One counsellor, two practices: report of a pilot scheme in Cambridgeshire

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SUMMARY

Background. *Despite limited evidence of their effectiveness, counsellors are increasingly being employed as part of the primary health care team. Evaluation of counsellor services is therefore important.*

Aim. *In 1990 the Cambridgeshire Family Health Services Authority initiated a pilot scheme to evaluate the role of counsellors in general practice and to help the authority determine its policy towards claims by general practitioners for reimbursement through the ancillary staff scheme.*

Method. *Two group practices were identified and an external evaluator appointed. The evaluator and the general practitioners developed their aims and objectives for counselling in the general practice context, the number of counsellor hours per week and the type and process of referral. An experienced counsellor was appointed to work in both practices. Information was gathered over two years about doctors' reasons for referral, counsellor's initial assessment, patient outcome at the end of treatment, the patients' and practice teams' opinions about the counselling service, and patient outcome a year after counselling.*

Results. *A total of 293 patients were referred in the first two years of the scheme, of whom 75% were women. The main reasons for referral were that the general practitioners considered the patients to be suffering from anxiety/stress (33%), interpersonal difficulties (33%) and depression (20%). Almost all referrals (98%) were considered by the counsellor to be appropriate. The counsellor was able to provide an assessment for the 248 patients who attended and either take on the case for short-term counselling (69%) or suggest referral to a more appropriate service (25%) (6% withdrew). The expected maximum of six sessions of 45 minutes duration per referral was achieved in 87% of cases. The service was valued by patients and doctors. It coped effectively with a high proportion of patients with problems who did not reappear as demand elsewhere in the practice, and achieved a reduction in dose of psychotropic drugs among those seen.*

Conclusion. *This study has shown the value of clarifying referral criteria and the intended role of the counsellor prior to the counsellor's introduction. This ensures effective use of a scarce resource and a high level of satisfaction among doctors and patients.*

Keywords: counselling; referral of patients; patterns of work; psychosocial problems; outcome.

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Introduction

THE debate continues about the effectiveness of counselling in general practice.[1-5] Corney and Jenkins reviewed the literature on the effectiveness of counselling[6] and of 32 references quoted only four were about generic counsellors as opposed to psychologists, community psychiatric nurses or social workers who may also undertake counselling.[7-10] Yet despite the relatively limited data on the effectiveness of counselling therapy, generic counsellors are increasingly being employed as part of the primary care team.[11]

In 1990 the Cambridgeshire Family Health Services Authority agreed to requests from general practitioners and mental health services planners to set up a pilot scheme in two group practices which would employ a counsellor and receive 70% reimbursement under the ancillary staff scheme. One practice is in suburban Cambridge and has a list size of about 5200 patients (three full-time and one part-time general practitioner) and the other covers two villages near Cambridge with a list of about 8200 patients (five full-time general practitioners). Neither practice has any attached community psychiatric nurses or social workers; both have easy access to a community mental health team. An external evaluator (J J) was appointed who worked with the general practitioners to clarify the aims and objectives of the service and the method of evaluation. It was agreed that in order to reduce the many variables the two practices would appoint the same counsellor (R S), adhere to the same referral criteria and collect comparable data. The counsellor was experienced and well acquainted with the local mental health services. It was not a controlled study but a pragmatic service evaluation designed to assist policy makers.

The pilot scheme was completed in the first year but the practices continued to employ the counsellor and collect further data. This paper describes two years' data involving 293 general practitioner referrals to the counsellor and a review in the second year of the 101 patients seen by the counsellor in the first year.

Method

The methodology was developed in consultation with the family health services authority, general practitioners and evaluator prior to the appointment of the counsellor. The general role of the counsellor was 'to provide a short term counselling service in general practice for adult patients (those aged 16 years and over) with acute life problems who would be referred by their general practitioner; and to act as a mental health resource within the primary care team.'

The referral protocol included case definitions for inclusion and exclusion. For example, those with mental illness requiring psychiatric help would be excluded, as would those with long-standing psychosocial problems. On receiving a referral the counsellor would telephone the patients at once to arrange an assessment consultation at the surgery. Criteria for urgent and non-urgent categories were discussed as well as the acceptable waiting time for an assessment interview followed by counselling or referral elsewhere. The length of appointments was set at 45 minutes and the maximum number of appointments per episode set at six with the possibility of a further six after review with the patient and consultation with the general practitioner.

Data were collected on several forms.

A referral form was completed by the referring general practitioner and included a description of the patient's presenting problem. Details of any psychotropic drugs currently prescribed were recorded. The referring doctor classified the presenting problem using a classification system adapted from that used in earlier published work.[12,13] This classification was used as there are problems using the *International classification of disease* and the *Diagnostic and statistical manual of mental disorders* coding in counselling practice because of the medical model and predominance of psychiatric diagnoses. General practitioners were also asked to indicate what action they would have taken in the absence of a practice based counsellor.

An assessment form was completed by the counsellor who recorded his opinion on the appropriateness of the referral after the initial interview. The option to accept the patient for counselling or refer elsewhere was also included. Patients referred elsewhere by the counsellor did not necessarily have to be referred immediately, they could receive some counselling before referral onwards. The counsellor also completed a form at the end of the treatment episode which included a recording of the number of sessions undertaken and the outcome.

A patient questionnaire was completed by every person referred to the counsellor in the first year and who attended for an assessment. The questionnaire was sent by post six weeks after the final counselling session and asked patients to rate how helpful they found the service and whether they would use it again if they needed further help.

After the pilot year all non-medical care staff, including administrative and secretarial staff, were sent a questionnaire which asked whether they felt they knew what the counsellor did and if they felt the service should continue. All general practitioners were interviewed individually by J J.

The medical records of all referrals in the first year were reviewed by the referring general practitioner. The doctor and counsellor completed a form designed to identify whether after a period of one year from the last counselling contact the original problem or related problems had recurred. It was also recorded if the patient was on psychotropic drugs and the drugs' dose.

Results

A total of 93 women and 38 men in the suburban practice were referred to the counsellor in the two years, giving a total of 131 out of 5200 patients (a referral rate of 12.6 per 1000 per year). In the village practice, 126 women and 36 men were referred to the counsellor, giving a total of 162 out of 8200 patients (a referral rate of 9.9 per 1000 per year). Women accounted for 74.7% of the 293 referrals. Of referrals 155 (52.9%) were in the 25–44 years age band. Only 17 referrals (5.8%) were of patients over 65 years of age.

The mean waiting time between referral and assessment visit was 2.4 weeks in the suburban practice and 2.8 weeks in the village practice. The proportion of patients who did not attend the first appointment was 3.1% in the suburban practice and 4.9% in the village practice, giving a total of 12 cases overall (4.1%). Thirty three people (11.3% of all referrals) wrote or telephoned to cancel the appointment, either because they had decided they did not need counselling or because they had found counselling elsewhere.

The patients' presenting problems as classified by the referring doctors, are shown in Table 1. The main presenting problems were anxiety/stress, interpersonal difficulties and depression. All of the 248 referrals apart from five (2.0%) were considered by the counsellor to be appropriate either for counselling or for a consultation about the most appropriate way of obtaining help.

Table 1. Patients' presenting problems, as classified by the referring doctor.

Reason for referral	% of 293 patients with problem
Anxiety/stress	*32.8*
Interpersonal difficulties	*32.8*
Depression	*20.1*
Adjustment to illness	*5.1*
Occupational problem	*4.1*
Habit disorders	*0.7*
Other	*4.4*

Of the 248 patients referred and assessed over the two years 25.8% were referred on elsewhere, 5.2% withdrew and 69.0% completed the agreed counselling contract and were discharged. Of the 171 patients accepted for counselling 86.5% completed the treatment episode in six or fewer sessions. The mean number of sessions was 4.3 and only 2.9% of referrals (five) had more than 10 sessions.

At the end of the second year the records of all referrals seen during the first year were examined by the referring doctor and by the counsellor. In the suburban practice, 50 patients were seen by the counsellor at least once. Six of the patients subsequently left the practice, and of the 44 remaining patients, 33 received counselling and 11 were referred elsewhere. Twenty eight patients completed their course of counselling, five withdrawing before completion. Six patients returned to the counsellor for further treatment. Meanwhile in the village practice, 51 patients were seen by the counsellor, five of whom subsequently left the practice. Ten patients were referred elsewhere and the other 36 patients received counselling, 33 of whom finished their course of counselling. Five patients returned to the counsellor for further treatment. These data show strong similarities between the two practices.

Of the 21 patients referred elsewhere by the counsellor, 10 were referred for psychotherapy, six were referred to the marriage counselling service Relate, two were referred for family therapy, two for behavioural treatment and one to an alcohol counselling service.

At the end of the second year, the notes of all patients seen during the first year were also examined to investigate whether there had been any changes in the prescription of psychotropic drugs one year after counselling (Table 2). Psychotropic drug doses were reduced or discontinued in 23.3% of patients after counselling and only 4.4% had an increase in prescribed drug dosage.

General practitioners were asked how many of the 90 people who had been assessed by the counsellor and who were still in the practices had consulted with their original problem or had mentioned it while consulting about something else since the

Table 2. Psychotropic drug therapy among patients seen for counselling in the first year in the suburban and village practices.

Drug therapy and counselling	% of patients in practice: Suburban (n = 44)	% of patients in practice: Village (n = 46)
Taking no drugs before or after	*56.8*	*50.0*
On same dosage before and after	*15.9*	*21.7*
Reduced dosage/discontinued drugs after	*25.0*	*21.7*
Increased dosage after	*2.3*	*6.5*

n = number of patients in practice seen by counsellor.

completion of counselling. Twenty six (28.9%) had done so; in 18 cases no further action was taken, five patients were referred back to the counsellor and three were referred elsewhere.

A total of 85 questionnaires were returned by patients who had attended for counselling in the first year (84.2% response rate). When asked to rate their counselling experience, 56.5% considered it had been very helpful, 34.1% considered it quite helpful and 7.1% were uncertain. Two patients (2.4%) considered it very unhelpful. When asked whether they would see a counsellor again should they need further help, 91.8% said they would, 4.7% said they would not, and 3.5% were unsure.

For each patient referred over the two years general practitioners were asked what action they would have taken if a counsellor had not been available. The doctors reported that in 165 cases (56.3%) they would have seen the patient in normal general practice consultations, in 73 cases (24.9%) they would have arranged special long consultations with the patient, in 49 cases (16.7%) the patient would have been referred to another agency and in the remaining six cases (2.0%) the doctors would have undertaken no action as they considered the cases self-limiting.

All 15 administrative/clerical staff and 16 nurses or health visitors responded to the questionnaire and 26 (83.9%) felt that they knew what the counsellor did and felt the service should continue. The interviews with the general practitioners revealed that the doctors considered the attachment of the counsellor to the practices to be very successful.

Discussion

This study demonstrated the benefit of defining the objectives of the service before starting, having explicit referral criteria and a clear referral method. The constraint on the number of sessions offered and the clarification of the assessment role proved workable. The appropriateness of referrals, the small proportion of non-attenders, and the ability to see urgent cases in less than the average waiting time of two or three weeks, ensured that the relatively scarce resource was used effectively. The evaluation showed that the service was proving satisfactory to both users and general practitioners, and drug prescriptions were reduced. The observed difference in referral rate between the practices is likely to be due to supply rather than demand as the same number of hours and appointments were offered in each practice despite the difference in list size. Therefore, the report on the pilot year recommended, on the basis of referral rates and acceptable waiting times, that the number of hours of reimbursable counsellor time to serve this client group in a general practice should be one to two hours per week per 1000 patients.

One of the interesting features of a primary care based counselling service is that it provides a service for a wide group of people with psychosocial needs rather than formal psychiatric needs. Almost half of patients seen for assessment by the counsellor were on some form of psychotropic medication yet were not considered to be psychiatric patients either by the counsellor or referring general practitioner. These findings suggest that general practitioner time would have been taken up in managing these patients or they would have been referred to other agencies.

The counselling methods offered vary according to the presenting problems and result from negotiation with the client. At least five broad categories of counselling emerged: bereavement counselling; supportive counselling, in the event of illness in the client or relative; counselling for family or marital problems; stress and anxiety counselling, to explore the underlying causes and to suggest coping techniques;[14] and short-term focused psychodynamic counselling, to explore connections between present difficulties and past relationships.

It is acknowledged that no generic counsellor will have the experience or skills to deal with the bewildering array of psychosocial problems which general practitioners see and which affect individual and family health. The assessment and knowledge of other resources is a crucially important part of the counsellor's job. The counsellor in this study had good liaison with the mental health teams and effective links with statutory and voluntary agencies. There may be anxiety about referring 25% of the patients on to other agencies. However, difficulties can be avoided if the counsellor explains that the assessment session is a chance to explore what is the best way to find help, and that the decision to continue or be referred elsewhere is a joint one between counsellor and patient. It can be distressing for the patient to start again with a new agency, but the process can be made easier by explanation, reassurance and perhaps an introduction to the new facility.

These results contribute to the debate about provision of appropriate mental health services. The data are descriptive but the findings are robust and may help the development of counselling in primary care. As a result of this pilot study, the Cambridgeshire Family Health Services Authority has produced guidelines on the appointment of counsellors, created a professional advisory group to oversee the scheme and agreed to fund 70% of the cost of accredited counsellors on the basis of one hour of counselling per week per 1000 patients. Seventeen practices have appointed counsellors in line with the guidance, and the utilization data they have reported are consistent with the present findings.

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