Ideal and Actual Referral Choices for Mental Health Problems in Primary Care

Tania Dolley, Powys Healthcare NHS Trust, Bryan Adams, City University & Dr James Hampton, City University.

With the increasing role of primary care in managing mental health problems there are now a number of different professionals who may deliver this service. GPs in one county were surveyed to find out which professionals they currently refer patients to with particular psychological problems, and which they would perceive to be the ideal referral choice if available. Results identified GPs' perceptions of ideal professionals to treat each problem, their degree of consensus on this and discrepancies between ideal and actual referral choices.

Overall, at least half the GPs could refer to their perceived ideal practitioner. There was greater discrepancy between actual and ideal referral choices for several problems, where 30 per cent to 50 per cent of patients were not currently being referred to the ideal choice. This may indicate shortfalls in service provision, for various practitioners, and raises questions about the effectiveness of treatment available to these patients. GPs often see patients themselves instead, or refer elsewhere, especially to CPNs who are readily available.

Consensus was high for some problems, and for others was spread between four or five different practitioners. Questions arise about appropriateness of some referral choices and practitioner qualifications. The need for clearer information and referral guidelines is highlighted, and perhaps a reassessment of priorities in service provision.

The case for referral guidelines has been made by 'Treatment Choice in Psychological Therapies and Counselling – evidence-based clinical practice guideline', *Department of Health, February 2001. (www.doh.gov.uk/mentalhealth/treatmentguideline).*

This study reinforces this need for clear referral guidelines.

Introduction

A NUMBER OF DIFFERENT professionals now service the growing number of mental health problems seen by general practitioners (GPs) (Corney, 1996). This growth has coincidentally coincided with the expansion of Counselling Psychology training courses. These practitioners may employ different psychological approaches and have different levels of qualification. Yet there has been relatively little research into GPs' referrals to this range of professionals offering psychological treatments. What determines GPs' referrals to different mental health professionals and what treatment would they consider to be appropriate for which problems? Service provision and referral patterns often appear somewhat idiosyncratic. On what criteria are these referral choices based? To what extent are GPs aware of the differences between the various therapies and what, if any, distinction do they see between counsellors,

psychotherapists, counselling psychologists, clinical psychologists and other practitioners? Do GPs take into account the practitioner's approach, training or areas of expertise when making a referral? To what extent might confusion or lack of information be a barrier to appropriate referrals?

This study investigated referral practices in one Primary Care Agency to find out to which professionals GPs refer patients with psychological problems, and to discover any discrepancies between these actual referrals and their preferred referral choice if the service were available. GP consensus on ideal referral was investigated and perceptions of the role of counselling psychologists was considered. This will inevitably highlight gaps in service provision which counselling psychologists might help to fill.

Mental health services in the NHS

Psychological therapies are becoming the treatment of choice for a wide range of psychological and psychiatric presentations (Kosviner, 1994). The White Paper 'Health of the Nation' (Department of Health, 1992) highlighted mental health as a key issue, encouraging primary care to take a lead in developing effective services for people with psychosocial and mental health problems. However, there appears to be some 'ignorance and confusion' (Clarkson, 1994) between different service provision, and a need for clearer referral guidelines.

The prevalence of mental health problems

Mental health problems are extremely common. It is estimated that at any given moment, 30 per cent of the UK population are suffering from symptoms of anxiety or depression (Huppert, Roth & Gore, 1987). Many GP trainees comment that their hospital-based psychiatric training does not prepare them appropriately for the psychological problems they encounter in general practice (Markus *et al.*, 1989).

Range and provision of mental health services

The number of mental health care professionals connected with a general practice has increased substantially since 1991 (Corney, 1996). Increases in the demand for counselling (Sherrard, 1993) and the range of psychological services has resulted in the growth of a vast assortment of professionals providing psychological help (Tyndall, 1993). Current government provision includes: psychotherapists (Temperley, 1978; Gask & McGrath, 1989), clinical psychologists (Milne & Souter, 1988; Salmon, 1984) and psychiatrists, who increasingly work in community mental health teams (Strathdee & Williams, 1984; Burns, 1990). Many community psychiatric nurses (CPNs) (Briscoe & Wilkinson, 1989; Robson, France & Bland, 1984; Espie & White, 1986), social workers (Corney, 1985) and counsellors (e.g. Waydenfeld & Waydenfeld, 1980; Rowland & Irving, 1984; McLeod, 1988; Pereira Grey, 1988; Martin & Mitchel, 1983; Sibbald *et al.*, 1993) also work in primary care settings.

These practitioners use a range of different approaches. Kosviner (1994) summarises the major psychological therapies available within the NHS that are substantiated by sound psychological theories and/or empirical research, including psychoanalytic, cognitive and behavioural, systemic, humanistic or existential psychotherapies and counselling approaches. Practitioners do not often, of course, fit into any one category and over the last two decades there has been a trend internationally towards 'integrative' approaches (Dryden, 1984).

In spite of this range – or perhaps because of it – there has been concern about the quality and accessibility of this broad spectrum of psychological services now available in the NHS. Kosviner (1994) suggests that psychotherapy services are often unevenly distributed and poorly integrated with other psychiatric and psychological services. This fragmented provision is neither conducive to good patient care nor comprehensible to most referrers (Kosviner, 1994). Confusion may perpetuate existing difficulties in providing the best cost-effective help for people with emotional or psychological difficulties (Clarkson, 1994). It is precisely this confusion that the new government guidelines (Department of Health, 2001) address.

Definitions and confusions

When it comes to distinguishing between therapies/therapists opinions differ on what, if any, the differences are. Clarkson (1994) suggests that identifying the factors differentiating counselling, psychotherapy, psychology, psychiatry and allied fields might help provide guidelines for referral agencies, professionals and the public to align needs and resources more accurately.

For example, a GP's perception of counselling may range from 'sympathetic chat' to skilled professional service. Although some GPs consider counselling to be specifically non-directive in nature (Pringle & Laverty, 1993), Curtis-Jenkins (1993b) points out that many other forms of counselling or psychotherapy are being used viz. brief therapy models, behaviour therapy and gestalt, as counsellors match patients needs to therapy and not vice versa. Farrell (1993) distinguishes between counselling and counselling skills - for example the difference between a nurse, community psychiatric nurse (CPN) or social worker with counselling skills, and a trained or experienced counsellor. He points to the complex distinction between 'counselling' and 'psychotherapy', which he considers as umbrella terms for sets of activities. Some writers consider there to be little essential difference and use the terms interchangeably (e.g. Dryden & Feltham, 1992).

Three main approaches to considering the relationship between counselling, psychotherapy, psychology and psychiatry have been identified (Carroll, 1991). There are those who 'lump' them all together and refuse to acknowledge any differences; those who refuse to acknowledge any similarities; and finally those who consider 'overlap' between the groups, with areas of both similarity and difference. Some inter-professional tensions, and anxieties about professional roles may consequently arise.

GP referrals to mental health services and related issues

Access to services inevitably depends on GPs' assessment skills and referral decisions, which may be influenced by a variety of factors, including resources and availability of services. Corney (1990) demonstrates the important role GPs play in the treatment of psychosocial problems, although early studies by Goldberg and Blackwell (1970) revealed that GPs missed much psychosocial disturbance and psychopathology, and not all are skilled at either detecting or managing these problems (Goldberg *et al.*, 1982). GPs show a wide variation in referral patterns, possibly due to their unique referral thresholds (Cummins *et al.*, 1981).

Qualifications

Psychological professionals vary in the range of therapy offered, and breadth and level of training. So what is an appropriate referral? This issue is particularly pertinent to counselling services in primary care, since for nearly ten years, a third of GPs in England and Wales have been employing counsellors (Kendrick *et al.*, 1993).

Sibbald *et al.*'s (1993) survey of counsellors found a high proportion lacked adequate qualifications, and many were referred problems outside their knowledge. GPs were often unaware what qualifications were held. They concluded that while many counsellors may be skilled in a range of approaches, any one counsellor is unlikely to be qualified to deal with such a broad range of illness, a concern echoed by Fallowfield (1993). Strouthos, Ronder and Hemmings (1995) also express concern on both the variable training and supervision that counsellors have received, and lack of clear guidelines on referral. Watts and Bor (1995) point out that the range of qualifications among the professionals who may provide counselling in primary care includes clinical psychologists, counselling psychologists, UCKP registered psychotherapists, community psychiatric nurses, social workers and nurses who may have counselling or psychotherapy qualifications and some GPs with training in counselling or psychotherapy. Areas of competence will inevitably differ.

Assessment

All this raises the question, how is need matched to therapy, and by whom? How are patients assessed? Are counsellors expected to be trained in a variety of models? Do GPs take into account training or type of qualification

when referring? To what extent are GPs even aware of the different types of training a counsellor or therapist may have received?

The important task of assessment and the need to determine which therapy(s) is appropriate, in what setting, and for what duration has been addressed in the BPS/Royal College of Psychiatry Statement (1993), emphasising that the present situation is clearly not in the best interests of service users. It stresses that the range of therapies offered should be broad, balanced and co-ordinated. It emphasises the need for specialist assessment, treatment and training. This sounds like a highly ideal situation, but may be a system to aspire to!

Choice of referrals

Sibbald *et al.* (1993) suggest GPs need to be more discriminating and need better research into which types of patient problems are best treated by which types of psychological intervention. Corney (1992, p.331) suggests that due to the wide range of therapies ranging from behavioural approaches to psychoanalysis *'We urgently need to know which therapies benefit which patients most and which ones are more acceptable to patients.'*

Fallowfield (1993) cites the lack of any clear model as one of the difficulties with evaluating counselling, a theme echoed by King *et al.* (1994) who suggest that the multifarious nature of counselling is partly responsible for the confusion about efficacy. Although a number of studies have highlighted the value of counselling (e.g. Corney, 1992; King *et al.*, 1994, Boot *et al.*, 1994), and a meta-analysis found that treatment by mental health professionals was about 10 per cent more effective than treatment by GPs (Balestrieri *et al.*, 1988), Webber *et al.* (1994) suggest that both the kinds of problems being referred and how they are met need further evaluation. For example, some treatments such as exposure therapy for phobias are offered by several professional groups. Who will provide the treatment often depends more on availability than clinical policy.

There have been few attempts to look at which problems are referred to which professionals. Webber *et al.* (1994) considered reasons for patients being referred to a practice counsellor. Sibbald *et al.* (1993) investigated which problems are referred to onsite counsellors, who may be a CPN, 'practice counsellor' or clinical psychologist. They found that affective and psychotic disorders were often referred to CPNs, suggesting that GPs see them as skilled in managing psychiatric illness; psychosexual difficulties, eating disorders, phobias and obsessive-compulsive disorders tended to be referred to clinical psychologists; and bereaved patients were often referred to practice counsellors. O'Neill-Byrne and Browning (1996) described the first study to compare referrals to, and activities of, psychiatrists, psychologists and CPNs working within primary care. They found that where GPs have access to mental health professionals of different disciplines, they refer different patients groups to each professional. Younger, more socially stable patients went to the psychologist and older patients to the CPN. Psychiatrists and CPNs were referred a higher proportion of patients perceived to have a risk of suicide, CPNs saw all patients referred for 'social support', and all psychotic patients. Patients referred to psychologists were more likely to be under 35 and in full-time employment.

There is little research into GPs' awareness of the various therapies available and the effect of this on referral patterns, or whether a lack of information may result in inappropriate referrals. The literature often refers to 'counselling' or 'psychotherapy' in generic terms, with little differentiation between either what kind of counselling or therapy is being talked about, what training/qualification is involved, or what other psychological therapies might be available or appropriate. The present confusion needs to be clarified and guidelines for assessment and referral are required.

All this paints a picture of a wide variety of psychological services and types of practitioner available, with various different models of therapy being practised and of fairly sporadic, ad hoc service provision with a great range of referral patterns. Small wonder then, that confusion reigns and that some GPs feel *'It's a minefield out there'!* (Markham, 1994)

This study was mounted to gain a clearer picture of how GPs are using mental health services and how this would be changed if they

had the freedom to refer to whomsoever they chose. It also aimed to identify the familiarity of GPs with the emerging profession of counselling psychology.

Method

A quantitative survey was carried out using a self-administered questionnaire and sent to 298 GPs in practices of varying size between one to nine GPs, in one of the Home Counties. There was an approximately equal distribution of male and female GPs.

A list of problems covering the range of psychological referrals that commonly occur in general practice was compiled. These were serious suicide attempt; depression, not suicidal; depression, possibly suicidal; simple phobia; unresolved bereavement; agoraphobia with panic attacks; post-traumatic stress disorder (PTSD); eating disorder; general anxiety disorder (GAD); chronic relationship difficulties; stress related headaches; possible psychosis; and alcohol/drug related problem. This list included a spectrum of problems from 'serious suicide attempt' or 'possible psychosis' where a greater consensus between GPs on referral choice would be expected, to those where there might conceivably be less referral agreement.

The five-page questionnaire consisted of two sections. Along with instructions and example chart, Section A included two identical charts listing the 13 patient diagnoses of psychological problems along the side and a list of 13 mental health professionals along the top. To reflect the wide range of professionals to whom a patient might be referred, the following choices were included: psychiatrist, clinical psychologist, counselling psychologist, counsellor, psychotherapist, family therapist, community psychiatric nurse, practice nurse, psychiatric social worker, nurse behaviour therapist, 'see patient myself rather than refer', 'whichever is available', and 'other (please specify)'.

The first chart related to their actual choice of practitioner, i.e. who they would refer this patient to if consulted today, and the second chart related to their ideal choice, i.e. who they would ideally refer the patient to if this practitioner were available. GPs were asked to indicate their first, second, and third choice of practitioner to whom they would refer a patient diagnosed which each psychological problem given.

In Section B, the first question asked GPs for the reasons for any differences in their actual and ideal choice of referral, giving four options of 'financial constraints', 'time constraints', 'unavailability of psychological services' and 'other (please specify)'. The remaining questions considered practice size, years of practice as a GP and amount of post-graduate mental health training, current availability of mental health professionals referred to, and professionals needed but not available.

Although categorising patients according to a simple diagnosis of psychological problem might be generalised and limiting, in order to keep the questionnaire simple and quick to complete it was decided to give GPs the diagnosis rather than in effect testing their diagnostic skills with a vignette, especially as referral thresholds vary widely.

Data analysis

Cross tabulation analyses were conducted to compare the actual and ideal referral choices for individual GPs. In addition a hierarchical classes (HICLAS) analysis was used to simplify the actual and preferred referral choices.

Differences between GPs in *actual* referrals might indicate disparities in resource availability in the area. In the *ideal* scenario, differences could also indicate varying perceptions among GPs as to which practitioners are the most appropriate for treating specific psychological problems. This could perhaps reflect GPs' knowledge (and possible confusion) of the differences between professionals and awareness of what is the most appropriate referral. Differences for the same GP between their actual and ideal choice could reflect service provision and indicate that GPs do have an idea of what they would consider to be the most appropriate referral, but are unable to do so.

Results

Sixty-eight completed questionnaires were returned – 23 per cent of those sent out. Over

half came from practices of between five and seven GPs. For simplicity, results are presented in two formats. First we have used a HICLAS diagram to give an overall pattern of Actual and Ideal referrals. Secondly we have presented some of the data in tabular form, to illustrate in more detail points of interest.

Hierarchical Class Analysis (HICLAS)

HICLAS is a general data reduction method developed by De Boeck and Rosenberg (1988) that takes as input a matrix of binary data. Data can be prepared for analysis using most spreadsheets. An introductory account can be found in De Boeck *et al.* (1993). As applied to our data HICLAS aims to provide a summary diagram that shows in a direct way which of the problems were referred to which type of practitioner. It achieves this by allocating both problems and practitioners to a hierarchy of classes, with those problems or practitioners at the most general level having the widest range of referral. In Figure 1 a HICLAS solution is shown for the average judgement for actual referrals. A problem was considered linked to a practitioner if five or more of the sample made that connection.

Problem categories are shown in the top half of the diagram, and practitioner categories in the lower half and the two are separated by the dotted line. For problems, the most general level of category [phobias] is at the top, while for practitioners the most general level (represented by the classes [See self, CPN and clinical psychologist]) is at the bottom. The two domains (problems and practitioners) are connected through a set of *bundles* at the lowest level, shown by the zig-zag lines connecting base level problems to base level practitioners. Thus, for example, the problem class [serious suicide risk, psychosis and alcohol/drug problems] was directly connected to the practitioner class [psychiatrist], showing that this group of problems was referred to that group of practitioners.

In general, to find which problems are referred to which practitioners and vice versa one simply looks to see if they can be connected by a vertical path through the network. Thus, since there are no further connections below the level of psychiatrist, no other practitioners would be referred the set of three problems just described. On the other hand, counsellors would be referred the problem class of [bereavement and GAD], and these problems could also be referred to the practitioner class [see self] and [CPN], as there are links to these below [counsellor]. The symbol Ø in a class indicates an empty set. The reader may wish to check their understanding of the diagram by confirming that the [clinical psychologist] class would be referred the problems in the classes of [agoraphobia/panic], [panic] and [eating disorder, PTSD].

The HICLAS diagram is useful in that: (a) it clusters together problems referred to the same set of practitioners and clusters together practitioners referred the same set of problems; and (b) it shows the class inclusion hierarchy of both problems and practitioners from the most specific, at the centre of the diagram, to the most general, at the top and bottom. In order to achieve this level of clarity it is necessary to introduce a degree of simplification. The amount of data distortion is indicated by the number of discrepancies (in the case of Figure 1, there were seven). A discrepancy occurs when a cell in the problem-by-practitioner matrix has had to be changed in order to generate the structure shown. The number of discrepancies is reduced as the number of base bundles (known as the rank) is increased, but as there is usually a corresponding increase in the complexity of the diagram, a compromise is needed between accuracy and readability. Cells that have had data changed are shown on the diagram with individual goodness-of-fit measures beside them. (See for example that PTSD had a goodness-of-fit measure of .67 next to it indicating that not all psychiatrists and clinical psychologists were the actual referral choices). In addition an overall goodness-of-fit is generated for the whole data file. In Figure 1 this figure is .767 indicating that just short of eighty per cent of the data is represented by the diagram. The final point to note in Figure 1 is that four types of practitioner (counselling psychologist, psychotherapist, family therapist and other) do not appear in the diagram, as there were no problems referred to them at a level that reached our inclusion criteria.

Figure 1: GPs' stated actual referrals based on problem data.
Rank = 5; Discrepancies = 7; Goodness of fit = .767

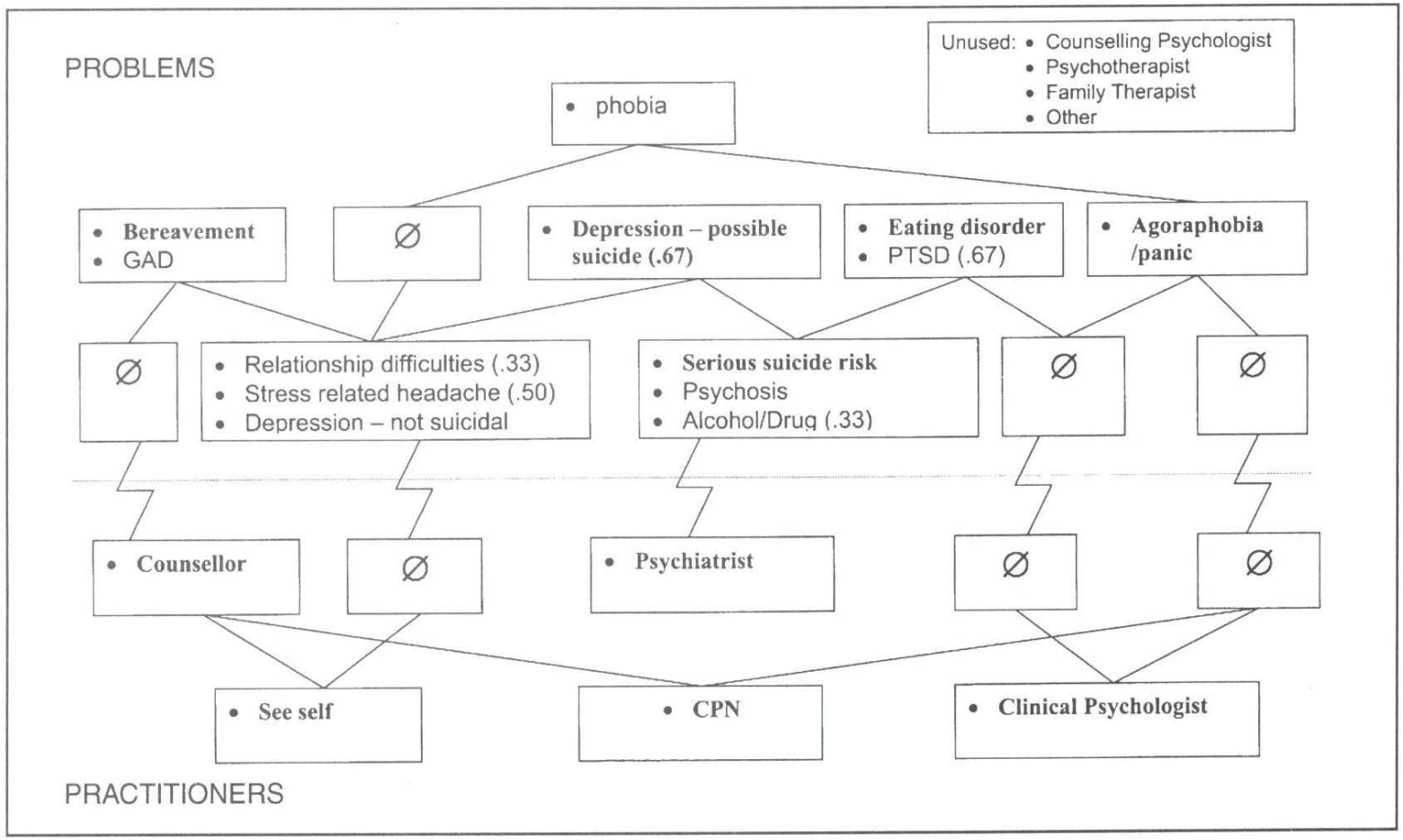


Figure 2 shows the HICLAS diagram for the ideal referral data.

It is immediately apparent that there was greater differentiation of both problems (10 distinct classes against six) and practitioners (six against five, and no class of practitioners with no referrals). Again for clarity, only practitioners chosen by five or more GPs in each case were considered. This accounted for over 90 per cent of the sample. The role of the counsellor in actual referrals was differentiated into two classes [counsellor and counselling psychologist] and [psychotherapist and family therapist]. The latter would ideally handle referrals only in relationship difficulties, whereas the former would also be referred problems of bereavement, stress related headaches and PTSD. The clinical psychologist continued to be referred the same problems as before, but in addition in an ideal world may be referred problems of GAD and stress related headaches. The role of psychiatrist was mostly unchanged. The category of 'other' practitioner was introduced to handle problems of alcohol and drug abuse, suggesting that the other practitioner that the GPs had in mind would be a specialist in addictive behaviour. Most interestingly the GPs saw themselves and the CPN as ideally fulfilling the same role as each other, and covering a much-reduced range of problems – GAD and mild or moderate forms of depression only. This is evidence that GPs would wish to make greater use of referrals for mental and behavioural problems, freeing up themselves and their CPNs for other forms of medical practice.

To illustrate where consensus on ideal referral was high and where it varied among GPs we have included the following examples.

For patients making a serious suicide attempt and with possible psychosis, virtually all GPs would refer to a psychiatrist. Over nine in 10 GPs would also refer patients with depression to a psychiatrist, CPN or see patients themselves. For convenience these can be considered *high consensus* choices.

Eating disorders, simple phobia and agoraphobia with panic attacks were areas of *moderate consensus* with over 60 per cent of GPs referring to either a psychiatrist or clinical psychologist. Thus 40 per cent of referral choices for patients with these problems were spread fairly evenly between six and eight other practitioners in some cases. These included counsellor, CPN, nurse behaviour therapist, see patients themselves and other – in this instance, the Community Mental Health Team or occupational therapist.

Stress-related headaches, PTSD and unresolved bereavement, GAD and chronic relationship difficulties were all areas of *low consensus* and would be referred to any one of five or more practitioners. Actual referrals were more likely to be informed by available resources than confusion, since GPs' ideal choices were often different from the actual choices with these disorders.

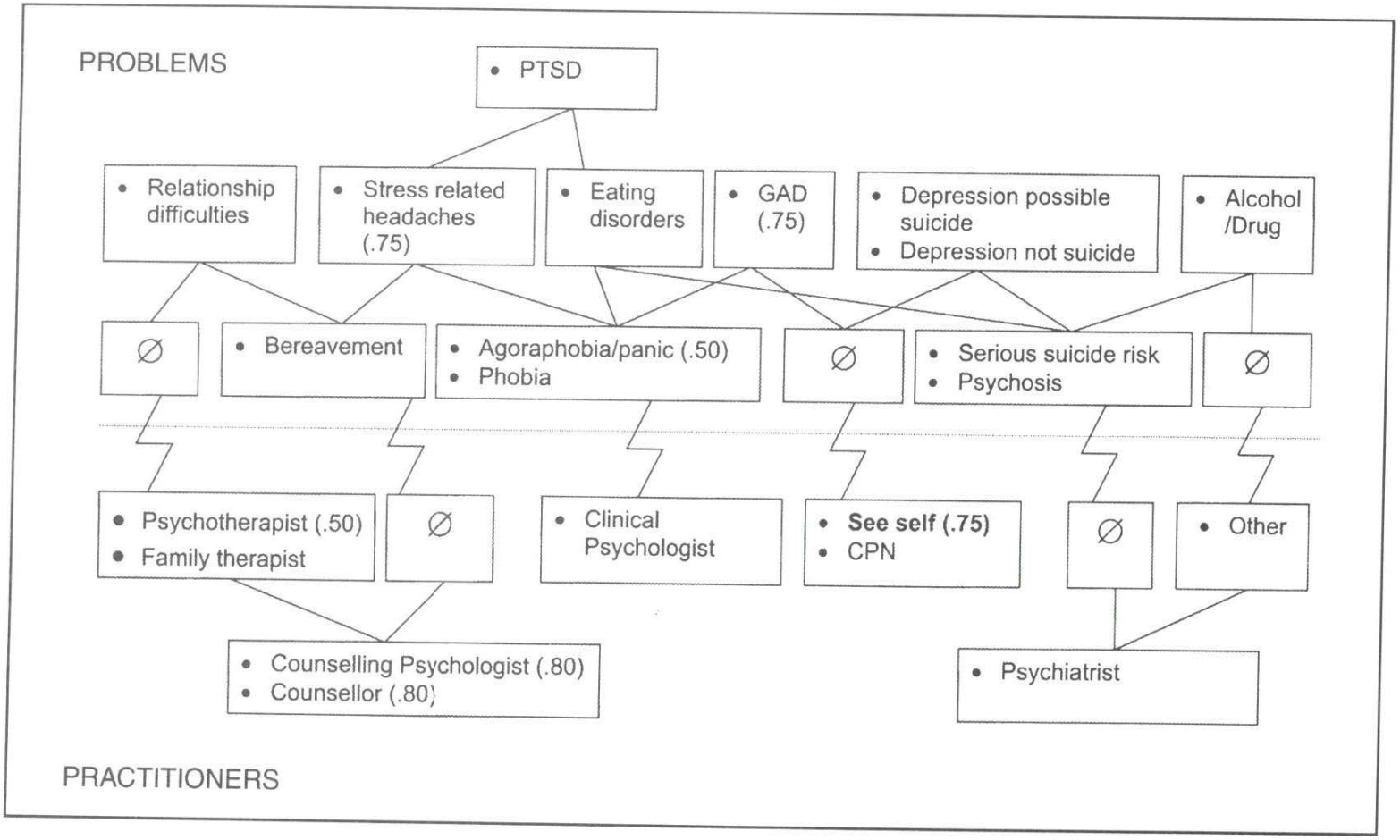
Comparing Figures 1 and 2 shows that with over half the problems GPs could refer to the practitioner of their choice. For several problems, between a third and a half of GPs, ideal referral choices were unavailable. Since these represent serious perceived shortfalls in primary mental health care services we have included Table 1 below to identify these areas.

Table 1: Overall per cent GPs unable to refer patients with a particular psychological problem to preferred practitioner.

Problem	GPs unable to refer (%)
Chronic relationship difficulties	47
Unresolved bereavement	44
Agoraphobia w. panic attacks	42
Stress related headaches	40
General anxiety	38
Simple phobia	35
PTSD	30

Chronic relationship difficulties and unresolved bereavement was an area where counsellor/counselling psychology numbers were perceived to be insufficient. In particular one in seven GPs differentiated between counsellors and counselling psychologists, preferring the latter to receive unresolved bereavement referrals. For agoraphobia with panic attacks, simple phobias, general anxiety and stress related headaches and PTSD, ideal

Figure 2: GPs' perception of ideal refferal choice based on problem data.
Rank = 6; Discrepancies = 4; Goodness of fit = .882



referral choices were varied and represented at times idiosyncratic choices which are examined in the discussion.

Discussion

Perceived ideal referrals

Nearly all GPs would refer to a psychiatrist patients making a serious suicide attempt or with possible psychosis, and patients with depression who were also possibly suicidal. This supports previous findings that psychiatrists and CPNs were referred a higher proportion of patients perceived to have a risk of suicide (O'Neill-Byrne & Browning, 1996). For depression without suicide risk, the majority of GPs would both actually and ideally see patients themselves although several would refer to a psychiatrist or CPN instead. For patients with a simple phobia, the professional of choice would be a clinical psychologist, but in fact more GPs were referring instead to a CPN or seeing these patients themselves. Similarly for agoraphobia with panic attacks, the largest proportion of GPs would refer to a clinical psychologist, but several were actually referring to a CPN. For these two problems, results support findings by Sibbald *et al.* (1993) that clinical psychologists tend to be referred problems such as psychosexual difficulties, eating disorders, phobias and obsessive-compulsive disorders which are believed amenable to the behavioural therapies practised by these professionals. However, substantially more GPs in the present study perceive a psychiatrist as the ideal professional to refer patients with eating disorders, in both actual and ideal scenarios.

For patients with unresolved bereavement and chronic relationship difficulties, the professional chosen by the largest proportion of GPs both actually and ideally was a counsellor. This again supports Sibbald *et al.*'s (1993) findings that bereaved patients are generally referred to practice counsellors, which they suggest indicates that GPs see this as a problem that responds to the non-directive forms of counselling associated with these professionals. For unresolved bereavement, the majority choice of counsellor was followed by a counselling psychologist in the ideal scenario but actually several GPs were seeing these patients themselves or referring to a CPN. Several GPs also considered a family therapist, counselling psychologist, and psychotherapist the ideal referral for chronic relationship difficulties. Specialist agencies or professionals, followed by a psychiatrist, were the actual and ideal referral choice for patients with alcohol and drug related problems. Many GPs were seeing patients with stress related headaches themselves, but would ideally use both clinical and counselling psychologists. For general anxiety, the ideal for most GPs would be to use either a clinical psychologist or CPN rather than either see themselves or refer to a counsellor which most were doing at present. Finally, patients suffering from PTSD were currently referred to a clinical psychologist, perceived to be the ideal professional by a similar number of GPs – followed by a psychiatrist and counsellor. Ideally others would also choose a counselling psychologist and psychotherapist, but fewer would ideally refer to a psychiatrist than currently do.

Results give a general indication of GPs' perception of the ideal mental health professional for specific problems and how this compares to current practices. They also indicate where service provision is perceived to match need, and where shortfalls arise. Obviously there were occasions where both actual and ideal choices were too few to be included in the analysis. However reference to Figures 1 and 2 shows how nearly 80 and 90 per cent respectively of GPs' choices were incorporated. A number of questions and issues arise from the results.

Perceived lack of service provision for specific practitioners

Although for many problems GPs appeared satisfied with the resources available and are referring patients to the professional they consider the ideal choice, there are discrepancies, possibly indicating a lack of service provision. Psychiatrists were perceived by 15 per cent of GPs as unavailable for patients with depression and possibly suicidal, though 95 per cent said that a psychiatrist was easily

available. The obvious reason for this would be long waiting lists. However, GPs may be rationing scarce resources and tending to refer only where suicide was a distinct possibility.

Less surprising, however, were cases where perceived need to refer to a clinical psychologist was not being met. For patients with a simple phobia and a similar proportion for agoraphobia with panic attacks, one in five GPs had no clinical psychologist available. In half as many cases GPs were unable to refer to a clinical psychologist for an eating disorder. Although all GPs said a clinical psychologist was available, two-thirds experienced long waits. This is the most likely reason for these patients' needs not being met by GPs' perceived ideal professional.

For counsellors the picture was mixed. Cases where a significant proportion of GPs perceived counsellors as the appropriate professional but were not actually able to refer to one included chronic relationship difficulties, general anxiety and unresolved bereavement. There was also a significant lack of counselling psychologists as the ideal professional for patients with unresolved bereavement, PTSD and chronic relationship difficulties. Half the GPs had no access to a counselling psychologist. Half of these said they would use one if available.

For psychotherapists and family therapists a low number of GPs perceived a need that was not being met, which possibly reflects less familiarity with these practitioners and types of appropriate referrals. Limited availability may also create less demand; where three-quarters of GPs had access to a family therapist, two thirds said there was a long wait. Of those with no access to a family therapist, seven in ten said they would use one if available. Availability was even less for psychotherapists, eight in ten GPs with access to one experienced a long wait. Perhaps this reduced availability/familiarity was reflected in only four in ten saying they would use one if available.

Alternative choices

Where GPs are unable to refer to the professional they would ideally choose, they see patients themselves or refer to another practitioner, in particular a CPN. Figure 1 shows the problems GPs presently deal with themselves. For agoraphobia with panic attacks in particular 20 per cent of GPs refer to a CPN instead of the preferred professional, generally a clinical psychologist. Similarly GPs refer patients with simple phobia, unresolved bereavement and general anxiety to a CPN instead of the preferred professional. CPNs appear to be one of the most readily available mental health professional with all GPs having access to one and nine in ten considering their services fairly quick or immediate. This perhaps raises questions about the scope of clinical activities expected of CPNs, about which concern has been raised, e.g. Tyrer (1990); Robertson and Scott (1985); Wooff and Goldberg (1989).

Significant shortages exist for stress related headaches, simple phobia, agoraphobia with panic attacks, general anxiety, PTSD and unresolved bereavement referrals, with less than half the GPs able to refer to their ideal choice. For chronic relationship difficulties, only one third of GPs were currently referring patients to their ideal professional. These are all common mental health problems, which raises the question of whether this significant proportion of patients are perhaps receiving less than optimal treatment. Where actual and ideal referral choices are the same it could be inferred that these GPs are satisfied with the services available. How appropriate are these choices in the light of outcome research?

GP consensus on ideal professional

Serious suicide attempt or possible psychosis, eating disorders, simple phobia and agoraphobia with panic attacks were being appropriately referred to either a psychiatrist or clinical psychologist by about six in ten of GPs. This fits with research showing for example that a cognitive-behavioural approach (as often practised by clinical psychologists, but certainly not exclusively) is most successful in treating these disorders (Hawton *et al.*, 1989). For the remaining 40 per cent, perceived ideal referrals were spread between six and eight practitioners. Are all the professionals chosen by GPs in this case assumed to be practising this type of approach? Or, are these patients too possibly receiving less than optimal treatment?

To what extent are GPs aware of the types of therapy practised by the various professionals to whom they may refer and what do they consider to be appropriate for whom?

For PTSD in particular, there was no clear consensus on referral, a third of GPs preferring a clinical psychologist. This raises similar questions. How appropriate are these referrals? Is there perhaps no evidence-based reason for choosing one practitioner over another? Are all likely to provide equally effective treatment? To what extent are GP referrals based on knowledge of types of treatment used by a practitioner (regardless of title) and are these supported by outcome research? Where, for example, a third of GPs would rather see patients with GAD themselves, does this reflect their own clinical skills? To what extent are GPs aware of research demonstrating the effectiveness of cognitive-behavioural therapy for GAD? Might they perhaps be prescribing tranquillisers instead? Would this be the most effective treatment? A lack of consensus would to some degree be expected and corresponds to the known wide variation in referral patterns (e.g. Cummins *et al.*, 1981). Yet it could also indicate confusion or lack of knowledge about which practitioners or treatments are likely to be most effective. Alternatively, a variety of professionals could achieve an equally successful outcome for many problems.

The NHS Executive paper 'Primary Care: The Future' (NHSE 1996) acknowledged that the wide variation in clinical practice for mental health problems needs to be addressed, and the frequently idiosyncratic service provision rationalised (Rowland & Irving, 1984; Clarkson, 1994). It highlights the need for evidence-based, locally developed guidelines for treating common mental disorders and locally agreed referral criteria, to improve diagnostic skills and increase knowledge of effective treatments. Training and education of health professionals to reflect the incidence of mental heath problems in primary care populations is also suggested. Despite the common occurrence of mild to moderate mental health problems, the likelihood is that many of these will either not be recognised or may be inadequately treated and recovery delayed with consequent social and economic costs.

Perceived role of counsellors and counselling psychologists

GPs frequently perceived counsellors to be appropriate for patients with unresolved bereavement and chronic relationship. Surprisingly many saw them as appropriate for GAD, stress related headaches and PTSD.

In this sample, three-quarters of GPs had a counsellor available, though a quarter said this involved a long wait. Although this study does not differentiate whether or not these counsellors are within the primary care setting, this figure is much higher than Sibbald *et al.*'s (1993) finding that only a third of all general practices have a dedicated counsellor. Sibbald *et al.* also included CPNs and clinical psychologists as counsellors, whereas in the present study 'counsellor' was a discrete practitioner. This sample of GPs thus seem to be relatively well resourced.

Counselling psychologists were perceived by fewer GPs as the ideal professional for patients with, for example, unresolved bereavement, PTSD, chronic relationship difficulties, agoraphobia with panic attacks and stress related headaches. Could this reflect less familiarity and GPs favouring 'tried and trusted' professionals they know better? Perhaps limited availability creates less demand? Is there any particular training needed to equip counselling psychologists to meet GPs' needs? To what extent could they help make up the shortfalls in clinical psychologists? How could they best promote their services?

Professional roles

Is there a need to clarify the roles and remits of the different professional groups as well as types of therapy? 'Confusion of roles and poor communication can lead to service gaps and poor patient care' states 'Primary Care – the Future' (NHSE, 1996); this also must include mental health services. Clarkson (1994) offers useful differentiation between the various mental health professionals in counselling, psychotherapy, psychology, psychiatry and allied fields which could help establish separate professional identities for these practitioners, and provide helpful guidelines, distinguishing between differing kinds of service provision to best match needs with available resources. It could also help alleviate

inter-professional tensions and anxieties about professional roles and conceptual differences between psychological therapies, (Kosviner, 1994) which could hinder the provision of effective and integrated mental health services. Otherwise there is a danger of an increasingly muddied field where no-one is really certain who does what, how, and for whom.

Addressing these issues would seem to be an important part of providing an effective, coordinated and comprehensive mental health service for the 21st century.

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Correspondence

Tania Dolley
Powys Healthcare NHS Trust,
Psychology Department, Bronllys Hospital,
Bronllys, Powys LD3 0LU.
E-mail: tania.dolley@powys-tr.wales.nhs.uk