national Classification of Diseases. Some are concerned that they are having intercourse without contraception yet are afraid of pregnancy, and the system was designed to bring such a "non-illness" to the fore. In other cases the condition is more complex, and some marital, coital, or personality problem is referred to the genital tract. Clinical acumen is required and detection is, if anything, more easily achieved with the questionnaire type of history, as incongruities and incompatibilities in answers are readily evident.

Much of the system's success depends on the care taken in presenting the information in a manner easily assimilated by the consultant. In the questionnaires the bypass procedure prevents superfluous answers being obtained. In the transcript irrelevant negatives are eliminated from the text, but the consultant has the advantage of knowing that the questions have been answered. In programming the calculator we took great care to translate the "lay" questions with their circled answers into concise "medical" statements, and by combining this with attention to layout, spacing, and the use of capital letters the important features were brought into prominence. The consultants feel freer to converse informally with the patient, often gaining a better insight into her problem.

Confidentiality is a most important aspect. The questionnaires remain anonymous until handed to the assistant at the clinic. She, like medical secretaries, is bound by the same code of confidentiality as a doctor.¹⁶ The programmed calculator has no capacity to retain information about patients and simply generates answer phrases. The system, therefore, carries none of the problems of confidentiality that are associated with computers.

The fact that history-taking by questionnaire has been less than successful in some cases is probably related to the accumulation of too much detail with insufficient attention paid to transcription for ease of assimilation. Our experience is that a

circumscribed questionnaire designed to obtain essential facts greatly facilitates gynaecological practice. There is a saving in medical manpower and the system has considerable teaching value for both students and postgraduates. The precise plan adopted in this investigation would require modification in other clinical circumstances, but the system is sufficiently simple and flexible to be readily adaptable. Material can be inserted or deleted according to the particular needs of the user. What is required at the outset is a clear definition of the information needed and the manner in which it is to be presented to the clinician.

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General Practice Observed

The clinical psychologist in a health centre: one year's work

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Summary

The Livingston integrated health services project is an attempt to provide a fully integrated area health service with special emphasis on developing multidisciplinary community health teams. As part of this experiment a clinical psychologist was appointed to work in general practice. Ninety-four patients with behavioural, emotional, and cognitive problems were referred in the first

year (1% of the 10 000 patients registered at the practice). The psychologist thus provided treatment for some patients who would otherwise have been seen by a general practitioner with neither the time nor the training to deal adequately with their problems.

Introduction

The principle of dealing with health problems in the community rather than in hospital led to the creation of the Livingston health services project,^{1,2} which has encouraged health service workers to develop new roles and relationships in order to increase the resources available for primary care and create an effective multidisciplinary team. The appointment of a clinical psychologist as a full-time member of this team was an attempt to provide general practitioners with direct access to a non-medical clinical specialist and to provide the psychologist with an opportunity to develop new areas of service.

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Livingston

Livingston is a new town in central Scotland. It was designated in 1962 and by the end of 1974 had a population of about 24 000. The first district to be completed was Craigshill, which has a population of about 10 500 and is served by one health centre. The population of Craigshill is a young one, with 36% being under the age of 15 years and only 5% over the age of 60 years; 53% of the women are of child-bearing age.

CRAIGSHILL HEALTH CENTRE

In 1974 there were six general practitioners at Craigshill Health Centre, each of whom had a list of about 1750 patients and also a sessional commitment in a particular specialty.¹ The specialties represented at Craigshill Health Centre were paediatrics, psychiatry, general medicine, obstetrics and gynaecology, and ophthalmology. The major aim of the experiment in providing a full-time clinical psychology service in the health centre was to assess how general practitioners used the services of the psychologist.

The nursing team at the health centre consisted of two health visitors, one midwife, one district nurse/midwife, two district nurses, two practice nurses, and a community nurse. There was regular collaboration with social workers, educational psychologists, youth and community workers, a disablement resettlement officer, a marriage guidance counsellor, physiotherapists, speech therapists, occupational therapists, and dietitians. The establishment and maintenance of good communications between the health centre and other community agencies was an important preliminary to the psychologist's work.

Review of one year's clinical work

A clinical psychologist was appointed to Craigshill Health Centre in October 1973. Much of the first four months was spent in observation and teaching (formal and informal) and in learning about the day-to-day functioning of a health centre. Referrals were accepted from 15 January 1974, and between then and 31 December 1974 94 patients were referred. Of these patients 48% were over 16 years of age, while 52% were less than 16 years old. The proportion of males to females was almost equal. There was, however, a definite preponderance of young males and adult women. Taking both sexes together slightly more juveniles than adults were referred, which was not surprising given the age structure of the area.

Nature of cases—The presenting problems of the patients fell into three main categories: (1) Behaviour problems, which included soiling, temper tantrums, stealing, refusing to go to school, etc, and thus occurred more often in younger patients. (2) Emotional problems, which occurred mainly in adults and included a variety of fears and phobias, and generalised anxiety. (3) Cognitive problems, which included learning difficulties, poor speech development, and mental handicap. Over 90% of cases were referred by the patient's own doctor, and when the initial referral was made by another member of the health team the case was fully discussed (and, if necessary, an appointment made) with the family doctor before the referral was accepted.

Length of treatment—Forty-seven patients had been discharged by 31 December, including six who had failed to attend the initial interview. The average length of a session was 32 minutes (range 15 minutes to 3 hours), and about half of the patients required fewer than six sessions. A quarter of the patients required 6-10 sessions, and the remaining quarter 11 or more sessions. When a patient had been assessed a letter was sent to the general practitioner for inclusion in the medical notes and when treatment was prolonged several interim reports were provided before the discharge letter was written.

Nature of clinical work—Firstly, the patient was assessed, using psychometric techniques, usually intelligence quotient (IQ) tests, or an interview. Assessment did not invariably lead to treatment by the psychologist. Several cases were referred to a member of another agency such as an educational psychologist, disablement resettlement officer, or a youth and community worker. Psychological problems within the individual or family were treated with various psychological techniques, such as relaxation training, systematic desensitisation, hypnosis, assertive training, other types of behaviour therapy, counselling, etc. In some cases treatment was brief and intensive, while in others it was prolonged over several weeks or months.

Previous treatment of patients—Asking the general practitioners to review the cases they had referred and consider how these patients would have been dealt with if the clinical psychologist had not been available showed that almost half the patients (46%) would have been dealt with by the general practitioner himself. This was a matter not

of choice but of necessity as no appropriate resource would have been available. A further 15% would have been passed to a psychiatrist or child psychiatrist and 13% to the educational psychology service. Thirteen per cent would have been referred to a paediatric clinic and a further 11% for assessment or treatment by hospital-based psychologists. For the remainder (2%) advice would have been sought from the social work department, marriage guidance counsellor, or a similar agency.

Conclusions

The clinical psychologist working in Craigshill Health Centre has been dealing mainly with behavioural and emotional problems, often in patients who suffered these problems as a result of physical illness or handicap—for example, after bilateral amputation. The experience gained from this experiment in primary care opens up an area of preventive work which is relatively new to clinical psychology, and a long-term study of the efficacy of this form of psychological intervention should be undertaken.

A wide range of work in the rehabilitative, preventive, and educational fields could be developed. Chronic disability after traumatic injuries or industrial accidents is a problem that faces every general practitioner, and holding group sessions to facilitate readjustment and rehabilitation could be a specific task of the clinical psychologist working in general practice.

The number of cases being referred will soon make it impractical to treat each patient on a one-to-one basis and we therefore hope soon to introduce some group work for suitable patients. To be of maximum benefit when working in an integrated service it may be useful for the psychologist to train and supervise other members of the health centre team in some of the techniques of clinical psychology. For example, community nurses could use relaxation training and systematic desensitisation in dealing with phobic patients.

Results obtained in retrospective surveys are always suspect, but the survey has, nevertheless, indicated that there are problems that the family doctor sees and deals with even though he feels that he is not the most appropriate person to do so in terms of his training or the time required.

The advantages to general practitioners of having a full-time clinical psychologist in the health centre are difficult to evaluate objectively. The general practitioner is often confronted with emotional illness, and a combined approach to these problems is required. Unfortunately, general practitioners in this country have limited opportunities to offer extended consultations and often do not have the therapeutic expertise to deal effectively with more complicated behavioural disturbances. It has often been claimed that general practitioners over-prescribe psychotropic drugs. If this is true the addition of a psychologist to the primary care team provides an opportunity for the doctors and psychologist to discuss appropriate treatments, and, with time, there may be a change in the approach to particular problems, in which drug treatment alone may not be appropriate.

Clinical psychologists have traditionally been linked to hospital departments of psychiatry and are therefore set at a distance from the general practitioner. In the health centre experiment close liaison between family doctor and the clinical psychologist has been of mutual benefit, the doctors learning at first hand of the skills that the clinical psychologist can offer, and the psychologist obtaining insight into the initial presentation of illness and the pressures operating on general practitioners.

With the development of an integrated health service and with the knowledge that emotional disturbance is one of the most common conditions in general practice, closer ties between clinical psychology and general practice should benefit both disciplines.

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