

Social Work in Psychosocial Crises: Analysis of a Voluntary Psychosocial Counseling Program to Close a Supply Gap in Psychosocial Therapy

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Abstract

Background: People suffering from acute psychosocial crises often require immediate help. To supplement existing institutions and services, a counseling program ("Hel.p") was founded; this study evaluates that program following a two-year trial period.

Methods: The program offered anonymous, free-of-charge appointments to the public conducted by consultants holding, at minimum, a bachelor's degree in social work. Supervised by a judge and a psychologist, client-centered counseling sessions were conducted each week.

Results: Thirty-five counselors counseled 70 people. The clients were 37.6 +/- 18.4 years old and mostly female (67.1%). The counseling topics included health and diseases (16.1%) and general family problems (11.3%). The majority of the sessions (63.5%) took place during acute psychosocial crises.

Conclusions: "Hel.p" functions as a supplement to established outreach clinics for people with acute psychosocial crises. It bridges the gap between individuals' acute psychosocial problems and the delayed psychiatric/psychotherapeutic treatment caused by resource restrictions in the health care system.

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Background:

Throughout Germany, numerous public, private and religious organizations offer counseling centers for people with various psychosocial problems [1]. In Neubrandenburg (NB), a city of 63,000 inhabitants in the rural area of the Federal State of Mecklenburg-Vorpommern (MV), counseling centers in diverse practice areas (e.g., family, pregnancy, youth, addiction) are available [2].

If psychosocial counseling is insufficient, clients/patients might require assistance from the professional medical and/or psychotherapeutic health care system, which imposes a significantly higher barrier to entry and is more cost-intensive. Such clients/patients must wait for available help [3]. According to a recent survey study of the Germany Association of Psychotherapists (DPTV), psychotherapists have waiting periods of more than 2.5 months for an appointment [4]. The SHIP study reveals that 12% of mentally ill people receive no psychiatric/psychotherapeutic treatment at all [5]. Another recent study reveals that 36% of mentally ill people are in contact with outpatient or inpatient psychiatric/psychotherapeutic services or a general practitioner [6].

Beyond the problem of immediate availability, other factors determine the use of the psychiatric/psychological/psychotherapeutic health care system, such as the type of diagnosis, comorbidity and individual sociodemographic characteristics [7]. Other important reasons for the lack of medical/psychological assistance include individual and social barriers, a lack of knowledge, a lack of motivation, a lack of low-threshold medical and/or psychological treatment services, and a lack of care services in the outpatient setting [8, 9]. Furthermore, 24-35% of surveyed psychotherapists reported that they frequently saw patients who were unwilling or unable to pay for psychotherapy [10].

Another complicating aspect, at least in Germany, is the interface problem between the medical health care system (which is primarily covered by health insurance) and the social system (which is primarily covered by the welfare system) and therefore between medical and/or psychological treatment options and counseling centers [11-13].

The current health care situation is such that in cases of sudden psychosocial crises, individuals have no prompt access to the high-threshold, cumbersome and expensive professional health care system, even if treatment by that system seems necessary. Therefore, the Hel.p project was founded at the University of Applied Sciences Neubrandenburg (UNB) to offer a cost-free, low-threshold, rapidly accessible alternative to close the gap between the need created by acute psychosocial crises and the treatment available from the professional health care system. This manuscript presents data from the evaluation of this program after a two-year period.

Methods:

On April 1, 2013, the Hel.p project was initiated by Dipl. Psych. Professor Robert Northoff, PhD, and his study group at UNB to offer a cost-free, low-threshold and rapidly accessible psychosocial counseling option.

Information about the project and contact details were distributed to the public via daily newspapers, local radio, and fliers published and distributed by network partners of the UNB (e.g., other psychosocial counseling centers and primary care physicians).

The Help team was available via telephone (24 hours per day, 7 days per week), via

email and in person at the counseling office (Monday through Thursday, 4-6 p.m.). Counseling was anonymous and free of charge; clients did not have to disclose their name or other personal data. To ensure the highest degree of anonymity, clients were allowed to waive documentation of the counseling session; consequently, documentation pertaining to several cases was missing. Evaluation of the counseling session was also optional.

Counseling sessions were conducted using client-centered negotiation performed in accordance with Carl Rogers' work [14, 15].

The criterion for admission to the Hel.p team as a counselor was to hold at least a bachelor's degree in social work or a bachelor's degree in a similar scientific field (e.g., psychology). The counseling project enabled students to gain practice in the field of counseling and/or social work. Counselors received no remuneration. All of the team members were supervised by the project leader, Robert Northoff, who is both an experienced psychologist and a judge.

As a supplement to the psycho-medical health care system, Hel.p counseling was restricted to a maximum of five counseling sessions; contact information for psychiatrists and psychotherapists were distributed.

The analyzed data were based on the data collected via anonymous questionnaires during the counseling sessions. As noted above, because of the offer of anonymity, clients had the choice to decline

documentation, and completing a questionnaire was optional. Clients had been counseled, as described above.

Statistical analysis was performed using IBM SPSS Statistics 23.0; means and standard deviations are provided. According to chi-square tests, p-values are given with confidence intervals.

The study was conducted in accordance with the Declaration of Helsinki of 1975. Prior to completing the questionnaire, clients were informed of the scientific goal of the data collection; they gave their written informed consent by filling in the questionnaire. The study was approved by the local ethics committee (Reg. No. 20.04.15).

Results

The Hel.p project was conducted by 35 counselors who had been recruited by the supervisor prior to the project start. All of the counselors (n = 35) were students at UNB. To provide patients continuous counseling, although n = 9 counselors were accepted without a bachelor's degree, they were six months away from receiving their degree and were strictly evaluated by the supervisor. The consultants (n = 35) were predominantly female (82.9%, n = 29 female; 17.1%, n = 6 male). For further characteristics, see table 1.

A total of n = 270 counseling sessions were offered during operating hours (during the 2-hour

Table 1. Structure of the Hel.p team:

Qualification of the counselor	Number of counselors	Quantity of counseling services offered during opening hours	Number of sessions
Master's Advisory	N = 22 (3 male, 19 female)	N = 163	N = 49
Master's Social Work	N = 4 (1 male, 3 female)	N = 26	N = 4
Bachelor's Social Work	N = 9 (2 male, 7 female)	N = 81	N = 17
Sum	N = 35 (6 male, 29 female)	N = 270	N = 70

opening time of the counseling office). The office was reachable without barriers.

Among the potential clients (n = 78), most initially contacted the Hel.p team via telephone. Compared to other contact types (email, in-person), this type of contact was associated with the lowest number of executed consultations (Tab. 2). Thus, the greatest adherence was achieved by recording local contacts with potential clients in the Hel.p office. In many cases (n = 28), consultation took place immediately after clients personally contacted the Hel.p team in the office (Tab. 2).

Significantly more women initially contacted the Hel.p team via telephone (p = 0,019, CI

(mean +/- standard deviation).

The clients' completion of the evaluation questionnaire was explicitly voluntary. Moreover, to ensure the highest degree of anonymity and the low threshold to entry, the consultants' records of the proceedings were also not compulsory. Therefore, only 68.6% (n = 48) of the counseling sessions (n = 70) were documented.

Following categorization, four main topics were identified and clustered as follows: 16.1% (n = 10) of the consultations primarily addressed the issue of health and disease; 12.9% (n = 8) primarily addressed education and socialization; 11.3% primarily addressed disability and inclusion; 11.3% (n = 7)

Table 2. Method of contacting the Hel.p team:

	First contact	Subsequent contact	Agreed-upon consultancy	Occurred consultancy	Questionnaire available
Phone	N = 30	N = 7	N = 34	N = 22	N = 19
Email	N = 15	N = 0	N = 15	N = 11	N = 9
In person by appointment	N = 5	N = 4	N = 9	N = 9	N = 9
In person without appointment during opening hours	N = 28	/	/	N = 28	N = 11
Sum	N = 78			N = 70	N = 48

0,130 – 1,407). Age and the approach to initial contact were not significantly associated. Similarly, with respect to psychosocial problems, there was no significant association between the counseling topic and the initial contact behavior (p = 0.070, CI -1.484 – 0.67). However, significantly more clients contacted the Hel.p team via telephone when experiencing acute psychosocial crises than for follow-up care and prevention (p = 0.000045, CI 0.861 – 1.599).

With regard to gender distribution, 67.1% (n = 47) of the clients were female and 32.9% (n = 23) were male. Clients were between 18 and 73 years of age, with an average age of 37.6 years +/- 18.4

primarily addressed general family problems; and 9.6% (n = 6) primarily addressed work and unemployment. For more detailed data, please see table 3. Clients were counseled on 1.6 subjects per consultation.

Clients who were counseled because of general family problems were not significantly older than average (p = 0.526 CI -0.276 – 0.143). The same was true for clients counseled on issues of health and disease (p = 0.685 CI -0.193 – 0.29). Furthermore, no significant differences could be detected in age or sex in relation to the counseling topic (p = 0.953, CI -1.22206 – 1.15539).

Regarding the timing of counseling

Table 3. Subjects of counseling sessions

	Quantity	Proportion
Money and tangible assets	N = 5	8.10%
Law and infringement	N = 2	3.2%
Habitation	N = 1	1.6%
Health and disease	N = 10	16.1%
Grief and death	N = 1	1.6%
Family in general	N = 7	11.3%
Conflicts and violence	N = 4	6.5%
(Medical) Care and assistance	N = 4	6.5%
(Un-) employment	N = 6	9.6%
Disability and inclusion	N = 8	12.9%
Education and socialization	N = 8	12.9%
Marriage and partnership	N = 4	6.5%
Learning and school	N = 2	3.2%
Sum	N= 62	100.0%

along the timeline of psychosocial problems, 20.3% (n = 15) of the consultations could be assigned to the field of prevention and 16.2% (n = 12) could be assigned to the field of follow-up care. Most of the consultations took place during psychosocial crises (63.5%, n = 47) (Tab. 4).

Table 4. Timeline of contacting the Hel.p team

	Male	Female	Quantity	Proportion
Prevention	N = 0	N = 15	N = 15	20.3%
Crisis	N = 7	N = 40	N = 47	63.5%
Follow-up	N = 1	N = 11	N = 12	16.2%
Sum	N = 8	N = 66	N = 74	100.0%

Slightly (but not significantly) more female than male clients received preventive counseling ($p = 0.055$, CI -0.008 – 0.74). There was no significant association between the clients' age and the timeline of psychosocial crises ($p = 0.198$, CI -13.01 – 61.223).

Discussion

The Hel.p project was founded to offer anonymous, low-threshold, barrier-free and cost-free psychosocial counseling to the public. The final analysis indicated that this service was requested by N = 78

potential clients. Most people contacted the counseling team via telephone; clients were 37.6 years old (mean), and most were female. N = 15 used Hel.p for prevention, N = 47 used it during acute psychosocial crises, and N = 12 used it for follow-up care in four main fields of counseling.

The main hypothesis was that professional psychosocial help is needed immediately during acute psychosocial crises. The majority of the clients verified this hypothesis, seeking psychosocial help during acute psychosocial crises (63.5%, N = 47). Significantly fewer than one-quarter of the clients used Hel.p for prevention or follow-up care. This aspect confirmed the assumption derived from national data about scarce resources in the medical and psychological field. A recent investigation of the German Association of Psychotherapists revealed 2.5-month waiting periods for patients seeking psychotherapy [4]. However, this waiting period was measured by the time between the first call and the first, preliminary talk (not the beginning of psychotherapy itself). Furthermore, in regions with a lower population density such as MV, an even worse situation was described: For small cities such as NB, the waiting period was found to be 104 days [4]. The SHIP study revealed that 12% of mentally ill people receive no psychiatric/psychotherapeutic treatment at all [5]. Although in Germany, some psychosocial support should be covered by general practitioners (GPs), time restrictions prevent GPs from offering deep psychotherapeutic treatment. Unfortunately, there are no data on waiting periods for outreach clinics.

Hel.p enabled 40% (N = 28) of clients who contacted the Hel.p team in person during consultation hours to receive immediate counseling sessions. These persons stated that they needed, or "diagnosed" themselves as needing, immediate psychosocial help. The SHIP study indicated that 12% of mentally ill people, despite high stress, received no

psychiatric/psychotherapeutic treatment, even though they were assessed as “needing treatment” [5].

However, it is difficult to make an international comparison because other countries’ health care resources and financing are not comparable to the German situation.

The problem of insufficient immediate access to psychosocial help during psychosocial crises derives not only from scarce resources but also from other limiting factors, such as the type of diagnosis, comorbidity, sociodemographic characteristics, individual and social barriers, a lack of knowledge, a lack of motivation, a lack of low-threshold medical and/or psychological treatment services, and a lack of care services in the outpatient setting. These factors are important and are depicted in the literature (e.g., [7-9]. The lack of money to pay for psychotherapeutic treatment constitutes another limitation [10].

Some of the abovementioned factors were solved by Hel.p, which was organized to be cost-free, low-threshold and completely anonymous.

In the German health care system, GPs have a special function as “gatekeepers” for further medical and psychological specialists; they are required to “guide” patients. This function was adopted by Hel.p, which not only counseled clients but also conveyed contact information to specialists. However, people must identify themselves using their personal health insurance card when consulting a GP. They therefore must identify themselves to others as having psychosocial problems (GP, receptionist, other patients in the waiting room), an issue that is linked to the putatively stigmatizing aspect of the problem. Furthermore, GPs are primarily consulted for somatic—not psychological or social—problems [16, 17]. Therefore, people who lack somatic problems but have stigmatizing psychosocial problems may avoid consulting a GP. Hel.p may thus represent an

adequate alternative, offering direct psychosocial counseling and distributing contact information for professional psychotherapists and psychiatrists. It could also provide contact information for other specialized outreach clinics.

Similarly to international studies regarding individuals seeking psychosocial help, the NASHIP survey demonstrates that psychotherapeutic treatment is provided to significantly more employed persons than retired persons [4, 18-20]. The international data were confirmed by our study: Clients seeking help from Hel.p were, on average, 36.7 years old, and therefore of employment age.

The SHIP study revealed that 75% of all health problems are “treated” in the so-called “informal health system,” which means that people attempt to obtain counseling and treatment from family members, other relatives, friends and self-help groups [5]. These 75% attempt to avoid contacting GPs or other professionals in the health care system or entering the system. These people can be reached much more easily via low-threshold services such as Hel.p.

The geographic accessibility of psychosocial treatment represents an important, frequently limiting factor for many people: In Germany, most patients (62%) reach physicians using a car, which presupposes the availability of a vehicle; 60% of physician visits require trips of approximately 10 minutes in general. To reach a specialist in Germany, trips of more than 20 minutes are required [18]. This situation is comparable to the corresponding situations in other countries [21].

This location problem is not encountered in Hel.p, which is situated at the regional center (NB) and is conveniently accessible by public transport (buses).

Problematic factors of the Hel.p project may be the counselors' age and status: counselors are comparatively young. They are beginning their (vocational) training and are not trained as physicians or psychotherapists. German psychotherapy patients are primarily aged 40-49 years; the mean client age of the Hel.p project was 37.6 years. The project's counselors lack work experience because of their youth, which could mean that clients do not take the counselors in their professional role "seriously" enough and could lead to premature termination of consulting services.

In addition, sex may be another relevant aspect: The majority of the consultants were female. This gender distribution is comparable to other psychosocial fields: The proportion of women among the occupational groups of social workers and social pedagogues is 70-80% [22-24]. For graduates of the psychology field of study, the proportion of women has trended upward in recent years and is now at 82% [23]. The gender distribution among medical psychotherapists is similar [23]. However, the majority of patients seeking psychotherapeutic help are female. The influence of sex roles on psychotherapeutic treatment, however, is a matter of controversy [25-28].

At the end of the discussion, some aspects of the study are worth discussing as limiting factors: This evaluation is based on anonymous data from 70 counseling sessions. Furthermore, there are missing records because of Hel.p's assurance of client anonymity by not recording any data. This approach might be source of a bias in which pursuant to the clients' wishes, particularly stigmatizing topics were not recorded. This aspect may have influenced not only the types of recorded topics but also the number of counseling sessions. Nevertheless, this aspect is both the main weakness and the main strength of the project: It provides a reduced number of topics and clients for statistical analysis but enables complete

anonymity.

Another limiting aspect is clients' frequency of contacting: Given the high frequency and variety of psychosocial crises based on the numbers of consultations in various counseling centers and outpatient and inpatient psychiatric-psychotherapeutic treatment, the frequency of contacts was very low. During the two-year time frame, there were only 78 contacts with the team (although due to anonymity (as discussed above), not all of the contacts and counseling sessions were recorded). Furthermore, Hel.p was a low-threshold, cost-free, barrier-free and anonymous psychosocial outreach clinic available four days a week from 4 to 6 p.m. We assume that there was not sufficient public awareness and knowledge of Hel.p. Because newspaper advertisements were too expensive, we distributed fliers and local radio information to the public. This low awareness may have led to the low frequency with which people consulted Hel.p.

Nevertheless, the Hel.p project represented a complementary addition to the professional health care system. It offered an interim alternative to the use of the health care system, if the obstacles to receiving a counseling session an established advisory body and/or psychiatric-psychotherapeutic treatment were too high (e.g., the wait for psychotherapeutic sessions, the shame of stigmatizing psychosocial problems, the lack of anonymity, the fear of costs). In such cases, Hel.p conveyed knowledge and skills related to the health and social system and established contacts with other mental health facilities. Offering a maximum of five to ten counseling sessions, Hel.p was tailored to close a supply gap rather than to replace other forms of professional treatment.

Conclusion

The "Hel.p" project is a low-threshold,

anonymous, cost-free and immediate program that supplements established outreach clinics and psychiatric/psychotherapeutic treatment for people experiencing acute psychosocial crises. This project bridges the gap between individuals' acute psychosocial problems and delayed psychiatric/psychotherapeutic treatment resulting from the German health care system's resource restrictions. It could curtail the development of psychiatric disorders from an early stage, which could prevent the later use of the health care system and possibly reduce both societal and individual costs.

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ETHICAL APPROVAL

The study was conducted in accordance with the Declaration of Helsinki of 1975. Prior to completing the questionnaire, clients were informed about the scientific aim of the data collection and gave written informed consent by filling in the questionnaire. The study was approved by the local ethics committee (Reg. No. 20.04.15).

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