Evaluation of counselling in the National Health Service

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In recent years, awareness of the multitude of social and psychological problems that contribute to the development of certain disease states or exacerbate poor coping and lack of adjustment to illness and its treatment has led to an increase in the number of posts created for counsellors. Many doctors, especially those in general practice and oncology, now see counsellors/specialist nurses as an integral part of the health care team. Although provision of a counselling service seems intuitively reasonable and patients themselves often provide a great deal of anecdotal evidence attesting to the benefits of having been counselled, scientific evaluation of efficacy is equivocal. Martin has argued that when resources within the NHS are so scarce, the widespread adoption of counselling is unsound until effectiveness has been established[1].

So what are the responses given by practitioners to the question 'Does counselling work?' Three frequently heard answers are: (1) 'I don't care if it works or not, I just get so much satisfaction from doing it' (the faith answer); (2) 'I see such good results in my work with patients, I know it works' (the anecdotal answer); and (3) 'Well-designed research studies show that it works' (the scientific answer). One tends to hear more of the first two justifications for efficacy of counselling than of the latter.

There have been a few systematic successful attempts at evaluating counselling in an oncology setting and showing benefit[2] but by and large, results from most studies are equivocal[3]. The primary difficulties with evaluation that can be identified in the literature centre around such issues as: (1) a lack of any clear counselling model being employed; (2) an inadequately trained counsellor providing intervention; and (3) using outcome measures of efficacy that are too gross to pick up subtle but meaningful and important change[4]. These difficulties will be elaborated later. A fundamental problem with much of the research evidence available purporting to show benefit concerns poor methodology; no control group; intervention and assessment conducted by the same researcher(s); intervention poorly described; outcome measure inappropriate; inappropriate statistics or sample too small for formal statistics. Arguably the biggest flaw is the difficulty in ascertaining what exactly is being evaluated under the name of counselling and thus what takes place in our hospitals and general practices. All too often the term is applied rather loosely to cover anything from general advice-giving to tea, sympathy and a shoulder to cry upon. There is rarely any information about the therapeutic model being used or the counselling goals being pursued. Furthermore, important information about how frequency of contact is determined or how patients are referred for counselling is usually missing.

A survey of oncology counsellors and specialist nurses in the United Kingdom gave cause for concern and demonstrates clearly some of the problems[4]. Two hundred and sixty-seven counsellors and specialist nurses were identified from a variety of sources and of these 219 (82%), returned questionnaires. More than half the sample comprised nurses who described themselves as either nurses, counsellors or specialist nurses. Other respondents were primarily social workers, chaplains and groups who worked in hospices, designated oncology counsellors who were usually psychologists, psychiatrists or psychotherapists. Only a minority of respondents (18.5%) had any kind of formal counselling qualification such as a certificate, diploma or degree. Very few used any identifiable counselling model in their work and formal assessment of patients' psychological status before and after counselling was only ever done by one third of respondents. Most of the counsellors, especially amongst the nurses, received no supervision and were tackling impossible work-loads.

The lack of training was acknowledged by respondents as problematic and short in-house training sessions run by the National Health Service (NHS) were seen as inadequate. Overall, the survey showed a sorry picture of overworked, under-valued, under-trained, under-supervised people struggling to provide at best, crisis counselling for the most distressed patients. There seemed little opportunity for good prophylactic, supportive counselling. Against such a backdrop it would seem unlikely that counselling could be shown to be a valuable and effective service.

Furthermore, there is evidence from several sources that counselling is still misunderstood by many professionals working within the health service. In a recent survey of district health authorities (DHAs), over half felt that none of their staff was engaged in counselling activities and only five of 39 DHAs felt that doctors had any counselling role to play[5]. The DHAs required none of their professional groups to have qualifications in counselling prior to employment, with the exception of clinical psychologists. As this is the one group of people who are likely to have had some communication skills and counselling teaching during their training, it seems strange that it is the only group for whom an extra qualification is expected. Perhaps this is due to a misunderstanding about how broad counselling needs are within the health care area, with even DHAs assuming that only patients who are referred to clinical psychologists require help.

This study, like the oncology survey, also revealed the paucity of in-service training provided. Most comprised short two-day workshops and participation in training was entirely voluntary. Thus, people employed as counsellors within the health service are not required to have any formal qualifications, neither are they required to accept any training. This is extremely disturbing, as it is vital that the well-motivated, hard-working people who counsel patients are provided with the right kind of training to enable them to offer the most appropriate help to their patients. Furthermore, the professional skills that counselling demands that protect patients from poor counselling, and protect counsellors from potential pitfalls such as emotional burn-out, cannot be acquired from a course lasting only a few days[6].

Perhaps we should return for a moment to the research evidence that counselling works, bearing

Table 1. Evaluation of counselling in National Health Service settings

Authors	*Setting*	*Intervention*	*Patient group*	*Outcome*
Waydenfield & Waydenfield[7]	GP	Psychodynamic counselling by volunteers	Anxiety and relationship difficulties	31% decrease in surgery attendance 30% decrease in psychotoxic drugs 80% subjective improvement
Holden *et al.*[8]	GP	Rogerian counselling by trained health visitors	Women depressed post-partum	69% recovery in counselled group compared with 38% of control
Gruen[9]	ICU	Daily counselling	Myocardial infarction	Counselled are less depressed whilst in hospital and less anxious 4 months later than non-counselled
Burton & Parker[10]	Hospital	Rogerian interview with surgeon or psychologist pre-op	Breast cancer	Better psychological adjustment at 3 months & 1 year
Parkes[11]	Hospice	Voluntary bereavement service	Bereaved relatives	Fewer adjustment problems. Lower alcohol, tobacco and drug consumption

GP=General practice; ICU=intensive care unit

in mind some of the limitations of evaluation mentioned earlier. A comprehensive up-to-date review has been published[6]. Table 1 lists some of the scientific evaluation studies done in a variety of NHS settings, showing positive outcomes.

This paper has concentrated on the psychological benefits which can accrue to patients and relatives who receive certain types of counselling in different settings. Improving the counselling and communication skills of all health care professionals can also increase patient satisfaction, diagnostic accuracy and treatment adherence, all of which lead to greater professional satisfaction. Few counsellors would engage in their work without firm conviction that they could help patients and we have many anecdotal references from people who feel that they have benefited from counselling. Mere assertion that counselling works or appealing for the provision of counselling services will not, however, encourage those of a more cynical persuasion that scarce resources should be used in this way. It is vitally important that more good, methodologically sound studies are funded to examine the putative benefits of counselling support. Finally, at the end of the day, counselling is only going to be as good as the person doing it and this means better training and support services for counsellors themselves[12].

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