

# **An exploratory study of GP perceptions of the impact of a primary care counselling service on their practice**

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This paper presents the results of research into GP perceptions of the impact of on-site counselling on general practice. The research is part of a larger evaluation of a local enhanced primary care mental service. The initial survey and in-depth interviews with GPs reported here focused on the pre-existing counselling service. The results suggest that the benefits of on-site counsellors included reductions in prescribing, cost efficiencies and increased confidence amongst some GPs about providing psychological care themselves. These reported benefits appeared more likely to result when counselling service levels were perceived to be adequate and GPs were satisfied with their partnerships with the counsellors. The key mechanisms to explain the reported benefits were the provision of a safety net for GPs to extend their own practice, particularly when combined with close working relationships with the counsellor. The study has implications for the development of primary care mental health in the UK, particularly in relation to how the interface and working relationships between counsellors and GPs are designed and developed.

**Keywords:** counselling; general practice; primary care; general practitioner; mental health

## **Introduction**

The research on which this paper is based is part of more extensive evaluation of the introduction of an enhanced primary care mental health service in one South Essex PCT (Primary Care Trust) locality. The focus of the present paper is on GPs' perceptions of the pre-existing primary-care-based counselling service for patients with common mental health problems.

The paper has particular relevance at this time when momentum is building towards the implementation of widespread primary care counselling for common mental health problems in general practice through the Increasing Access to Psychological Treatment (IAPT) Programme being developed in response to the Layard report (Layard, 2004) with support from five major mental health charities (Mental Health Foundation, 2006). The GP role in existing services and the developing IAPT programme is pivotal. This paper explores how GPs utilise an existing practice-based counselling service and identifies some of the important ingredients required for a successful primary-care-based service.

## **Background**

The argument for targeting resources in primary care is compelling in light of evidence about the impact of mental health need in primary care. Globally, it is estimated that 23% of the total burden of disease in the developed countries is due to mental illness (World Health Organisation, 1999), now predicted to become the leading cause of disability and second leading contributor to the worldwide burden of disease by 2020 (World Health Organisation, 2001).

The prevalence of mental health problems in people living at home in the UK is considerable. The most recent survey of psychiatric morbidity amongst adults living in private households found that just over 19% of women and 13.5% of men were suffering from some form of mental illness (ONS, 2001). More recent research estimates an average size GP practice with a population of 10,000 can expect to see 650 cases of minor or major depression in a year and 224 cases of anxiety. For a PCT locality with a population of 250,000, the figures multiply to 16,256 and 5598, respectively (Sainsbury Centre for Mental Health, 2007).

Mental health consultations in primary care are estimated to account for between 30% (Jenkins, McCulloch, Friedli, & Parker, 2002) and 40% (Goldberg, 1999) of primary care consultations, with a presentation rate of around 230 per 1000 people each year. Mental

health consultations are the second most frequent reasons for attendance, after respiratory infections (McCormick, Fleming, & Charlton, 1995).

Despite this considerable burden of care, evidence suggests that the majority of mental health need in primary care is unmet (Boardman, Henshaw, & Willmott, 2004; Lawson & Guite, 2005; Mental Health Foundation, 2005a, 2005b).

According to Layard (2004), mental health problems have now superseded unemployment as the major cause of misery in contemporary Britain, yet the main illnesses, anxiety and depression, are eminently treatable in general practice with adequate and effectively targeted resources. The National Institute for Clinical Excellence (NICE) guidelines for depression and anxiety disorders (NICE, 2004a, 2004b) recommend the provision of cognitive behavioural therapy (CBT) within a stepped care model of provision. CBT-based approaches are particularly effective in people with mild to moderate symptoms but they also increase the effectiveness of treatment for major depression, when combined with antidepressant therapy (NICE, 2004a). As well as CBT, there is evidence that other structured time-limited psychological therapies have achieved effect sizes similar to hip replacements on quality of life, suggesting that much suffering can be relieved through the provision of brief interventions in general practice (Department of Health, 2001). A Cochrane review of counselling in primary care found that counselling, though problematic to define and not extensively trialled, did provide benefits, particularly in the short term, and achieved high satisfaction ratings from clients (Bower & Rowland, 2006). There is also an increasing demand for psychological therapies from a public who want alternatives to drug treatments. The costs of antidepressant medication to the NHS in 2005 was £338 million (Hairon, 2006) and there is evidence that providing adequate and timely access to psychological therapy can reduce this cost (Boot *et al.*, 1994; Bower & Sibbald, 2000; Gordon & Graham, 1996).

The estimates for a workforce to meet the mental health need in primary care in Britain vary between 10,000 (Layard, 2004) and 11,377 (Sainsbury Centre for Mental Health, 2007). Layard estimates that the costs of providing this workforce will be more than met by reducing the current costs to the country and exchequer of £46 billion per annum in respect of carers' costs, lost output, public services and welfare benefits (Layard, 2004). Calls for greater priority and funding are bringing some results, including funding for two increased access to IAPT pilot sites in Newham and Doncaster and the announcement of £2 million funding for a further 10 pathfinder sites (Department of Health, 2007). In October 2007, the government announced a substantial new investment of up to £170 million per annum in 2010/11 to treat 900,000 new patients with anxiety and depression.

### **Impacts of on-site counsellors in general practice**

This paper presents data on GPs' perceptions of the impact of practice-based psychological therapies on their practice. Bower and Sibbald (2000) reviewed controlled trials of on-site mental health workers but concluded that this provision did not produce substantial changes in GP practice, although some GPs did prescribe less medication and rates of referral to secondary services were lower in practices with on-site mental health workers. However, the studies reviewed included not only on-site counsellors, but also psychologists and secondary care mental health professionals, making it difficult to draw conclusions in relation to the impacts of counselling alone. Gordon and Graham's (1996) study of the impact of counselling on symptoms found some evidence for a reduction in prescribing and less frequent GP attendance. Several studies (e.g. Knight, 2003; Pilgrim, Rogers, Clarke, & Clarke, 1997) found that satisfaction with contact and liaison with a specialist team was crucial in determining whether a GP would utilise a mental health service. When GPs had direct access to team members, they were more likely to be satisfied with the service (Warner, Gater, Jackson, & Goldberg, 1993). Waydenfeld and Waydenfeld (1980), in their evaluation of an in-house counselling service, found that GPs appreciated the direct and personal contact with a known and valued practitioner. As well as issues around access to workers, waiting times for appointments and quality of service are also important, with one study citing these as the most important factors determining referral decisions (Ghiacy, 1995). Knight (2003) concludes that 'referral decisions are complex' (p. 199) but since the effectiveness of on-site therapy services and the IAPT programme is largely dependent on GP referral, it is crucial that

services engage GPs constructively. Some studies have examined the impact of on-site counselling on referrals to psychology and secondary mental health services but the findings are inconsistent (e.g. Cape & Parham, 1998; Corney, 1986), suggesting more exploratory research is needed to identify the key causal mechanisms. Other studies have identified that close working between GPs and on-site counsellors leads to more accurate referrals and greater clarity about the types of people and problems that counsellors can work with effectively (Cape & Parham, 1998; Pilgrim *et al.*, 1997).

An area that has not been reported on extensively is the 'value added' impact of on-site mental health workers. Knight (2003) identifies that GP interest in psychosocial approaches is an important determinant of referral practice but there is arguably a case for exploring the impact of on-site mental health workers on the quality of GPs' own interventions. To summarise, there is a relative paucity of evidence about the impact of primary-care-based mental health workers on general practice and little evidence on the impacts on primary care in terms of capacity and skills.

### **The South Essex primary care mental health service**

Prior to the introduction of an enhanced service, the pre-existing service had been providing on-site counselling across four of the five South Essex PCT localities since its inception in 2000. The service was provided by the South Essex Partnership NHS Foundation Trust and was managed from within the Psychology Directorate. In April 2006, the Trust was commissioned to extend and expand the service in the Castlepoint and Rochford PCT area in line with the locally determined enhanced mental health service specification. The enhanced service includes increased counselling provision, increased groupwork provision in primary care, the introduction of 'Beating the Blues' (a computerised CBT programme) and structured self-help provision. The enhanced service will be delivered using the stepped care approach and a graduate worker and group facilitator were employed to deliver the extended service. The research described here was undertaken just prior to the full implementation of the enhanced service. Hence the data provide a baseline for the further evaluation of the enhanced service.

The PCT serves a population of 166,000 cared for by 89 GPs working from 27 practices. The pre-existing counselling service provided on-site counselling to all the practices at the service level of one session (four individual appointments) per 5000 patients. Sessions were provided by 12 counsellors, all trained to a minimum of diploma level in a British Association of Counselling and Psychotherapy approved course. The counsellors came from a variety of backgrounds, including nursing, business, social work, teaching and life coaching. The service provided brief, evidence-based interventions, largely integrating CBT-based approaches with solution focused methods. A previous evaluation found that the mean number of sessions provided for each patient was 3.65 (report available from the corresponding author).

### **Methods**

The research design and methods were selected to explore how GPs perceived the impacts of the on-site counselling service on their practice and to identify the important ingredients required to maximise the benefits. In order to encourage depth, breadth and practical insights, a realistic evaluation approach was used. Realistic evaluation (Pawson & Tilley, 1997) provides for evaluation based on a critical realist research paradigm (McEvoy & Richards, 2003). Specific research methods are not prescribed, rather the rigorous use and triangulation of a variety of methods is encouraged. A key difference between realist evaluation and clinical trials is that trials are interested in overall effect sizes and mean differences, whereas realistic evaluation seeks to develop knowledge about what works, for whom, and in what circumstances (Kazi, 2003). The focus is on how mechanisms operate within contexts to produce outcomes (Robson, 2000), hence realistic evaluation aims to identify and test a range of possible context, mechanism and outcome (C+M=O) configurations.

The study combined a survey of GPs and in-depth interviews with a sub-sample of GPs from the locality in order to facilitate interplay between these two research components and inductive and deductive reasoning (Cresswell, 1994). The research was carried out by a team of independent university-based researchers. The survey and in-depth interviews are described in turn below.

### ***GP survey***

The questionnaire used for the GP survey had been piloted during two previous studies of GP satisfaction and included Likert scale rating questions together with space for open-ended comments. Questions relating to the focus of this paper concerned rates of referral to the counselling service, GPs' satisfaction with service levels, perceived benefits to patients, impact on prescribing practice, quality of communication and confidence in the counsellor, and impact on practice capacity and skills.

All 89 GPs in the locality were sent the questionnaire between May and June 2006, followed up with one reminder. Data were analysed using SPSS to produce tables and test for difference and association between variables.

### ***In-depth interviews***

A semi-structured interview schedule was developed to guide the individual interviews and piloted with two colleagues. Questions focused on:

- perceptions of the counselling service's impact on GPs' practice and their patients' health, and
- views about access to the service and relationships with the counsellors.

Three GP practices (based in two surgeries) were selected according to theoretical sampling principles to maximise the range of responses. This was achieved by selecting one site that had scored well and one that had scored poorly on a recent shared care audit (not related to the current evaluation).

All GPs (17) from the two sites were sent information sheets and asked to opt-in if they were interested in being interviewed. Eight GPs, eight men and two women, agreed to participate. They appeared to be typical of the 17 GPs invited to take part in that they represented all three practices and included both experienced and recently qualified GPs. However, it was not possible to obtain information to compare the characteristics of those who took part and those who did not and to the extent to which the sample was representative is therefore open to question. The GPs were not selected to provide a representative sample but to maximise the range of insights offered whilst providing more depth than would have been possible with the survey alone.

The interviews were carried out by three members of the research team between June and August 2006. They were tape recorded and transcribed to facilitate thematic analysis based on the process outlined by Miles and Huberman (1984). Nvivo software was used to aid data management. Issues of validity and dependability were addressed in four ways:

1. Categories were developed following independent analysis of four transcripts by each of the three researchers.
2. One transcript was coded independently by each researcher, then compared, to promote theoretical sensitivity to the data.
3. The transcripts were then coded into the categories and the categories further coded to identify sub-categories and to highlight links with other categories.
4. The categories were then organised into the broad themes of context, mechanisms and outcomes that were adopted from the realistic evaluation framework.

The completed analysis was reviewed and edited by the same team together with a fourth researcher who had not been involved in data collection.

## Survey results

Fifty-two usable questionnaires were returned, giving an acceptable response rate of 58%. GPs were asked to estimate the percentage of patients with common mental health problems that they referred to the counselling service. Responses ranged from 1% to 100%. One explanation for the low referral rates from some GPs relates to the adequacy of service levels, as the following comment illustrates:

When I quoted 'difficult to access' regarding accessibility to counselling service I meant long waiting list, such is the demand. The 66% patients rate (proportion of suitable pts referred to service) could be even higher 85% if patients weren't put off because of this delay in being seen. (GP survey respondent)

The vast majority of GPs (82%,  $n=41$ ) stated that the patients they referred did not subsequently require referral to secondary services. The counselling service appeared to be holding patients in primary care and managing most without the need for secondary or specialist services.

In addition, GPs felt their patients benefited from the service, with three quarters disagreeing with a statement suggesting the service was not of benefit (Table 1). Fifty percent ( $n=25$ ) also believed the service had led to a reduction in prescribing and only 22% ( $n=11$ ) felt it had had no impact in this respect (Table 2).

Table 1. GP responses to the statement: 'Many patients I refer to the service do not benefit from it.'			
		Frequency	Valid percent
Valid	Strongly agree	1	2.0
	Agree	6	12.0
	Unsure	4	8.0
	Disagree	27	54.0
	Strongly disagree	12	24.0
	Total	50	100.0

Table 2. GP responses to the statement: 'The existence of the counselling service has led to a reduction in my prescribing of antidepressant and anxiolytic drugs.'			
		Frequency	Valid percent
Valid	Strongly agree	2	4.0
	Agree	9	18.0
	Unsure	14	28.0
	Disagree	24	48.0
	Strongly disagree	1	2.0
	Total	50	100.0

In response to a statement concerning the counselling service's impact on general practice, 54% ( $n=27$ ) of the GPs believed that skills within their practices in working with patients had improved as a result of the counselling service (Table 3). The counsellors did not have a training role in the surgeries but the interview data revealed possible indirect mechanisms to explain this finding (see interview results section).

Table 3. GP responses to the statement: 'The counsellor plays an important role in helping our practice staff improve our skills in working with patients with mental health problems.'			
		Frequency	Valid percent
Valid	Strongly agree	9	18.0
	Agree	7	14.0
	Unsure	7	14.0
	Disagree	20	40.0
	Strongly disagree	7	14.0
	Total	50	100.0

Table 4 shows the results for satisfaction with service levels.

Although the majority of respondents (61%,  $n=30$ ) were happy with the current levels of service provision, a significant number were not. One respondent described reducing referrals as part of a service protection strategy:

Access very poor initially but now much improved although still inadequate. Have reduced level of referrals to that what the service can cope with so 'milder' cases not being seen. (GP survey respondent)

Correlations were computed testing the relationships between perceived satisfaction with service levels, reported prescribing activity and perceptions of the counsellors' role in skilling up practice staff. Satisfaction with service levels was significantly correlated (two-tailed Spearman test) with a reported reduction in prescribing (0.331,  $p=0.02$ ,  $n=49$ ) and increased perception that the counsellor plays an important role in helping practice staff develop their mental health skills (0.382,  $p=0.007$ ,  $n=49$ ).

Further correlations were computed to test the relationships between satisfaction with communication with the counsellor and other variables. GPs with positive perceptions of communication were significantly more likely (two-tailed Spearman test) to believe that patients benefited from the service (0.432,  $p=0.002$ ,  $n=49$ ), to believe that the counsellor played an important role in helping practice staff develop their mental health skills (0.364,  $p=0.002$ ,  $n=49$ ) and to have confidence in the training and professional qualities of the counsellor (0.550,  $p<0.001$ ,  $n=49$ ).

Table 4. GP responses to the statement: 'The level of counselling service currently provided to my practice is adequate to meet the needs of my patients.'			
		Frequency	Valid percent
Valid	Strongly agree	4	8.2
	Agree	13	26.5
	Unsure	2	4.1
	Disagree	27	55.1
	Strongly disagree	3	6.1
	Total	49	100.0

In summary, the GPs valued the service and referred significant numbers of patients to it, although the numbers referred were affected by the level of service experienced. GPs perceived the service as useful in preventing referrals to secondary services and felt overall that patients benefited from the service. Half the GPs felt the service had led to reduced prescribing. Satisfaction with the level of the service provided was variable and appeared to be related to level of prescribing and primary care skill development. Satisfaction with communication with the counsellor also appeared to relate to perceptions of how clinically useful the service was to clients.

The survey results suggested that there were some important impacts on GP practice but that the underpinning mechanisms and required contexts needed further investigation. Questions specifically relating to the impact of the service on GP practice were therefore incorporated into the in-depth interview schedule.

### Interview results

Results from the in-depth interviews are presented in relation to the perceived impact of the counselling service and the contextual factors associated with the impact described.

#### *Perceived impact of the counselling service*

The GPs' responses to questions about the impact of the counselling service on their practice and their patients' health indicated that the service was perceived to have had many beneficial effects since its inception, including reduced use of psychoactive medication, increased capacity in primary care and cost efficiency.

### *Reduced use of psychoactive medication*

Of the eight GPs interviewed, six felt that the counselling service had facilitated a reduction in their prescribing of psychoactive medication, for example:

It certainly enters the thought process now not to prescribe because you know there is something that should work better. (Informant 5)

The likelihood is the tendency to prescribe them drugs would be higher. [If the counselling service was unavailable] Currently I don't prescribe to everybody, I say 'Let's have a go at counselling first. If that doesn't help, I will think about it.' The tendency otherwise could be alright, take a pill and then go home, see how you go on that drug. (Informant 7)

### *Increasing capacity in primary care*

The interviews revealed that for some GPs, the counselling service had enabled improved practice in psychological interventions. It appeared that the presence of a counsellor in the practice provided a kind of safety net for some GPs, who felt better able to use basic counselling approaches themselves in the knowledge that support was available:

Another thing...that it does make you think. Previously someone would come in and say I am scared of flying, I am going on holiday and we would prescribe something, diazepam or...give them some drugs, but now you are starting to think, Okay, well why are you scared of flying? Would you like some help to get over the fact that you are scared of flying or you are scared of going out? Lets change that so that you don't need to come each time and that would disappear. (Informant 5)

The same GP described how he was able to provide an initial intervention, to be followed up by the counsellor:

For example, there was a girl who came in after a bank holiday, was fed up, and in despair. [GP describes how he challenged her negative thinking] And you know, short intervention like that sometimes gets people thinking, and if you can follow that up with the counsellor doing CBT that's fine. But if you haven't got the counsellor then you haven't got that follow up...(Informant 5).

The existence of the service also enabled some GPs to engage with their patients in a way that promoted more meaningful patient involvement and influence in their care:

When you perhaps talk to patients and say well we have an option of that particular treatment or that treatment patients are quite naturally quite reluctant to take medication and have all sorts of preconceived ideas about antidepressants and that sort of thing and therefore if they hear something that may not require antidepressants and still maybe helpful. And when you explain to them that it is not just you sit and listen and then go away again, there is a medical treatment behind it CBT treatment behind it and that it's a proven therapy for depression etc they are quite happy to go along and try it. (Informant 3)

One GP described how he now felt he could be more proactive in caring for his patients with mental health problems:

Whereas we were fire-fighting before, we are now actually trying to prevent the fires, at least that is how I look at it...I think we are all pleased with the service. It has filled a hole it has given us a different way to treat people and hopefully a way that will be more beneficial in the long term. (Informant 5)

This GP (Informant 5) valued the ease of access to the counsellor and also the close personal contacts that on-site counselling permitted.

### *Cost efficiency*

The GPs mentioned the cost efficiency of the service in relation both to the cost of providing the care themselves and costs to patients:

Well, I think GPs may have to offer some kind of service themselves [if the counselling service was not available]...and there's not much point to GPs spending half an hour counselling someone when a counsellor's cheaper (Informant 8)

If it were not available. Then one would be recommending, as I mentioned earlier, the [local voluntary counselling agency] which we did before and then there was a much longer wait. There are one or two other agencies which provide counselling but you would be looking to the voluntary and independent sector. Probably mostly voluntary because they are free and a lot of patients don't have the money to spend on counselling. Some people have to pay 40 or 50 pounds on a single session. If they need three or four sessions some people just can't afford to do it. (Informant 5)

A third issue related to costs of referral to specialists, implicit in the following comment:

Whether now if the counselling became...they'd probably end up being referred elsewhere. But they'd be referred to clinics dealing with their physical symptoms. So the anxious would be going see the cardiologists for their heart palpitations and their gastroenterologists for their irritable bowel stress symptoms. And they'd be back into the physical, what's the word I'm looking for, somatisation, which is a hugely expensive route (Informant 6).

To summarise, the on-site counselling service was perceived by GPs as providing a clinically and cost-efficient intervention to patients with common mental health problems. Most GPs believed it had helped them to reduce prescribing and for some it had supported the development of a stronger psychological element to their practice.

### ***Key requirements for outcomes***

The factors associated with the impacts described above revolved around service levels and access and personal contacts.

#### ***Service levels***

The level of service provided emerged as key to its effectiveness from the GPs' perspective. In the interviews, three GPs described how they limited referrals in order to maintain and protect the service and permit speedy access when most needed. For example:

In terms of the counselling a lot of it depends on the availability of the services,...but previously what has been the problem is that, because the services weren't there to meet the demands, then we sort of rationed our referrals according to the amount of counselling services that were available, so we tended to refer more seriously depressed patients to the counsellors and ones that were more moderate, because there wasn't sufficient counsellors, we sort of ended up keeping them and not referring them. (Informant 2)

This suggests that the increased counselling levels being implemented in the enhanced service could permit a broader range of referrals, thus improving the impact of the service from the baseline described here.

#### ***Access and personal contacts***

When asked about partnerships with the counselling service, the key consideration for the GPs was ease of access for themselves and their patients. One of the main issues when deciding whether, and to whom to refer, was the perceived likelihood of a prompt response:

You make an assessment of the patient and I think if it's, particularly if it's reacted to circumstances, you know if someone has got a reactive depression but it's been brought on by relationship difficulty, loss of job, bereavement something like that...then we are more likely to send that to our in-house counsellors because we know we can get them seen probably within a month or six weeks. (Informant 5)

Another GP stressed the importance of access and of the personal contacts that onsite counselling enables:



[Describing why counselling was preferred to a secondary care service] One, access is easy primarily because the appointments are organised by one of our staff and I can pick up the phone and say I have got someone who is fairly urgent. Has there been a cancellation or something. Easy to fit in somebody who is urgent. If they are not urgent then they will fit them in, in the normal time. You can pick up the phone and know where your patient is in the system. The counsellors come here and you often bump into them, you can chat to them so you have got contact. (Informant 3)

A GP who was particularly positive about the service described how the counsellor came to be seen as integral member of the primary care team:

I mean, she was the counsellor and the girls were treating her as part of the team, the same as anybody else. She brought a recipe for Christmas cake [laughter] and was, you know, treated just like any other member of staff. (Informant 5)

Overall, the informants valued their partnerships with the counsellors with ease of access being the most important consideration. Those that commented on having positive partnerships with the counsellors were more likely to incorporate a psychological approach in their own practice.

### Summary of results

The survey identified that from the GP perspective the counselling service was having a significant impact on practice in primary care and this was supported by the interview results. The interviews added more depth of understanding in illuminating the contexts and key mechanisms underpinning the impacts described.

In terms of the realistic evaluation C+M=O framework, the outcomes identified were:

- On-site counselling was perceived as very positive by most GPs.
- The service was seen to be leading to a reduction in prescriptions for psychoactive medication and to be encouraging motivated GPs to develop their psychological practice with support from the on-site counsellors.

The *contexts* required for these outcomes were service levels that were perceived to be adequate, ready access to the counselling service and personal contacts with the counsellors.

The key *mechanisms* enabling the outcomes described appeared to be the security associated with the safety net effect provided by accessible counsellors who were perceived as supporting GP practice in psychological interventions, and counsellors modelling psychological interventions for GPs through their work with clients.

### Discussion

Previous studies have found that most important factor in relation to GP referral decisions was the waiting times and perceived quality of service (Ghiacy, 1995; Knight, 2003). These were also important considerations in this study with a 'rationing' of referrals evident to avoid long waiting times for the client or to avoid overwhelming the counsellor. In addition, the survey revealed significant correlations between satisfaction with service levels and reduced prescribing and increased influence of the service in increasing skills and capacity in primary care. The GPs valued the counselling service and, despite some variations in delivery and satisfaction across the locality, the majority felt the service was helping to improve their own skills with working with patients with mental health problems. The interviews with the GPs highlighted the importance of good working access to a counsellor who is known personally to the GP; reinforcing the assertion that 'communication between referrer and service provider is essential for effective referral and treatment' (Knight, 2003, p. 198). Although counsellors were not based in the surgeries and visited on a sessional basis, some GPs and counsellors clearly did achieve close working relationships incorporating formal contacts at practice meetings and informal contact where patient referrals could be discussed and interested GPs could be supported by the counsellor in their work. This type of close contact is crucial if quality referral and treatment is to be achieved (Epstein, 1995). An area of difference in

relation to earlier research was the relative importance given to cost issues by GPs, unsurprising perhaps given the increasing financial responsibilities and opportunities afforded by the GMS contract (Department of Health, 2003).

### **Implications for practice**

In terms of local issues, the study raised some important issues that the counselling service has been dealing with. There was a lack of consistency in practices regarding written feedback mechanisms with some employing paper-based records and others using computer-based records. There was also a lack of clarity for some about confidentiality requirements in written feedback to GPs from counsellors and a tension between what GPs might want to know about the patient's problems and progress and the counsellors' desire to provide confidentiality and a safe counselling environment. There was also variable knowledge amongst the GPs about the new enhanced service and efforts were redoubled at both the practice level and at the regular PCT wide GP training events to inform and educate about the service.

The counselling service that was evaluated here is similar to the proposed IAPT services in two important respects, the primary care location of the service delivery and the externally managed nature of the service. The general service principles for the IAPT pathfinder sites specify that they should have close relationships with primary care and that much of the treatment should take place in GP practices. It is also envisaged that the majority of referrals will be from GPs, though the sites should also permit self-referral and referral from other agencies (CSIP, 2007). It is important that close relationships with GPs, practice nurses and others are nurtured and promoted. This study suggests that where GPs perceive the service to be responsive, easily accessible and personal, appropriate referrals will be maximised and the quality of the GP response will be improved. In particular, GPs are less likely to prescribe medication in the knowledge of readily accessible alternatives and some may actually feel more confident about delivering brief, evidence-based support and interventions themselves. Conversely, a counselling service that does not facilitate appropriate referrals and speedy access to patients when needed is likely to leave many with their mental health needs unmet and many more relying on psychoactive medication as the sole or primary means of help. By locating counselling within surgeries and health centres, the capacity of primary care to provide mental health care is enhanced, rather than the problem just removed as in the replacement model (Gask & Croft, 2000). As the IAPT programme rolls out and expands, it becomes very important to make key decisions about how these teams will operate. The evidence from this study suggests that integrating closely with primary care and selecting and training staff to develop close working relationships with primary care staff could be crucial to the success of the programme.

The interviews revealed that the effects of the increased capacity and greater choice within the enhanced service were beginning to be felt, with increased service capacity leading to increased numbers of referrals for patients with a wider range of mental health needs. The potential for those with common mental health problems to recover through the use of bibliotherapy (Frude, 2005), computerised CBT (Proudfoot *et al.*, 2003), psycho-educational groups, self-help groups or individually tailored self-help packages, could be enhanced with appropriate skill mix and resources allocated to teams responsible for primary care. The evidence suggests that many currently being treated with antidepressant and/or anxiolytic medication could be treated more safely, effectively, appropriately and less intrusively through the range of approaches that could be provided in stepped care systems (Bower & Gilbody, 2005). It is plausible to argue that treating people early through self-help could reduce the need for subsequent, more expensive formal counselling, CBT, medication and secondary care referral, though more research is needed to support this.

### **Strengths and limitations**

In combining survey and interview methods in a realistic evaluation design, the study both identified the perceived impact of an on-site counselling service in one PCT locality, and illuminated the ways in which the benefits can be maximised. However, care has to be taken in applying the insights from this study to other localities. In particular, the context for this

study was a locality that had benefited from an on-site counselling service for nearly seven years and it should not be assumed that the benefits evident in this area can be quickly achieved elsewhere.

Care should also be taken in attaching too much importance to the causal insights in the study. The research was primarily exploratory and although the identified mechanisms are plausible, they remain theoretical and require further testing and development in future studies in different geographical areas. A good response rate was obtained in the survey and all practices were represented. An analysis of non-responders was not completed, however, so it was not possible to specify how representative the sample was. The interviews were limited to GPs working in three practices and although they highlighted a range of issues and added depth to the survey, other practices may have had particular issues or perspectives that were not highlighted.

## Conclusions

This paper has focused on GP perceptions of a counselling service that preceded the introduction of an enhanced primary care mental health service. The wider evaluation of the enhanced service, which also includes the perceptions of clients and counsellors, and measures client outcomes using validated measures, aims to contribute further to knowledge in this area.

The research presented here has provided confirmation and support to the existing knowledge base summarised in the literature review and strengthened understanding of the contexts and mechanisms leading to GP referral and prescribing practice. In addition, it has identified how on-site counselling can, in the right conditions, promote improved practice and increased mental health capacity in general practice.

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