REVIEW ARTICLE

Towards a rationalization of counselling in general practice

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SUMMARY. While there is good evidence to show that counselling may be beneficial to those patients in general practice with non-organic problems, deployment of the available resources lacks standardization and rationalization. The Counselling in Medical Settings Working Party of the British Association for Counselling is pressing for standardized training and accreditation of counsellors so that general practitioners will feel more confident about taking on workers who will ultimately be incorporated into the NHS team.

The role of counselling in general practice

THERE is no formal procedure for providing the main body of general practitioners with information about the full range of counselling activities, the main theoretical models on which counsellors draw and the methods of implementing a counselling scheme in the doctor's own surgery. The literature suggests that, in general, doctors have a skimpy knowledge and experience of counselling;[1] only 5–10 per cent of practices have an attached social worker;[2] and few have a professional relationship with agencies such as Marriage Guidance.[3]

Nevertheless, the numerous practice counselling schemes that have been established do reflect the general practitioner's growing interest in counselling. Attachments evaluated for their effectiveness (with varying study design and different criteria of success) have shown that a counselling service benefits both patient and general practitioner — as well as providing the counsellor with a satisfactory and effective method of working.[4-8]

It has been suggested that approximately one third of all patients who consult their general practitioner have a 'life problem' or symptoms reflecting an underlying psychosocial problem rather than an organic complaint.[3,9] The consultation will last on average six minutes[10] and the 'life problem' may well be 'medicalized' — that is, treated as an organic complaint, usually by the prescription of psychotropic drugs.[11] As a result, the condition may become chronic or at least remain unchanged, as will the frequency of consultations.

Nearly 39 million prescriptions for psychotropic drugs were issued in 1980[12] at an approximate cost of £58 million (Department of Health and Social Security 1980, unpublished statistics). These figures do not reflect the cost in general practitioner's time, in pharmacist's salary, in administration and packaging, not to mention the cost of hospitalization for those patients who abuse the prescribed drugs by overdosage or by becoming dependent.[13] In contrast, the presence of a counsellor in the surgery results, it would appear, in a reduction in demand on the general practitioner's time and a reduction in the prescription of psychotropic drugs.[4,7,14] It has been noted that these results must be viewed with caution until more extensive and rigorous research is done.[7,15]

The gains evinced most frequently have been through the role of the counsellor in the therapeutic team: early identification of the patient's problem, ease of referral and access,[4,6,16] and continuity and evaluation of care.[9] These gains mean fewer inappropriate referrals and investigations, fewer hospital admissions and less of the stigma associated with psychiatric illness.[9,10] Various studies show specific benefits such as improvement in the health of children of disturbed marriages,[8] a reduction in psychosomatic symptoms,[6] and patients' satisfaction with a counselling service.[7] Improved patient care is matched by a division of the workload, which leads to increased satisfaction and a growth of mutual respect between members of the primary care team.[10] The subjective evaluation of placements showed in favour of such attachments in all studies reviewed.[4,6,14,15]

Counselling method

Although other attachments have been observed, notably social workers, clinical psychologists, psychotherapists and general counsellors, research studies have used marriage guidance counsellors in the main. Some differences exist

between schemes in the problems addressed by the counsellor, but these are wide ranging and include problems of anxiety and depression, bereavement, divorce, infidelity, school phobia and alcoholism.

The counselling method most frequently referred to is non-directive. Whatever the orientation, however, counselling is seen to be about the process of relationship, where the counsellor listens to and supports the client yet remains neutral in attitude, thus facilitating the client's own resolution of the problem. By not giving advice, reassurance or medication, counsellors systematically attempt to avoid long-term dependency on them: the main help offered is insight and understanding so that clients are enabled to help themselves rather than use the directives of others.

Many doctors consciously use counselling in their clinical interviews, but these skills are more often developed through experience than formal training.[17] Counselling requires a 'new' technique for doctors, but one that fits in well with current ideas about patient participation[18] and general practitioners' training in consultation skills.[19,20] It involves a shift from the authoritarian model of 'distance, diagnosis and reassurance'[2] and demands a more active than passive response from the patient, whose autonomy is recognized in the title 'client'. Most general practitioners see themselves as the ones who should be helping patients with their emotional problems;[10] but whether they should do it all is arguable. However advanced their therapeutic training and interests might be, it is unlikely that they can satisfy the demands of the community without adversely affecting clinical work. No extra remuneration is available for time incurred by counselling, as general practitioners are paid per capita. Apart from these considerations, it is questionable whether expertise and the use of counselling as a therapeutic intervention is fully appreciated or understood. With the exception of the Balint seminars, few training schemes offer doctors the time to explore their own attitudes, beliefs and anxieties — an aspect considered central to the training and supervision of counsellors.

Thus the research reviewed has repeatedly shown the need for, and the benefits accruing from, the counsellor attachment in general practice. Any difficulties encountered are usually due to administrative problems rather than the nature of the service offered. The 'problem' of counselling in general practice lies in its ad hoc nature in terms of availability, selection and lack of standardization.

Organizational problems

Different groups of professionals and volunteers cite evidence for their own appropriateness for counselling in the primary care team, without acknowledging and rarely assessing the contributions of others.[9] Counsellor training, supervision and practice vary between individuals and between professions, and the lack of standardization or accreditation results in a hotchpotch of offers of services.

The general practitioner has little way of selecting a counsellor. Counselling in general practice is seen to be generalist in nature,[9,18] so that in one sense theoretical orientation is not a major problem. However, it might be surmised that general practitioners would be more inclined to employ a counsellor if the working aims and theoretical model were made clear and easily accessible.

Despite the profusion of professionals interested in becoming involved in the primary care team, the scarcity of trained personnel and the heavy demands made on their resources means that there are too few available to make more than a transient impact here. Volunteers are more readily available but have limited time or cannot afford more time because of lack of payment.[9]

Marriage guidance counsellors who work mainly on a voluntary basis are overwhelmed with the amount of work at their centres. The absence of formal remuneration is a deterrent in seeking work in the primary care team despite apparent demand. Jarman, a London general practitioner, commented that marriage guidance counsellors were of far greater help to patients than psychiatric referral:[21] the preliminary findings of a referral study he set up showed that almost half of the patients referred to the NHS psychiatric services receive no treatment at all from a service that cost £886 million in 1981/82 (DHSS 1981/82, unpublished statistics). He went on to suggest that there should be a major reallocation of funds to enable general practitioners to cope more effectively with patients' psychological problems through visiting psychiatrists, psychologists and counsellor attachments.

Unsatisfactory payment is a major restriction in providing adequate counselling services[21] (CMS Working Party 1982–84, unpublished results of survey). At present there is no DHSS/NHS money available. Counsellors are not eligible for payment under the ancillary staff scheme whereby 70 per cent of an employee's wages are reimbursed by the Family Practitioner Committee. This is despite the fact that counsellors could easily fit into the treatment team, the DHSS definition of nursing and treatment involving 'such medical attention as is normally provided as part of general medical services and which is appropriate for a general medical practitioner to delegate to a suitably trained worker'.[22]

Methods of payment vary from charging the patient direct, paying by 'underhand' methods, working on an unpaid basis (the only member of the team to do so) to being paid by private medical insurance if the patient is referred by a psychiatrist (who retains overall supervision of the client). The counselling service may occasionally be financed out of practice funds (CMS Working Party 1982–84, unpublished results of survey).

The question of how much to pay and how much time counsellors should make available to general practitioners is somewhat difficult to assess from the literature. One scheme failed to use the full amount of time available (M. De Groot, unpublished observations), while another found a need to increase the amount of time allocated.[4] Referrals depend on various factors such as whether all doctors in the practice use the counsellor (doctors' attitudes vary and often the referral pattern is skewed),[16] the number of patients in the practice and the newness of the

counselling services.[10] In general there is a lack of formal organization of counselling schemes and confusion about terms of employment. Individual schemes which flourish seem to do so because of their particular structure for communication (M. De Groot, unpublished observations).

Proposals for rationalization of resources

As Wyld pointed out,[9] the value of immediately available counselling in a general practice setting cannot be widely exploited without recognition of the service by the NHS and incorporation into its structure. That is unlikely to happen unless general practitioners press for such an addition to their services; and this will not happen until 'some kind of cohesion of appropriate counselling skills takes place from among the diversity of professionals and volunteers involved, so that they can be presented in a marketable, unified form'.[9] With this aim in view, the Counselling in Medical Settings division of the British Association for Counselling set up a working party in 1982 to study pay and expenses of counsellors working in general practice. After the first year its members began to work on several proposals including accreditation, a register of accredited counsellors and information booklets for general practitioners and counsellors respectively.

The British Association for Counselling (BAC) has recently instituted a system of accreditation in order to standardize counselling practice in a way helpful to general practitioners as potential employers. According to the guidelines issued by BAC, the accreditated counsellor will have received a recognized training in counselling and will have had not less than three years of experience in counselling under supervision, or three years of experience plus a further year under an approved supervisor. Those with no basic training in counselling will be considered for accreditation after five years of practice, with the last year being under supervision. The accredited counsellor will have an agreed arrangement for consultation or supervision and will furthermore be able to give assurance of a serious commitment to continuing personal and professional development. All accredited counsellors will have accepted the BAC Code of Ethics and will be required to reapply for accreditation every five years.

The Counselling in Medical Settings Division of BAC recommends that counsellors wishing to work in general practice apply for accreditation. There is discussion about further training needs and specific accreditation for practice counsellors. It is suggested that all volunteers and professionals who use counselling skills in their work do not call themselves counsellors unless their formal training and expertise satisfies BAC accreditation.

The working party is also preparing an information booklet for general practitioners. This will include a review of the practice of counselling in the primary care setting and outline the advantages of such schemes as well as the difficulties that may occur. Information on the nature and scope of counselling as well as different treatment models will be included. There will be sections on the role of the counsellor in the therapeutic team, the referral process and types of referral. Guidelines will be given on issues such as pay, hours and conditions. A similar booklet is being prepared for counsellors, with special emphasis on accreditation, training and supervision, the role of medication and the structure of the practice team.

It is recommended that patients are given the BAC leaflet on counselling along with a personal statement prepared by the practice counsellor and agreed by the general practitioner.

It is hoped that these developments will be the first steps towards the provision of a formal structure to inform general practitioners about counselling. The information booklets may be of help to the general practitioner who wants to establish a counsellor attachment but is unsure how to go about it. Selection and availability will be eased by the existence of a register of accredited counsellors.

Moreover, it is hoped that the standardization of counselling practice will be a major step towards the long overdue incorporation into the NHS of the paid counsellor in the primary care team.

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