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Counselling in Primary Care - standards, approaches and evidence

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Proposals for Counselling in Primary Care settings

Outlined below are proposals for the further continuation of counselling services in primary care. These are in accordance with the National Service Framework (NSF) and emphasise

- the integration of existing disparate services to provide high quality primary care services for people with mild to moderate mental health problems
- a shift in the balance of care from a medical model to a community social care model.

The proposals fall into 3 broad categories:

1. Quality of provision

We recommend that all counselling services commissioned by the Health Authority or Primary Care Trusts adhere to the standards and protocols outlined in the attached document (Counselling in primary care, standards, approaches and evidence). to ensure standards of best practice. It follows therefore that contracting with managed services/agencies offers benefits in the following areas:

- coherence and consistency
- ease of maintaining standards of best practice including standards of training and continuing professional development
- consultation and support for counsellors covering issues of service provision
- developing and maintaining links with national and local primary care counselling organisations.

However, it is also important to retain diversity in present counselling provision both in terms of individual and organisational approach in order to maximise client choice.

2. Equity of provision

We recommend that provision of counselling form part of an integrated package of care for people with mental health needs. The emphasis must be on prevention. It is essential to ensure equity of counselling provision across the city ensuring a minimum provision of 2 hours of counselling per week per 1000 patients.

This would have the following benefits

- ease of access for patients, who would be seen in local, familiar and non-stigmatising settings (which would reduce the occurrence of DNAs)
- ease of access for Primary Health Care Team
- opportunities for communication and collaboration with referring GPs and Primary Health Care members
- cost effective early assessment, leading to early and/or preventative intervention and/or appropriate secondary service referral if necessary
- reducing GPs workload with certain patients

- appropriate and professional therapeutic treatment either as an alternative to drug intervention for those who are concerned about the costs and effects of medication, or to work in tandem with medication as appropriate.
- Empowering people with mental health problems to work through their own difficulties. This may result in long term changes in terms of dependency on the primary care service for individuals and families.

3. Evidence based provision

Whilst the RCT is a useful method for evaluating the efficacy of clearly defined treatments for clearly defined clinical conditions (and has become a "gold standard" for evidence of treatment efficacy. There are considerable difficulties in applying this method to effectiveness field trials of counselling; problems being introduced by the process of randomisation itself. To date all studies have flaws and have provided only equivocal and unreliable evidence. Research methodology has to be relevant and realistic to the phenomena being researched. Quantitative methods alone cannot access the less tangible qualities of human experience, which are central to counselling practice. Further research must be conducted using qualitative methods which explore outcomes from the perspective of patients and also ascertains who is most likely to benefit from counselling interventions and in what time scale. It would also be useful to set up research projects which would attempt to replicate Heal's study (1997) which paid for the counsellors' time in savings on SSRIs.

Martina Street (CHRC Ltd)

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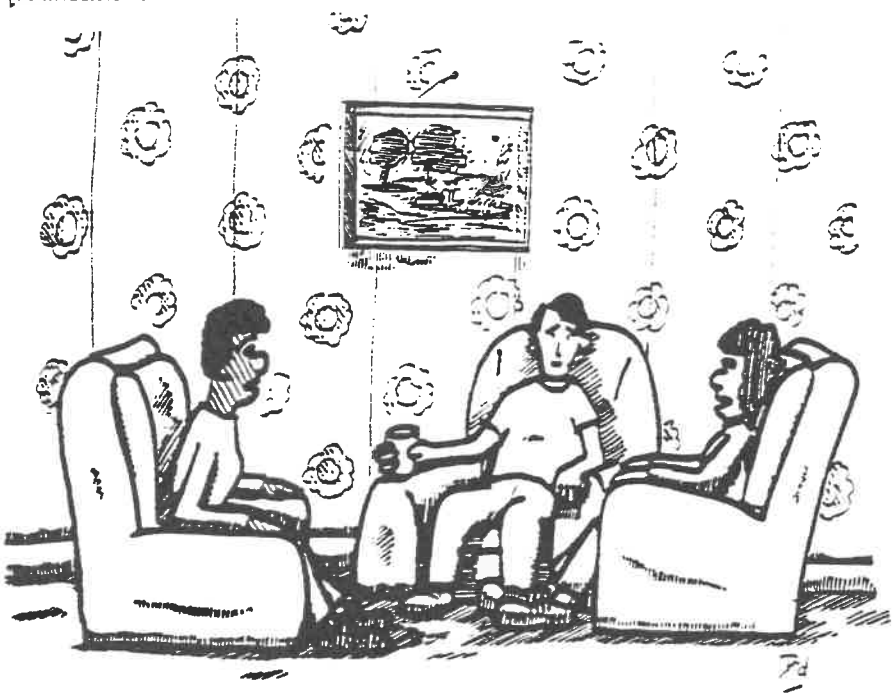
Standards and protocols for the Employment of Counsellors in Primary Care Settings

Introduction

In establishing a counselling service within primary care settings it is essential that purchasers and providers clarify key elements within the role and the work of a counsellor/team of counsellors in order to ensure quality and effectiveness of the service.

These elements include procedures of

- referral and assessment
- confidentiality, communication and collaboration
- record keeping
- sharing of information
- monitoring and evaluation
- accountability and management
- training
- qualifications



1. Referral and Assessment

"Well targeted treatments ... are also more likely to be cost effective. Treatments can be cost-ineffective by being too long...or conversely, by being too short to deliver a therapeutic 'dose' of an otherwise effective treatment" (Parry, 1996).

Within a GP practice, counsellors receive referrals from the General Practitioner. Within primary care settings referrals may also be made by other members of the primary care team. It is the responsibility of the counsellor at the first point of contact with the client, to make an assessment regarding appropriateness of the referral. This will vary depending on the referrer's knowledge and understanding of counselling.

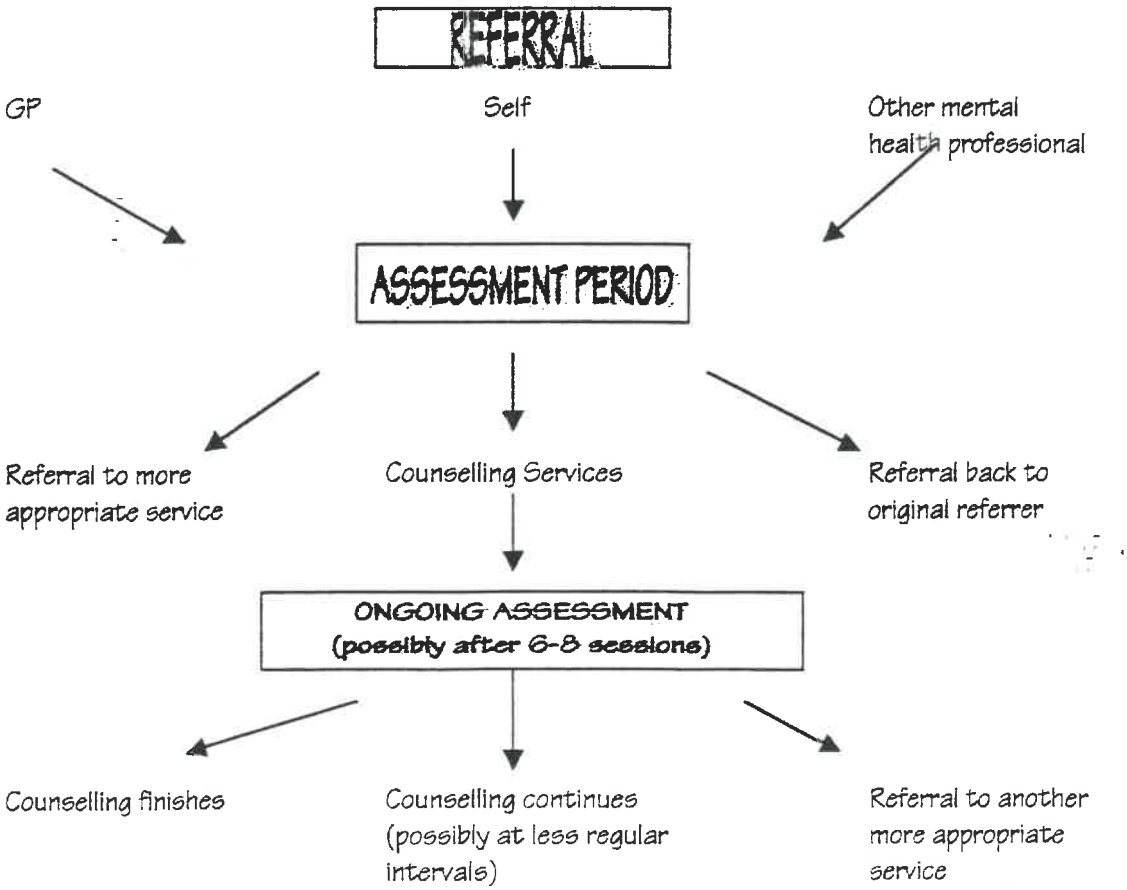
However, there is evidence to suggest that 1 in 4 people with mental health needs do not consult a professional about their mental health. (Mann et al, 1998). This may be as a result of a fear of being stigmatised. (Rogers, 1996). Some counselling service, therefore, may also incorporate self-referral procedures to be as inclusive as possible.

Appropriate referral and assessment procedures are essential for effective counselling outcomes. Brief-focussed counselling is an effective intervention for people with mild to moderate mental health needs. However, it is important to recognise that counselling may also be appropriate for more severe and enduring mental health needs if clients have a preference for this form of help. There is evidence that matching clients to their preferred treatment results in fewer drop-outs and better clinical outcomes. Matching to preferred treatment probably improves client motivation which is known to enhance clinical outcomes. Preference needs to be adequately informed and based on accurate information about different treatments.

Clients also need to be given time and support to come to a considered judgement about the options available.

The BAC Code of Ethics and Practice states, "The terms in which counselling is being offered should be made clear before counselling commences. Subsequent revision of these terms should be agreed in advance of any changes". It is essential that all parties engaged in the provision of a counselling service, have agreed on the boundaries of counselling before the counsellor starts work with the client. Should assessment or subsequent work reveal an inappropriate referral, the counsellor should have the provision for referring back to the original referrer (if there is one) or onto more specialist services (if they exist).

Summary



2. Confidentiality, communication and collaboration

Counsellors adhere to the confidentiality policy of the organisation by whom they are employed. It is recognised that communication between GP and counsellor is essential, and therefore, an end of contact report is completed, with the client's agreement, and/or involvement. (See Appendix K).

This is passed on to the GP and placed on the client's file. If a client does not wish any information be passed on (apart from exceptions, later described) then this would be respected. The provision of safety and privacy through confidentiality is a foundation stone of counselling practice.

"Confidentiality is usually extremely important to clients and without it they may be unwilling to discuss things, which they regard as personally sensitive...Any reduction in the level of confidentiality offered to clients often inhibits the growth of trust and what the client is willing to discuss. The counsellor's management of confidentiality is also closely related to the ethical priority of respect for his/her client's autonomy. As a general principle, the client is expected to be in control of what is communicated about the counselling. This means that there are some significant differences between medical and counselling confidentiality...A client's explicit consent is required for counsellors to communicate personally identifiable information to other counsellors or colleagues within the primary care team". (Curtis-Jenkins, 1997).

However, effective communication with the original referrer (if there is one) and a collaborative approach to the work is an important consideration in primary care settings. The counsellor is a member of the primary care team which shares the care of clients. If GPs refer clients for counselling, s/he retains medical responsibility of the client.

However, in addition to the collaboration of primary care, it is an ethical and legal requirement to share information with other professionals in some instances.

The BAC Code of Ethics and Practice permits counsellors to break confidentiality when the counsellor has good grounds for believing clients will cause serious physical harm to others or themselves. In addition, disclosure of current child abuse or of abuse in childhood, with the perpetrator still being in a position to continue abusing, would occasion the need to break confidentiality. According to the Children's Act (1989) there is a duty on Primary Health Care teams to be aware of their responsibilities and their role in identifying children in need. The ethical way to resolve this dilemma involves collaboration between the counsellor, client and referrer. It is important that counsellors/GPs/Primary Care Teams have regular reviews to discuss issues regarding confidentiality, referral etc to ensure full effectiveness of a holistic service.

3. Record keeping

Any records kept should be written with the client's right of access in mind. They would normally include:

1) record of attendance
2) monitoring information (see Appendix I)
3) End of contact report (for GPs and other referrers, not appropriate for self-referrals see Appendix K)
4) Process notes - may contain details about the client's case. They should be kept in a way that does not identify the client and are the property of the agency. These notes should be destroyed after the client has finished counselling. (see Appendix H)

4. Sharing of information

Purchasers/referrers and providers of a counselling service need to establish and clearly define the pathways and process of communication. Information about clients should be shared as appropriate, after discussion with the client concerned. Quarterly or half-yearly review meetings are a useful means of sharing service information and may include discussions around

- appropriate referral criteria
- management of waiting lists
- monitoring and evaluation information

5. Monitoring and evaluation

This is a vital part of the service and there are a range of ways this can be addressed. Examples of monitoring and evaluation forms can be found in Appendix I and J.

6. Accountability and Management

Counsellors are accountable for the management and organisation of the service they provide to the organisation for which they work, and usually have a specific line manager within the organisation.

As qualified, experienced professionals, counsellors are answerable for their practice in line with their professional Code of Ethics and Practice in addition to their employer's Code of Ethics and Practice. Counsellors must hold current membership of a national professional body such as the BAC.

Casework Supervision

In accordance with the BAC Code of Ethics, counsellors require a minimum of one and a half-hours of individual casework supervision per month or the equivalent in group supervision in order to practice. There are different ways of co-ordinating casework supervision but as a general rule the following principles apply:

- counsellors should be allocated paid time to attend supervision
- counselling supervisors (whether working within the counselling service or externally) should be an experienced counsellor eligible for accreditation
- if counsellors are receiving casework supervision from someone outside of the agency a contribution towards the cost of it would normally be paid. Some salaries (including sessional payments) may encompass provision for supervision costs.
- the amount of casework supervision needed may vary from counsellor to counsellor according to experience and workload.

Job description and person specification

As a result of the above issues the job description should out-line:

1. The main tasks expected of the counsellor including counselling sessions, supervision,

administration, professional and organisational development, meetings and training.

2. Who the counsellor is accountable to within the organisation.
   (See Appendix A for example of job description and Appendix B for person specification.)

Payment

We are aware that many counsellors work on a self-employed basis. However, we recommend that counsellors be employed by an organisation for the following reasons:

- Increased accountability for the service offered
- More support/employment rights for the counsellor
- Greater opportunities for professional development of counsellors
- Recognition of counselling as a profession in its own right with associated payscales
  (Counselling in Medical Settings (CMS) proposed payscales can be found in Appendix D)

NB National Insurance Contributions Agency regulations state that people working for longer than a few months should legally be paid as employees of the organisation.

Contract

Would normally include:

- Terms and conditions of the service including pay, length of contract, termination of contract procedures, holiday and sick pay procedures, grievance and disciplinary procedures, probationary and appraisal procedures. (See Appendix C for example of contract)

Insurance

In order to practice, counselling agencies must arrange professional liability insurance of counsellors or arrange for their counsellors to provide their own. (For information see Appendix E).

7. Training

Counsellors need a clear understanding of the opportunities and constraints of working within a primary care setting, and to be adequately prepared for the multi-disciplinary networking and collaboration that is required when sharing the care of clients with other health professionals. The majority of formal counselling training courses do not equip counsellors to work in a primary care setting. Therefore it is unrealistic to assume that a counsellor can do this work effectively without undergoing further specific training and/or induction. Also, in order to address the perception of counselling as being a white, middle class, female profession some counselling agencies may wish to offer placements to trainees and encourage a diverse range of ethnicities, sexualities, disabilities etc to reflect the nature of the client population they serve.

Guidelines for training placements

It is becoming common for trainee counsellors to approach a practice, offering their services free of charge, in order to gain the clinical experience that is necessary for their qualification. A GP Practice or counselling agency should only consider taking on such a trainee if it already has in post at least 1 fully qualified and experienced counsellor who is prepared to act as a mentor to the

trainee. The responsibilities and implications of having a trainee should be discussed fully with the partnership of the practice counsellor/counselling agency, the training institution and the trainee counsellor. Trainee counsellors would normally be expected to be undertaking a counselling course at Diploma level to apply for a placement. The trainee does not receive any payment for their work in the practice. (See Appendix F for trainee contract).

8. Qualifications

All counsellors need to have a relevant qualification in order to practice. The most recognised qualification is the Diploma in Counselling, which ensures between 200-400 hours of training of which at least 100 are supervised counselling practice. However, some organisations will also accept a relevant social work qualification. (See Appendix L for notes on accreditation).

Counselling Approaches

"The overall aim of counselling is to provide an opportunity for the client to work towards living in a more satisfying and resourceful way.
The term 'counselling' includes work with individuals, pairs or groups of people, often, but not always, referred to as 'clients'. The objectives of particular counselling relationships will vary according to the client's needs.
Counselling may be concerned with developmental issues, addressing and resolving specific problems, making decisions, coping with crisis, developing personal insight and knowledge, working through feelings of inner conflict or improving relationships with others.
The counsellor's role is to facilitate the client's work in ways which respect the client's values, personal resources and capacity for self-determination."

BAC Code of Ethics and Practice (3.1)

In this section some of the most effective approaches to counselling will be considered, that in ways which have a track record of the facilitation of richer and satisfying ways of being.

One of the first , basic questions asked is :

What background and training will counsellors have?

Many counsellors now in primary care settings will have trained in one of three classic schools of psychology - either humanist, behavioural or psychoanalytic/psychodynamic. Person-centred counsellors often integrate techniques to help facilitate helping relationships.

General Practitioners are using counselling services because it is cost-effective, so counsellors are working to meet the demands of long waiting lists. Therefore 'brief therapy' (a term to define a counselling relationship which is bound by a limited number of sessions, e.g 6)is an example of an approach which evolve as a response to this. Nowadays, many counsellors, recognising time as an element crucial to the demands of working in primary care integrate this discipline into their own personal approach.

Does it work?

It does because the counsellor has more resources available to her/him. An integrated approach can work on a behavioural level as well as emotionally and make for an even greater holistic approach enabling more integration for the client within their own awareness.

Self-awareness - that is, awareness of one's thoughts, feelings, patterns of behaviour and

so on - really is the key to a reconciliation of conflicts within the self.

How might an integrative approach work in practice?

Here's an illustration

Terry is a male in his late thirties. He is married with two children and was recently made redundant on grounds of ill health. His mother died ten months ago.

In the first interview he talks about feeling as if he has let everyone down, and describes feeling like a failure, of being a hindrance to his loved ones.

He expresses a need to snap out of this depression, of perhaps taking something to switch off these feelings. And it is not uncommon for clients to come to counselling with such expectations for a 'magic wand' - although one cannot dismiss out of hand such yearnings since at best they convey an expression of the will, the need for change - even transformation.

When Terry first visits the counsellor he is diagnosing himself as 'depressed'. This is extremely common since many people have identified their psychological state already with another professional, be it GP, CPN or other. In counselling we often call this initial 'diagnosis' the presenting issue. However, as we will see with Terry, there are other significant themes going on in his personal world.

Two weeks/sessions later, Terry begins to reveal other issues. As the relationship progresses, Terry begins to 'unwrap' feelings he has for his mother who died earlier in the year - and he talks of feelings 'lost' without her.

What is now happening is that Terry is touching on his personal theme of loss and grief. Again he is expressing a sense of powerlessness - now at not being able to bring his mother back. It emerges that there are things Terry feels he still has to say to his mother, so the counsellor suggests they look at methods which might be an appropriate form for this.

The counsellor may suggest exercises to move Terry on such as writing a long letter to his mother telling her how he feels, or even using drawing utensils to depict his own current state of being.

This is a very directive approach by the counsellor since it puts forward the helper's point of view without, it must be said, imposing it as an absolute - yet enabling the client to facilitate for themselves their own personal process.

From further interviews, terry reveals a conflict in his marriage and expresses distress at the tension experienced by him and his partner.

He feels she has no interest in their marriage and that he is unattractive to his wife. This seems to increase his feelings of powerlessness.

From the counsellor's point of view the picture has become a lot clearer now, since what began as counselling for "depression" is now a process of addressing highly potent causal factors in the person's life. In fact there appear to be three major influences:-

- redundancy; loss of a loved one and obstacles to trust and communication in his marriage. There are different characteristics in each causal factor yet the individual's experience of these events and the emotional themes he manifests in response to these are inherently the same, which are, in this particular case - feelings of powerlessness, inferiority and loss.

So beneath the presenting label of "depression" we are able to eventually distinguish a pattern of past events that have led up to this current state of distress. We know that we cannot separate the present person from past experiences, especially when unprocessed emotions may be having a physical effect upon the person and we know that core techniques from many of the therapies listed below can be convenient tools in helping relationships.

HUMANIST

Person-Centred Counselling

This is a humanistic therapy and is the commonest approach of most counsellors in primary care settings. It focuses primarily on the emotions and life experiences of the individual and the therapist's task is to listen to their client's disclosures with an attitude of acceptant non-judgementalism, thereby acknowledging and validating that person's inner world as fundamentally real.

This very specific type of listening is a skill, which uses an element of intuition as much as intellectual comprehension, since to listen to the feelings and meaning being expressed by another, entails a certain kind of sensitivity. It is often this experience of feeling sincerely listened to by another that gives all people an important feeling of being accepted, of having been taken seriously.

The quality of this encounter between two people beyond the roles of a counsellor and client is seen as the key to successful therapy. Successful therapy in person centred terms has been seen as something of a misnomer in itself since achievable outcomes are rarely quantifiable in an existential sense since there is not the availability of measuring data common to more cognitive techniques.

Person centred therapy has been able to work with people who carry past histories of childhood abuse and neglect, as well as being a useful tool for people coming to terms with significant issues such as bereavement, divorce, redundancy and other major traumas. The emphasis is based on the client feeling enabled to empower themselves by means of a cleansing of old thoughts and beliefs about their self and trusting more fully their own organismic experience.

In recent years time-bound experiential therapy has been tried and tested and there is anecdotal evidence to suggest that brief person centred therapy is effective.

Thorne (1999) has written on his experiment of focussed person centred counselling and has described its rigorous limits (a total of merely three sessions in all) as a liberating experience, noting elsewhere that to his surprise that he found himself "bonding with short-term clients in a deep but complicated way". In addition - Moshe Talmon (1990) has experimented with Single Session Therapy (SST) and through his research was able to conclude that 73% of his clients felt that there was major change in their life and perception of themselves from just one encounter.

What seems fundamental to the success of any therapy is the issue of an individual clients motivation to heal from their distress. This is not to suggest that there are people who do not wish to move on but it is the level of commitment they make to co-operate with the process, which will determine some positive outcomes.

When a client is ready to become responsible for his or her own needs and behaviours and works in equilibrium with the facilitative approach of the counsellor, this becomes a crucial factor in therapy. It follows however that counselling models in primary care do not have the capacity to work with people suffering from severe personality symptoms of chronic disorder do not just have an issue about suitability for the setting but there is also the contributing factor of the level of awareness of individual clients. Effective counselling begins with both parties having a clarity about what the models and approaches being used in the process can enable the client to do.

In person to person encounters it is the empathy displayed by one for another, which contributes to the therapeutic meaningfulness of that dialogue. Therapists of many approaches have integrated the humanistic attitude of hearing the client speak from their own world, accepting the need for validation and acknowledgement of the client. This humanistic attitude is perhaps also central to the outcome of good therapy.

In the primary care settings where budgets are limited and demand by users is often great, it emerges that what seems to work best within counselling relationships that have a finite life, is counselling with people who have the time, the motivation and the significant personal resources - i.e. able to think clearly, use imaginal and cognitive functions without great difficulty, etc - to be able to make it work for themselves.

Gestalt

As a humanistic perspective on therapy, gestalt therapy sees the person as a whole organism, and the person within an organismic state of being. The aim of therapy is to bring into awareness previously denied material, and to reclaim lost aspects of the self so that the person may move towards a state of psychological homeostasis. In effect, the gestaltian is working on the grounds that our behaviour is largely influenced by the avoidance of things we do not wish to experience, which suggests that past trauma is stored as matter in cellular memory. The view of the person as an organism implies that the individual is neither a good nor bad person yet simply 'just is'.

There is very little cognitive structure to the therapy and works in the dynamics of the here and now.

It can be applied to group as well as individual settings and the powerful exercises can often produce intense emotions. This can be seen as challenging since it forces uncomfortable emotions to surface.

Existential

The fear of death/ obliteration is seen to be the core-state of the individual. Reconciliation through therapy of this classic anxiety enables the client to come to terms with their guilt, and fear and ultimately allows them to freely choose what path the course of their life will take.

Once the conscious mind has processed the core-self's anxiety over its own mortality the quest for meaningfulness in life can be achieved.
In therapeutic terms, the quality - that is - the depth of the relationship that exists between two human beings, therapist and client, are fundamental to the outcome of therapy.

An existential approach to the self can facilitate changes and transitions from one phase of life to another.

Social work counselling

This is an holistic approach, which acknowledges both the psychological and sociological needs of the individual user. It therefore attempts to combine the best from both social work models as well as humanistic counselling models since it offers support in a practical sense in terms of information generation, as well as allowing the psychotherapeutic process to occur.

It is recognised that emotional support on its own may not be enough if - for instance - a client, or clients are distressed about chronic debts. In circumstances such as these practical support can be offered to sustain the individual through processes which have an obviously emotional aspect.

This relationship may differ from other therapeutic relationships since the focus of the encounter between therapist and client is on the enabling and empowerment of the client in not just a psychological context but also a socio-economic one too.

In relation to the case illustration presented earlier with Terry, the humanist model may approach the issues of Terry feeling a failure in an existential sense. That is - by not attempting to 'rescue' him from his despair but to facilitate an exploration of his sense of having let others down. How might his unhappiness relate - for instance - to a quest for meaningfulness in his life now that a previous routine has gone? The task of the counsellor at having this point is to not tell Terry what he 'ought' to do, but to adhere to the model that each person, given the right and positive conditions - created by the counsellor - will intrinsically pursue a life-enhancing direction.

PSYCHODYNAMIC

This is the classical developmental model of therapy, which sees childhood experience as central to the formation of the personality.

The psyche houses memories, which continue to manifest in present-day relationships. This phenomenon is known as transference and counter-transference.

Transferential relationships relate to unmet childhood desires, fears, traumas and/or other experiences.

It is recognised as an effective treatment in the recovery of abuse, depression and other severely distressed states.

The therapist will work with the client's transference, enabling them to process old material and to face the emotions it raises and then let go, thus bringing closure to long-running conflicts with the self.

Transactional analysis

T.A believes that adults have the capacity to interact with others from different ego states. Communication is seen as a series of transactions, which are then reflected upon in the therapeutic encounter.

The therapist will assess the 'life-script' written by clients when they were young in their response to socialisation experiences, and ultimately to take responsibility for the re-writing of their life-script. In this light, dramas, difficulties and self-defeating behaviours are seen as choices made by the client - new choices can be made from an empowered standpoint.

Not unlike many other developmental therapies, T.A believes that therapeutic movement will come from reliving past traumas, and the releasing of old and denied feelings enable the person to cleanse past wounds.

This is a therapy applicable to individuals and groups alike and can function as a long or short-term relationship.

Transpersonal therapy

Evolving from the Jungian philosophy of the self as an intrinsically spiritual being, the therapy works to validate the spiritual and cosmological aspect of the self and integrate into the social personality. The psyche is seen more as an impersonal structure, as opposed to an organism - and archetypal material is seen to reside within the collective unconscious of every person.

These deep structures of the self are seen as sources of goodness and potential healing and wisdom.

It uses techniques such as visualisation, guided meditation, and relaxation as well as creative techniques such as painting and writing. It encourages the client to use imaginal thinking and dialogues between aspects of the self.

Its aim is to work towards equilibrium, that is - clear channels of communication between the ego-consciousness and unconscious storehouses.

To relate some of this theory to the case of Terry, we might want to analyse the type of

communication Terry and his wife are having. Using these analytical models can assist to ascertain what is taking place unconsciously in the marriage.

A counsellor may feel it is appropriate to work on the hunch that there are remnants of previous parent-child relationships still actively influencing the client and their behaviour in current relationships.

It may turn out to be that both partners are still carrying unresolved issues from their pasts and are therefore 'transferring' old emotions from "then" onto "now".

BEHAVIORIST

Cognitive Behavioural Therapy (CBT)

Whilst CBT is skilled at redressing behaviours and cycles of distressing thoughts, it has been criticised for not being able to meet longer-term needs for validation. A recent study on its efficacy in the treatment of depression in patients who were HIV positive concluded that CBT had "less value in the face of real life events" and that this "may be because it does not address existential issues" - meaning in this case, a coming to terms with mortality.(General Psychiatry, Vol. 55, May 1998)

CBT offers a precise, structured approach to addressing client needs in terms of symptom reduction. It is usually time-bound in that practitioners tend to work in 6-week pockets.

Initial consultation involves therapist and client engaging in assessment formulation using Becks Depression Inventory (BDI) and other clinical measuring systems, such as Maudsley OCD inventory. From this point, therapist and client negotiate significant goals to work towards based on the collection of data. The CBT model takes a rational approach toward symptoms and behaviours, which are distressing to clients. Thoughts and ultimately core-beliefs are addressed and evaluated and new perspectives on negative thoughts are offered from the therapist. Clients are kept in alignment with rigorous standardised measures such as BDI and Maudsleys OCD Inventory to maintain a sense of awareness and remind clients of their ongoing successes.

The CBT principle of thoughts affecting behaviour means it stays very much in the here and now and is directed towards the maintenance of an improved response to everyday stimuli - and its primary concern is not to address developmental factors. Cycles of thought are seen to perpetuate distress but the cycle can be interrupted by therapists bringing in contrary evidence to challenge negative thoughts, therefore enabling clients to shift to a more realistic and positive evaluation of themselves.

Clients are empowered to think specifically about/for themselves. CBT works successfully with people suffering from anxiety and the attributive perceptions of the self as powerless

where such manifestations as panic attacks, dizzy spells, sweating, fear of embarrassment and shame are common, as well as counteracting the negative beliefs about the self which trademark depression. But factors, which may have precipitated the onset of these conditions, may not be addressed, such as divorce, bereavement, redundancy etc.

Clients are often recalled 3 months after the conclusion of therapy for a review and 'booster' session, again an element, which re-emphasises the ongoing nature of continuing care and individual responsibility needed for psychological well-being.

Rational Emotive Behaviour Therapy

The therapist addresses behaviour modelled in the present by the client and attempts to remould the behaviour to prevent psychic distress. Environmental factors are believed to have an impact on clients in that thoughts, core-beliefs and behaviours in response to self and others are seen as a direct consequence of one's life situation.

The role of the therapist is to educate the client, teaching them objective reflection on their own behaviour, thereby using awareness as a tool for self-diagnosis. This means that limiting beliefs and thoughts about one's self in relation to the environment must be monitored, challenged, re-evaluated and discarded - only to be replaced by a more life-enhancing set of values.

Counsellor and client work together in the relationship to reality-test previous beliefs and to set new goals; due mainly to the view that all behaviour is seen to be learnt and is therefore mutable. Therefore the accent is on experimentation of new ways of thinking and behaving, with changes of behaving precipitating changes of thinking.

.....

*In relation to the case illustration with Terry, a behaviourist approach would enable Terry to actively rationalise his feelings of being a hindrance with his loved ones. The behavioural therapist co-operates with the client to 'reality test' his thoughts against his experience. For example what evidence does he have to **prove** that his family feel he is a hindrance? Or, is he making a self-fulfilling prophecy for himself by creating an atmosphere in the environment whereby others really will eventually reject him since his behaviour has left them scant option?*

Summary

Each of these three philosophical perspectives has a validity in themselves as approaches to helping the person in need.

The Schools of Thought have significant differences, such as the psychodynamic point of view insists that our present state of being has been determined by past experience, and although the humanist school may acknowledge this too. There is also a belief in the principle that each human being has at their centre, a core of fundamental goodness, which seeks to maintain, enhance and fulfil itself in ways which are both positive for the individual and as well the wider community.

It is this model - which puts the person at the centre - that is the groundbase for an approach that may integrate some or all of the therapeutic approaches listed above, which the skilled counsellor will use to enable their clients to live in more satisfying, meaningful and rewarding ways.

It is a necessary ethical requirement that professional counsellors continue to upgrade their skills base and expand their working knowledge, and in the counselling community there are a host of short courses in many different fields.

Counselling research - The Evidence

1. Issues in counselling research

Research into counselling is relatively recent and is characterized by poor methodologies such as inappropriate research designs, failure to specify the approach used and inadequate measures. These studies therefore often produce inconclusive results. However, Professor Michael King and colleagues (1994), in a study of randomised controlled trials in the evaluation of counselling in general practice, noted that previous studies gave *"tentative support to the value of counselling in general practice" (p.231)*

The basic question to be answered is "Does counselling work ?" noting is it efficacious in a research environment? This document explores the question in terms of clinical effectiveness, health care utilization, and client and general practitioner satisfaction with counselling. In order to understand the evidence, we need to look at how we answer the question and the difficulties of this process.

Evaluation Criteria

It is important to note that there are different sets of criteria for evaluating counselling services. These will vary depending on the perspective of the client, GP and significant others. The outcomes of counselling can be assessed by considering a client's emotions, their thoughts and behaviour, the quality of their relationships, any life stresses they have experienced or are experiencing and the degree of potential risk.

Qualitative measures include client self report and observations by others. Research can cover the potentially important changes in health care utilisation, in terms of a reduction in GP consultations and referrals to secondary mental health care, and in prescribing costs (quantitative measures). There is a relationship between psychological health and physical health with implications for the use of services and quality of life for clients and their significant others. Other effects include non-clinical costs such as effects on employment and welfare benefits. There are also implications for families and the wider community in terms of the quality of life and relationships.

Research Measures

A number of validated psychometric tests are available and used to assess outcomes: for example the General Health Questionnaire (GHQ); Hospital Anxiety and Depression Scale (HADS) which

was developed for use in inpatient settings; the SCL90 (symptom check list); the Beck Depression Inventory (BDI) and the IIP (Inventory of Interpersonal problems). These tests vary in their ease of administration and some have been criticised on methodological grounds. For example the GHQ should not be used as a follow-up measure (Hemmings 1997) due to its lack of sensitivity to outcome factors; and the BDI is most appropriate for assessing the specific outcomes of cognitive therapy and does not reveal equally important changes brought about any other forms of therapy. The use of the SCL90 and the BDI in routine health care is very costly as both are copyrighted tests and users are liable for a fee every time they are used.

In a review of the use of outcome measures in published research, Froyd et al (1996) looked at 334 research papers and found that they used, in total, 1430 different measures. 60% of these tools were used only once and even the Beck Depression Inventory, the most commonly used, was only used in 13% of the studies. This makes it extremely difficult to compare the results of different studies.

To resolve this problem the Psychological Therapies Research Centre at the University of Leeds has developed a standardised CORE (Clinical Outcomes in Routine Evaluation) system for audit, evaluation and outcome which is intended for use across the range of psychotherapy services. The CORE is designed to be a user friendly and relatively short measure (34 items) and covers the areas of functioning, physical symptoms, well-being and risk. The specific questions are derived from a massive exercise analysing over 35,000 existing data sets of psychometric functioning to find key questions. There has been a rapidly escalating amount of data generated from the use of this tool, which is not yet published. The Psychological Therapies Research Centre has also developed an ideographic tool for measuring client goals, from the perspective of the client, and the degree of attainment of these goals at the end of therapy.

Many services already use simple questionnaires to assess client satisfaction at the end of the counselling. Burton (1995) has described a six item quality of life questionnaire which covers the areas of work, leisure, family and intimate relationships and allows patients to indicate the degree of disablement and distress caused by their problems in these areas before and after counselling.

When researching into the effects of counselling it is important to compare results with those of other forms of help in terms of outcome, cost, acceptability accessibility and appropriateness. Some have argued that many problems are self-limiting and would change in time anyway. Mann (1981) and Lloyd (1996) note that approximately 50% of non-psychotic mental health problems remit spontaneously. This implies that 50% do not and we now know that this group of patients still have often severe symptoms and associated disability ten years later (Lloyd 1996). King (1994) states that patients seeing counsellors in primary care are "often seriously emotionally distressed and recovery is slow" (p.229).

Patmore identifies the group of patients who are unlikely to recover spontaneously who are likely to take up a large proportion of GP time who have "feelings that they have no-one to support them, by unhappy marriages and lack of other confiding relationships, by persistent practical difficulties in their everyday life, or by previous emotional disturbance."

Randomised Controlled Trials – A Critique

Proof of the efficacy of treatments for psychological problems has traditionally involved the use of randomised controlled trials (RCTs). Study designs that were developed for evaluating medication have serious limitations when applied to research on counselling. Counselling is not a drug as it involves a complex interaction between people. Unlike medication, in counselling, and other psychological therapies, it is difficult to isolate the active ingredients of the therapy. In addition the number of variables and their mediating or potentiating effects make the traditional RCT very difficult to perform.

However a number of RCTs have attempted the task. Friedli et al (1996) list 19 RCTs in their review of counselling research in general practice. They only identified five RCTs of counselling performed by counsellors (rather than nurses, doctors, psychologists and social workers). In these five studies two had major problems with randomisation and one involved the unusual practice of 30 minute sessions. It is therefore almost impossible to draw any conclusions about the effectiveness of counselling from these RCTs of efficacy except that it is largely an untested intervention rather than an inert one. The Cochrane review has only identified four RCTs that fulfill their criteria. This will be published as a report shortly.

There are many problems in using the RCT method to test the efficacy of a counselling intervention. Firstly, random allocation of clients is inappropriate and virtually impossible when motivation and preference are essential ingredients of outcome. Client choice in itself can have an important remoralizing affect, which is undermined by the randomisation process. For example, in one study (Ashurst and Ward 1983) the results were distorted due to a high drop out rate due to unmotivated clients being allocated to the counselling group. The high attrition rates from many of the RCTs of Cognitive Behavioural Therapy is probably due to similar effects.

Patients eligible for inclusion in RCTs are often a highly selected group. The group bears little resemblance to people seen by counsellors in primary care who often have complex problems and who do not fit current diagnostic systems easily. In RCTs treatment delivery is highly controlled with the use of treatment manuals and adherence ratings. In practice, many counsellors change the way they work depending on the client, their difficulties and the development of the necessary prerequisites for outcome success: empathy, trust, alliance and shared aims.

For these reasons it is difficult to generalize from RCTs of efficacy due to the very specific research conditions that are defined in terms of client and counsellor characteristics. Patients who are prepared to have their treatment allocated on a random basis probably have particular characteristics, which might affect the process and outcome of an intervention like counselling.

Many authors have described the difficulties of allocating patients in controlled trials to treatment and control groups: Brodaty and Andrews (1983) assessed 1500 patients before finally allocating only 56 to their control and treatment groups. This clearly has enormous resource

implications. Fairhurst and Dowrick (1996) were only able to recruit one patient over a period of five months because GPs were reluctant to allocate to the control condition as they felt that counselling was the preferable option. In a study by King et al (1994), GPs allocated the 19 patients with the highest psychiatric scores, out of a total of 24, to the counselling group somehow circumventing the randomisation procedures designed to produce comparative groups.

A more appropriate approach to researching psychological therapies is field trials of effectiveness in clinical practice. These include cohort studies, descriptive studies, questionnaires and interviews. These methods attempt to examine rather than control unspecific and environmental factors and counsellor variables. They allow for patient preference and are better able to accommodate "dual diagnosis". They are more representative of typical practice and, therefore, more generalizable. They also use fewer resources.

Summary

In the absence of credible RCTs, clinical effectiveness in the field should inform service provision not efficacy as determined by research trials.

2. Is counselling clinically effective?

Current research into the clinical efficacy of counselling is marred by the factors outlined above. Despite this King et al (1994) reported *"that patients referred by family doctors to counsellors are often seriously emotionally distressed and recovery is slow."* (p.229) In their RCT study in the counselled group only two clients felt worse and one felt abandoned by being offered a brief contract. The predominance of rigidly prescribed or controlled brief, time-limited counselling in general practice is inappropriate for this group of patients. In most primary care counselling services a small number of clients are often seen intermittently over much longer periods and the supportive nature of this form of therapy is of considerable benefit to the 10-15% of patients cared for in this way.

Other studies have noted a small proportion of clients who have worsened during or following counselling. The CORE data set, which allows for comparison between outcomes in primary and secondary care is not yet published. Some studies (for example Ashurst and Ward 1983) believed that some individuals benefited considerably from counselling. Gordon and Graham (1996) found that 18 out of 95 clients showed deterioration in their psychiatric symptom as measured by HADS and SCL-90-R. The authors also note consistent and highly significant improvements for the majority of clients: "more than half the cases of mood disorder, identified using the HADS, are in the normal range of scores after six weekly one-hour sessions." (p.521) The provisional analysis of the 3,000 CORE data set (unpublished as yet) from primary care shows that of the 30% of patients seen who didn't improve only a tiny minority worsened.

The possibility of drawing conclusions from all the studies so far performed is limited by low rate of return, by both counselled and control groups, of measures at the end of treatment and at follow up. They cannot be used to assess effectiveness of service delivery. Somerset Health Authority's

study (1996) shows how a well performed effectiveness study involving counsellors working in 180 practices can tell us much more than any efficacy RCT. Reduction in referrals to Community Mental Health Teams and outpatient psychiatry and a greater detection and treatment of patients with psychological distress in practices with counsellors, compared to those without, confirmed that effectiveness studies are much more informative at this time.

Other studies of efficacy include Boot et al (1994) who found a significant improvement in scores on the General Health Questionnaire (GHQ) when assessing the short-term impact of counselling compared to routine GP care. Brodaty and Andrews (1983) using the GHQ as an outcome measure in their study however showed no significant differences between the two groups. In each case the use of the GHQ limited the validity of the findings. Additionally Brodaty and Andrews used counselling sessions of only thirty minutes which is a most unusual practice.

Another source of error was reported by Hemmings (1997) who found no significant differences between the group who received in-house counselling and patients who received routine GP care, in terms of the psychological measures used. In this study 1/3 of the control group were referred elsewhere for counselling or psychological treatment, which is highly likely to have affected the outcome. Also randomisation failed as the GPs refused to implement the process. That the patients recovered as quickly and as completely in both groups is a remarkable finding suggesting as it does that counselling is as effective as routine GP care even in the artificial construct of an efficacy RCT.

Baker et al's (1998) evaluation of a primary care counselling service in Dorset showed significant improvements, in terms of quality of life and self-esteem, for the counselled group when compared with waiting list controls. Improvements in symptoms were highly significant. Patients were selected for this service who had acute, clearly definable problems although symptoms included obsessional, phobic, somatic and dissociative ones.

Booth et al (1997) using measures to assess quality of life, problem resolution and goal attainment found a very significant improvement in quality of life in the counselled group of clients from on average bad to moderate to moderate to good. On average, problems were resolved "for the most part" (p. 36) and clients perceived their attainment of goals as halfway between improved and much improved.

Counselling for Depression

Attempts have also been made to assess the usefulness of counselling for depressed patients. Churchill et al (1999) in a systematic review of RCTs used indirect evidence as there are no studies of counselling in primary care as a treatment for depression. The review looked at the efficacy of "generic counselling" in general practice and other forms of psychological treatments for depression. The authors refer to Friedli et al's (1997) study in which , "There was a significantly greater fall in BDI scores in counselled patients than those receiving treatment as usual". This could indicate that counselling can be effective with patients who have moderate to severe

depression. However they felt it could also be a chance finding. Churchill et al recommended that GPs only refer patients with major depression to counsellors when "antidepressants are unacceptable, poorly tolerated, or ineffective" and that counselling should not be the "sole mode of treatment, unless specific therapeutic models are used." (p.742) Churchill's review failed to find some of the important studies reported in journals they did not search.

This belief in the effectiveness of counselling in mild to moderate depression is supported by BACTERIA (1999) in their review of treatments for depression in primary care. Also, Roth and Fonagy (1996), in their review of "What Works for Whom ?" note that there is "very preliminary evidence that supportive counselling may be useful" in depression (p.100). However they did not describe what they actually meant by "supportive" counselling, a term rarely used by counsellors themselves to describe the variety of brief therapy models they practice.

One typical study on the effects of client-centred and process experiential interventions in major depression was carried out by Greenberg and Watson (1998). This study compared results on the BDI, the Inventory of Interpersonal Problems, Target Complaints, number of symptoms and self-esteem. The results showed that effect sizes were equivalent to those found in other approaches. 70% of clients, whatever the therapy modality, had a clinically important improvement as a result of the therapy offered.

"Professor Michael King announced at a Psychological Therapies in primary care conference at Charing Cross Hospital post graduate centre London 23 March 1999 that his latest RCT measuring efficacy of counselling in primary care demonstrated very clearly that counselling was "effective" with an effect size of 0.5. He also went on to say that it was more effective than CBT [this was the] first time that unequivocal evidence of the effectiveness of counselling was demonstrated in an RCT research format." (Counselling in Primary Care Trust website)

3. Does counselling reduce the rate of referrals to secondary mental health care?

The rise of counselling services in primary care has occurred in the context of changes in mental health services generally. The development of Care in the Community and the Care Programme Approach has led to focussing of the resources of psychiatric and community mental health teams onto patients with severe and enduring mental health problems (Davidson et al 1998). This has left a large group of patients with emotional and psychological needs who would no longer be receiving a service. Brief therapy delivered by counsellors has been found to be a way of fulfilling some of these needs by over half of all general practices in the UK. Over the past 30 years there has been a dramatic increase in, and awareness of, patients presenting in general practice with emotional difficulties. However, despite recognition, very little other than medication has been available for these patients. Churchill (1999) stated that between 20 –70% of GP patients were

suffering from depression when seen by GPs. This shows the extreme confusion that exists in trying to define life crises, sadness, misery and social exclusion in terms of a psychiatric diagnosis.

The evidence for changes in the rate of referrals to secondary mental health care is mixed. Cape and Parham (1998) found that referrals to outpatient psychiatry were unchanged. Referrals to clinical psychology increased in practices with a counsellor and fell in those without. The authors speculate that this result may be because the counselling service was a fairly recent innovation. They also note that practices with a counsellor were more aware of psychological problems and of the resources to help with them. They did not speculate on the poor rates of detection and referral from practices without a counsellor – a very important consideration in the light of this research finding. Baker et al (1998) also found no change in referrals to other mental health professionals.

More positive evidence was found in the following studies: Boot et al (1994) found that there were significantly less referrals to psychiatry and clinical psychology in the counselled group compared to the control group. Cubitt noted that referral rates to community mental health teams were 8.15 per 1000 in practices without a counsellor and 5.65 in practices with an in house counsellor. These results were confirmed by Buckley (1999) and in the Somerset Health Authority (1996) study which revealed a 43% reduction in referrals to community mental health teams from practices with a counsellor compared to those without. There was a 4% drop in referrals to outpatient psychiatry from the same practices compared to a rise of 65% in practices without a counsellor; Hemmings (1997) found in his RCT study that clients in the counselling group were not only less likely to be referred to mental health services but also were as distressed as those who were referred. He notes that this result has "clear clinical and financial implications" (p.229)

Summary

The provision of a counselling service in primary care can increase detection of emotional and psychological problems. Local and accessible services are more popular with patients. A reduction in referrals to secondary mental health services has clear financial implications and can reduce client feelings of being stigmatised.

4. Does counselling reduce GP consultations?

Reductions in visits to the GP are one indicator that could be used to justify the cost effectiveness of counselling. If the provision of counselling does reduce the number of consultations this is likely to decrease GP resource costs and stress on the GP and other primary care team members and may be one of the strongest reasons for the popularity of counselling with GPs.

Eight out of ten studies reviewed, which investigated the effect of counselling on GP consultations, demonstrated a reduction in visits. In Buckley's (1999) study there was a 39% annual decrease in GP consultation in the counselled group and in Waydenfield and Waydenfield's

1980) research there was a 31% reduction in GP consultation rate six months post counselling compared to the six months prior to counselling. A study by Warrington Health Care Trust's counselling service showed that 2/3rds of clients did not return to their GP with psychological problems in the six month period following counselling (Davies, J and Hughes, A – personal communication). Booth et al (1997) reported a 46% drop in consultations for psychological problems after even only one session of counselling. In the clients who had more than one session their was a significant decrease in consultations for physical as well as psychological problems. This has major financial resource implications as this group of patients are often high untilisers of GP services.

Summary

The provision of a counselling service in general practice has been shown to decrease workload, and subsequent stress, on GPs. Patients with psychosocial problems and who are lacking in supportive relationships and coping strategies often take up a great deal of GP time but can benefit from counselling.

5. Does counselling reduce prescribing of psychotropic medication?

The question of whether counselling reduces the rate of prescribing of psychotropic medication is important in two ways: does counselling save money and what are the opinions of patients regarding different kinds of help with psychological problems ? The Defeat Depression Campaign mori poll found that many people preferred not to take antidepressants at all believing them to be addictive and ineffective. (Paykel et al 1998) The population questioned said they believed that counselling was an effective intervention and should be offered to people suffering with depression. Many clients who come to see counsellors in general practice are unhappy about taking medication. Some have tried it and found it to be unhelpful or have had unacceptable side effects. Many are desperate for help in alleviating their distress and in making sense of their feelings.

The research reveals mixed results, which are due to methodological flaws in the studies and also to the complexity of factors involved. An overview of the research evidence suggests that a decrease in prescribing often occurs but in some practices there are no significant differences and even an increase in prescribing in practices with a counsellor. As the decision to prescribe is taken by the GP it is surprising that counsellors produce any effects at all.

In one study (Martin and Martin 1985) the minor increase in prescriptions for psychotropic medicine was accounted for by a large number of prescriptions being given to four clients in the counselled group. This might indicate that, for some clients, counselling may (at least in the short term) increase their feelings of distress. This study was flawed because the counselled and control groups were not matched for social and psychological characteristics, an essential for an RCT.

Studies by Sibbald et al (1996) and Fletcher et al (1995) compared prescribing rates in a small number of practices, in Oxfordshire, with and without counsellors. In the former case there were no significant differences between practices with and without a counsellor. In the latter there was

actually an increase in prescribing in practices that employed a counsellor. However the tiny number of hours provided by the counsellors to the practices concerned could not possible have had any effect on overall rates of prescribing.

Despite the efforts of Sibbald to match the practices in terms of "location, list size, proportion of elderly patients, training and fundholding status, and number of health promotion clinics" (p.63) they did not match the number of counselling hours per capita of population or the prevalence of social and emotional problems.

Prescribing practices vary due to a number of complex factors. Medication is often used as one part of the treatment and Corney (1998) quoted evidence that combined treatments are the most successful. Changes in prescribing need to be seen against the background of major changes in the 1990s, which have resulted in less prescribing of hypnotics and anxiolytics and a major increase in prescribing of very expensive new antidepressants. Counselling may uncover psychological problems, which were previously undiagnosed, and general practices with counsellors are bound to be more sensitive to the emotional difficulties of patients.

In the study by Fletcher et al (1995) the counselling service was fairly new and it may have been too early to see an improvement. Interestingly, the lowest level of prescribing was seen in those practices, which referred patients to a counsellor who did not work on the premises. It is hard to draw any conclusions from this result but it does illustrate the complexity of the issues. It is important to note that we know nothing at all about the experience and training of the counsellors used in this study. Similarly, in Sibbald's work the definition of counsellor includes other professionals and there are doubts about the accuracy of information regarding counsellors experience and qualifications.

Waydenfield and Waydenfield (1980) demonstrated a 30% reduction in prescriptions for psychotropic medication and a 48% reduction in prescriptions for other drugs when they compared the six months prior to counselling with the six months following. Spiers and Jewell (1995) and Boot et al (1994) reported identical findings. Anderson and Hasler (1979) showed that 35% of clients had stopped using psychotropic medication when they followed them up three months after counselling. These clients had been taking medication intermittently or continuously for an average of seven years. Ten from this group were known to be still not taking medication six to nine months later and three of these had been taking medication almost continuously for the previous four, seven and eight years. Of the remaining clients more than half were not on medication to begin with.

A small research project in a London general practice (Heal 1997) focussed on patients receiving repeat prescriptions of SSRIs. These patients were offered counselling sessions and the opportunity to review their use of medication. Also, an early counselling intervention was offered, when patients initially presented with depression, as an alternative to medication. After nine months the total monthly users of SSRIs was reduced from 58 to 22 and there were gross annual savings of £13,000 leaving a net saving of £4,400 after a deduction to pay for 6 hours a week of counselling time. The daily attendance of the counsellor in the practice enabled him to meet

frequently all the members of the primary care team including the GPs. This and other studies show how important collaborative working is. Similarly, Spiers and Jewell (1995) partially attribute the success of their service to the clarification of the counsellor's role and of referral criteria prior to the introduction of the service.

Summary

The provision of a counselling service can reduce the prescribing of psychotropic medication and therefore save money. This is dependent on there being an adequate number of counselling hours and time allocated for regular liaison with the primary care team. Additionally, counselling provides a satisfactory alternative for many patients who are unhappy with medication.

6. Satisfaction with counselling services

The routine assessment of client satisfaction is a crucial element in evaluating counselling services. As part of the referral process patients are initially assessed in terms of their thoughts and feelings. These factors must be taken into consideration when evaluating the outcomes of a service.

There is a high reported rate of satisfaction, and client reported treatment gains, with counselling services by patients and general practitioners. There is a strong relationship between client satisfaction with services provided and adherence to treatment and it has been noted that "minimal satisfaction is requisite in effectiveness." (Lebow 1982 p.255) There is also a positive relationship between satisfaction and outcome measures (Larsen et al 1979). The use of anonymous questionnaires to assess satisfaction reduces the likelihood of clients saying what they think researchers want to hear. All the studies of satisfaction show a surprising lack of negative feedback.

Boot et al (1994) reported that significantly more of the counselled group reported that they were coping better and feeling happier. Waydenfield and Waydenfield (1980) found that 40% of clients stated they were much improved and another 40% that they were somewhat improved. Spiers and Jewell (1995) had a response rate of 84.2% to their satisfaction questionnaire. 56.5% of those found counselling very helpful and 34.1% said it was quite helpful. Hemmings (1997) states that an overwhelming number of clients found counselling helpful (82%). Currently there is, in press, a review of reports from Health Authorities and NHS trusts, which surveyed local counselling services (Hemmings 1999). Of 26 such reports 17 included a measure of client satisfaction and similar, positive, results were found.

In a survey of 100 general practice patients Thomas (1993) found that 84% would prefer to see a counsellor if they were stressed, depressed or anxious compared to 6% who wanted a medical certificate and 4% who would have preferred medication. This finding has clear financial implicat ions.

GP satisfaction with service provision.

In surveys of GP satisfaction with counselling services the Somerset Health Authority report(1996) found that 94% of GPs reported positive patient feedback, 49% of the GPs considered the counselling service to be important and 51% saw it as essential. Baker et al (1998), in their study of a primary care counselling service in Dorset, found that 28% of GPs considered counselling to reduce their work load and 31% said that it offered more treatment options and better care. All the GPs were happy with the service and agreed on its benefits for patients.

APPENDICES

A: Job Description

B: Person Specification

C: Contract

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E: Insurance Information

F: Trainee Contract

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L: Accreditation

APPENDIX A

COUNSELLOR

JOB DESCRIPTION

1. To provide a counselling service within a primary care setting e.g. GP Practice.

2. To establish and oversee an appointment and referral system.

3. To undertake assessment and counselling of individuals and where appropriate refer to other service.

4. To communicate and collaborate with other members of the Primary Care Team.

5. To maintain appropriate records e.g. attendance and end of contact records.

6. To attend, where appropriate, meetings with other professionals within the primary care setting e.g. review meetings with GPs or at the employing organisation.

7. To monitor and evaluate the counselling service.

APPENDIX B

COUNSELLOR

PERSON SPECIFICATION

1. A recognised and relevant qualification e.g. Diploma in Counselling, CQSW with evidence of counselling experience post qualification.

2. An understanding of the role of counsellor within a primary care setting.

3. Understanding of the opportunities and constraints of counselling in primary care settings.

4. Experience of working with a wide range of client needs.

5. Considerable experience of supervised practice.

6. Ability to organise own workload.

7. Well developed communication skills - written, verbal and non-verbal.

8. Commitment to the effective use of supervision and ongoing professional development.

9. Commitment to anti-oppressive practice.

APPENDIX C

CONTRACT

1. This contract is between _____(Employing agency)_____ and _____(Employee counsellor)_____

2. Applicable period. This contract is for the period of _____
To _____

3. Payscale
You are appointed on scale _____.

4. Hours of work
Your normal working hours are _____.

You are required to complete records of hours worked and return these monthly to your line manager.

5. Location
Your primary site is _____.

6. Holidays
You are entitled to _____ days and Bank Holidays pro rata per annum paid leave.

Leave must be booked in advance (a minimum of five days notice). All leave must be approved by line managers and taken at a time appropriate to the organisation.

On termination of your employment you will be paid for leave you are due on a pro rata basis, and any excess leave taken will be deducted from your final salary.

7. Sick leave
You are entitled up to _____ days paid sick leave per annum pro rate.

All sick leave must be recorded and accounted for, using the appropriate forms. You should provide a self-certificate after five consecutive days absence, and a medical certificate after seven consecutive days absence.

8. Probationary period
New members of staff are required to work a three-month probationary period and will be required to demonstrate competencies identified in the person specification. Appraisal will take place by line manager. On successful completion of probation your contract will be confirmed by _____.
Failure to demonstrate competencies could result in either extension of your probationary period, or in termination of employment.

9. Policies

You are required to work within the policies of _____(Employing agency)_____ failure to do so will result in disciplinary action.

10. Grievance and disciplinary

Grievance and Disciplinary procedures are attached. Employing agency wishes to encourage staff to resolve issues through line management and resort to grievance and disciplinary procedures only as a last resort.

11. Termination of contract

This contract can be terminated by either party giving one/two months notice in writing.

Signed
On behalf of employing agency

Date

Signed
Employee

Date

APPENDIX D

Counselling in Medical Settings (CMS) Proposals for a Grading Criteria & Payscale

Payment for employees

In an attempt to promote similar terms and conditions as other health professions within similar roles CMS (which is a division of British Association of Counselling (BAC)) has proposed a grading criteria and payscale for counsellors.

Why has CMS produced these proposals?

Counsellors working in Medical Settings need a pay structure and the grading criteria to go with it.

Proposals on payscales and grading criteria aim to bring greater order, equity and quality control to the employment of counsellors. The time to recognise the professional status of counsellors is overdue. The CMS proposals give professional counsellors a distinct and separate payscale within the NHS pay structure.

CMS has nearly 2,000 members, mainly professional counsellors in the NHS. There are others such as nurses who use counselling skills in the course of their duties in healthcare settings.

How did CMS arrive at these proposals?

Principles underpinning the proposals are:

1. Counselling is a distinct therapeutic discipline. Counsellors employed in medical setting and in the NHS are a discrete professional group.

This paper is concerned with designated professionals qualified and trained to offer counselling services to patients in medical settings, in accordance with their clinical assessment.

Anyone involved in providing counselling must be clear about the distinction between those who are formally qualified as counsellors, working solely in that professional role, and as those who use counselling skills as an adjunct to their primary role.

It is essential that purchasers and providers of counselling services know which codes of ethics, practice and discipline are in force. This means greater safety for the client, health professional and employer.

2. Fully trained and qualified counsellors have made an investment in time and money. Since they form a separate professional group, their grading, pay and contractual status should be different from those of other NHS professionals.

Payscales should, however, relate realistically to those of other professionals, such as Community Psychiatric Nurses, NHS Psychotherapists and NHS Psychologists. The CMS proposals take this into account and aim to do away with the disparity of pay which counsellors currently experience in the NHS.

3. The management of counsellors belongs within the counselling profession. This principle can be seen in the grading which recommends a management scale as distinct from, but parallel to, a senior clinician scale.

4. Counsellors will have professional counselling supervision at all times, as required by BAC.

5. All counsellors employed must be members of a professional counselling organisation such as BAC, with codes of ethics and practice, a complaints procedure and a disciplinary process.

GRADE 1 - What is a Grade 1 Counsellor?

A Grade 1 counsellor will be someone who:

- has completed a formal training course in counselling (a list of courses can be found in the BAC publication The Training in Counselling and Psychotherapy Directory). The course content should be at least the equivalent of that required in a BAC Accredited Course.

At present this grade may include counsellors with several years clinical experience but with less formal training. However, within the next few years it is expected that all counsellors will achieve BAC Accreditation or an equivalent. A counsellor will remain in this grade until they have achieved accreditation with a professional body.

A Grade 1 counsellor would not be employed without a Grade 2 counsellor also employed in the same General Practice or Hospital Trust, and preferably in the same department, acting as a mentor.

It is recommended by BAC that any counsellor working full time should not exceed more that twenty (20) hours of face to face client work. A normal counselling session is viewed as a 50 minute therapeutic hour. It is suggested by BAC that a counsellor's workload should contain no more than five therapeutic hours per day, the other hours to be used for administration, meetings, counselling supervision and training. For detailed information see the information sheets produced by BAC entitled 'Counselling Workloads'. Those working less than full time would have the proportion of their activity adjusted accordingly.

This is consistent with the BAC Accreditation procedure.

Payments of Grade 1 counsellor will be between points 1-8 of the payscale, with annual progression to the top of the grade.

GRADE 2 - How are they different from a Grade 1

A Grade 2 counsellor will have qualified for counsellor accreditation. The duties will include those of a grade 1 counsellor. Employment at this grade reflects greater experience and/or training. A Grade 2 post-holder, alongside their clinical practice, can be expected to provide appropriate support and guidance (mentoring) to Grade 1 counsellors. They may also have received training in mentoring and counselling supervision. As with Grade 1 they will receive ongoing professional counselling supervision as required by BAC and it is

expected that they will gain wider relevant experience and knowledge through continuing professional development. Eventually it is expected that they will qualify for admission to the UK Register of Counsellors.

A Grade 2 counsellor will be paid between points 7-16 of the payscale, with annual progression to the top of the grade.

GRADE 3A

This grade is seen as being a senior clinical grade where the post-holder will have substantial experience as/or equivalent to a Grade 2 counsellor. In addition the post-holder may offer training and maintain a strong clinical role that reflects their extensive clinical experience.

GRADE 3B

This grade is seen as being a senior clinical manager grade. The post-holder will:

- carry out management responsibilities
- advise on the appointment of counsellors
- advise on policy and protocols
- manage and monitor the professional development of counsellors
- co-ordinate counselling services
- liaise with other departments and agencies and continue to have a clinical counselling practice

They will receive ongoing professional counselling as required by BAC.

A Grade 3 counsellor will be paid between points 15-22 of the pay spine, with annual progression to the top of the grade.

Payecale for counsellors

GRADE 1		GRADE 2		GRADE 3	
Scale	Point salary	Scale	Point salary	Scale	Point salary
1	£15,577	7	£19,709	15	£26,937
2	£16,201	8	£20,497	16	£28,052
3	£16,846	9	£21,317	17	£29,091
4	£17,522	10	£22,171	18	£30,071
5	£18,223	11	£23,055	19	£31,209
6	£18,951	12	£23,980	20	£32,288
7	£19,709	13	£24,937	21	£33,327
8	£20,497	14	£25,934	22	£34,406
		15	£26,937		
		16	£28,053		

APPENDIX E

Indemnity Insurance Information

BAC has negotiated a Professional Liability Scheme for members with advantageous premiums and provides wide cover with:

mithson Mason Ltd
SMG House
31 Clarendon Road
London
LS2 9PA

Tel: 0113 294 4000
Fax: 0113 294 4100

Other companies offering indemnity insurance include:

Stephenson Corporate Risks Ltd
100 Whitechapel Road
London
E1 1JB

Tel: 0171 247 8888

essrs Harvey Pettitt & Partners
271 Upper Street
London
N1 2UQ

Tel: 0171 226 8846

APPENDIX F

Contract for Trainee Placement

Partners _____ Address _____

_____ _____

_____ _____

_____ Tel No _____

TRAINEE DETAILS

TRAINEE Name _____

Address _____

_____

_____

Tel No _____

DATE OF PLACEMENT _____

CLIENT HOURS Day _____

Times _____

PRACTICE MENTOR Name _____

Address _____

_____

_____

Tel No _____

COURSE DETAILS Title _____

University _____

TUTOR Name _____

Address _____

_____

_____

Tel No _____

SUPERVISOR DETAILS Name _____

Address _____

_____

_____

Tel No _____

APPENDIX G

COUNSELLING REFERRAL FORM

Client's name: .....

Address: .....

.....

Telephone No. .....

Is she/he aware that this referral has been made? YES/NO

Are there any restrictions or special instructions about contacting him/her? YES/NO

(if yes, please specify) .....

Brief reasons for this referral .....

.....

.....

.....

Are there any special circumstances, which you think, may affect the counselling process in this instance (e.g. medical condition, medication, treatment)? YES/NO

(If yes, please specify) .....

If there is a specific medical diagnosis, is the patient aware of it? YES/NO

Any additional comments .....

.....

.....

Signed ..... Date .....

APPENDIX H

Client Record Form

Client Ref.No: .....

Appointment date: ..... Session summary
Appointment date:..... Session summary
Appointment date: ..... Session summary
Appointment date: ..... Session summary
Appointment date: ..... Session summary
Appointment date:. ..... Session summary

APPENDIX I

COUNSELLING SERVICE MONITORING FORM

Gender: Male: ..... Female: .....

Age group: 16-25 ..... 26-35 .....
36-65 ..... Over 66 .....

Postcode:

Please state: .....

Ethnic background:

White: .....
Black Caribean .....
Black African .....
Black other .....
Indian .....
Pakistani .....
Bangladeshi .....
Chinese .....
Asian .....
Mixed parentage .....
Other (please specify) .....

Sexuality:

Heterosexual/straight .....
Gay .....
Lesbian .....
Bisexual .....
Other .....
Not disclosed .....

Disability (please state):

.....

Referred by:

GP .....
Self .....
Other (please state) .....

APPENDIX J

EVALUATION

WHAT DID YOU THINK OF OUR COUNSELLING SERVICE?

We want to improve our counselling service.
It would help us if you let us know what you thought of it by filling in this form.

1. How did you hear about the service?

Self	☐	Support worker	☐
GP	☐	CPN	☐
Friend/relation	☐	Other (please state)	☐

2. Why did you come for counselling?

3. How many sessions did you have?

1-4	☐	20-29	☐
5-9	☐	30-39	☐
10-14	☐	40+	☐
15-19	☐		

4. Did you have a preference for a counsellor?

Yes	☐	No	☐

a. If yes, what?

Male	☐	Female	☐
Lesbian	☐	Gay	☐
Bisexual	☐	Racial background	☐
		Other (please state)	☐

b. If yes, did you get the type of counsellor you asked for?

Yes	☐	No	☐

If no, have you any comments to make?

5. Why did you choose to see a counsellor? (Tick as many boxes as you like)

Depressed	☐	Confused	☐
Relationship issues	☐	Lack of confidence	☐
Anxiety/panic attacks	☐	Lack of self-esteem	☐
Bereavement	☐	Alcohol/drug issues	☐
Identity issues	☐	Eating disorder	☐

Abuse issues ☐ Other (please specify) ☐

6. How useful did you find counselling?

Very useful ☐

Useful ☐

Not useful ☐ If not, why?

7. If counselling helped, can you tell us how?

	Any comments you'd like to make
I had a better understanding of myself	☐
I was able to express my feelings	☐
I gained confidence	☐
I was more aware of other people's feelings and situations	☐

Other ways counselling helped (please specify)

8. Which comment relates most to your experience?

	Any comments you would like to make
The counsellor had a good understanding and helped a lot	☐
The counsellor had a good understanding and helped a little	☐
The counsellor had a fair understanding and helped a lot	☐
The counsellor had a fair understanding and helped a little	☐
The counsellor had little understanding and was not helpful	☐

9. Would you recommend this service to your friends/others?

Yes ☐ Why?

No ☐ Why?

10. What did you appreciate about the service?

11. What did you appreciate least about the service?

12. How long did you wait for an appointment?

2-4 weeks	☐	11-13 weeks	☐
5-7 weeks	☐	14-16 weeks	☐
8-10 weeks	☐	17+ weeks	☐

Did you find the waiting time reasonable?

Yes	☐	No	☐

If no, what would you consider to be a reasonable wait?

13. Did you find the information pack useful?

Yes	☐	No	☐
How?		Why not?	

Thank you for taking the time to fill in this form.
Hopefully, your feedback will help us to improve our service.

APPENDIX K

COUNSELLING REFERRAL FORM

Client's name: .....

Address: .....

.....

Telephone No. .....

Total no. of sessions .....

Of which
Attended .....

Cancelled with notification .....

Cancelled without notification .....

Brief assessment of counselling contact .....

.....

.....

.....

Brief details of outcome agreed with patient.....

.....

.....

.....

IAny additional comments .....

.....

.....

Signed ..... Date .....

APPENDIX L

ACCREDITATION

Counsellor Accreditation

These criteria apply only to counsellors working with individuals or couples. They do not apply to group counselling.

There are THREE routes to Accreditation. The successful applicant will be one who prior to application:

1. i. Has completed a BAC Accredited Counsellor Training Course **and** has had at least 450 hours of counselling practice supervised in accordance with paragraph 2, or a minimum period of three years

OR

Has undertaken a total of 450 hours of counselling training comprising two elements:

a) 200 hours of skills development
b) 250 hours of theory

and has had at least 450 hours of counselling practice supervised in accordance with paragraph 2, over a minimum period of three years.

OR

ii. Is claiming little formal (course based) counselling training, but can provide evidence of seven years experience in counselling as understood by BAC with a minimum of 150 practice hours per year under formal supervision. The last three submitted years must have been supervised in accordance with paragraph 2. (NB: This route will no longer be available to applicants after 31 December 2002).

OR

iii. Can provide evidence of:

(a) some formal counselling training and

(b) several years of practice (of 150 hours minimum per year, under formal supervision). This includes a requirement for at least 450 hours of counselling practice supervised in accordance with paragraph 2, over three years.

75 hours of completed counsellor training	=	1 unit
1 year of supervised practice	=	1 unit

Together, the total must add up to 10 units.

Applicants claiming two or more training units must show a balance of theory and skills approximately in line with that stated in 1.i.

In addition to the above, the applicant is required to meet the following criteria:

2. Has an agreed formal arrangement for counselling supervision, as understood by BAC, of a minimum of one and a half hours monthly on the applicant's work, and a commitment to continue this for the period of the Accreditation.
3. Gives evidence of serious commitment to on-going professional and personal development, such as regular participation in further training courses, study, personal therapy etc.
4. Is a current individual member of BAC and undertakes to remain so for the Accreditation period.
5. Has a philosophy of counselling which integrates training, experience, further development and practice. Evidence of at least one core theoretical model should be demonstrated.
6. Demonstrates practice, which adheres to the **BAC Code of Ethics and Practice** for Counsellors, and undertakes to continue working within this Code.
7. Can show evidence of having completed a minimum of 40 hours of personal counselling or has engaged in an equivalent activity consistent with the applicant's core theoretical model.

Applicants are asked to give evidence of the above in the form of a written application including two case studies. Assessors will be looking for congruence between all parts of the application, as well as checking that the above criteria have been, and are being, met.

The following amendment to criterion 1.i will be implemented from October 2000.

1.i and has had at least 450 hours of counselling practice, supervised in accordance with paragraph 2, over not less than three and not more than five years.

The following additional criterion will be implemented from October 2000.

8. Can show evidence of serious commitment to working with issues of difference and equality in counselling practice.

There is also a commitment for a fourth route to Counsellor Accreditation (1.iv) based on S/NVQs in counselling/psychotherapy to be implemented from 1 October 2000. (Specific criteria will be submitted to future Annual General Meetings).

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