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Impact of counsellors in primary care on referrals to secondary mental health services

AIMS AND METHOD

A questionnaire survey of all general practices in one health authority plus an assessment of a random sample of referrals were used to evaluate the impact of counsellors in primary care on referrals to mental health services.

RESULTS

A total of 91.1% of practices responded to the survey. A counsellor

was present in 20.3% of these practices. A random sample of 180 referrals to community mental health teams was reviewed. There was a significantly higher referral rate from practices that employed a counsellor ($P=0.003$). There was no evidence of a difference in rates of caseness of referrals between practices that employed a counsellor and those that did not.

CLINICAL IMPLICATIONS

Practices employing counsellors had significantly higher referral rates to mental health services, with no difference in the level of caseness between the two groups of referrals.

The study

A national survey found that 31% of general practices employed a counsellor (Sibbald *et al*, 1993), but there have been few evaluations of their impact on patient management and outcome. Fletcher *et al* (1995) found less prescribing of psychotropic medication among practices that employed counsellors. This finding was supported by another study, which also concluded that patients receiving counselling were less likely to be referred on to secondary mental health services (Boot *et al*, 1994). A comparison of referral rates has shown an increase in referrals to clinical psychology, but not to psychiatric out-patient clinics (Cape & Parham, 1998) from practices that employed a counsellor compared with those that did not. There have been no studies of the impact of general practice counsellors on referrals to community mental health teams (CMHTs).

Our study aimed to demonstrate whether the presence of a practice counsellor was associated with a difference in referral rate and whether the appropriateness of referrals was affected.

All general practices within Merton, Sutton and Wandsworth Health Authority were sent a structured questionnaire seeking information about the practice (list size, number of partners, presence of partner with special interest in psychiatry, presence of a practice counsellor) and the partner with most interest in mental health was asked to complete the questionnaire. We used the definition of a practice counsellor adopted by Sibbald *et al* (1993):

"Someone who offers (formal) sessions to patients, in which patients are helped to define their problems and enabled to reach their own solutions."

The definition excluded support provided by staff as part of their routine work.

Referrals received by the 14 CMHTs operating within the health authority were collected over a 1-year period and a random sample of case notes from each CMHT was reviewed by an experienced clinical researcher (N.B.) to obtain demographic details and diagnoses. An

assessment of caseness was made as a measure of the appropriateness of the referral; this was categorised as case (experiencing a mental or psychological disorder), non-case (no evidence of a mental or psychological disorder) or borderline case (where the evidence for the presence of a mental disorder was uncertain).

Findings

Practice survey

There were 135 practices in the area covered by the health authority. The questionnaire was completed by 123 (91.1%) of these and a counsellor was employed by 25 practices (20.3%). There was a tendency for practices that did not employ a counsellor to have a smaller list size than those that did, but this was not significant ($P=0.29$). Fund-holding practices and those with a partner with a special interest in psychiatry had significantly higher rates of employment of counsellors ($P=0.001$ and $P=0.03$, respectively).

Referral/assessment data

A total of 180 referrals were selected and reviewed; 76 (42.2%) were from practices that employed a counsellor, 104 (57.8%) from practices that did not. There were no significant differences in age or gender between the two groups of patients.

Assessment of caseness

The distribution of caseness of referrals is shown in Table 1. There was no significant difference between the two groups in the rates of caseness of the referrals, with fewer than 10% in both groups rated as non-case.



Referral rates

The mean rate of referral from practices that employed a counsellor was over double that of the ones that did not. The distribution of referrals between practices was skewed, but analysis using non-parametric tests showed a significant difference ($P=0.003$).

Comments

The only differences revealed by our study between the two groups of practices were higher rates of fund-holding and presence of partners with a special interest in psychiatry among practices that employed a counsellor. These factors are unlikely to be independent and probably reflect the ability of fund-holding practices to direct resources towards the priorities of partners; partners with a special interest in mental health would be more likely to see the employment of a practice counsellor as a priority area.

Our data showed a lower rate of employment of practice counsellors than data reported by Sibbald *et al* (1993) (20.3% v. 31%). We looked at practices within an urban/suburban setting only, whereas the previous survey was nationwide. In urban areas, which tend to have higher levels of deprivation and higher rates of severe mental illness, the provision of counselling for more minor psychological problems may be given a lower priority by general practitioners (GPs).

Our data showed that the presence of a counsellor was associated with an increased rate of referral to mental health services, which is in contrast to the commonly held assumption that it should lead to a reduction. This will have significant clinical implications for the workload of CMHTs, with more time being spent on

assessment of new referrals than working with the long term case-load of people with severe mental illness.

Levels of caseness of referrals were not affected by the presence of a counsellor. It would appear, therefore, that the sensitivity of detection of mental distress is increased in practices that employ a counsellor, without causing a reduction in the specificity, indicating that substantial psychological morbidity remains undetected in practices that do not employ a counsellor. This is consistent with the work of Johnstone & Goldberg (1976) on the detection of morbidity in primary care. Training in interview techniques has been shown to improve GPs' detection of depression (Goldberg & Huxley, 1992), and many cases of depression and short term mental health problems should be managed in primary care.

Our study covers an area with well-developed CMHTs (where psychologists work as integral members of the multi-disciplinary team) and shows that, in this setting, the presence of practice counsellors is associated with an increase in the rates of referral to the secondary mental health service as a whole. This is in contrast to the findings of Cape & Parham (1998), who demonstrated an increase in direct psychology referral rates only from practices that employed counsellors, but in a less integrated mental health system.

There are limitations to this study, particularly in the assessment of referrals' caseness. This was achieved entirely by a review of case notes and not by interview with the patient or consultation with the CMHTs. The three categories used in the assessment of caseness do not allow for grading of the severity of mental health problems, only the likely presence of a disorder. The sample is restricted to routine written referrals and does not include urgent telephone referrals, but many of the CMHTs follow a model of home-based assessment (Burns *et al*, 1993) and have a rapid response to written requests.

This study has shown a higher rate of routine referral to CMHTs from practices that employ a counsellor. We cannot, however, draw any conclusions as to whether the referrals were inappropriate or not. Our data support evidence from previous research that a special interest or previous training in mental health is associated with improved detection of psychological morbidity (and hence higher rates of referral). An appropriate response would be closer links between the CMHTs and GPs to provide advice and training. This would enable patients with short term or minor mental disorders to be detected and treated within the primary care setting. Practices with lower than average referral rates to CMHTs may also

Table 1. Assessment of caseness of referrals

| | Referrals from practices employing a counsellor (n=76) (%) | Referrals from practices not employing a counsellor (n=104) (%) |
|-----------------|--|---|
| Case | 60 (78.9) | 78 (75.0) |
| Borderline case | 10 (13.1) | 18 (17.3) |
| Non-case | 6 (7.9) | 8 (7.7) |
| Total | 76 (100) | 104 (100) |

All differences not significant between practices employing and not employing a counsellor.

Table 2. Referral rates from practices employing and not employing a counsellor (per 1000 patients on practice list)

| | Practices employing a counsellor | Practices not employing a counsellor |
|---------------------------|----------------------------------|--------------------------------------|
| Mean referral rate/1000 | 0.516 | 0.204 |
| Median referral rate/1000 | 0.556 | 0.000 |
| 25th centile | 0.000 | 0.000 |
| 75th centile | 0.867 | 0.287 |

Mann-Whitney $U=786.0$, $P=0.003$ for mean referral rate.



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benefit from training in clinical skills to enhance their ability to detect psychological disorders.

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HELEN PURCELL AND SHÖN LEWIS

Postcode prescribing in psychiatry

Clozapine in an English county

AIMS AND METHOD

We aimed to examine variations in clozapine prescribing in all 12 NHS trusts with catchment area mental health services in one English county, over a 2-year period. We tested a series of hypotheses to explain the variation in prescribing of clozapine.

RESULTS

A 34-fold variation between trusts in rates of clozapine provision was found after adjusting for measures of local population need. This variation did not change over the 2 years examined. It was not explained by differences in resource level.

CLINICAL IMPLICATIONS

The evidence base is strong for the effectiveness and likely cost-effectiveness of clozapine in severe schizophrenia. Our data indicate that variations in evidence-based clinical practice at the provider level led to the wide variation in clozapine prescribing.

Clozapine has been shown to be better in treating symptoms of schizophrenia than conventional antipsychotic drugs. Forty to 60 per cent of patients with refractory chronic schizophrenia will make clinically significant improvements with clozapine, based on high-quality evidence accepted by opinion leaders, policy-makers and purchasers of care (Wahlbeck et al, 1998). Clozapine, although essentially free of extrapyramidal side-effects, has a wide range of side-effects of its own, the most important being agranulocytosis. Although expensive, there is evidence to suggest that acquisition costs are recouped by future savings on in-patient care (Aitchison & Kerwin, 1997). In view of this evidence base 10 years after its UK licence, we aimed to examine patterns of clozapine prescribing in the NHS. We set out to explain any inequalities in prescribing either arising as variations in need or in provision, since analysis of such variations can reveal insights into policy and practice (Knapp, 1997).

The study

We obtained prescribing data from all 12 NHS catchment area mental health provider units in an English county (total population 2 499 487), at three census dates: 1 April 1996, 1 November 1997 and 1 May 1998. Specialist tertiary care services such as forensic units were not included. We also obtained prescribing analysis and cost

(PACT) information for the same timescale. PACT information was from the six health authorities that provided month-on-month expenditure details for other atypical antipsychotic drugs in primary care. This allowed for a longitudinal analysis over the 2-year period.

Findings

Raw data for the first census date showed cross-sectional prescribing rates to range between two and 52 patients

Table 1. Clozapine prescribing – raw data

| NHS trust | Census Date | | |
|-----------|-------------|---------------|----------|
| | 1 April 96 | 1 November 97 | 1 May 98 |
| A | 11 | 20 | 13 |
| B | 37 | 32 | 32 |
| C | 41 | 40 | 41 |
| D | 24 | 25 | 26 |
| E | 6 | 4 | 4 |
| F | 2 | 2 | 5 |
| G | 15 | 14 | 15 |
| H | 52 | 60 | 65 |
| I | 39 | 35 | 37 |
| J | 28 | 25 | 29 |
| K | 18 | 23 | 61 |
| L | 14 | 16 | 17 |