GP provision of counselling

More research is necessary

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As general practitioners, we are familiar with providing counselling, of one kind or another, to our patients. Depending on our interest and training this ranges from nonspecific supportive counselling to more structured psychological techniques. Counselling forms an integral part of general practice.

So it is of interest that this year the Medicare Benefits Schedule includes new item numbers to support GPs providing time limited 'focussed psychological strategies' as part of the Better Outcomes in Mental Health Care Initiative.[1] This item number will support GPs who have undertaken recognised training in one of the accepted psychological skills, such as cognitive behavioral therapy, interpersonal therapy, and a range of other approaches.[1] Although there are a number of hoops to jump through to access the item number, including recognition of appropriate training by a standards committee providing the service in a practice participating in the Practice Incentives Program or which is accredited, and registration with the Health Insurance Commission, the higher rebate Medicare item will be paid to GPs who provide focussed psychological treatments.[2]

Why is it that policymakers have chosen to support GP provision of counselling? The public health rationale is fairly straightforward. High prevalence mental health disorders, such as depression, anxiety and substance abuse are known to be a great cause of disability for individuals and a burden on the community.[3] Of those people in the community suffering from mental disorders who do seek professional help, the majority seek that help from GPs.[4] In part, this is explained by patients' preference for GPs as their provider of mental health care.[5] Therefore, GPs make up an important part of Australia's mental health workforce. Improving the quality of GP care is a key strategy to alleviating the distress for this group of patients.

With the investment of public funds in supporting GPs to provide counselling, one would hope there is good evidence to do so. Indeed, many of the psychological approaches that are being supported are tried and true methods which have been used by psychologists and psychiatrists for many years, and have also been shown to lead to improved clinical outcomes for patients.[6]

However, a leap of faith is required to generalise specialists' techniques to general practice. The contextual issues in general practice do matter and these differentiate the doctor-patient relationship from those occurring in specialist settings.[7] For example, the GP's long standing ongoing relationship with a patient is an entirely different scenario to a finite number of consultation sessions with a specialist, at the end of which the patient is usually discharged. Another important difference is that the GP retains responsibility for diagnosing and managing physical problems as well, a role which becomes fairly complicated given the high rates of somatisation in mental disorders. Add to this the time limitations and competing demands of general practice,[8] and it is clear that generalisations from the specialist setting is a poor proxy for research in general practice.[9]

In order to explore the effectiveness of GP counselling some understanding of usual GP practises are necessary. An estimate of the frequency with which counselling is conducted by Australian GPs for depressed patients can be extracted from the BEACH study.[10] General practitioners report that they have provided 'psychological counselling' in 3490 of encounters with depressed patients. The same study reports that a further 1270 of depressed patients receive treatment advice, relationship counselling, relaxation counselling, unspecified counselling or reassurance. Reported rates of counselling are even higher for newly diagnosed depressed patients, with 'psychological counselling' said to be undertaken by GPs in 47% of encounters with such patients. Further research is still needed to tease out the exact nature of the counselling which GPs already provide.

When one goes searching for studies regarding the effectiveness of GP delivered psychological treatments, the research is limited and inconsistent. For example, four diverse general practice studies of cognitive behavioural therapy for depressed patients report it to be:

- superior to drug treatment[11]
- temporarily better than usual GP care

but no better at three month follow up[12]
- better than usual GP care at four months but no better at 12 month follow up,[13] and
- no better than usual GP care.[14]

Of these three supportive primary care studies utilising interpersonal therapy approaches,[15–17] none actually involved a GP providing the psychotherapy. Two recent studies provide some support for structured problem solving[18,19] utilising GPs as therapists, although another study found it to be no better than the control group.[20]

There is a significant gap in the literature which needs to be filled. More GP based research of counselling is necessary, ie. research which is conceptualised with substantial GP input and which involves GPs as the providers of counselling in real GP settings. Not only will this assist the development of appropriate GP training, but it will also provide a guide to policy makers as to what is possible in general practice and what requires specialist care. In Australia, there is an increasing number of academically trained GPs, eg. graduates of the Masters of General Practice Psychiatry[21] and Masters of Psychological Medicine[22] who have the capacity and interest to undertake research. With significant policy changes occurring, supporting the development of an evidence base for GP counselling would be a good investment.

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