

Evaluating a primary care counselling service: outcomes and issues

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This paper reports an evaluation of a counselling service that was introduced into 20 general practices within Bradford City Primary Care Trust. Clinical Outcomes in Routine Evaluation (CORE) Assessment and End of Therapy forms were used to record referral and attendance information along with problems identified and demographic information about clients. There was a large disparity in the number of referrals across practices illustrating a range of influences on take-up of the service. Levels of attrition from referral for counselling to commencing were relatively high (188 invitations: 89 took up counselling). A longitudinal evaluation of outcomes was conducted using the CORE outcome measure and the SF-36 Health Survey Questionnaire. Data was collected at the beginning of counselling, at six months and at 12 months follow-up. We found some indication of positive change relating to severity of problems and ability to engage in social activities. However, evaluators should be aware that high attrition rates can create problems in achieving statistical reliability in contexts where overall population numbers are relatively small and/or the time for data collection is relatively short. In light of the recent growth of counselling within primary care, and the need to evaluate these services, the issues encountered in setting up this counselling service, and in seeking to evaluate it, may be instructive to others. Focus groups with counsellors and practice staff explored the benefits and problems in providing the service within practices.

Key words: counselling; evaluation; general practice; primary care

Introduction: counselling in primary care

Mental health issues are the third most common reason for consulting a general practitioner (GP), after respiratory disorders and cardiovascular disorders (Department of Health, 1991; Hemmings, 2000). A quarter of routine GP consultations relate to people with a mental health problem, most commonly depression and anxiety. It has been estimated that each year, one in 15 women and one in 30 men will be affected by depression, and every GP will see between 60 and 100 people with depression (Department of Health, 1999). A survey

of 325 GPs conducted by the Mental Health After Care Association in 1999 found that 30% of their time, roughly 1.5 days a week, is spent working on patients' mental health problems, particularly relating to anxiety and depression (Davidson, 2000). The direct costs of treating depression in the UK in the early 1990s was estimated to be around £400 million a year and the indirect costs, including mortality costs and lost productivity was £3000 million (Kendrick, 2002).

Standard two of the National Service Framework for mental health (Department of Health, 1999) states that: 'Any service user who contacts their primary health care team with a common mental health problem should: 1) have their mental health needs identified and assessed; 2) be offered effective treatments, including referral to specialist services for further assessment, treatment and care if they require it' (p. 28). To achieve this, primary

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care groups/trusts (PCG/Ts) should ‘develop the resources within each practice to assess mental health needs’ (p. 35).

During the past 20 years counselling as a specific undertaking has been introduced into primary care, and the last decade has seen a rapid expansion. In the early 1990s Sibbald *et al.* (1993) estimated that about one-third of practices provided a counselling service (this included counselling conducted by community psychiatric nurses, practices nurses and health visitors); in the most recent estimate for England and Wales (Mellor-Clark, 2000a) this has risen to over half (51%). The type of counselling provided varies widely, but there is an emerging consensus about some of its aspects: it should be conducted by a trained counsellor with a recognized and specific qualification; it is typically short-term/brief counselling of between six and 12 sessions; the level of severity of patient need should be mild to moderate, patients with severe and complex mental health issues or personality disorders should be referred elsewhere, e.g., to a community mental health team. It should be noted that there has been considerable debate and concern within counselling and psychotherapy professional organizations about what constitutes an acceptable qualification and also how far what is offered in short-term interventions is correctly termed ‘counselling’ (Casemore, 2002; Coren, 2002).

While there is both an expansion of provision and some sense of focus there is continuing debate about the evidence base underpinning these services. Mellor-Clark (2000b) argues that ‘the provision of counselling in primary care is a domain of mental health care provision that has seen considerable growth despite a paucity of information on the structure of the provision (the counsellors), the process involved (the counselling), the problems treated (the counselled), and the outcomes gained (effectiveness)’ (p. 156). A recent systematic review of randomized controlled trials (RCTs) comparing counselling with ‘usual GP care’ found that in the short-term (up to six months) counselling led to a greater reduction in psychological symptoms, but in the long term (8–12 months) there was no difference (NHS Centre for Reviews and Dissemination, 2001).

Evidence from RCTs has, however, been criticized because the level of control required in the design of RCTs makes them unrepresentative of everyday practice (Hemmings, 2000; Mellor-Clark,

2000b; 2000c; Howey and Ormrod, 2002). In this respect Hemmings (2000) draws a distinction between efficacy and effectiveness research. Whereas RCTs may be appropriate for establishing the efficacy of certain treatments – using controlled environments in which the intervention is strictly regulated, these interventions then need to be tested in ‘the real world’ of everyday clinical practice. This is known as effectiveness research. The problem is that counselling in clinical practice contains a number of important elements that may not be accounted for in RCTs. Seligman (1995) has noted the following:

- 1) The therapy is not always of fixed duration.
- 2) The therapy tends to be self-correcting, disregarding unsuccessful techniques or modalities and replacing them with others.
- 3) Patients often actively choose their therapist and their therapeutic models rather than being assigned to a particular therapist delivering a defined intervention.
- 4) Patients often have multiple problems requiring interactive choices between therapist and client.
- 5) The focus is often on general functioning rather than specific symptoms.

Seligman therefore concludes that ‘the efficacy study is the wrong method for empirically validating psychotherapy as it is actually done, because it omits too many crucial elements of what is done in the field’ (p. 966).

Hemmings (2000), who lists further limitations of RCTs for evaluating counselling, reviewed effectiveness studies of counselling as delivered in naturalistic, everyday practice and found improved psychological well-being measured across a range of measures. A number of studies evaluating counselling in primary care contexts have reported improvements in patient well-being (Baker *et al.*, 1998; Nettleton *et al.*, 2000; Howey and Ormrod, 2002), often maintained in the long term (two years’ follow-up) (Gordon and Wedge, 1998; Baker *et al.*, 2002).

The Health plus counselling service

The Health Plus primary care counselling service was funded by a Health Action Zone Innovations grant to Bradford City Primary Care Trust. The

inner city has a high level of deprivation with seven wards (political geographical districts) falling within England's poorest 10% (DETR, 2000). Twenty-eight of the 44 practices are single handed. The population is of mixed ethnic origin, with people of South Asian origin constituting the majority at 55% of the population.

The project was initiated by primary care staff in response to an expressed need amongst practices for a counselling service. The service began in March 2001 with four qualified counsellors (2 WTE) taking referrals from 20 inner city practices. In order to facilitate appropriate referrals, the counsellors provided GPs with an information sheet about the service and a referral protocol. Referrals were allocated to a particular counsellor who then arranged to see the patient at the practice.

Evaluation method

Design

A longitudinal design was adopted, with measures taken at the beginning of counselling, at six months and 12 months follow-up. This decision was made in the light of comments on the need to supplement the research base for counselling via focussed studies around specific initiatives and to consider impact over time (Kendrick, 2002).

RCTs, in which patients are randomly allocated to treatment (counselling) or not (e.g., 'normal GP care') are regarded by many as providing the most powerful form of evidence for health care interventions (Harris *et al.*, 1998). However, as we have discussed above, their validity in evaluating the effectiveness of counselling has been widely criticized because the level of control required in the design of RCTs makes them unrepresentative of everyday practice. Furthermore, from an ethical perspective, randomly allocating clients to counselling or not, when they had been referred for counselling, would not have been acceptable to the primary care team in Bradford City. There was a view that the need for counsellors arose from clinical experience alongside evidence from some published studies suggesting that patients benefit from such interventions.

In effect then the shape of the evaluation reflects the perceived 'reality' of primary care where both the context of patient demand and the way priority decisions are made draws on understandings

of evidence that are some distance from the RCT paradigm (Mant, 1997; Medical Research Council, 1997; Small, 2003).

Measures

Two main measures were used in the study:

- 1) CORE: Clinical Outcomes in Routine Evaluation System (CORE System Group, 1998). This was designed specifically for the evaluation of psychological therapy services. It consists of:
 - a) Assessment and End of Therapy forms, which are completed by the practitioner for every client. Information includes routine audit items (e.g., attendance rates), problems identified, type of therapy, duration and frequency;
 - b) a 34 item questionnaire for patients to complete measuring four dimensions: subjective well being, life functioning, problems/symptoms, and risk.
- 2) The SF-36 Health Survey Questionnaire (Ware *et al.*, 2000), which consists of 36 questions measuring eight dimensions:
 - a) general health rating;
 - b) bodily pain – severity and impact on activities;
 - c) vitality – level of energy/tiredness;
 - d) physical functioning – the extent to which health limits physical activities (e.g., walking);
 - e) social functioning – impact of physical and emotional problems on social activities;
 - f) mental health – levels of nervousness, calmness, happiness and sadness;
 - g) role limitations due to physical problems – the extent to which physical health limits activities;
 - h) role limitations due to emotional problems – the extent to which emotional problems limit activities.

Procedure

All clients attending the initial counselling assessment session were informed of the need to evaluate the service and were provided with an information sheet and consent form to be returned at the next session. The information sheet provided an outline of the project and emphasized that participation was optional and would not affect the service received.

The counsellor completed the CORE therapy assessment form at the first session and the End of

Therapy form after the last attended session. The client completed the CORE questionnaire and SF-36 questionnaire at the first session; follow-up questionnaires were sent to clients at six months and 12 months, with a freepost envelope for their return. Reminders, including another copy of the questionnaires, were sent two weeks after the initial letter if there had been no response.

Qualitative evaluation

A focus group interview was conducted firstly with the four counsellors and then with staff at eight practices 10–12 months after the project's inception. A total of 10 GPs, 10 practice managers, five nursing staff and seven office staff attended the practice focus groups. In both cases the topic agenda covered the following issues: What are the benefits of providing counselling in primary health care? What problems/obstacles have there been establishing the service in practices?

Interviews were tape-recorded, transcribed and analysed according to emergent themes.

Results

Referrals

In the first year the counselling service received 254 referrals from the 20 practices. The number of referrals varied widely across practices, ranging from 1 to 32 (mean 9; median 5) with three practices accounting for 45% of referrals. Variations in practice list sizes may account for some of this disparity in the number of referrals: there was a positive correlation between list size and number of referrals: $r = 0.6, p < 0.01$; Practice list size ranged from 1768 to 7102; mean, 3924; median, 3354. A focus group with the counsellors did, however, identify two other reasons. First, the difficulty in arranging rooms for counselling sessions may have deterred practice staff from referring patients for counselling. Secondly, it was perceived that some GPs were less favourable than others towards the value and legitimacy of counselling for their patients. These issues are further considered in the counsellors focus group and the Discussion.

Of the patients referred, 188 had been invited for the initial assessment session with 66 remaining on a gradually accumulating waiting list. However,

Table 1 How counselling ended

How counselling ended	Number	Percentage
Unplanned due to crisis	4	4.5
Unplanned due to loss of contact	14	15.7
Unplanned – client did not want to continue	15	16.9
Other unplanned ending	10	11.2
Total unplanned	43	48.3
Planned – from outset	32	36.0
Planned – agreed during counselling	11	12.4
Planned – agreed at end of counselling	1	1.1
Planned – other	2	2.2
Total planned	46	51.7
Total	89	100.0

56 patients (30%) did not attend (DNA) and seven (4%) cancelled the assessment. This is a relatively high ratio of DNAs compared to similar studies (Gordon and Graham, 1995; Speirs and Jewell, 1995) and was clearly a cause for concern for the project, and the evaluation (i.e., sample size). A focus group with the counsellors highlighted various reasons for DNAs, which are reported in the qualitative evaluation.

Of the 125 patients who attended the assessment session, 11 were invited for one session only, three for a long consultation, and seven were referred to another service (e.g., community mental health team). This left 104 patients who were accepted for counselling or for a trial period of counselling, of which 89 actually commenced (there were three DNAs and 12 cancellations at the first counselling session). Thus, of the 188 clients invited for the initial assessment session, only 89, less than half (47%), commenced counselling.

The average number of sessions attended was four (median, 3; range, 1–12). From Table 1 we can see that for half of the patients (48%) the cessation of counselling was unplanned.

The majority of patients who commenced counselling were female (67%). In terms of ethnic origin, 61% were 'white' and 30% of South Asian origin (9% 'other'). This did not reflect the proportion of South Asian people in the Bradford City PCT area who constitute 55% of the population. It may be

that the ethnic profile of the study population was biased because not all practices in the city were involved in the study and the distribution of South Asian people in the inner city is not uniform across practices. More generally however, there is evidence to suggest that people from minority ethnic communities are much less likely to be referred for psychological therapies (Bhugra and Bahl, 1999; Department of Health, 1999; Mind, 2002). Language difficulties and social isolation, particularly for older south Asian women, may be important factors: in our study 59% of 'white' patients were over 40 years old, compared to 20% of people from South Asian origin. There may also be a cultural deterrent to seeking outside help because seeking support outside the family may be perceived as bringing shame or dishonour ('izzat') on the family, an issue exacerbated by what are often strong 'community grapevines' (Chew-Graham *et al.*, 2002; Mind, 2002; Weir, 2002). This may also influence the referral rates from South Asian GPs.

Unfortunately, the referral form did not include details of ethnicity so we cannot determine relative proportions of those referred for counselling and further compare this figure with those who actually attended for counselling. (We might hypothesize, in light of the issues discussed above, that South Asian patients would be less likely to attend for counselling after referral.)

A study in the UK examining the uptake of mental health services found that members of the Asian community were much more likely to seek help from the voluntary sector (Beliappa, 1991). This was partly due to a lack of awareness of statutory services but also due to a lack of confidence in the ability of service providers to understand and meet their needs, and fears around confidentiality. A concurrent evaluation of a welfare advice service provided within general practices in Bradford inner city (Greasley and Small, 2002) found that 75% of referrals were of South Asian origin, more than reflecting the proportion of that population in the area.

Problems identified

Patients presented with an average of four problems (range, 1–8), the majority of which were causing 'moderate' to 'severe' difficulty (77%) and were recurring/continuous (52%). Table 2 lists the problems identified by the counsellors (using the

Table 2 Problems identified (89 clients)

Problem	Number	Percentage
Anxiety/stress	71	80
Depression	66	74
Interpersonal relationships	62	70
Self-esteem	44	49
Trauma/abuse	35	39
Bereavement/loss	33	37
Work/academic	25	28
Living/welfare	20	23
Physical problems	17	19
Personality problems	8	9
Eating disorder	6	7
Addictions	4	5
Psychosis	1	1
Cognitive/learning	1	1
Other	4	5

categories provided in the CORE Therapy Assessment form). We can see that 80% of patients were suffering from anxiety/stress, 74% from depression, and 70% were having problems with interpersonal relationships. The high prevalence of anxiety/stress, depression, and relationship problems accords with profiles from other studies (Hemmings, 2000). In addition, there was also a high level of trauma/abuse (39%) and bereavement/loss (37%). There were no significant differences across gender or ethnicity.

Follow-up outcome measures: CORE and SF-36

The follow-up evaluation encountered serious difficulties in recruitment. It had been envisaged that the seven month recruitment period would provide a sample of about 100 patients. However, fewer than anticipated referrals in the initial three months, and the low ratio of referrals actually commencing counselling (47%), due in particular to the high ratio of DNAs, conspired to reduce the final sample. After the seven month recruitment period, 55 clients had commenced counselling, of which 32 (58%) consented to the follow-up evaluation. Only 16 (29%) of these clients returned the follow-up questionnaires at six months and only 11 of these at 12 months.

This is a relatively small sample and we must be careful when drawing conclusions from statistical analysis. That is, since the power of the study is low,

the chance of a type B error (incorrectly accepting that no difference exists) is high. A post hoc power analysis based on a minimally important difference (MID) of 0.5 on the CORE (compare Barkham *et al.*, 2001), and standard deviation of 0.79 for 'all non-risk items' gives a power of 0.75 (Altman, 1991). This would mean that we only have a 75% chance of obtaining a significant result. For the SF-36, with a power of 0.80, alpha of 0.05 and a MID of 10 points, 50 clients is recommended (Ware *et al.*, 2000).

CORE outcome measure

Table 3 provides the mean scores for the 32 participants across the dimensions of the CORE Outcome Measure with norms for clinical and non-clinical samples provided from the authors of CORE for comparison. We can see that the clients seen by the counsellors were very similar to the clinical population on all dimensions.

Table 3 Mean CORE outcome scores ($n = 32$) compared to clinical/non-clinical samples

Dimension	All clients	Non-clinical norms	Clinical norms
Subjective well-being	2.5	0.91	2.37
Symptoms	2.4	0.90	2.31
Life functioning	1.9	0.85	1.86
Risk	0.5	0.20	0.63
All non-risk items	2.2	0.88	2.12
All items	1.9	0.76	1.86

Non-clinical sample ($n = 1084$; primarily university students) and Clinical sample ($n = 863$; clients waiting or receiving psychological interventions) taken from CORE System Group (1998)

Table 4 Repeated measures random effects linear model for scores on the CORE

Dimension	At referral $n = 16$ mean (S.D.)	At 6 months $n = 16$ mean (S.D.)	At 12 months $n = 11$ mean (S.D.)	Wald χ^2	p value
Subjective well-being	2.50 (0.89)	2.13 (1.08)	1.62 (0.97)	9.07	0.01
Symptoms	2.38 (0.79)	2.27 (1.08)	1.79 (1.01)	4.08	0.13
Life functioning	1.74 (0.73)	1.79 (0.78)	1.51 (1.01)	1.56	0.46
Risk	0.42 (0.45)	0.38 (0.49)	0.38 (0.64)	0.20	0.90
All nonrisk items	2.11 (0.69)	2.03 (0.88)	1.64 (1.03)	3.94	0.14
All items	1.82 (0.60)	1.75 (0.76)	1.43 (0.92)	3.63	0.16

An independent t -test was conducted to compare the baseline scores (i.e., at referral) on each dimension for those clients who returned and who did not return the questionnaires at six months. There were no significant differences.

A repeated measures random effects linear model was conducted to examine scores at referral, six months and 12 months follow-up. From Table 4 we can see that there was one main effect for the dimension of 'subjective well-being'. A paired comparison with referral scores found that this had improved at 12 months ($z = -3.0$, $p < 0.003$, 95% CI: -1.51 to -0.32).

SF-36 health questionnaire

Scores on the SF-36 questionnaire were transformed to a 0–100 scale (Ware *et al.*, 2000). A high score indicates better health and functioning. Table 5 provides the means for all clients who completed the form at referral. On each dimension health status was significantly lower than that for the 'normal' population, particularly in terms of role limitations due to emotional problems, and social functioning.

An independent t -test was conducted to compare the baseline scores (i.e., at referral) on each dimension for those clients who returned and who did not return the questionnaires at six months. There were no significant differences.

Correlations with scores on the CORE were high. For example 'subjective well-being' (CORE) and 'mental health' (SF-36) were highly negatively correlated (a higher score signifies improvement on the SF-36, compared to a lower score on the CORE) at referral ($r = -0.7$, $p < 0.000$), at six months ($r = -0.7$, $p < 0.004$) and 12 months ($r = -0.9$, $p < 0.000$).

A repeated measures random effects linear model was conducted to examine scores at referral, six months and 12 months follow-up. From Table 6 we can see that there was a significant main effect on the dimensions of 'social functioning' and 'role limitations due to emotional problems'. A paired comparison with referral scores found that the extent to which emotional problems limit activities was reduced at six months ($z = 2.28, p < 0.023, 95\% \text{ CI: } 2.01\text{--}26.89$) and at 12 months ($z = 3.08, p < 0.002, 95\% \text{ CI: } 8.22\text{--}36.98$). The impact of physical and emotional problems on social activities was reduced at 12 months ($z = 2.74, p < 0.006, 95\% \text{ CI: } 5.99\text{--}36.2$); and was close to significance at six months ($z = 1.77, p < 0.077, 95\% \text{ CI: } -1.23 \text{ to } 24.83$). These results may suggest that counselling has enabled clients to re-engage in social activities despite the continued presence of physical and psychological symptoms.

Individual analysis

Analysis of the results for individuals confirmed the heterogeneity of outcomes reflected in the statistical tests. For example, on the CORE, using the all items (non-risk) score, and a change criteria of ≥ 0.5 (compare Barkham *et al.*, 2001) we found that, of the 16 who returned questionnaires at six months: six showed improvement, five deteriorated, and for five there was 'no change'. Of the 11 who returned questionnaires at 12 months:

CORE status	6 months	12 months
Improved	4	All four maintained improvement
No change	4	three no change; one deteriorated
Deterioration	3	two improved; one deteriorated

Table 5 Mean scores for all clients who completed the form at referral

Dimension	<i>n</i>	Mean	Normative data	Difference
Physical function	31	77.6	88.0	-10.4
Bodily pain	31	54.1	79.2	-25.1
General health	31	44.2	70.9	-26.7
Vitality	31	30.8	58.4	-27.6
Social function	31	36.7	82.8	-46.1
Mental health	31	37.3	72.0	-34.7
Role physical	30	59.2	87.3	-28.1
Role emotional	30	36.7	85.7	-49.0

Normative data obtained from the Health Services Research Unit, University of Oxford (www.hsr.uox.ac.uk/sf36v2.htm). Norms are provided for males and females across age categories. These were averaged

Table 6 Repeated measures random effects linear model for scores on the SF-36

SF-36 dimension	At referral <i>n</i> = 16 mean (S.D.)	6 months <i>n</i> = 16 mean (S.D.)	At 12 months <i>n</i> = 11 mean (S.D.)	Wald χ^2	<i>p</i> value
Physical function	79.06 (27.52)	74.38 (24.35)	77.27 (28.67)	1.24	0.54
Bodily pain	53.56 (33.58)	45.38 (27.33)	49.09 (19.45)	2.03	0.36
General health	46.50 (23.10)	41.88 (25.54)	48.00 (27.29)	1.66	0.44
Vitality	29.30 (15.60)	32.81 (22.65)	38.64 (29.82)	1.59	0.45
Social function	34.38 (17.38)	47.66 (22.92)	54.55 (32.73)	8.24	0.016
Mental health	37.50 (14.02)	42.50 (22.29)	50.00 (24.39)	3.91	0.14
Role physical	59.38 (33.23)	58.59 (33.14)	63.64 (31.23)	0.28	0.87
Role emotional	38.02 (15.58)	49.44 (24.08)	55.83 (25.47)	11.12	0.003

Although it is difficult to attribute any changes to counselling, these results would seem to reflect the view of Mellor-Clark (2000c) who concludes from the literature: 'it appears that we know that counselling in primary care works for some of the patients some of the time, but not all of the patients all of the time' (p. 257). Indeed, Hemmings (2000) argues that the focus of counselling effectiveness research should broaden from the oversimplistic 'does it work?' to under what circumstances does it work, with whom, when, where, and how? (p. 249). Pawson and Tilley (1997) have levelled similar criticisms of positivistic experimental designs in evaluation, arguing for explanatory elements of what works for whom and in what circumstances.

Qualitative evaluation

The counsellors identified a number of benefits in providing their service in general practices. It enables patients with mild to moderate mental health issues relatively easy access to a counsellor and provides an alternative to making more formal referrals to community mental health teams, which often have long waiting lists. Primary care centred counselling also reduces the level of stigma associated with referrals to the community mental health services; it fosters less sense of foreboding for patients who may be more amenable to seeing the practice based counsellor compared to referrals to secondary services:

I've had patients who have come who wouldn't have gone to counselling if they'd been told it's the counselling service – I don't think they'd have turned up – and I think they did because it's the doctor's surgery and somehow it wasn't quite so unpleasant.

The importance of local access to counselling was also emphasized by practice staff who felt that referrals outside the practice ('trailing off to a strange place') deterred patients from taking up counselling: 'if somebody has come to you for help and then you present them with quite a difficult path to get help it is quite discouraging for them'.

There were, however, a number of problems with practice-based counselling. The counsellors raised concerns about the level of confidentiality/anonymity at some practices where staff and other

patients who they know socially may be aware that they are attending counselling:

I've had one patient who doesn't want to come because it's at the GP surgery – because people will know that she's coming for counselling – she'll know other patients and practice staff as well – so she doesn't want it at the surgery for that reason.

It was felt that this lack of anonymity deterred some patients from attending for counselling and was one reason for the high rate of DNAs subsequent to referral. As one counsellor commented, 'you almost feel your client looking round and then diving in the door quickly'.

A major concern for counsellors was the difficulty arranging rooms for counselling at the practices:

Every time we turn up to somewhere we have to book a room each time – so we never have a room put aside for us – *each time we have to book a room* – and things are changing all the time – and that's a real waste of time having to get that room sorted out.

These administrative problems were exacerbated by the lack of a relationship between the counsellors and practice staff. This was due to the limited amount of time the counsellors each spent within the practices. Time was used solely for seeing the client before moving on to the next session at another practice. It was felt that if the counsellors were allocated to particular practices this would allow a relationship with practice staff to develop:

Recently I've been going to one particular surgery every week and they've become more helpful. So when you get the chance to keep going to the same surgery people really do start to be more helpful. So that would be more helpful – if we got to go to the same surgeries again and again. But the lack of education about counselling [directed at GPs] is because there is no relationship to build up any education – no relationship to build up reception and referral procedures – if you keep going in you build up that relationship.

There was some concern about the appropriateness of referrals. It was felt that some patients were being referred by their GP without proper

discussion with the patient about their willingness to enter into counselling. This was felt to be one reason for the large number of patients either not turning up at all or dropping out of counselling:

The high number of DNAs is reflective of people referring inappropriately or GPs telling clients to come without having a discussion. Now that's something we could have tackled if we'd been able to be around [the surgery] more ... If GPs are telling their patients to come for counselling most will say 'yes' because they do as they're told by their doctor because there's this power thing. And they think it's being prescribed like medicine therefore they should do it. But they won't do it because they actually don't want to and they're too scared [to say to the doctor]. But they're not going to tell the doctor that – so it's a complete and utter waste of our time. So if we could have educated the GPs more – we did try – we gave them things they could read – guidelines. But if we could have got through to the GPs on a personal one-to-one level we may have been actually able to sell that idea to them – and actually convince them that they need to approach their referrals slightly differently to the way they're doing – which would have cut down on the number of DNAs.

These issues may reflect a more general concern in practice-based counselling. Hence, Jenkins (1999) reported that 40% of practice-based counsellors rarely, if ever, meet with GPs to discuss prognosis for shared patients.

A further problem was the absence of administrative support at a central base which meant that all communication between counsellors and patients had to be conducted indirectly through the practice staff:

[Often] patients do not have [direct] access to us – they can't ring us – and that causes another problem because we've got to constantly ring up the practice staff and they get annoyed – and patients can only contact them as well ... And they don't necessarily take the messages.

For practice staff there were three major concerns. First, concern about the length of waiting times,

which gradually increased as the service became established and referrals increased. This may also have contributed to the problem of DNAs. Secondly, the flip side to the counsellors' problem with rooms, was the pressure put on them to find an appropriate room for counselling; the counsellors had pointed out that some rooms were inappropriate for counselling because they were, for example, too noisy, too small, too clinical. Thirdly, there was a desire for more feedback about the service, e.g., number of patients seen, sessions attended and where possible some indication of outcomes – though it was appreciated that full feedback would not be possible due to the confidentiality of the service.

Discussion

Given the enthusiasm within which many primary care organizations have developed counselling services and the recognition that the evidence base for their value is contested, the issues encountered in setting up this counselling service, and in seeking to evaluate it, may be instructive to others. The overwhelming problem for our evaluation was the level of attrition, primarily due to DNAs, from those referred to the service to those who actually took up counselling: less than half of those invited for assessment (47%) actually commenced counselling. This had serious consequences for the projected sample size. Various reasons for this have been discussed: 1) inappropriate referrals due to lack of discussion with clients about counselling; 2) lack of anonymity at the general practice; 3) lack of efficient communication channels between the client, practice and counsellor. Increasing waiting times, as the service became more established, may also have contributed to DNAs.

We should point out that whilst these levels of attrition were relatively higher than those of some services (Gordon and Graham, 1995; Speirs and Jewell, 1995; Brown and Lloyd, 2000; Nettleton *et al.*, 2000), they are in fact comparable to levels reported in two large scale evaluations (Barkham *et al.*, 2001; Baker *et al.*, 2002). For example, in the Barkham *et al.* (2001) study details are provided for one particular service in which there was roughly a 50% rate of attrition from referral (1422) to assessment (649), pretherapy (337), discharge (196) and six month follow-up (100). Managers of

such services, and evaluators should be aware of this information. In our own project these unexpected levels of attrition had caused a significant amount of anxiety amongst management of the service which was reflected onto the counsellors. Armed with comparable data listed above, these levels of attrition may be seen as more acceptable factors in the development and establishment of similar services.

In the latter stages of the project the counsellors attempted to address the issue of 'inappropriate referrals' by initiating an opt-in letter to clients: after receiving the referral form from the GP, clients were sent a letter about the counselling service which required confirmation of their attendance. However, this strategy has since been discontinued because it raised an additional barrier to accessing the service for some clients, particularly those from minority ethnic origins who have difficulties in accessing English-language-centred services. At the time of writing the high ratio of DNAs has not subsided and continued efforts are being made to address this problem.

The differential rates of referral from practices were also an issue of concern for the service and the evaluation. We have noted that practice list size, difficulties arranging rooms and the attitude of GPs towards counselling were all factors. Other studies have noted wide variations in rates of referral across and within practices (Hemmings, 1997; Brown and Lloyd, 2000; Nettleton *et al.*, 2000). For example, Brown and Lloyd (2000) in a study examining referrals for counselling across 12 practices (47 GPs) found that referrals were significantly more likely to be from five GPs. Nettleton *et al.* (2000) reported a disproportionate rate of referrals to a counsellor servicing three practices (14 GPs) with 65% coming from three (21%) GPs (two of whom were female and part-time). They report that GPs who attended an information meeting at the start of project had lower rates of inappropriate referral and non-attendance of patients for counselling.

This paper identifies the difficulties in undertaking robust quantitative studies in general practice. The pressures generated by the demographics of one's population and the wish in primary care organizations to respond to need with services even if the evidence base for those services is not yet in place, has to be accommodated. Researchers timeframes to generate meaningful results before

further service development, and primary care organization timeframes to respond to identified need with service provisions are often not in harmony. For example, a recent initiative has seen the four counsellors involved in this project merged with a larger City Therapeutic Resource Team providing an extended service throughout the inner city.

Conclusion

The introduction of a counselling service into general practices is a desirable resource to many GPs, though the wide disparity in the number of referrals across practices illustrated a range of influences on take-up of the service. This included the availability of appropriate premises for conducting counselling, the attitude of GPs towards the value of counselling for their patients, and in our context, cultural values which may deter patients from entering into counselling.

This study has highlighted the potential wastage of resources through clients referred to the service who do not actually attend for counselling (i.e., DNAs and cancellations). Health service managers and counsellors may need to proactively develop strategies to address this issue when implementing such services. Evaluators should also be aware that attrition rates might create problems in achieving statistical reliability in contexts where overall population numbers are relatively small and/or the time for data collection is relatively short. Despite the problems encountered in this evaluation we have found some evidence of positive change relating to severity of problems and ability to engage in social activities.

Primary care organizations and researchers should also be aware that implementing a formal evaluation of such services can exact a considerable burden on the time and resources of counsellors. Barkham *et al.* (2001) found that services identified lack of time and lack of secretarial or administrative staff as key factors hindering routine outcome evaluation of counselling. Where possible these should be factored into the workload of counsellors, and may include time to contact DNAs, additional follow-up contacts, or contributing to qualitative evaluation of patients' experience and outcomes of counselling.

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