopathology among clients at the Secondary Care tier, although service factors (such as accessibility) may also have contributed.

At the Primary Care tier anxiety and mood disorders formed the bulk of presenting difficulties. Referrals at this tier were far from being the pejoratively labelled 'worried well', initial CORE scores falling within 'caseness' on all CORE domains, confirming the findings of Rowan and Chandrakumar (1996) among others about the significant needs of clients in Primary Care. PCCS clients previous service utilisation, where it existed, tended to be within a similar counselling context, mirroring that of clients within secondary services, findings in line with both Hannay (1986) and Dew *et al.* (1991) who highlighted past patterns of service utilisation as being predictive of similar future use.

The client outcomes across tiers were broadly similar, with both clinician ratings and clients self-ratings (as portrayed in their CORE outcome scores) revealing no statistically significant differences, and both having fallen below 'caseness'. Whilst clearly a welcome finding and in line with comparable other NHS psychology studies (Ambrose, Botton & Ormrod, 1998; Turvey, Humphreys, Smith & Smeddle, 1998), the present CORE discharge scores would need to be compared to the CORE national discharge data when this becomes available.

Within the present study, gender trends proved to be one area of emergent interest during the analysis of the results. While women formed the majority in both tiers, a factor that supports previous findings (Briscoe, 1987; Fylkesnes *et al.*, 1992; Scambler & Scambler, 1984), there were proportionately more males within Secondary services. Women's CORE scores in both tiers at intake and at discharge were in general higher on all domains with the exception of the risk scale than men's. While CORE scores overall were higher at the secondary care tier, as previously noted, the differences between the tiers only reached statistical significance in relation to women's scores. The degree of risk may partly account for men's facilitated access to secondary tier services, however other issues, such as gender-related help-seeking behaviour or referrer attitudes and perceptions, would need to be considered.

Obviously there are caveats that go with the present study in terms of possible selectivity

and the generalisability of both the Service and the client population data. Outcome data primarily for Secondary tier longer-term clients was limited given continuing treatments, a factor that would be expected to impact significantly on the average length of treatments reported. Nevertheless, the study should aid other adult community psychology services in developing client and tier appropriate provision and quality benchmarking within that process, with psychological practitioners contributions informed by awareness of clients actual needs and not merely supposition.

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