Relationship between practice counselling and referral to outpatient psychiatry and clinical psychology

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SUMMARY

Background. *Although reduction in the use of secondary care mental health services is a suggested benefit of counselling in general practice, there has been little empirical investigation of this relationship.*

Aim. *To investigate the relationship between the provision of counselling in general practice and the use of outpatient psychiatry and clinical psychology services across a geographical area.*

Method. *Information on referrals to outpatient psychiatry and clinical psychology from all general practices in the London Borough of Islington over one year (October 1993 to September 1994) was collected from the routine information systems of the main hospital departments serving this area. Referral rates per 1000 practice population were compared for practices with and without a practice-based counsellor.*

Results. *Fifteen (35%) of the 43 practices had a counsellor based in the practice. The median referral rate to clinical psychology was higher in practices with a counsellor (4.1 per 1000) than in practices without a counsellor (0.8 per 1000). There was no relationship between the provision of practice counselling and median referral rates to outpatient psychiatry (1.8 per 1000 with a counsellor, 1.7 per 1000 without a counsellor).*

Conclusion. *Provision of practice counselling in the study was associated with higher referral rates to clinical psychology and no difference in referral rates to outpatient psychiatry. This is in contrast to the hypothesis that counselling reduces the use of secondary care mental health services.*

Keywords: practice counselling; outpatient psychiatry; clinical psychology.

Introduction

THE past decade has seen a large increase in the provision of counselling services in primary care in the United Kingdom (UK), with an estimated 30% or more of general practices now having a dedicated counsellor in the practice.[1] This increase has occurred despite concerns about the appropriateness and clinical effectiveness of these developments.[2,3]

Three kinds of benefits of counselling in general practice are commonly suggested: improved clinical outcomes for patients; reduction in utilization of other primary care resources (especially in general practitioner (GP) workload and psychotropic medication); and reduction in the use of secondary care mental health services.[4–6] The evidence is inconclusive in all three areas.

Controlled evaluations of clinical outcomes of counselling in general practice are few in number and show a mixed pattern of results,[7,8] with some more consistent positive results found with cognitive therapy in primary care.[9] Studies of the impact of counselling on psychotropic drug use have been generally consistent in finding a reduction in drug use during counselling treatment,[10,11] but this is not necessarily maintained at follow-up[12,13] and is not associated with a reduced prescription of psychotropic medication across all patients in a practice.[14–16]

The relationship between counselling in general practice and the use of secondary care mental health services has been studied less frequently. A few small sample studies have examined the use of inpatient and outpatient psychiatry as a by-product of a more general controlled evaluation of counselling in primary care, some finding a decrease in referrals to psychiatry[17,18] and others showing no change.[12] The relationship between counselling and use of secondary care mental health services other than psychiatry — for example clinical psychology or community psychiatric nursing — has not been studied. Despite this lack of evidence, one rationale for funding counselling in general practice is that it is assumed to reduce referrals to secondary care mental health services, allowing these services to concentrate on those with severe mental illness.[5,6]

A retrospective study was undertaken to investigate the relationship between the provision of counselling in general practice and the use of outpatient psychiatry and clinical psychology services across a geographical area. Outpatient psychiatry and clinical psychology were selected because of evidence that GPs may differ in their referral patterns to these two services.[19,20]

Method

General practices located within the inner city London Borough of Islington (LBI) were approached in September 1994 to determine whether a dedicated counselling service was provided within the practice. A counsellor was defined as an independent practitioner whose sole role in the practice was to provide counselling. Clinical psychologists and community psychiatric nurses employed by the secondary care services with visiting arrangements to some general practices were excluded. These were few in number and tended to be found in larger practices that also had a counsellor. Counsellors so identified were contacted directly and surveyed as to the level and nature of the counselling provision and their training as a counsellor. Responses were checked against information held by the family health services authority (FHSA) and inconsistencies clarified with the counsellor.

Information on referrals to outpatient psychiatry and clinical psychology services were obtained from the routine information systems (PAS for psychiatry, FIP for clinical psychology) of the local secondary mental health provider of these two services. As a result of local mental health catchment policies in operation at the time of the study, all patients residing in the LBI who required National Health Service (NHS) mental health services were referred by GPs to this single mental health provider. The

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main GP options for referral were to outpatient psychiatry, clinical psychology, or community mental health teams (CMHTs), the CMHTs focusing on patients with severe and enduring mental illness. There was also some use of NHS psychotherapy services and voluntary sector providers of counselling and psychotherapy. For each practice, the number of patients seen in outpatient psychiatry and clinical psychology in the period October 1993 to September 1994 was calculated. Patients who were not referred directly from the practice were excluded, in order to exclude duplicate patients, these being primarily tertiary referrals within the mental health services (especially from psychiatry to clinical psychology). Referral rates for each practice to each service were calculated as the number of patients seen per 1000 practice population.

Differences between referral rates from practices with and without a counsellor were evaluated by Mann–Whitney *U*-tests. Parametric tests were considered inappropriate given the small sample sizes and skew of some of the data. Data analyses were undertaken using the Statistical Package for the Social Sciences (SPSS).

Results

Information was obtained for all 43 Islington general practices as to counselling provision. Fifteen (35%) of the practices had a counsellor based in the practice in the period under consideration (October 1993 to September 1994). The majority of these practices had a half-day (four practices) or one day (seven practices) of counselling time based in the practice, with four practices having counsellors available for 1.5–2.5 days. Nine of the 15 practices had had a counsellor for less than two years.

In terms of training and practice orientation, all counsellors reported having received over a year's training in counselling, with half having degrees or other formal qualifications in counselling. Two had previous training as social workers and two had training in nursing. Most counsellors described themselves as practising counselling from either a psychodynamic or a person-centred orientation.

A total of 484 patients referred by Islington practices were seen in outpatient psychiatry in the study period and 506 patients in clinical psychology. Referrals from the 15 practices with a counsellor accounted for 253 (52%) of the total referrals from Islington practices to outpatient psychiatry and for 400 (79%) of the referrals to clinical psychology. Referral rates (standardized against practice list size) for practices with and without a counsellor are given in Table 1. Practices with a counsellor were more likely to refer patients to clinical psychology, but there was no difference between practices with and without a counsellor in referrals to psychiatry.

Practices with counsellors were more likely to be group practices ($\chi^2 = 8.2$, df = 1, $P < 0.01$). Of the single-handed practices, 10% (two out of 20) had counsellors, whereas 57% (13 out of 23) of group practices had counsellors. Group practices made significantly more referrals to clinical psychology than single-handed practices (Mann–Whitney $U = 116.5$, $P < 0.01$), but no differences between group and single-handed practices were found for outpatient psychiatry referrals (Mann–Whitney $U = 196.5$, $P = 0.41$). The relation between the size of practice, provision of counselling, and referral rate to clinical psychology is shown in Table 2. Counselling provision was related to increased referral rate to clinical psychology for group practices, but not for single-handed practices, although the number of single-handed practices with counsellors was small ($n = 2$).

Discussion

The study aimed to investigate the relationship between the presence of a counsellor in a practice and referral to outpatient psychiatry and clinical psychology services. The finding of higher referral rates to clinical psychology and no difference in referral rates to outpatient psychiatry for practices with a counsellor compared with practices without a counsellor is, if replicated, in contrast to the suggestion and anecdotal reports[5,6] that counselling in general practice reduces referrals to secondary care mental health services.

There are several significant limitations to the study. The overall number of practices studied was small. Although concentrating the study on a geographical area linked with a single secondary mental health provider reduces problems associated with multiple referral networks and associated information systems, it increases the problems of generalizability. In addition to the small number of practices in the study, Islington as an inner city area with a large number of single-handed practices is atypical of general practice nationally.

The majority of practices with a counsellor had only relatively recently initiated the counselling arrangement. The referral pattern to other services may accordingly still have been in transition.

Only referrals to outpatient psychiatry and to clinical psychology were examined. The use of other services locally was not explored. These include inpatient psychiatric admissions, community psychiatric nursing (CMHTs), NHS psychotherapy, and voluntary sector counselling and psychotherapy. GPs probably distribute their referrals to different services in complex and often individualized ways, so that isolating only two services to examine risks missing how these fit in with a more complex picture.

The finding that the presence of a practice counsellor is not associated with a change in the referral rate to outpatient psychiatry is in contrast with the decrease in the use of psychiatry found in some[17,18] but not all[12] evaluations of counselling that have examined the use of psychiatry as an outcome. All these evaluations involved single practices that obtained a counsellor in the practice for the first time as part of the trial, and it is possible that the effects on referral rate found in these experimental studies are not maintained in routine practice.

The difference in referral patterns for clinical psychology and psychiatry have also been noted by other research teams.[19,20]

No study has previously examined the relationship between

Table 1. Referral rates from practices with and without a counsellor to outpatient psychiatry and clinical psychology (rates are per 1000 practice population).

	Median referral rate (25th, 75th centile)		
	Practices with counsellor (n = 15)	Practices without counsellor (n = 28)	Difference between medians
Outpatient psychiatry	1.8 (1.4, 3.6)	1.7 (1.2, 3.3)	0.1[a] NS
Clinical psychology	4.1 (1.4, 5.2)	0.8 (0.4, 1.3)	3.3[b] P < 0.001

[a]Mann–Whitney U = 203.6. [b]Mann–Whitney U = 69.0. NS, not significant.

Table 2. Referral rates to clinical psychology from single-handed and group practices with and without a counsellor (rates are per 1000 practice population).

	Median referral rate (25th, 75th centile) Practices with counsellor	Practices without counsellor	Difference between medians
Single-handed practices	0.3[a] n = 2	0.8 (0.4, 1.2) n = 18	–0.5[b] NS
Group practices	4.5 (2.5, 5.7) n = 13	0.6 (0.3, 1.8) n = 10	3.9[c] P < 0.001

[a]Number of practices too small to calculate centiles. [b]Mann–Whitney U = 6.5. [c]Mann–Whitney U = 8.5. NS, not significant. n = number of practices.

practice counselling and the use of mental health services other than psychiatry. The finding of an increase in the referral rate to clinical psychology services associated with the presence of a counsellor in the practice is therefore new. If replicated, there are a number of possible explanations. First, counsellors may ask GPs to refer to clinical psychology patients whom they have assessed or seen for brief counselling. Discussion with the clinical psychology service in the study suggests that this might account for a few cases but is unlikely to have had a major impact. Secondly, practices with counsellors may have wider information networks regarding mental health services, in addition to psychiatry, outside the practice to whom they can refer. In the study, group practices were more likely than single-handed practices to have counsellors, and group practices generally might be expected to have wider information networks about local resources. Thirdly, having a counsellor in the practice might lower the threshold for detection and/or referral of psychological problems for psychological therapies, through GPs becoming more aware of such problems and their treatability by psychological therapies as a result of the presence of the counsellor in the practice.[21] Finally, GPs who are more aware of the psychological treatment needs of their patients or who are in areas where there is a high demand for psychological treatment services may act to maximize all opportunities for obtaining such treatments for their patients, both organizing counsellors for their practices and referring to psychological therapies outside the practice.

The last two explanations assume there is variation between GPs in awareness of psychological problems and their treatability by psychological therapies (including counselling). Although there is evidence of variation between GPs in their ability to detect psychological problems,[22–25] the relationship between detection and referral for psychological therapies has not been studied directly. Creed *et al*[19] found that GPs who wrote more detailed referral letters, a possible indicator of greater psychological awareness, were more likely to refer to clinical psychology. This was not a general referral bias, as these same GPs were also less likely to refer to outpatient psychiatry.

A counter-intuitive association of the presence of a counsellor in a practice with increased prescribing of antidepressants, hypnotics, and anxiolytics has been reported from a study of Oxfordshire practices.[14] The authors considered parallel explanations of this increase to those used for the association of counselling with increased referral to clinical psychology in this study. However, other contemporary studies have failed to find any association between practice counselling and psychotropic drug prescription, again indicating the danger of extrapolating from a single study.[15,16]

The suggestion that one of the benefits of counselling in general practice is that it reduces referral to secondary care mental health services needs to be questioned on the basis of these findings. If replicated and with increasing evidence that practice-wide psychotropic drug prescription is unlikely to be influenced by the presence of a counsellor,[14–16] attention can focus on the clinical benefits of counselling. In the absence of adequate clinical trials of counselling in general practice,[8] there has been a tendency for proponents and funders to promote hypothesized secondary resource saving benefits for counselling. The importance of confirming the clinical efficacy of counselling[26] and establishing its clinical effectiveness for key populations in general practice is paramount.

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