Evaluation of a primary care counselling service in Dorset

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SUMMARY

Background. *Research into the effectiveness of counselling in primary care is rare. This study attempts to provide a thorough evaluation of the effects of a new counselling service introduced throughout Dorset.*

Aim. *To evaluate the impact of counselling on client symptomatology, self-esteem, and quality of life. The effect of counselling on drug prescribing, referrals to other mental health professionals, and client and general practitioner (GP) satisfaction were also assessed.*

Method. *All new clients referred for counselling were asked to complete and return questionnaires before and after counselling. A total of 385 clients took part in the study. The first and second assessments were compared statistically. Clients were ascribed a psychiatric diagnosis using a simplified version of DSM-IIIR (Diagnostic and Statistical Manual of the American Psychiatric Association). GPs' views of the service were determined using a specially designed questionnaire. Drug data were obtained from the Prescription Pricing Authority and referral statistics from Dorset HealthCare National Health Service (NHS) Trust.*

Results. *The number of psychiatric symptoms and their severity were significantly reduced by counselling. There were no significant differences in the prescription of anxiolytic/hypnotic and anti-depressant medication between matched practices with and without counsellors. The presence of a counsellor did not affect the rate of referral to other mental health professionals. Clients and GPs valued the service highly.*

Conclusions. *The Psychology Managed Counselling Service is an effective method of running a counselling service and is well received by both clients and GPs. Counselled clients improved significantly on several measures.*

Keywords: counselling; evaluation; patient satisfaction; symptoms.

Introduction

IN the past decade, there has been rapid growth in the number of counsellors working in general practice. A postal survey in 1992 indicated that 9% of surgeries had a generic practice counsellor.[1] Some 80% of general practitioners (GPs) who did not provide a counselling service wished to do so, indicating the potential for further growth. It has been estimated that, nationally, there are between 500 and 1000 counsellors working in primary care.[2]

It has been suggested that the development of counselling services should proceed cautiously, and the need for more scientific evidence of the effectiveness of different types of counselling has been emphasized.[3] To date, the expansion of counselling services has not been matched by research into their effectiveness. As such, the efficacy of counselling is, at best, uncertain.[4]

The sparse research that has been conducted has been fraught with methodological problems. Controlled studies are rare.[5] Several controlled studies have evaluated the work of mental health professionals other than generic practice counsellors, such as clinical psychologists or marriage guidance counsellors. Other studies were very specific, investigating counselling for one particular problem, such as smoking.[6] The number of counsellors studied has often been small. One of the few randomized controlled trials reported on only two counsellors.[7] Outcome measures of patient functioning are often 'soft', e.g. asking the counsellors whether clients improved.[8] Properly validated and reliable assessment instruments should be used to provide measurable, objective, and reliable data, and they should be completed by an independent source. Although one would expect the effects of counselling to vary with the depth and complexity of patients' problems, there is often no attempt to measure problem severity, and analysis by patient diagnosis is rare. Most counselling research has been on the short-term effects of counselling in the United Kingdom (UK) ,[8] and there is an urgent need to include follow-up data in an evaluation.

One of the few randomized controlled trials of the short-term impact of counselling in general practice was undertaken by Boot *et al* in 1994.[9] They found that the psychological health of clients who received counselling from qualified counsellors improved more than that of those who did not receive counselling. Fewer counselled clients than control subjects were prescribed anti-depressant drugs by their GPs or were referred to psychiatrists or clinical psychologists.

The Dorset Primary Care Counselling Service

An imaginative counselling service based in general practices in Dorset was started in 1993. The service is managed by the departments of psychological therapies of Dorset HealthCare NHS Trust (East Dorset) and Dorset Community NHS Trust (West Dorset). Each counsellor is selected and employed by the psychology service. Counsellors are required to have had at least two years' training involving some practical experience. British Association for Counselling accreditation is preferred. As part of their employment contract, counsellors are bound by the counselling standards and codes of practice laid down by the Clinical Psychology Services. Counsellors are also required to complete weekly Korner statistics.

Counsellors receive one hour's supervision a week with a designated clinical psychologist. This involves casework, skills development, and examination of personal and professional issues. An ongoing training and development programme of

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workshops and seminars is also available.

Counselling is provided to general practices by the Psychology Services. The recommended level of service provision is three patient–session hours per 2000 patients in the practice population per week. The mean number of hours actually provided is 2.5 (range 0.7–8.7 h). GPs refer directly to counsellors within their practices. Counsellors normally have eight-session contracts with clients. By April 1995, 22 counsellors were based in 26 general practices. A study of the counsellors in east Dorset found that most counsellors described their practice as client-centred.[10]

In view of the size and scope of the new service, it was crucial to evaluate its effect on the counselled clients, the GPs involved, and the degree to which the referring and prescribing practices of GPs were altered by having counsellors working in their practice. An 18-month research evaluation project, commissioned by Dorset Health Commission, was conducted by the Research Support Unit, Dorset HealthCare NHS Trust. This paper describes the first stage of the evaluation.

The aims of the study were

- To evaluate the impact of the counselling service on client symptomatology, self-esteem and quality of life
- To assess the impact of the counselling service on the prescription of anxiolytic, hypnotic, and anti-depressant medication
- To evaluate the impact of the counselling service on referrals to psychiatrists, community psychiatric nurses, community occupational therapists, and clinical psychologists
- To evaluate GPs' satisfaction with the counselling service, its impact on their work, and their assessment of its effectiveness, and
- To evaluate client satisfaction with counselling.

Method

In terms of administrative procedures, diagnostic procedures, questionnaire design, and data collection and analysis, the project was based upon an earlier evaluation performed by the main author.[11] The original evaluation was of a clinical psychology service in Aberdeen, where the work of 16 clinical psychologists was assessed over a three-year period.

Approval was sought and obtained from the local research and ethics committees of East and West Dorset.

Participants

All new clients referred for counselling in the designated practices were included in the evaluation. The referral protocol supplied to GPs by the clinical psychology services stated that clients were eligible for counselling if

- They did not have a long history of emotional problems
- Their distress was acute and in response to some clearly definable situation, e.g. marital problems, and
- They had no formal psychopathology, i.e. no psychiatric symptoms beyond moderate anxiety/depression.

Assessment

A questionnaire assessment package was compiled to measure different aspects of client functioning. The selection of each scale was based on literature reviews and, in some cases, extensive prior use. The instruments used were as follows:

- A shortened version of the Bedford and Foulds Delusion–Symptoms–States Inventory (DSSI).[12] This scale has 49 items, which make up seven subscales. It assesses the number and severity of symptoms in the previous two to three weeks.
- The Rosenberg self-esteem scale (1965),[13] which, although old, has demonstrable reliability and validity.
- The Watson and Marks Life Impairment Scale (1971),[14] which was used to assess the degree of impairment caused to work, home management, social leisure activities, private leisure activities, family relationships, and sexual relationships.

These scales were used in the earlier Aberdeen study, where they were shown to be valid and sensitive to change.

Client satisfaction was measured by a specially designed section on the questionnaire. General practitioners' views of the counselling service were obtained by a specially designed questionnaire.

Procedure

All new clients received questionnaires from their counsellors. These were either sent out with the referral letter before counselling began or given during the first counselling session. Clients were asked to return completed questionnaires to the research team in prepaid envelopes. After three months, by which time most clients had completed counselling, each client received a second questionnaire from research staff.

After a new client had been seen twice, their counsellor completed a client problem sheet. Using a modified version of DSM-IIIR (Diagnostic and Statistical Manual of the American Psychiatric Association),[15] the client's main problem was categorized. Up to three contributory factors could also be specified (using a categorization system devised in the Aberdeen study), e.g. being made redundant or marital disharmony.

Data from the questionnaires and problem sheets were entered onto a spreadsheet, and statistical analysis was performed using Statistica software (Statsoft Ltd, Tulsa, USA). Repeated measures analysis of variance was used to test whether there was any significant change between the pre- and post-counselling questionnaires.

Results

A total of 385 clients entered the study by returning a pre-counselling questionnaire (66% return rate). Of these, 204 were sent post-counselling questionnaires, and 117 (57%) returned these. Post-counselling questionnaires were not sent to clients who returned first questionnaires but never attended counselling or to those who were referred to other professionals by counsellors. Only clients who returned both first and second questionnaires were included in the analyses.

Most clients (84%) completed counselling within the eight-session contract. Overall, 30% received six to eight sessions, 35% three to five sessions, and 19% one or two sessions. These figures include clients who 'dropped out' of counselling and those who agreed to finish counselling early.

More than twice as many women as men were referred for counselling. The most common DSM-IIIR diagnosis was adjustment disorder (adverse reaction to life events; 38%) followed by problems without a definite diagnosis (11%) and depressive disorder (10%). Where counsellors had recorded the main causes of client problems, the most frequently noted were relationship issues with partners, bereavement, and work-related issues.

Impact on client symptomatology, self-esteem and quality of life

Anxiety and depression. Table 1 shows the number of symptoms of anxiety and depression in counselled clients before coun-

Table 1. Analysis of variance and comparison data: number of symptoms of anxiety and depression.

	Start of study Mean	SD	Three months later Mean	SD	F	df	P
Counselled patients (n = 117)							
No. of anxiety symptoms[a]	4.31	2.05	2.82	1.99	29.9	1,215	<0.0000001
No. of depression symptoms	3.79	2.04	2.03	2.29	35.12	1,210	<0.0000001
Waiting list[b] patients (n = 64)							
No. of anxiety symptoms	4.03	2.09	3.74	2.19	0.52	1,112	NS
No. of depression symptoms	3.44	2.22	3.04	2.33	0.92	1,115	NS
Normal subjects[c] (n = 122)							
No. of anxiety symptoms	1.45	1.79	–	–	–	–	–
No. of depression symptoms	0.69	1.37	–	–	–	–	–

[a]Maximum possible number of anxiety/depression symptoms is seven. [b]Comparison data from a separate study.[16] [c]Comparison data from Baker and Bell (submitted for publication).

selling and three months later. In addition to the original normative data published with the DSSI,[12] scores for 122 normal subjects from the Aberdeen University Psychology Department's subject panel (Baker R, Bell S, submitted manuscript) are provided for comparison with clients' pretreatment symptom scores. Compared with the normal subjects, the counselled clients showed many more symptoms of anxiety and depression before treatment.

There was a highly significant decrease in the number of both anxiety symptoms (F = 29.9, df = 1, 215, $P \leqslant 0.0001$) and depression symptoms (F = 35.12, df = 1, 210, $P<0.0001$) after counselling. There were no significant changes in the number of anxiety and depression symptoms in an untreated (waiting list) control group over the same period. This group was taken from a similar study using the same organizational system.[18]

There were highly significant reductions in the number of client symptoms reported on the first and second questionnaires for all other subscales on the DSSI. Client symptomatology thus improved during the first three months of counselling.

The untreated waiting list control group showed no significant improvements.[16] This would suggest that improvement would not otherwise have occurred in counselled clients but, as this was not a concurrently run control group, this is not definitive.

Self-esteem. Table 2 shows mean self-esteem scores for clients' precounselling and three months later. Clients' self-esteem improved significantly (F = 7.69, df = 1, 216, $P<0.01$) during counselling.

Quality of life. Table 2 also shows mean life impairment scores for clients before and after counselling. There were significant improvements during counselling in clients' work, home management, social and private leisure activities, and family and sexual relationships.

Impact on the prescription of anxiolytic, hypnotic and anti-depressant medication

To assess the impact of the counselling service on the prescription of medication and on referrals, calculations were based on matched practices. Practices with and without counsellors were matched on the following variables in order of priority: Jarman 8 indices, size of practice population, fundholding versus non-fundholding status, and rural versus urban location of practice. Independent t-tests comparing the two groups of practices showed no significant differences on any variable, indicating that the matching with control practices was good.

The two areas of prescribing most relevant to the study were anxiolytic/hypnotic drugs and anti-depressants. Data were provided by Dorset Health Commission per practice per month from January 1992 to July 1994. As counsellors were first introduced to practices in April 1993, these data provided a long baseline before the introduction of counsellors (Figure 1).

The prescribing of anxiolytic/hypnotic medication and of anti-depressant drugs in practices with counsellors (n = 15) was compared with that of matched practices without counsellors (n = 15). A repeated measures analysis of variance was performed, with months as the repeated measure. Although there was a highly significant reduction in prescribing over time (F = 9.94, df = 30, 810, $P \leqslant 0.00001$), there was no significant difference between practices with a counsellor and those without (F = 0.94, df = 30, 810, P = NS; Figure 2).

There was a highly significant increase in anti-depressant prescribing from 1992 to 1994 (F = 15.89, df = 30, 840, $P \leqslant 0.00001$). The group x time interaction (F = 0.70, df = 30, 840, P = NS) shows that this increase was no different for prac-

Table 2. Analysis of variance: self-esteem and quality of life in the counselled patients (n = 117).

	Start of study Mean	SD	Three months later Mean	SD	F	df	P
Self-esteem[a]	19.7	7.19	16.96	7.39	7.69	1,216	<0.01
Quality of life[b]							
Work	1.98	1.36	1.08	1.17	22.07	1,174	<0.00001
Home management	1.41	1.13	0.96	0.94	10.58	1,225	<0.01
Social activities	2.05	1.29	1.37	1.28	15.69	1,226	<0.0001
Private activities	1.24	1.27	0.83	1.08	7.29	1,227	<0.01
Family relationships	1.8	1.46	1.3	1.15	8.47	1,225	<0.01
Sexual relationships	2.18	1.53	1.5	1.43	9.86	1,186	<0.01

[a]Higher scores indicate lower self-esteem. [b]Higher scores indicate a greater degree of life impairment in these areas.

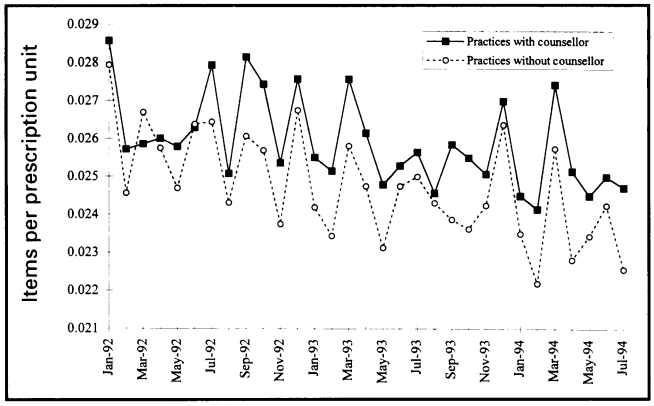

Figure 1. Anxiolytic and hypnotic drugs prescribed in practices with and without a counsellor.

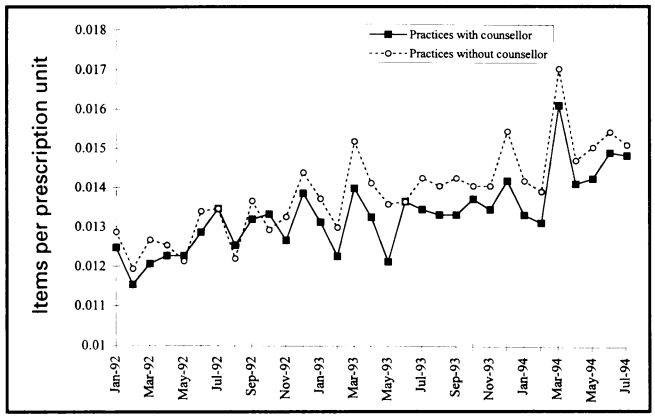

Figure 2. Antidepressant drugs prescribed in practices with and without a counsellor.

tices with a counsellor than for those without one.

For both classes of drugs, the same trend was apparent in practices in which counsellors started in 1993 as in practices that employed no counsellors. It would seem that the presence of counsellors makes no difference to the total prescribing of practices.

Impact on referrals

There was a significant reduction in outpatient psychiatry referrals over time, but no significant differential rate in practices with and without counsellors. There were significant changes in psychiatric inpatient referrals over time, but there was no significant difference in the referral patterns between practices with counsellors and those without.

Although there were changes in both psychiatric outpatient and inpatient referrals from 1992 to 1994, the findings suggest that counselling is not responsible for these changes. Similarly, although there were increases in referrals to psychology, group therapy units, community psychiatric nurses, and community occupational health, it did not appear that this was due to the presence of the counsellor.

Client satisfaction with the counselling service

Some 84% of clients were satisfied with the counselling service, and nearly all expressed one or more positive reactions. This is in keeping with other findings.[3] The opportunity to talk to an independent non-judgemental professional and gaining an understanding of their problem were the aspects of counselling most valued by patients.

GP satisfaction with the counselling service

Fifty-one questionnaires were returned, a response rate of 75%. All the GPs were happy with the counselling service and agreed that patients benefit from counselling. This is in keeping with another study,[17] which found that the majority of GPs thought that counselling was an important part of general practice. Jewell[3] also found professional satisfaction with a counselling service. The main benefits perceived by GPs were the ability to offer more treatment options and better care (31%), a reduction in their own workload (28%), and a reduction in the time they themselves spent counselling (23%). Overall, 45% saw no drawbacks in having the service. Many more positive than negative views were expressed.

Discussion

The results of the study reveal very positive findings concerning counselling. The findings suggest that clients made highly significant improvements in several areas of functioning during counselling. Both the number and the severity of psychiatric symptoms showed a highly significant reduction during counselling. These symptoms included depressive, anxiety, obsessional, phobic, somatic, and dissociative symptoms.

The length of completed treatment varied. Early discharge or dropout from counselling could indicate either speedy benefit or dissatisfaction. However, both clients and GPs expressed high levels of satisfaction with the service.

Over the study period, prescribing of anxiolytic/hypnotic drugs was greatly reduced and anti-depressant prescribing increased, but these trends were unrelated to the presence of a counsellor in the practice.

The absence of a concurrent control group in this study should be considered in view of current debate surrounding psychotherapy research. Randomized control trials have been considered the gold standard for evaluation. These studies are needed to make causal inferences about effects observed in practice. However, limitations have been described.[19] These include

- Inappropriateness for evaluating interventions where patient motivation and preference are integral to the outcome[21]
- The need for strictly controlled treatment regimes
- Study of only highly specified groups of patients
- Study of relatively short-term effects.

The value of naturalistic, observational studies such as ours has been described.[20] These large-scale, long-term studies are needed to evaluate the effectiveness of treatments delivered to patients in real clinical settings. Both approaches to treatment evaluation are necessary and, indeed, complementary.

The study reported here forms the first stage of a long-term, ongoing counselling evaluation. Later stages include several different types of control conditions. Conclusions will then be possible regarding the long-term efficacy of counselling for patients in general practice settings.

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