

**Attracting the Opposite sex? A more psychological
approach in primary care?**
**An evaluation using a case study surgery in Islington,
north London**

Jeff Fernandez
Islington PCT

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There has been much written on gender in the academic world and its impact upon shaping our society. In terms of examining inequality, women in particular are seen to suffer disproportionately (Haralambos, 1999). The workplace and affluence are seen as important in identifying and designing social policy to try and address this however, with limiting results.

In health care gender factors can influence presentations (Gabe, 2004). In terms of health problems single women are much more likely to be more frequent presenters to primary care, as they have young children and are more vulnerable to poverty and therefore communicable diseases. Also they are more prone to stress and therefore seek help from health care. However, in America this can have an exclusive effect, as many single women suffering from poverty have no health insurance. Therefore access to health care is limited. This does have implications for treating women for sexually transmitted diseases, cervical screening and breast cancer. In specific gender healthcare issues it is important to have as much access as possible. In Britain with the national health services still being free at the point of delivery it tries to ensure that. But there are still often barriers to access (NTORS, 1998).

In primary care and in the area of substance misuse the ratio for treatment when broken down in terms of gender is in the ratio of 3:1 (NTORS, 1998). This has been stable with efforts made to attract women who have a problem with either alcohol or drugs. There are some to say that children protection fears and poverty play a part in making the referral from females to substance misuse services low. Also the therapy model being based on the medical model approach can be limited in trying to reach some populations and women as they fail to take into account the environmental factors of poverty (Rhodes and Johnson, 1997).

This paper shows that for a service in primary care delivered by a specialist nurse with more emphasis on a psychological approach than medical, can lead to a better ratio than the constant 3:1 in the field of problematic alcohol drinking. This is shown with a description of a case study in-depth from a review conducted in a general practice in Islington.

The Practice: RiverPlace

The surgery used for this research, was a typical surgery, based in the centre of Islington, London called the RiverPlace surgery. The practice was managed as a partnership and routinely managed on a day-to-day level by a practice manager. It can be described as a GMS practice with 5 partners, 2 salaried GP's, 2 practice nurses and HCA. Other services at practice include 3 counsellors, refugee counsellor, Turkish advocate, Islington Peoples Rights, Smoking cessation advisor, dietician, stress project worker, District Nurses and Health Visitors on site.

The practice was considered a well-staffed 'High' functioning surgery with diverse services from its practice aiming to serve its population. Its total patient population is 8,412 and its gender breakdown is shown below:

Fig 1

Age groups	0-4	5-16	17-24	25-34	35-44	45-54	55-64	65-74	75-84	85-89	90+
Males	238	579	383	1050	907	486	289	186	115	24	9
Females	213	511	545	1046	756	384	239	218	171	39	24
Total males: 4266		Total of males with problematic drinking levels: 117									
Total females: 4146		Total of females with problematic drinking:: 37									
Total both sexes: 8412		Total = 214									

The level of problematic drinkers is at a small percentage of around three percent of the overall practice population. However, within this figure it is clear that the male population has a higher level of drinking than the female population. As the paper explains they also have a poorer engagement of the service as a whole and maybe this can be looked at in terms of restructuring the clinic approach in order to accommodate this patient group. However, this practice has a large population and therefore the number of potential clients for the service is still at a high level.

The Clinic:

There were six sessions allocated for the GP's to refer into. The slots were for half an hour for each patient and brief interventions were used in the sessions.

The referrals were made either electronically through the EMIS system, or through a brief referral on a suitably designed referral form. Straight through the Emis system, which is the easiest way for GP's to refer. Only if there are complex cases, a referral form was preferred in order to give an outline of what is needed.

The sessions used a structured assessment, psychological interventions such as, reflective practices and motivational interviewing for a minimum of eight sessions. Progress was reviewed after eight sessions with the client. The first session was for an assessment, the second looked to explain health educational messages; the third looked to map out the pattern of drinking; the fourth focuses upon identifying triggers. The last of the three sessions looked to try and initiate change through motivational interviewing.

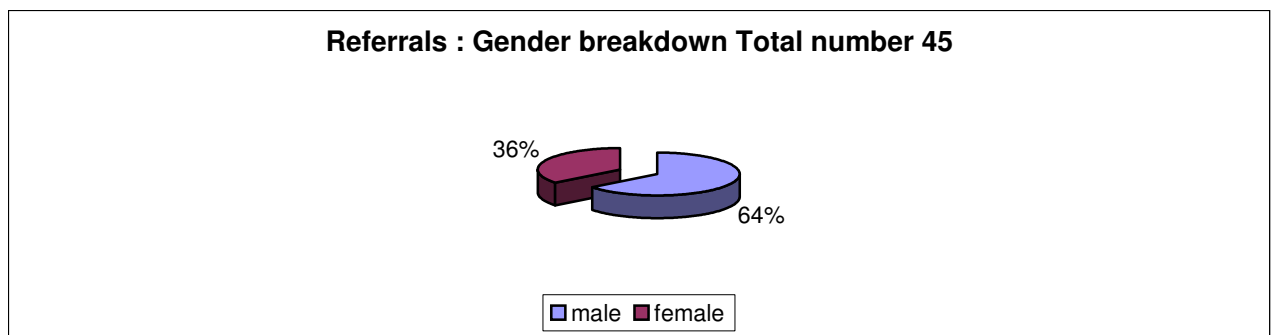
Through the process of an evaluation, if there is steady progress the client can be seen as a maintenance client. If no real in roads appear after eight sessions a review with the GP will see if there is any need to continue care or refer onto a better suited service. If a patient feels they do not want to engage further, a discharge will be considered. If a client Dna'd after the first session, they were contacted by letter to see if they would like to re-engage. If there is no contact they are discharged from the clinic after two weeks, but they can be referred back through the GP.

Motivational interviewing

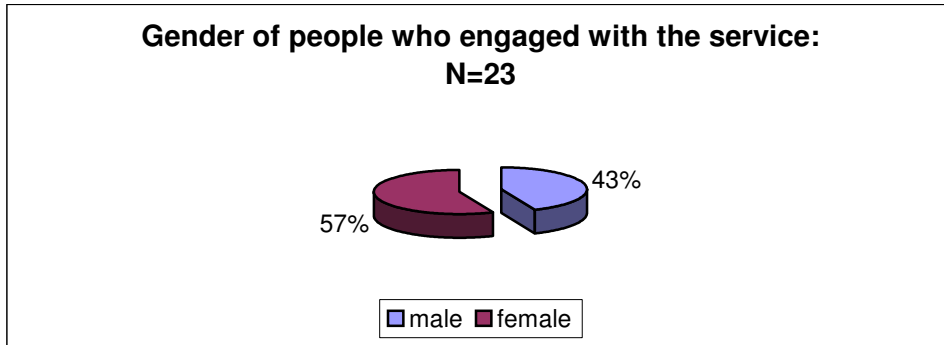
The approach is to look at the psychological factors firstly which underlie the dependent pattern on alcohol before looking to any medical model approach complimented with prescribing. This is based on a CBT (Cognitive Behavioural Therapy) approach were the therapist taken on a collaborative approach. This uses the skills of listening and summarising the patient statements and reflecting them back to the client to provide affirmation. Hence trying to get the patient to identify problems and encourage problem-solving skills. This is seen as a good approach in the field of substance misuse (Wanigaratne, Davis, Pryce, Brotchie, 2005). As mentioned, this may be a more flexible approach to accommodate issues of poverty which females often find themselves in than a medical model approach (Rhodes and Johnson, 1997).

Demographic Results:

Referrals: Gender Fig 2



The number of referrals from the GP's at the surgery showed that there was a male to female ratio showing a larger population of males in general practice have problematic drinking patterns. However, the next pie-chart shows that despite the referral rate being higher for men on the ratio of nearly 3:1 similar to that for substance misuse, males were less likely to engage in this service, despite the gender breakdown of the practice being near a 50:50 split. The reasons for this are not yet apparent, but the female population who are vulnerable to problematic drinking are more likely to engage in the service.



This pie-chart above shows the level of engagement for females of the service offering motivational interviewing for problematic drinkers being higher than that of males. Why this is so is unclear but the case study analysis planned next would have some answers. This is near a 60:40 split in percentage terms and is better than the NTORS figure for female engagement of 3:1. This is a positive step and to understand why is the next approach for the research. This will hopefully be achieved through qualitative work. However the case study used here highlight some possible factors.

Fig 4

Number of people who engaged in sessions	23 (13=females)
Number of people engaged after four sessions	8 (5=females)
Number who engaged for one sessions	12 (8=males)

Overall, while it may be noted that they are small in comparison to the overall figure for problematic drinkers at the surgery, these figures and their levels need to be received in a positive light. Many of the problematic drinkers are unaware or in denial, so this figure is a good start for this approach. The above figures also show that even though the number of people who engage maybe over fifty percent there was a limit to what they are willing to do. However, they may just need to focus upon the health educational aspect or triggers, or look reflectively at their pattern in order to change their drinking habits. This would therefore show that for some ‘binge’ drinkers they would not need extensive interventions based upon motivational interviewing. They could be successful in changing their drinking habits short-term. Only, it is hard to evaluate whether the benefits would be long-term after such a short time reflecting upon their drinking. Other results in substance misuse would state that the longer the engagement the better the outcome. This is well-established evidence (NTORS, 1998). It would be therefore limiting and potentially wrong to state that three or two sessions can result in a successful outcome long-term. But this has yet to be established in the field of alcohol.

The number who engaged in one session is just under half the overall sample that engaged in total. It would indicate that for this cohort they are not ready to either

acknowledge or reflect on their drinking patterns. But evidence has shown that even after one session engaging in a brief intervention, such as extended assessment, could lead to a reduction in drinking. But the debate to see if this has had a long-term benefit is hard to quantify (Waller et al, 2003).

Importantly for this paper it has to be noted that there was a better engagement of females overall than males, but the number of males who engaged long-term was overall poor. In some counselling services the uptake of women using this services from mental health institutions is higher (Smith, 1996). Reasons for this are not yet fully researched but important to examine in shaping services for the future. It would be interesting to see how this varies or not over time in the year review whether the engagement was still better for females.

Age: Fig 5.

Mean age of females who engaged: 48
Mean age of men who engaged: 58

As one can see in the age groups that engaged in this service they tended to be older and in the age groups just beyond the post popular grouping. For in Fig one the most popular age group registered at RiverPlace was the 25-34 and the 34-39 age groups for both genders. These are identified in the literature as the main binge drinkers, but from the data provided this 'at risk' age group do not seem to engage in the GP based alcohol service. The female mean age is also beyond this age group. There was no real reason that emerged of why this was so. This evaluation was not looking in detail of the pathways and patterns of referral. But this could be a research project, which would be both relevant and interesting to conduct in the future. For the men, this age does show that the majority of men referred are of the post retirement age or coming to the end of their careers. From a clinical and anecdotal perspective, these men have developed an unhealthy pattern of alcohol through an inability to deal with stress from the home or from work. It becomes more of a problem when retirement happens as the drinking pattern that existed in one's leisure time transfers to the extended leisure time gained through retirement. This is then a more obvious problem to the GP and the patient to pick up upon and hence the referral rate for the age group is probably higher. However, a more rigorous analysis would ensure whether this was the case and could be a future evaluation.

Conclusion:

This paper shows some interesting figures and a better engagement of females in the service, which uses motivational interviewing and a less rigid medical model approach. As stated in the introduction this can be more flexible and better at engaging women in

treatment of problematic alcohol drinking (Rhodes and Johnson, 1997). This reason why are the next stage of the research and a case study analysis is planned for this through a qualitative perspective to see if there are and common reasons for a greater gender (female) engagement. But it has to be noted that this ratio while not being significant in terms of referral has a better ratio with females that the national ratio for substance misuse service at 3:1(NTORS, 1998).

Similar evaluations can hopefully show that more psychological interventions based on Motivational interviewing are the way forward to engaging females who have substance misuse problems in the setting of primary care.

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