Children with special educational needs

Sir,

It was good to see Dr Ní Brolcháin's interesting study of children with special educational needs (February *Journal,* p.56). They form a small but important subgroup of a practice child population. I suspect these children and their families may well have higher consultation rates than a control group without special educational needs. I trained for general practice (including nine months in acute hospital paediatrics) without learning about the 1981 education act but hopefully course organizers are now including it in their programmes.

I would like to emphasize a few practical points about the education act:

1. Any person who is concerned that a child may have an educational problem may request an assessment under the act (parents, teachers, doctors and so on).
2. The district health authority is obliged to inform the education authority about children who may have such needs.
3. Three professionals have to assess and report on the child's needs: a teacher, an educational psychologist, and a doctor with experience in educational medicine (a community paediatrician or senior clinical medical officer). Others may also be asked to make an assessment.
4. Parents are involved at all stages and can have copies of all reports made under the act.
5. Assessment is often a long and daunting process for both parents and children.

General practitioners have an important role to play in the early detection and care of these children and their families and Dr Ní Bhrolcháin illustrates the range of handicaps suffered. Specialist knowledge may be required in order to arrange for a radio hearing aid to be provided for a deaf child in a junior school or to diagnose the cause of deteriorating performance in a secondary school child. Effective liaison between the different agencies is essential if good care is to be achieved.

Dr Ní Bhrolcháin has probably underestimated the number of children with special needs as many may not be identified under the terms of the 1981 act. As many as 20% of children will have special educational needs at some point and only 2% undergo formal assessment.

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Can general practitioners counsel?

Sir,

Dr Rowland and colleagues' discussion paper (March *Journal,* p.118) raises several issues which need addressing.

The article quotes, without qualification, the British Association for Counselling's definition of the counselling process. These rather vague goals are common to many different schools of counselling: directive, informative, confrontational, cathartic, catalytic and supportive. The therapeutic models are based on psychodynamic and behavioural theory whose definitions are some way removed from the commonsense concepts of help, empathy and listening.

The emphasis placed by the authors on the distinction between counselling skills and the process of counselling side-steps the basic unresolved question of whether the 'talking therapies' (including psychotherapy) constitute effective modes of treatment. The authors, however, make the assumption that the efficacy of the counselling process is proven, but there is no body of research which is not predominantly anecdotal that supports this claim. In particular, the use of counsellors and counselling techniques by general practitioners is haphazard and reflects the wide range of possible responses to large numbers of patients with problems which are loosely defined as psychosocial. The management of these problems over years rather than months renders assessment difficult, as Anderson points out in his study.[1]

A general practitioner is the only member of the primary health care team with legal responsibility for the patient. Therefore, the medicolegal consequences of any breakdown in communication or confidentiality between general practitioner, patient and counsellor is borne by the general practitioner.[2] The status of the counsellor as therapist within the context of general practice raises serious ethical problems. The harmful or negative effects of counselling are perhaps recognized more reluctantly by patients and counsellors than by general practitioners who are responsible for the continuity of care.

The cost-effectiveness of counselling is not mentioned by the authors in their discussion paper even though they are all affiliated to the Centre for Health Economics, University of York. The cost of counselling to the patient in the open market is £25.00 (1985 price) per session — the minimum rate for an accredited counsellor.[3] Despite the lack of evidence of long-term benefits to the patient, the decision to reimburse general practitioners for attached counsellors is taken exclusively by individual family practitioner committees.

It is also relevant to reaffirm that counselling, or the use of counselling skills, occurs in the course of consultation between patients and all members of the primary health care team, including health visitors, community psychiatric nurses, social workers, practice nurses, district nurses and receptionists. The assessment of the need for the addition of a professional counsellor or a clinical psychologist acting as counsellor for specific management problems would vary according to the approach and attitudes of the individual general practitioner. The use of marriage guidance counsellors and psychosexual counsellors is very different from the help demanded by those 'help-seeking and vulnerable' patients whose demands for support are often life-long.

Finally, I would disagree with the underlying assumption of the authors, one of whom is writing from the standpoint of a counsellor in general practice, that 'counsellor attachment schemes' are self-evidently beneficial. The question whether general practitioners themselves can act as counsellors remains undecided and rooted in the definition and qualification of the term 'counsel'. As Roslyn Corney concludes from her own study 'Promoting a large counselling service in general practice before establishing what benefit occurs from this service is unwise.'[4]

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Management of benzodiazepine withdrawal

Sir,

I read with interest Mr Onyett's comprehensive review article on the management of the benzodiazepine withdrawal syndrome (April *Journal,* p.160) in which he concludes that supplementary effort from other primary care staff or agencies with specific psychological expertise may be necessary in the management of benzodiazepine withdrawal. In a recent survey of patients in my own practice,[1] however,