Counsellors in primary care in Southampton: a questionnaire survey of their qualifications, working arrangements, and casemix

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SUMMARY

Background. *There has been an upsurge of interest in counselling in primary care over the past five years. This has been stimulated by a growing demand for non-drug treatment of emotional disorders and by the extension of reimbursement for the costs of counsellors. Continued calls for careful evaluation have been largely unheeded in the face of heady growth.*

Aim. *To establish the prevalence of counselling services in the 67 general practices in the Southampton and South West Hampshire Health District, and to describe in detail their qualifications, working arrangements, and casemix.*

Method. *A questionnaire enquiring about counselling services was sent to all the general practices in the district. A second questionnaire was then posted to all the counsellors identified as working in these practices.*

Results. *Twenty-six (39%) practices employed one or more counsellors. Fundholding practices were four times more likely than non-fundholders to employ a counsellor. Most of the counselling work was short term (4–20 sessions). The most common presenting complaints were relationship problems, depression, anxiety, and bereavement.*

Conclusion. *This descriptive study highlights the wide variation in the qualifications and training of counsellors. Until the issue of effectiveness is resolved through further research, the best safeguard of quality is to ensure that counsellors meet the appropriate training standards laid down by the British Association of Counsellors. Monitoring standards is a legitimate task for those commissioning health care who are increasingly responsible for reimbursement of a counsellor's salary. Counsellors who meet appropriate training criteria should be encouraged to pursue accreditation with the British Association of Counsellors. Those who do not meet these criteria should be encouraged to undergo additional training.*

Keywords: counselling; qualifications; training.

Introduction

WITH the recent growth of interest in counselling in primary care, it is easy to forget that people have been writing about this subject since Michael Balint's seminal work with general practitioners (GPs) 40 years ago.[1] Alexis Brook[2] and his colleagues at the Tavistock Clinic, London, wrote a number of descriptive papers examining the contribution of a psychotherapist to primary care. They concluded that general practice offers unique opportunities for the early identification and treatment of emotional disorders.

The 1980s saw a growing number of reports on the use of counselling and brief psychotherapy in primary care by a variety of professions. Attempts to evaluate such interventions produced conflicting results. At the end of the decade, a review of outcome studies by Corney[3] found benefit for patients in two thirds of the studies. Several reports demonstrated reduced consultation rates with GPs and reduced rates of prescription of psychoactive drugs.[4] McCleod[5] conducted a descriptive survey of 17 counsellors working in 14 general practices in various parts of England. She drew attention to the lingering image of the counsellor as a non-professional voluntary worker, which counsellors were struggling to dispel. She found that the training of counsellors varied considerably and concluded that 'the greatest needs now are for training schemes to be assessed, the (counselling) work to be evaluated and remuneration to be reviewed.'

The upsurge of interest during this decade has been stimulated by a rising tide of public demand for the non-drug treatment of emotional disorders. In a recent survey on public attitudes to depression, commissioned by the Royal College of Psychiatrists and Royal College of General Practitioners as part of the Defeat Depression Campaign, 91% of the 2003 people interviewed believed that counselling should be offered to those suffering from depression. In comparison, only 16% thought that antidepressants should be prescribed.[6]

Further impetus has come from the extension of reimbursement for the costs of employing counsellors, and the shift towards fundholding and primary care-led purchasing of health care. The continued call for a convincing evaluation of counselling in this setting before further expansion[7-9] has been largely unheeded.

A recent extensive survey of one in 20 GPs in England and Wales found that 31% of general practices have counsellors.[10] This survey found that three types of counsellor predominated in primary care: community psychiatric nurses, who were more likely to have patients with anxiety, depression, personality disorders, or psychotic illness referred to them; clinical psychologists, who were generally referred patients with psychosexual disorders, eating disorders, phobias, or obsessive–compulsive disorders; and practice counsellors, who were mostly referred bereaved patients. A worrying finding was that GPs were unaware of what counselling qualifications were held by a fifth of the people who provided this service within their practice. Altogether, 142 out of the 342 (42%) counsellors whose qualifications were known to the GP had had no training in counselling.

Although there have been several recent reports describing the working arrangements and casemix of individual counsellors,[11,12] there has been no larger survey of the counsellors themselves since McCleod[5] conducted her survey a decade ago.

The aim of the present study was to establish the prevalence of counsellors in the 67 general practices in the Southampton and South West Hampshire Health District, and to describe in detail

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their qualifications, working arrangements, and casemix. The unique feature of this descriptive study is that both the GPs and the counsellors were surveyed.

Method

The questionnaire survey was divided into two stages. The stage 1 questionnaire was sent to the practice manager of each general practice, seeking information about the employment of counsellors, the contractual arrangements including funding, and the referral mix. The manager was asked to consult one of the partners when completing the questionnaire.

The definition of a counsellor, for the purposes of this study, was based on that used by Sibbald *et al*,[10] namely, 'someone who offers formal sessions in which patients are helped to define and understand their psychological problem(s) and enabled to reach their own solutions.' It was emphasized that, although most health care professionals use counselling skills in their work, this study was only interested in the provision of counselling as a distinct, separate activity. In this paper, the term 'practice counsellor' is used to refer specifically to those who have no other professional role in the practice.

The more detailed stage 2 questionnaire was sent to each of the counsellors identified. This sought information about training and qualifications, supervision arrangements, model of counselling, casemix, and liaison with GPs and with secondary mental health services. Postal and telephone reminders were used to maximize the response rate. Where there were discrepancies between the information provided by the GP and the corresponding counsellor, the counsellor's information was used. These discrepancies mostly concerned the counsellor's qualifications, with the GP believing the counsellor to be more qualified than they actually were.

Results

Sixty of the 67 practices (90%) responded. Fourteen (23%) were fundholding practices. Twenty-six (39%) practices employed one or more counsellors. Of these, 17 practices employed one counsellor, eight employed two, and one employed three. Thirty-one counsellors were identified, five of whom worked in two practices. Fundholders were over four times more likely than non-fundholders to have a counsellor (odds ratio = 4.69, 95% confidence interval 1.10 to 21.49, $P = 0.03$). Telephone contact with non-responding practices revealed that they did not employ counsellors.

Table 1 gives details of the professional roles and sources of funding of the counsellors as reported in the stage 1 questionnaires returned by the practice managers.

Nineteen (56%) of the 34 practices with no counsellor expressed a desire to have one. Lack of funding was identified as the main barrier to developing counselling services. Other concerns expressed were lack of availability of suitably trained counsellors and accommodation.

The stage 2 questionnaire was returned by 25 of the 31 counsellors (response rate 81%). The mean age of the counsellors was 50 years (range 41–68 years). There were 20 female and five male counsellors. They had been offering formal counselling sessions in primary care for a mean of seven years (range 1–30 years).

Table 2 illustrates the wide range of qualifications held by the counsellors. Fourteen (56%) of the counsellors had a diploma in counselling. Counselling diplomas vary enormously in the length, content and quality of the course. A further six (24%) had completed or were close to completion of the Southampton Pastoral Counselling Service training. This is a respected three-year training affiliated to the Westminster Pastoral Foundation. Ten (48%) of the 'practice counsellors' fulfilled the criteria for

Table 1. Professional roles and sources of funding of identified counsellors.

Professional role (*n*)	Funding source				
	FHSA	Fundholding budget	Community NHS trust	Patient	Not paid
Practice counsellor (22)	7	3	–	8	4
CPN (4)	–	–	4	–	–
Practice nurse (2)	2	–	–	–	–
Health visitor (2)	–	–	2	–	–
General practitioner (1)	1	–	–	–	–
Total (31)	10	3	6	8	4

CPN, community psychiatric nurse; FHSA, family health services authority.

Table 2. Qualifications of counsellors.

Profession	Qualifications and courses							
	Diploma	SPCS	Christian counselling	Group therapy	MA/MSc	Psycho-sexual	Relate	Family
Practice counsellor (21)	13	5	3	4	2	1	1	1
CPN (1)	–	–	1	–	–	–	–	–
Practice nurse (1)	1	–	–	–	–	1	–	–
Health visitor (1)	–	1	–	–	–	–	–	–
General practitioner (1)	–	1	–	–	–	–	–	–
Total (25)	14	7	4	4	2	2	1	1

SPCS, Southampton Pastoral Counselling Service (affiliated to Westminster Pastoral Foundation). Seven practice counsellors and the practice nurse held two or more counselling qualifications.

accreditation with the British Association of Counsellors, although none of them were actually accredited members. These criteria include at least 450 hours of counselling training in theory and skills, and at least 450 hours of supervised practice. By contrast, none of the other counselling professionals met these criteria. Eighteen (86%) of the 'practice counsellors' received regular external supervision for their counselling work. None of the other professionals had their counselling work supervised.

The primary models of counselling used by the counsellors are shown in Table 3. All but three of the counsellors used more than one model. All worked with individual adult patients, 12 (48%) with couples, eight (32%) with children, and two (8%) with families.

The details of working arrangements are shown in Table 4. It is noteworthy that the mean weekly contracted hours was only one hour longer than the mean number of hours actually spent counselling patients each week. The implication is that very little contracted time was available for administration, supervision, and audit. Although most of the counselling work was short term (4–20 sessions), 12 counsellors regularly saw selected patients for more than 20 sessions.

The counsellors were asked to provide a breakdown of the main presenting problems in their current caseload. Excluding the community psychiatric nurse and health visitor, who did not supply figures, the main presenting problems were as follows: relationship problem, 71 (27%); depression, 53 (20%); anxiety, 45 (17%); bereavement, 33 (13%); psychosexual problem, 12 (5%); personality disorder, 9 (3%); physical disorder, 9 (3%); eating disorder, 8 (3%); obsessive–compulsive disorder, 7 (3%); phobia, 6 (2%); substance misuse, 5 (2%); child management problem, 3 (1%); and schizophrenia, 1 (0.4%). Although many patients present with more than one problem, this study concentrated only on the counsellor's view of the main presenting problem.

Table 4. Working arrangements of counsellors.

	Mean	Range
Number of hours per week contracted to work as counsellors[a]	10.3	3–24
Number of hours per week counselling	9.2	3–24
Size of caseload	11[b]	3–30
Usual number of sessions per patient	–	4–20[c]

[a]Refers only to 'practice counsellors', as the other counselling professionals were not specifically contracted for their counselling work. [b]To nearest whole number. [c]12 counsellors regularly saw selected patients for more than 20 sessions.

Seven (28%) of the counsellors were invited to attend regular meetings with the referring GPs to discuss patients. The remainder had only *ad hoc* contact. Five (20%) expressed dissatisfaction with the lack of opportunity to discuss their patients with the GPs. Nine (36%) were unhappy with their accommodation, several having to see patients in clinical treatment rooms that were not conducive to counselling work.

Seventeen (68%) of the counsellors regularly referred patients on to the local mental health services after discussion with the referring GP. This applied particularly to those patients with a psychotic illness, suicidal thoughts, and substance misuse. Those patients who required specialist psychotherapy were referred on to the local psychological therapies service. The counsellors expressed a general interest in developing closer links with these secondary services.

Discussion

Our figure of 39% for the prevalence of counselling in Southampton general practices represents a small increase on the national prevalence of 31% reported by Sibbald *et al*[10] in 1993. However, our figure is a more striking increase on their specific data for the old Wessex region. They found that 12 out of 85 (14%) of those practices sampled in this region had a counsellor. These counsellors comprised 10 community psychiatric nurses, one clinical psychologist, and one practice counsellor. Our results suggest that, in the three years since this survey, the main

Table 5. Main presenting problem of patients being seen by the counsellors at the time of the study.[a]

Main presenting problem	Number (percentage) of patients (n = 262)
Relationship problem	71 (27)
Depression	53 (20)
Anxiety	45 (17)
Bereavement	33 (13)
Psychosexual	12 (5)
Personality disorder	9 (3)
Physical disorder	9 (3)
Eating disorder	8 (3)
Obsessive-compulsive disorder	7 (3)
Phobia	6 (2)
Substance misuse	6 (2)
Child management problem	3 (1)
Schizophrenia	1 (0.4)

[a]Excludes data from community psychiatric nurse and health visitor who did not supply this data. n = total number of patients being seen by counsellors at the time of the study.

Table 3. Primary model of counselling used by counsellors.

Profession (n)	Model				
	Psychodynamic	Person-centred	Cognitive-behavioural	Gestalt	Common-sense
Practice counsellor (21)	9	8	3	1	–
CPN (1)	–	–	1	–	–
Practice nurse (1)	–	–	1	–	–
Health visitor (1)	–	–	–	–	1
General practitioner (1)	1	–	–	–	–
Total (25)	10	8	5	1	1

expansion in primary care counsellors locally is among generic 'practice counsellors' as opposed to community psychiatric nurses. This may be a response to the increasing pressures on community psychiatric nurses to confine their work to the 'seriously mentally ill' for whom counselling as a specific intervention is deemed less appropriate.

The higher prevalence of counsellors in fundholding practices is probably related to the fundholders' greater financial freedom to develop such services rather than greater need among their patients. Fundholding practices in this district serve significantly less deprived populations than non-fundholders.[14]

The wide range of qualifications accords with previous findings.[5,10] Without appropriate advice, it is difficult for employers to know what status to give to these increasingly diverse qualifications. As counselling courses multiply, the need for these to be assessed becomes all the more pressing. The British Association of Counsellors now operates a system of recognizing courses, but many do not meet their criteria.

Supervision is an integral part of counselling work, and the British Association of Counsellors insists that its members receive regular supervision. The majority of primary care counsellors in Southampton recognize the importance of this and pay for their own supervision with an external supervisor. None of the counsellors were remunerated for either the cost or the time spent receiving supervision. This contrasts sharply with the recommendations of the British Association of Counsellors and the Counselling in Primary Care Trust that 30–40% and 25–30% respectively of the counsellor's contracted hours should be for non-contact duties, such as administration, audit, and supervision.[15,16] It is noteworthy that none of the small number of other professionals in this study received supervision for their counselling work. They would be more familiar with supervision of their professional work in general rather than supervision specific to their counselling work.

The four main types of patient seen by the counsellors are those with relationship problems, depression, anxiety, or who have suffered bereavement. These are consistently emerging as forming the bulk of the primary care counsellor's caseload.[5,11,12,17] Although there is some overlap between the population seen by these counsellors and those seen in a specialist psychological therapies service, our local experience supports the findings of Burton *et al*,[18] who showed that, in comparison, the specialist services see more complex cases. The complexity and severity of these cases is highlighted by Amies[19] in a recent study of patients waiting for treatment at a district psychotherapy department. Using standardized symptom-rating scales, he showed that patients awaiting treatment at a district psychotherapy department suffer high levels of morbidity and distress from psychiatric symptoms with a high frequency of personality disorder diagnoses. Counsellors in primary care are not trained to treat patients with this level of disturbance. Far from relieving the pressure on referrals to specialist services, the growth in counselling in primary care in Southampton over the past five years has been paralleled by a doubling in the referral rate to the psychological therapies service. This is currently over 1000 per year. It is important that counselling in primary care is seen not as an alternative to specialist psychological therapies but as a complementary tier of service suitable for those suffering with less severe psychological disturbance.

The difficulties in communication between counsellors and other members of the primary health care team experienced by some counsellors in this survey is well documented in the literature. McCleod[5] suggests that in some cases the GP's ambivalence about the work of a counsellor may be reflected in a reluctance to hold joint meetings. Salinsky and Curtis Jenkins[20] recommend that counsellors be included in practice meetings and be given time for joint consultations so that the counsellor can be fully integrated into the practice team. This would certainly reduce the professional isolation that many counsellors in our study felt.

Conclusion

The two most frequently expressed cautions about counselling in primary care relate to effectiveness and standards of training. While not providing evidence for effectiveness, this descriptive study highlights the wide variation in the qualifications, training, and supervision of counsellors. Until the issue of effectiveness is resolved through further research, the best safeguard of quality is to ensure that counsellors meet appropriate standards of training and practice, such as those laid down by the British Association of Counsellors. With the increasing professionalization of counselling, other health care professions may need to review whether their training programmes equip their members with the means to offer formal counselling sessions, in contrast to the use of counselling skills in their generic work. In this study, these professionals did not meet the national standards required by the British Association of Counsellors.

Monitoring these standards is a legitimate task for commissioning authorities. In Southampton, the local health authority has convened an advisory group on counselling in primary care. This group consists of a consultant in public health medicine, representatives from the local psychological therapies service (consultant psychotherapist, clinical nurse specialist in psychotherapy, and senior registrar in psychotherapy), the community trust's clinical psychology adviser, two GPs, a counsellor, and the director of the Southampton Pastoral Counselling Service. Using the data presented in this paper and guidelines published by the Cambridge and Huntingdon Health Commission,[21] the advisory group has developed guidelines for the employment of counsellors in primary care. These specify minimum standards of training and practice in order for the counsellor's salary to be reimbursed by the health authority. These minimum standards include a substantial initial training course lasting three years, and 250 hours of supervised counselling practice gained over a period of at least two years. These guidelines have been widely disseminated to GPs and discussed at local meetings.

In conjunction with the Southampton Pastoral Counselling Service, the group has also organized an innovative 18-week post-qualification training course addressing the specific issues of counselling in the primary care setting. Finally, the advisory group has facilitated the formation of a peer group for the local primary care counsellors. The initial meeting was much valued and a programme of educational and supportive meetings has been inaugurated.

Using these data as a baseline, the above developments have all served to promote greater awareness of the complex issues involved in primary care counselling. A repeat survey in five years' time will tell us how much standards of counselling training and practice have changed as a result. Good outcomes would include an increase in the number of counsellors who have achieved accreditation with the British Association of Counsellors and changes in working arrangements reflecting the importance of regular supervision.

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