approach may have avoided chronicity with the return of patients to the care of their GP.

Our study identified difficulties and omissions in data recording. This has been radically modified as the result, particularly in recording dates of attendance, default rates, first contact to service, specific interventions, prescribing practice, and rating scales. It has been essential to make these improvements to our database in advance of any expansion of the service to take referrals directly from GPs or to manage a small in-patient unit. We propose further studies looking at those patients re-referred to Panmure House, as well as the subsequent functioning and use of mental health services by a random group of those patients discharged from this new service.

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Psychiatric morbidity in patients referred for individual psychotherapy within and outwith the NHS

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Aims and method Demographic and medical characteristics of waiting list patients for National Health Service (NHS) psychotherapy, non-NHS psychotherapy or NHS general adult psychiatry were compared by postal questionnaires.

Results One hundred and eighty-three subjects replied. High rates of psychiatric morbidity were reported in both psychotherapy populations but general psychiatric referrals were more disturbed, taking more psychotropic medication than non-NHS psychotherapy but not NHS psychotherapy subjects. The biggest referral source to non-NHS psychotherapy was general practitioners.

Clinical implications Non-NHS psychotherapists should be able to recognise severe mental illness and have a basic understanding of psychotropic medication and psychiatric services.

Controversy exists as to whether psychotherapy is an effective treatment for psychiatric disorder (Andrews, 1993; Holmes & Marks, 1994) and whether psychotherapy patients are the 'worried well' (Amies, 1996). Despite a joint statement by the British Psychological Society and Royal College of Psychiatrists (1993), psychiatrists are

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divided in their opinions of psychotherapy (Hinshelwood, 1994). The general public perceives 'counselling' as the answer to all problems resulting from personal unhappiness (Furnham & Wardley, 1990). No single, UK body regulates non-National Health Service (NHS) psychotherapists although the establishment of the United Kingdom Council for Psychotherapy (UKCP) in 1993 and the British Confederation of Psychotherapists (BCP) in 1995 is progress. Current Government policy targets NHS resources at the seriously mentally ill. Less resource for the 'neurotic' or 'worried well' makes general practitioners (GPs) and individuals look beyond traditional psychiatric services for counselling. Little is known about non-NHS psychotherapy service users. Levels of psychiatric morbidity, proportions that would be assessed as suitable for NHS psychotherapy and reasons for individual preference of treatment models are uncertain (Tasca *et al*, 1994). This study looks at levels of psychiatric morbidity, referral and demographic details in waiting list subjects for non-NHS psychotherapy and compares these with waiting list NHS psychotherapy and NHS general adult psychiatry subjects.

The study

Subjects were from three sources: NHS individual psychotherapy patients (n=23) on the waiting list for psychodynamic psychotherapy at the Royal Edinburgh Hospital Department of Psychotherapy; non-NHS individual psychotherapy patients (n=99) on the waiting list for individual psychotherapy/counselling at the "Number 21 Counselling Service", a voluntary organisation in the centre of Edinburgh; and NHS general psychiatric out-patients (n=61) on the waiting list for general adult psychiatric out-patient assessment and treatment, referred by south-west Edinburgh GPs.

Subjects were sent a study explanation, an anonymous questionnaire asking personal details, and the Symptom-Check List SCL-90-R, a 90-item self report symptom inventory developed by Derogatis (1983), which reflects psychological symptom patterns.

Findings

Response for the groups' rates were NHS psychotherapy, 74%, non-NHS psychotherapy, 52%, and NHS general psychiatry, 41%. The majority of subjects awaiting psychotherapy were women, 70% of the NHS group and 77% of the non-NHS group compared with 56% of the NHS general psychiatry group (Pearson χ^2 analysis P=0.02). Analysis of variance showed no significant difference between the age of subjects, but the majority of non-NHS psychotherapy subjects were around 30 years old.

NHS psychotherapy subjects and non-NHS psychotherapy subjects lived across Edinburgh with no postcode differences representing socio-economic class extremes. Non-NHS psychotherapy patients had significantly longer education since the age of five years than general psychiatry patients (P=0.048).

Thirty-one per cent of non-NHS psychotherapy subjects were on psychotropic medication with 24% taking antidepressants. This was significantly less (P=0.006) than the 48% of NHS psychotherapy subjects and 57% of NHS general psychiatry subjects taking psychotropic medication. Non-NHS psychotherapy subjects took more non-psychotropic medication (22%) than NHS psychotherapy subjects (9%) and NHS general psychiatry subjects (8%) (P=0.041).

Eleven per cent of non-NHS psychotherapy and 40% of NHS psychotherapy subjects were attending a psychiatrist (P<0.001). There was no significant difference between the past contact of either psychotherapy group subjects with general psychiatry, NHS or non-NHS psychotherapy, and no significant differences in attitudes to past experience of psychotherapy whether NHS or non-NHS.

Thirty-three per cent of referrals to non-NHS psychotherapy were self-referrals, 48% came from GPs and 2% from psychiatrists, other sources included social workers, support workers and friends. GPs also had made the most referrals to NHS psychiatry (52%).

SCL-90-R responses were converted into gender adjusted 'T' scores. Higher T scores indicate greater symptom severity. Analysis of variance was performed using F ratios. T-tests were used to compare means as shown in Table 1.

NHS and non-NHS psychotherapy subjects had little difference in symptom severity. General psychiatry subjects had significantly higher levels of depression and anxiety compared to non-NHS psychotherapy subjects as reflected by higher use of antidepressants and anxiolytics. Somatisation scores were lowest in non-NHS psychotherapy subjects although this group reported the highest use of non-psychotropic prescribed medication. This suggests that non-NHS psychotherapy subjects either have higher levels of physical illness but do not complain about it as much or they were more precise in recording all the medicines they were on compared to NHS psychotherapy and NHS psychiatry patients.

The Global Severity Index of the SCL-90-R represents the best summary indicator of the current depth of an individual's distress. General psychiatry subjects were significantly more distressed than non-NHS psychotherapy subjects. Caseness analysis indicates that NHS

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Table 1. Symptom Check-List (SCL-90-R) dimension and index means

Dimension	Group 1 NHS psychotherapy (*n*=21)	Non-NHS psychotherapy (*n*=97)	NHS general psychiatry (*n*=58)
Somatisation	50.86	49.92	54.71 *P*=0.022*
Obsessive-compulsive	53.62	50.95	51.24
Interpersonal sensitivity	55.95	51.76	52.24
Depression	54.19	51.99	55.03 *P*=0.035*
Anxiety	49.24	48.59	52.16 *P*=0.012*
Hostility	54.10	50.52	50.12
Phobic anxiety	45.29	41.59	47.60
Paranoid ideation	55.52	49.45 *P*=0.04*	50.31
Psychoticism	48.10	47.42	48.32
Global Severity Index	53.32	50.46	54.16 *P*=0.014*
Positive Symptom Total	56.33	53.26	53.76
Positive Symptom Distress Index	48.48	48.53	51.69 *P*=0.025*
Caseness (% subjects)	47.6	22.7	37.9 χ^2 *P*=0.028*

*$P<0.05$.

psychotherapy subjects were the most distressed and non-NHS subjects the least.

Comment

Differing response rates and group sizes limit results, however it is helpful that the largest group of subjects belonged to the group of primary interest, the non-NHS psychotherapy service users.

Non-NHS individual psychotherapy service users tended to be women, in their 30s and better educated than general psychiatry patients. The gender difference was similar in previous studies (Doidge *et al*, 1994; Evans *et al*, 1995). These were not the 'worried well' – around a third were on psychotropic medications, over a tenth were attending a psychiatrist and over a fifth fulfilled caseness criteria. They were, however, less psychiatrically disturbed than their NHS psychotherapy counterparts who were less disturbed than general psychiatry out-patients. This is reassuring. However, a tenth of the individuals awaiting non-NHS psychotherapy and fulfilling caseness criteria had no ongoing psychiatric contact, including two subjects on antipsychotic medication.

No significant differences existed between NHS and non-NHS psychotherapy subjects past contact with psychiatry/psychotherapy or their attitudes to this. Handwritten comments requested more NHS counselling provision. Over half (59%) of non-NHS subjects had past experience of NHS mental health services, either psychiatric or psychotherapeutic. Only 37% were coming to non-NHS psychotherapy with no past experience of NHS or non-NHS mental health services. Sixteen per cent of non-NHS subjects with attitudes to past NHS psychotherapy were positive and an equal number were negative. The same was found of non-NHS treatment. Subjects going to non-NHS services had not necessarily a bad past experience of NHS care.

GPs had made the majority of referrals to the Number 21 Counselling centre with Edinburgh wide distribution. The 1994 annual report of the Number 21 Counselling centre records 26% of referrals from GPs and none from psychiatrists. GP referral increase may reflect recent mental health care changes in Edinburgh. GP purchasers may be less keen to buy psychotherapy from the NHS when it is free from the voluntary agencies who had shorter waiting lists. However, the increase in out-patient general psychiatric referrals by 163% between 1989 and 1995 would make it necessary to look at referrals specifically to NHS psychotherapy and community psychiatric nurses. The general public are more informed about health care rights with the notion of 'counselling' as the panacea of all ills (Wong, 1994). GPs may be referring secondary to more patient demand.

Margison & Stewart (1996) looked at GP and specialist referrals to a NHS psychotherapy centre. They found agreement on the level of service and the indications for its use. GPs seemed well informed. Other studies have focused on GP referrals to NHS psychotherapy (Morton & Staines, 1993; Maloney, 1993), but this study looks at referrals to a non-NHS service. GPs may not know what they want when they refer a patient. Undergraduate psychiatry teaching includes little on psychotherapy and doctors often remain confused as to what it is and what it is for. In a recent unpublished survey of 60 Edinburgh GPs (further details available from the author upon request), under a half had senior house officer psychiatry experience.

Current public demand for 'counselling' with the limited resources of NHS psychiatry means other sources of psychotherapy are used. NHS psychiatrists ought to identify ways in which services can

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more effectively coexist. To protect vulnerable individuals who may be treated with psychotherapy outwith the NHS appropriate standards of ethics, practice and training are essential for non-NHS psychotherapists. These psychotherapists should be able to recognise severe mental illness and have a basic understanding of psychotropic medication and psychiatric services.

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Psychotherapy and old age psychiatry

Jane Garner

Aims and Methods This report was prepared as the basis for wider consultation within the Old Age Faculty and the College. Some literature and practice is reviewed and practical suggestions made for the future in this area.
Results Although older patients are less likely to be refused for psychological intervention attitudes are slowly changing.
Clinical Implications The clinical implications of this development include a greater consideration of the unique emotional life of each of our patients and an improved understanding of our reluctance to engage in psychotherapeutic work with older people.

> "... near or above the age of fifty the elasticity of the mental processes on which treatment depends is as a rule lacking – old people are no longer educable ..." (Freud, 1905).

Hildebrand (1982) points to a certain irony in these comments as Freud, at the age of 49, was

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