Counselling in an inner city general practice: analysis of its use and uptake

VIVIEN WEBBER

PETER DAVIES

PATRICK PIETRONI

SUMMARY

Background. *In recognition of the emotional problems which frequently underlie somatic complaints, practices increasingly offer counselling as part of their services to patients. In an inner city practice, a combination of short term counselling, volunteer befriending, community outreach and social work services is offered as a means of responding to the full range of patients' counselling needs.*
Aim. *This study set out to establish the use and uptake of these services.*
Method. *A retrospective analysis of patients referred for counselling over one year was carried out.*
Results. *The analysis identified a broad range of emotional problems among referred patients as well as problems of a practical nature. A quarter of the patients referred failed to keep their initial appointments or to complete their contracts. One fifth of the patients were referred on for longer term counselling and/or psychotherapy. Subsequent feedback revealed that preparation of a patient before referral was an important factor affecting uptake of counselling.*
Conclusion. *Early assessment of the use and uptake of such services is essential if they are to be integrated successfully and a counsellor's individual skills employed effectively.*

Keywords: counselling; patient satisfaction; uptake; inner city general practice.

Introduction

THE increasing number of counsellors working in general practice[1] has coincided with a change in the pattern of primary health care. Practitioners, by choice and necessity, now work in a multidisciplinary network.[2] Frequently, these networks link medical care with nursing care, social work and, more recently, complementary therapies.[3] Moreover, patients as well as practitioners now tend to perceive illness as the result of a complex interaction of social, psychological, physical and environmental factors.[4,5] This change has taken place against a background of cultural and environmental changes, for instance, the fact that more varied social and ethnic class groupings now live in the same area.[6] As these changes have occurred, so the need for counsellors has become widely recognized.[7]

The literature on counselling in primary health care emphasizes the subjective, positive experiences of general practitioners and counsellors working together.[8-10] Research projects, in which the experiences of social workers with psychotherapeutic skills and psychotherapists in primary health care are described, also emphasize the importance of interdisciplinary collaboration.[11,12] In addition, various studies have attempted to look at the effectiveness of different styles of counselling[13-15] while others have compared trained staff with non-trained helpers.[16-18]

Although these studies have highlighted the value of counselling in general practice there is a pressing need for further evaluation both of the types of problems being referred and how they are being met.[19] At present, no standardized training guidelines exist for counsellors working in general practice[20] and only recently have generally accepted standards of practice been set.[21] Furthermore, few studies have addressed how practices might respond more imaginatively to the full breadth of counselling need.

The aim of the present study was to analyse and assess how a range of counselling, volunteer befriending, community outreach and social work services was being employed in an inner city health centre, as well as how these services might be developed further.

P Davies, PhD, director of research, Marylebone Centre Trust, London. P Pietroni, FRCGP, MRCP, general practitioner and V Webber, BSc, social worker/psychoanalytic psychotherapist, London.
Submitted: 8 June 1992; accepted: 25 June 1993.

© *British Journal of General Practice,* 1994, **44,** 175-178.

Method

Marylebone health centre

The Marylebone health centre is a National Health Service general practice which emphasizes a multidisciplinary approach to patient care. In addition to a core team of one full-time and two part-time general practitioners, a practice nurse, and health visiting and district nursing staff, the centre provides counselling, complementary therapies (traditional Chinese medicine, massage, homoeopathy and osteopathy), a community care and outreach programme and stress management group activities.

At the time of this analysis, the practice had just under 3700 registered patients. The practice has an 'open door' policy towards new registrations. It is situated in an area of social extremes, and attracts a high proportion of underprivileged patients, as a result of the large number of local bed and breakfast hotels for homeless families.[6] The practice population generally reflects local demography, although it has relatively more patients in the 20–29 years age group (31% versus the mean for the family health services authority of 23%) and fewer patients over 65 years of age (8% versus 13%). The proportions of male and female patients are 42% and 58%, respectively; approximately a quarter of patients are from an ethnic minority background.

Counselling

The counsellor is trained as a social worker and psychoanalytic psychotherapist as well as having counselling, stress management and family therapy skills. She is employed for nine hours per week. The usual channel of referral for counselling is directly from the general practitioner with the patient making an appointment to see the counsellor through reception. Occasionally, referrals are made by the complementary practitioners following discussion with the general practitioner and in one or two instances patients refer themselves. Details of the patient's problems are written in the patient's notes as well as on a separate referral form, with a comment on the type of help required. In some instances, either after the first assessment meeting or after several sessions, the counsellor may refer a patient for long-term psychotherapy or some other service, as appropriate.

Depending on the nature of the problem, patients are normally offered a counselling contract of a maximum of six to eight sessions at either the first or second appointment. This can be extended by mutual agreement as a result of ongoing assessment. A focus for the work is agreed early on. Each session usually lasts 50 minutes, but can be shorter. At the end of each session, a summary is written in the patient's notes which are accessible to all members of the multidisciplinary team. Patients are made aware of this and if they wish information to remain confidential, this wish is normally respected.

A social work student, trainee counsellor and a group of volunteer befrienders, attached to the health centre, provide a wide range of resources for the counsellor to draw upon. They offer more flexibility in the amount of contact that is possible with patients and in the case of the trainee counsellor and social work student this flexibility also meets their training needs. It also means that home visiting is possible, an aspect of work not normally considered part of a trained counsellor's role. Feedback from homeless families staying in temporary hotel accommodation and from patients living on their own suggests they particularly value this extended length of involvement.

Analysis

A retrospective analysis was carried out of patients referred for counselling between September 1989 and August 1990, inclusive. The information compiled included patients' date of birth, sex, referring general practitioner, date of referral, reason(s) for referral (as corroborated by the counsellor), and uptake and length of treatment. General practitioner consultation and referral rates were calculated by reviewing the practice's appointment sheets and referral letters over this period.

Results

Referrals

A total of 92 patients were referred by general practitioners for counselling over the study period and three further patients referred themselves. Of the total of 2260 patients who consulted a general practitioner over the analysis period 37.7% were male and 62.3% were female.

The high number of referrals for counselling and the high referral rate in the 20–29 years age group reflected the high number of patients in this age group in the practice (Table 1). However, patients aged 40–49 years were also more likely to be referred to the counsellor than patients from other age groups. The mean referral rate for counselling was 13.5 referrals per 1000 general practitioner consultations and the rates of the three general practitioners ranged from 8.1 to 18.9. In comparison, the practice made 1.7 referrals per 1000 general practitioner consultations to psychiatric outpatient services over the same period.

Table 1. Age distribution of patients on the practice list and of those referred for counselling, and the referral rate for each age group.

	% of patients		
Age (years)	On practice list (n = 3697)	Referred for counselling (n = 95[a])	No. of referrals per 1000 GP consultations
0–9	*12.3*	*0*	0
10–19	*7.0*	*3*	10.1
20–29	*31.4*	*38*	19.2
30–39	*18.9*	*20*	15.1
40–49	*10.8*	*16*	19.2
50–59	*7.7*	*11*	14.3
60–74	*8.1*	*12*	11.1
75+	*3.8*	*1*	1.8

n = total number of patients. [a]Includes three self-referrals.

Length of time before first appointment

Of the 95 patients referred for counselling 60% were offered appointments within a week of referral (including three self-referrals) and 87% within three weeks. Of the 12 patients seen after this period four had delayed making an appointment with the counsellor following referral.

Reasons for referral

The primary and secondary reasons for referral were broken down into the following problem areas: alcoholism, bereavement, depression, financial problem, housing problem, refugee issue, relationship problem and general stress. Often, these were defined by the general practitioner at the referral stage and then confirmed by the counsellor following assessment (Table 2). Patients were referred either with straightforward practical problems, such as housing, and/or with a single or combination of emotional problems. By far the largest numbers of referrals were for relationship problems (primary reason for 42 patients, 45%), followed by problems causing general stress (21 patients, 23%), such as the burden of caring for a handicapped child, mid-life crises or traumatic experiences. No families or patients with psychotic illness were referred. Of those for whom reasons for referral were known, 77% were women.

Table 2. Reasons for referral for 93 patients.[a]

Primary/secondary reason for referral	Number of patients		
	Men	Women	Total
Alcoholism	2	0	2
Alcoholism/relationship problem	0	1	1
Bereavement	2	10	12
Depression	3	5	8
Depression/bereavement	0	1	1
Financial/relationship problem	1	0	1
Housing problem	0	3	3
Housing problem/ bereavement	0	1	1
Refugee issue	1	0	1
Relationship problem	3	25	28
Relationship problem/ depression	0	3	3
Relationship/housing problem	0	1	1
Relationship problem/ bereavement	2	3	5
Relationship problem/ general stress	1	4	5
General stress	6	13	19
General stress/ bereavement	0	2	2
Total	21	72	93

[a]Reason for referral unavailable for two patients.

Treatment

Of the 95 patients referred, 12 never attended, 12 terminated their contract prematurely (four missing the final session), three had their contract reassessed and shortened and the remaining 68 completed their contract. The treatment provided to the 83 patients attending is shown in Table 3. Eleven patients were seen by the social work student, and two by befrienders and two by a trainee counsellor, all four following assessment by the counsellor. Nineteen patients were referred for longer term therapy following a period of counselling. Issues that could not be resolved by short term counselling were usually related to long-standing problems and almost always concerned relationship problems.

Of the 83 patients who kept their first appointment, 28 were seen for one session only — these tended to be patients who wanted practical advice or for whom it was appropriate to make an immediate referral to another community resource. Thirty eight patients were seen for between two and five sessions, 12 were seen for six to 10 sessions and five were seen for more than 10. Of those patients who were seen for between six and 10 sessions, two were referred on for longer term counselling and psychotherapy. Feedback from general practitioners suggested that for all those who were referred on, the initial short term counselling often provided a 'safe space' to begin exploring their problems and the confidence to continue the exploration in another setting. Of the 68 patients who completed their contracts, 47 (69%) did so within a 13-week period.

Discussion

The British Association for Counselling defines the counsellor's task as being 'to give the client an opportunity to explore, discover and clarify ways of living more resourcefully and towards greater well being'[22] This analysis highlighted the wide range of problems referred. It also showed that practical advice on self-help, such as breathing and relaxation techniques or information about local group resources, was often required. It was therefore important for the counsellor use her skills flexibly.

The reasons for referral could only be categorized broadly since different general practitioners tended to emphasize different aspects of the patient's problems. For example, although a separate category of bereavement (following a death) was included, underlying themes of loss (the end of a relationship, mid-life crisis) were present in many of the referrals. These may not have been stated by the general practitioner as a reason for referral but they were identified during the initial counselling assessment.

Table 3. Treatment provided to 83 patients.

Treatment	Number of patients		
	Men	Women	Total
Assessment only	2	4	6
Assessment plus:			
Counselling	6	26	32
Counselling and practical advice[a]	2	8	10
Counselling and referral for further counselling/ psychotherapy	2	17	19
Immediate referral to another resource	1	3	4
Practical advice[a]	3	7	10
Referral to befriender	2	0	2

[a]Self-help, such as breathing and relaxation techniques or information about local group resources.

A general practitioner would occasionally refer a patient in order to alleviate pressure on him/herself and gain extra support. Patients were also sometimes referred if a difficulty in communication between doctor and patient arose. Feedback both from the analysis and from individual counsellor–client contacts regarding the appropriateness of referrals refined the understanding and collaboration between the general practitioner and counsellor

Given the demand for the counselling service and its limited resources, emphasis was placed on short-term work as a way of responding to the needs of as many patients as possible. The short-term counselling contracts were seen in the context of a primary health care philosophy of continuing general practitioner care of the patient. It was therefore accepted by all concerned that a patient could be referred again at a future date if further problems arose. However, more than one fifth of patients were referred on for longer term counselling and/or psychotherapy. It should be recognized that, even if the counsellor had had additional skills in cognitive and behavioural therapy, a number of patients would require further referral.

The analysis showed that 24 of the 95 patients failed to keep the initial appointment or complete their contract. Although this group was not followed up specifically, feedback from general practitioners, the complementary practitioners and from patients themselves allowed some insight into the reasons for these failures. A lack of patient preparation by the general practitioners sometimes appeared to be a factor in patients not attending their first appointment. Patients were sometimes referred for counselling at a time when they did not feel confident enough to explore their attitudes, behaviour and feelings. Although they would respond positively to a general practitioner's invitation to see a counsellor, it was discovered during subsequent consultations with the general practitioner that they had not, in fact, wanted to be referred and so had experienced a sense of rejection.

For the 12 patients who failed to complete the counselling contract several factors are relevant. In some instances, patients commented that they felt better after two or three appointments and so simply did not return. For others, the style of counselling was different from what they were expecting. They came wanting advice or instant solutions to their problems, when this was neither appropriate nor possible. Others felt ambivalent about the opportunity to explore and understand their problems within the context of a short counselling contract — while they welcomed the opportunity, they felt unsafe about exploring very personal struggles, knowing that they might be referred to someone else at the conclusion of the contract. Four patients missed the final session. This may have been related to difficulty in facing the sense of loss associated with the ending of counselling, even though patients knew they could be re-referred at a future date.

Following up the patients who did not complete their contract would have given a better indication of the reasons for defaulting. It might also have enabled those individuals who missed the final session to face and contain feelings about the ending and helped them to deal with similar situations in the future. Since this analysis, a change in policy has meant that all patients who do not complete their contracts are contacted and offered the opportunity to complete the initial agreed number of sessions. Subsequent discussion has also resulted in better preparation of patients and a reduction in the number who default.

One aspect of the analysis was to look at the value of having a spectrum of resources available including a befriending service provided by patient volunteers.[23] The fact that only two referrals were made to befrienders by general practitioners via the counsellor prompted an appraisal of how this new service was being used. It transpired that the service's novelty, combined with a general uncertainty on the part of the general practitioners as to

what it could offer, resulted in fewer referrals than expected being made. There is now greater understanding between befrienders and general practitioners, and this has meant referrals to befrienders of elderly and isolated patients, in particular, have increased and the service has become more integrated into the practice.

It is widely recognized that patients present to general practitioners with a wide range of psychological and social problems[7] and that emotional problems frequently underlie presenting somatic complaints.[24] In addition, the relevance of short-term counselling is now widely accepted in the primary health care field.[21]

Patient analysis features centrally in the planning and monitoring of a number of primary health care services. The increased use of analysis of referrals to counsellors would not only help training organizations to 'fine tune' their training programmes but would also provide general practitioners with a better understanding of how best to meet their practice's counselling needs.

A similar analysis undertaken in another practice would be expected to highlight a different set of problems to those reported here. It is unlikely, however, that a single counsellor in an average size practice will have the time or expertise to respond to the full range of patients' counselling needs. Therefore, depending on what these needs are, general practitioners might consider taking on other team members, such as those with skills in social work and befriending, who have a good working knowledge of local support services and community facilities. This would ensure the provision of a more comprehensive range of counselling care and support which, with the current emphasis on care in the community, will almost certainly have an increasingly important role to play in the future.[25]

References

1. Sibbald B, Addington-Hall J, Brenneman D, Freeling B. Counselling in English and Welsh general practices: their nature and distribution. *BMJ* 1993; **306:** 29-33.
2. Kilcoyne A, Pietroni PC. The history of the primary health care team. In: Royal College of General Practitioners. *1990 members' reference book.* London: Sabrecrown, 1990.
3. Reason P, Chase HD, Desser A, *et al.* Towards a clinical framework for collaboration between general and complementary practitioners: discussion paper. *J R Soc Med* 1992; **85:** 161-164.
4. Helman C. *Culture, health and illness: an introduction for health professionals.* Bristol: Wright, 1984.
5. Pietroni P. *The greening of medicine.* London: Victor Gollancz, 1990.
6. Chase HD, Davies PRT. Calculation of the underprivileged area score for a practice in inner London. *Br J Gen Pract* 1991; **41:** 63-66.
7. McLeod J. *The work of counsellors in general practice. Occasional paper 37.* London: Royal College of General Practitioners, 1988.
8. Gray DP. Counsellors in general practice [editorial]. *J R Coll Gen Pract* 1988; **38:** 50-51.
9. Bhaduri R. A prescription for counselling — GP attached social work. *Social Work Today* 1989; **30:** 16-17.
10. Rowland N, Irving J, Maynard A. Can general practitioners counsel? *J R Coll Gen Pract* 1989; **39:** 118-120.
11. Graham H, Sher M. Social work and general practice. *J R Coll Gen Pract* 1976; **26:** 95-105.
12. Brook A, Temperley J. The contribution of a psychotherapist to general practice. *J R Coll Gen Pract* 1976; **26:** 86-94.
13. Waydenfeld D, Waydenfeld SW. Counselling in general practice. *J R Coll Gen Pract* 1980; **30:** 671-677.
14. Brodaty H, Andrews G. Brief psychotherapy in family practice. A controlled prospective intervention trial. *Br J Psychiatry* 1983; **143:** 11-19
15. Martin E, Martin PML. Changes in psychological diagnosis and prescription in a practice employing a counsellor. *Fam Pract* 1985; **2:** 241-243.
16. Durlak JA. Comparative effectiveness of paraprofessional and professional helpers. *Psychol Bull* 1979; **86:** 80-92.
17. Hattie JA, Sharpley CF, Rogers JH. Comparative effectiveness of professional and paraprofessional helpers. *Psychol Bull* 1984; **95:** 534-541.
18. Berman JS, Norton NC. Does professional training make a therapist more effective? *Psychol Bull* 1985; **98:** 401-407.
19. Corney RH. Counselling in general practice — does it work? *J R Soc Med* 1990; **83:** 253-257.
20. Rowland N, Irving J. Towards a rationalization of counselling in general practice. *J R Coll Gen Pract* 1984; **34:** 685-687.
21. Working party of British Association for Counselling. *Counselling in medical settings. Guidelines for the employment of counsellors in general practice.* Rugby: BAC, 1993.
22. Rowland N, Hurd J. *Counselling in general practice: a guide for counsellors.* Rugby: British Association for Counselling, 1989.
23. Webber V, Barry V, Davies P, Pietroni P. The impact of a volunteer community care project in a primary health care setting. *J Soc Work Pract* 1991; **5:** 83-90.
24. Irving J, Heath V. *Counselling in general practice: a guide for general practitioners.* Rugby: British Association for Counselling, 1989.
25. Means R, Harrison L. *Community care before and after the Griffiths report.* Bristol: School for Advanced Urban Studies, University of Bristol, 1988.

Acknowledgements

We thank Dr Derek Chase for his comments and the Wates Foundation for its generous support.

Address for correspondence

Dr P Davies, Marylebone Centre Trust, 33 Queen Anne Street, London W1M 9FB.

RCGP

Scholarships and Awards

INTERNATIONAL TRAVEL SCHOLARSHIPS AND THE KATHARINA VON KUENSSBERG AWARD

The Royal College of General Practitioners invites applications for international scholarships to enable general practitioners from this country to travel overseas to study aspects of health care relevant to this country's needs or to help other countries develop their own systems of primary care.

The scholarships are also available to doctors from overseas who wish to visit this country to study an aspect of primary care relevant to their own country's needs.

The outstanding international travel scholarship application submitted each year is eligible for the Katharina Von Kuenssberg Award.

The value of each scholarship will not normally exceed £1000.

If you would like further details or an application form please contact: The Clerk to the International Committee, Royal College of General Practitioners, 14 Princes Gate, Hyde Park, London SW7 1PU. Telephone: 071-581 3232, extension 233.

The closing date for applications is Monday 22 August 1994.