CHANGING LIVES FOR THE BETTER:

A National Evaluation of the Counselling in Primary Care (CIPC) Service

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National Counselling Service
CIPC Research Group
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The Counselling in Primary Care (CIPC) National Evaluation Study has been an ambitious and wide-ranging project which relied on the participation and collaboration of many individuals. The integrated and comprehensive nature of this final report is testament to the contribution, commitment and goodwill of all involved and the CIPC National Research Group would like to thank all those who contributed to this research.

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List of abbreviations

APA	American Psychological Association
BZRA	benzodiazepine/Z-drug use
CHO	community healthcare organisation
CIPC	Counselling in Primary Care
CMHDs	common mental health disorders
CORE	Clinical Outcomes in Routine Evaluation - Outcome Measure (CORE OM)
DALYs	disability-adjusted life years
DOH	Department of Health
EOT	End of Therapy
ES	Effect Size
GDPR	General Data Protection Regulations
GMS	General Medical Services
GP	General practitioner
HRQOL	Health-Related Quality of Life
HSE	Health Service Executive
IAPT	Improving Access to Psychological Therapies
JCFHC	Joint Committee on the Future of Mental Health Care
MHC	Mental Health Commission
MHR	Mental Health Reform
MI	multiple imputation
NCS	National Counselling Service
NICE	National Institute for Health and Care Excellence
OCFH	Oireachtas Committee on the Future of Healthcare
OECD	Organisation for Economic Co-operation and Development
RCSC	reliable and clinically significant change
TAF	Therapy Assessment Form
VfC	Vision for Change
WHO	World Health Organization
WMA	World Medical Association
WSAS	Work and Social Adjustment Scale

Note: The terms counsellor, counsellor/therapist and therapist are used interchangeably throughout this report.

Foreword

Talking therapies are an essential element in the effective treatment of mental health difficulties and should be considered a first-line treatment option for most people who experience mental health difficulties. The HSE Counselling in Primary Care (CIPC) service, established in 2013 as a Mental Health in Primary Care initiative, delivered one of the key aims of the Vision for Change report (Department of Health, 2006) to develop "a comprehensive range of psychological therapies to be provided at primary, secondary and tertiary levels" (Department of Health, 2006, p. 60). Sharing the Vision (2020), its successor policy, further endorses the importance of mental health provision to the overall health and well-being of Irish citizens, emphasising that "a range of counselling supports and talk therapies in community/primary care should be available on the basis of identified need so that all individuals… can receive prompt access to accessible care". CIPC is key to the implementation of this objective and has played a crucial role in improving access to counselling in Ireland, evidenced by the fact that almost 150,000 clients have been referred to the service since 2013.

This national evaluation was initiated to examine the overall effectiveness of the CIPC service. It includes the first practice-based research of its kind to evaluate service provision and clinical outcomes for clients on a national scale by a counselling service in Ireland. In addition to examining the clinical effectiveness of counselling in the short and long term, the study examines GP and client experiences of the service and includes an exploratory investigation of the patterns of psychotropic medication prescription associated with counselling.

This much-anticipated CIPC National Evaluation Report adds to the existing international evidence base which shows that counselling and psychotherapy are clinically effective, cost effective and the preferred treatment choice for common mental health issues such as anxiety and depression. Of the clients who participated in this large-scale national study, 72% improved or recovered, demonstrating that counselling with CIPC was effective in reducing their psychological distress. These improvements continued to be reported a year after counselling ended for most participants. Client feedback highlighted the positive, trusting therapeutic relationship they had with their counsellor as integral to the effectiveness of their counselling experience. The findings of this report have significant implications when considering the future direction and development of mental health services as outlined in Sláintecare and Sharing the Vision. The resounding message from clients and GPs alike is that CIPC is a much-valued service, which positively impacts the mental health and well-being of those who attend.

Never has access to mental health support been so important, especially considering the impact of the COVID-19 pandemic. CIPC's contribution in offering psychological help to the adult population in the Republic of Ireland must be acknowledged. Telehealth developments meant that throughout the pandemic CIPC continued to work with clients, maintaining consistent access to counselling.

This National Evaluation Report sets out recommendations for future planning and development of CIPC based on collective findings about clinical effectiveness and stakeholder analysis. CIPC is uniquely positioned to provide an expanded primary care counselling service beyond its current remit with General Medical Services (GMS) scheme card holders to include any adult living in Ireland who is experiencing mild to moderate psychological difficulties. CIPC in providing increased access to talk therapies has the potential to positively impact on the public's overall health through reduced dependence on psychotropic medication and improved quality of life. In addition, the expansion of CIPC has the potential to reduce demands on GP time and secondary mental health services. The development of CIPC will require appropriate investment to meet the demands and ensure equitable access, a key requirement for positive psychological outcomes.

I would like to express my appreciation of GPs and Primary Care Teams as supporters and advocates for their patients in accessing psychological support. I would like to thank the Directors of Counselling for their leadership, the CIPC counselling co-ordinators for their commitment and energy in facilitating the roll-out of the CIPC service and for their key role in this important study. In addition, CIPC counsellors/therapists must be acknowledged for the integral role they play in providing a such a high-quality, accessible counselling service and for their role in ensuring this research could take place. I would also like to extend my thanks to the research group for their significant contribution to the CIPC National Evaluation Study. Finally on behalf of the HSE, I would like to thank every client who agreed to take part in this study; such evaluations are of critical importance in ensuring quality improvement on a national scale in Ireland's Health Service.

Yvonne O'Neill
National Director, Community Operations

A message from the Minister for Mental Health and Older People

Sláintecare recognises the importance of mental health to overall health and well-being. The importance of timely access to health care, in particular the "*right intervention at the right time*" is emphasised. The HSE Counselling in Primary Care service helps to achieve this objective by addressing mental health needs at a lower level of complexity, often preventing the onset of more acute illness.

The vision of our mental health system as set out in Sharing the Vision is one which spans promotion of positive mental health in the community, early intervention at primary care level, through to supporting recovery from complex mental health difficulties. Sharing the Vision recognises that a significant proportion of mental health needs can be met in primary care with the provision of a comprehensive range of interventions within a 'stepped-care' approach.

The Counselling in Primary Care Service demonstrates how a mental health service can be professionally and efficiently delivered in an accessible manner at primary care level. It is a service designed to be accessed at an early stage when individuals are struggling with emotional and psychological issues, in so doing it helps to prevent problems developing and reduces unnecessary use of secondary mental health services. I am very pleased to welcome this report, which demonstrates CIPC's commitment to accountability and continuous improvement. This National Evaluation, the first of its kind in Ireland, provides clear evidence of the effectiveness of counselling. It highlights the views key stakeholders, GPs who refer, and most importantly the individuals who avail of counselling. The experience reported by service users has indeed been positively 'life-changing'.

The last two years have presented many challenges, the impact on mental health of the COVID-19 pandemic is only beginning to be seen. CIPC continued to provide care to individuals throughout, adapting to the challenges of telehealth to ensure that vital psychological support was available to service users during at time characterised by anxiety and isolation.

As minister with responsibility for mental health, I am impressed by how this research has been integrated as part of the service provided. It provides a roadmap for maintaining and building on the quality service being delivered. I am heartened to see the fruits of collaboration and integration between GPs and mental health services. I look forward to seeing how this collaboration will help to yield further efficiencies in service delivery, and improve how we support individuals to address their mental health needs.

I would like to sincerely thank all those involved in conducting this study. I would particularly like to thank the GPs and clients who shared their insights and feedback. It is only by listening to the voice of our service users that we can discover if the vision we share for mental healthcare is becoming a reality.

Mary Butler, TD

Minister for Mental Health and Older People

Chapter summary

Chapter 1. Origins: The development of CIPC

This chapter describes the policy context which led to the establishment of the CIPC service and outlines the model of service. The aims and main research questions of the CIPC National Evaluation Study are described. How the study addressed confidentiality, ethics and client consent are outlined followed by a description of the methodological framework used - a combination of practice-based evidence gathering and evaluative enquiry.

Chapter 2. CIPC counselling: Is it effective? Clinical outcomes post counselling

Chapter 2 gives a brief description of recent psychotherapy effectiveness literature focusing mainly on practice-based research and outcomes from real world studies conducted in a primary care context. The method used to measure effectiveness of the CIPC service in this study is described, followed by the reporting of results.

Chapter 3. How effective is CIPC? Do the effects of counselling last?

This chapter outlines an overview of the literature related to outcomes for periods of 6 to 12 months after counselling ends. The method used to gather the data for this phase of the study is described. Results for 6 and 12-month outcomes were reported for the CORE OM 34, HRQOL-4 and WSAS measures.

Chapter 4. Counselling and medication prescription: What the scripts tell us

Chapter 4 outlines Phase 4 of the National Evaluation Study which examined psychotropic medication prescription patterns for clients attending counselling including details of the methodology and results.

Chapter 5. Counselling and GP satisfaction: What GPs say about CIPC

The results of a national survey of GP satisfaction with CIPC is detailed along with discussion of quantitative results and key issues identified by GPs regarding their experience of the CIPC service.

Chapter 6. The voice that matters most: What do clients say about CIPC?

Chapter 6 reports on an evaluation of client satisfaction with the CIPC service. The main themes which emerged from a thematic analysis of qualitative data are outlined. The relationship between a subsample of client satisfaction data and their clinical outcomes as measured on the CORE OM 34 are also explored.

Chapter 7. Evidence of CIPC from the real world: What have we learned? Conclusions and recommendations

The final chapter considers the results of this National Evaluation study and outlines the main conclusions and recommendations arising from the key findings. Implications for the CIPC service, clinical practice, service policy and CIPC service development are highlighted.

1 Origins: The Counselling in Primary Care (CIPC) service

1.1 Origins of Counselling in Primary Care (CIPC)

Increasing access to counselling in primary care was set out as an objective in the 2011 Programme for Government (Department of the Taoiseach, 2011). Funding of €5 million was allocated in the 2012 budget with an additional €2.5 million in 2013 to develop the service nationally for medical card holders. Having acknowledged "significant gaps in provision and access to psychological therapies in Ireland with an over reliance on medication", (Health Service Executive [HSE], 2012, p. 11), the HSE provided for the development of a national Counselling in Primary Care (CIPC) service as one of its mental health initiatives in the 2012 service plan. The HSE National Counselling Service (NCS), which was established in 2000 for adults who experienced childhood abuse, extended its remit when it was tasked with implementing this development. The CIPC service was subsequently launched in July 2013. The development of CIPC had its origins in a local NCS primary care counselling initiative in the HSE North East region (Ward, 2007) which began offering counselling to patients of 20 GPs in 2006. By 2010 it had offered counselling to almost 3,000 individuals (McDaid, 2013).

CIPC is now available in each HSE Community Health Area. It provides time-limited counselling of up to 8 sessions to adults who experience mild to moderate psychological difficulties. Eligibility criteria currently limit referrals to patients holding a valid General Medical Services (GMS) card on referral from their GP or Primary Care Practitioner. CIPC has been described as a 'welcome development' by GPs and other mental health stakeholders (Houghton, 2014, p. 69; MHR, 2017) however it has been criticised as inequitable given that access remains limited to GMS card holders (Cullinan et al., 2016; Houghton, 2014).

The critical role of CIPC in providing access to counselling for common mental health disorders is highlighted by the rapid growth in referrals since its launch in 2013 when 5,153 clients were referred. Just 7 years later in 2019, the service received 20,192 referrals. By the end of 2021 almost 150,000 people were referred to CIPC.

1.2 CIPC model of service

The CIPC model of service is anchored in a client centred therapeutic approach with a counsellor/therapist employing a range of psychological therapies depending on the presenting issues and assessed needs of clients. These include person-centred, cognitive behavioural, psychodynamic, integrative and supportive therapeutic approaches. Depression and anxiety were the main reasons for referral (CIPC National Research Group, 2018).

The CIPC model of service encompasses:

- On-site provision of counselling in primary care settings
- Counselling information to GPs and patients with agreed referral criteria and standardised referral protocols
- Client opt-in system
- Standardised assessment process
- Time-limited therapeutic approach
- Formal and informal feedback to GPs
- Evaluation of clinical outcomes.

The national CIPC service operates from over 240 locations situated throughout Ireland. Counselling is delivered from a variety of different sites including Primary Care Centres, dedicated NCS counselling locations as well as local community/voluntary sector centres. NCS Directors of Counselling hold clinical and operational responsibility for the service, which is coordinated by local CIPC Clinical Coordinators.

Counselling is delivered by a mix of employed counsellors/therapists and counsellors/therapists contracted through an agency (CIPC National Research Group, 2018). All counsellors/therapists meet minimum qualification criteria including a recognised qualification at Level 7 or higher in a relevant human science as well as an accredited qualification in counselling or psychotherapy. This qualification must be recognised by the Irish Association for Counselling and Psychotherapy or the Irish Council for Psychotherapy together with a minimum of 2 years' clinical experience. A postgraduate qualification in counselling or clinical psychology recognised by the Psychological Society of Ireland is also recognised.

1.3 From Sláintecare to 'Sharing the Vision': How CIPC meets core health policy objectives

Sláintecare highlighted an overdependence on medication and acute services for addressing mental health issues. As a mental health service delivered in primary care CIPC delivers a key objective of Sláintecare - the re-orientation of provision away from acute services towards a preventative approach with more integrated delivery through primary care as noted by the Oireachtas Committee on the Future of Healthcare (OCFH, 2017, p. 51). Sláintecare recommended that CIPC be extended to the whole population (OCFH, 2017) as a way of "addressing mental health needs at a lower level of complexity", the rationale being that if people get "the right intervention at the right time" they may not require more acute mental health services (OCFH, 2017, p. 65).

Sláintecare's recommendation to expand CIPC highlights key elements of the health strategy: the need for greater integration between acute and community services; earlier intervention through primary care to ensure a preventative approach to health and recognition of the importance of mental health to overall health and well-being:

> *"Currently, GPs can refer medical card holders to counselling without charge but this service is not available to non-medical card holders. The Committee considers that greater integration is needed between primary and acute care for people with acute mental health needs and publicly provided counselling services as part of primary care." (OCFH, 2017, p. 51)*

Sláintecare's recommendation was re-emphasised by the Joint Committee on the Future of Mental Health Care which highlighted the extent of health service spend on antidepressants (€44.36 million) compared with that on Counselling in Primary Care (€10 million) reflecting a lack of psychological therapies provision in Ireland (O'Regan, 2018). The Committee recommended that to "reduce the over-reliance on the prescribing of medication" (Joint Committee on the Future of Mental Health Care: JCFHC, 2018, p. 17) there should be increased investment in talking therapies and an extension of counselling in primary care to non-medical card holders (JCFHC, 2018).

The over-reliance on psychotropic medication in the absence of access to psychological therapies has been highlighted in several studies, most recently in a review of benzodiazepine prescription practices (Cadogan et al., 2018). The authors conclude that one of the consequences of under resourcing of mental health services, with specific reference to CIPC, is an over-reliance on benzodiazepine medications. CIPC is considered as central to addressing this over-reliance: "If adequately resourced, the [CIPC] programme has the potential to reduce expenditure on psychotropic medication (which is currently 10% of the Primary Care Reimbursement Services budget)" (MHR, 2021, p. 12).

The national mental health policy framework, 'Sharing the Vision' (2020), recommends that "all service elements [...] should include access to talk therapies as a first-line treatment option for most people who experience mental health difficulties" (Department of Health: DOH, 2020). Specifically, *Sharing the Vision* recommends that "access to a range of counselling supports and talk therapies in community/primary care should be available on the basis of identified need so that all individuals, across the lifespan, with a mild to-moderate mental health difficulty can receive prompt access to accessible care" (DOH, 2020, p. 98).

1.4 Impact of COVID-19 on mental health in Ireland

COVID-19 has had a major impact on the mental health of the Irish population with 27% of people experiencing anxiety and depression during the initial phase of the pandemic (Hyland et al., 2020). The full legacy of the pandemic is not yet clear but there is growing evidence of the mental health impact with one in five people reported as having significant increased psychological distress (Crowley & Hughes, 2021). There is a recognition of the need for enhanced mental health services and in particular access to psychological therapies, to address the effects of COVID-19 evidenced for example by the 30% increase in the prescription of antidepressants in December 2020 compared to the previous year as reported by the Primary Care Reimbursement Service (Crowley & Hughes, 2021, p. 19).

Sláintecare, the Committee on the Future of Mental Health and Sharing the Vision all recognise the importance of ensuring access to psychological therapies for mild to moderate psychological difficulties at primary care level. CIPC is central to this provision and is viewed “as an efficient and good value programme which can deliver positive outcomes for service users.” (MHR, 2021, p. 12).

The impact of COVID-19 on the mental health of the population and increasing demand for talk therapies to address these effects further highlights the need for accessible talk therapy services. As outlined above, expansion of CIPC is considered by policymakers as essential to delivering accessible psychological therapy and ensuring early intervention for mental health difficulties: “Expanding this model of care is also an effective way to screen for more complex needs while shielding secondary care from overuse.” (MHR, 2021, p. 12).

1.5 Service evaluation and practice-based evidence gathering

Studies such as this CIPC national evaluation are required to inform the literature and clinical practice about the impact and effectiveness of counselling in public health service provision. Conducting a practice based study allows for the possibility of a large sample of participants which are not constrained by exclusion criteria such as types of presenting problem, age range, co-morbidity status or previous diagnoses etc.

Effectiveness research is a form of outcome research differentiated from efficacy or experimental outcome research by its being conducted in naturalistic settings (Hatfield & Ogles, 2004; Nathan et al., 2000; Seligman, 1995). There is a growing consensus that results from Randomised Control Trials (RCTs) and pragmatic style RCTs should be appraised alongside studies that focus on evaluating psychotherapy effectiveness from real world clinical research to enhance the psychotherapy outcome evidence base (Ammerman et al., 2014; Barkham et al., 2010; Castonguay et al., 2013; Leichsenring, 2004; Mellor-Clark, 2000). Data from practice-based studies can be used to inform clinicians, services and stakeholders such as policymakers (Henton, 2012).

The CIPC National Evaluation study is a combination of evaluative enquiry and practice-based evidence gathering. Practice-based studies focus on routine data collection from clients attending real services. They include all data collected from a large and heterogeneous sample of clients presenting to that service (in both personal characteristics and range of presenting problems). The study designs incorporate routinely collected data but do not rely on the inclusion of control groups or deem necessary a comparative approach during the design or analyses (Castonguay et al., 2013). Importantly, the utilisation of large data sets for the selection of subgroups for the purposes of analyses can also be a feature. This allows for a more flexible approach to the construction of samples either not readily accessible by researchers of RCT studies in adequate numbers (i.e., under-represented groups in the population), or to the testing of study conditions when randomisation is not possible (Barkham et al., 2010). Additionally, psychological treatments are delivered in usual service locations by real practitioners and are not manualised for the purposes of a study which is more reflective of real world clinical settings.

Barkham et al. (2010) devised a five-stage methodological framework to illustrate the processes necessary in practice based research (Figure 1).

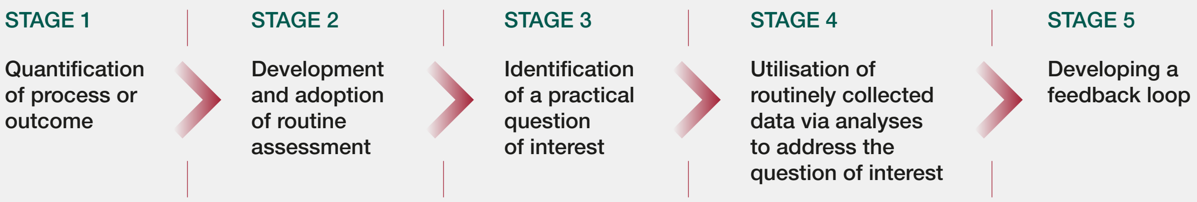

Figure 1. Five-stage methodological framework necessary in practice-based research.
Source: Barkham et al. (2010, p. 44)

The CIPC National Evaluation Study addresses each of these stages in the following ways:

Stage 1 **Quantification of process or outcome:** CIPC service adopted the CORE OM 34 as its main outcome measure and employed two further measures to broaden the scope and generalisability of the findings.

Stage 2 **Development and adoption of routine assessment:** Routine assessment is built into the CIPC model of service. The national implementation of an electronic centralised recording system for all client data including clinical outcomes - CORENET© - has enabled this to be implemented consistently in practice on a national level.

Stage 3 **Identification of a practical question of interest:** The overriding concern for funders, policymakers, health service management, staff and users of the CIPC service is the question of the overall performance and effectiveness of the CIPC service.

Stage 4 **Utilisation of routinely collected data via analyses to address the question of interest:** This study employs methodological procedures such as all-inclusive participant criteria and the use of statistical models that vary at more than one level to capture and examine data in a manner suitable to meet the needs of the research questions.

Stage 5 **Developing a feedback loop:** This study is the first national study of its kind by a counselling service in Ireland to evaluate service provision and clinical outcomes for clients. It will provide a baseline for benchmarking service performance with future data collection providing a feedback loop for the benefit of service policy and development.

In addition to the stage-based framework which contextualises each distinct methodological phase of this study, a major research paradigm relevant to practice based studies is evaluative research. Evaluative enquiry seeks to measure the worth of a program or service (Glass, 1972; Haig, 2018). Potter et al. (2006) describe evaluation research as that which "…seeks to assess processes and outcomes of the treatment applied to a problem or the outcome of prevailing practices." (Potter et al., 2006, p. 6).

1.6 The CIPC National Evaluation Study

Purpose

Data for the CIPC National Evaluation Study was collected by the HSE National Counselling Service between 2015 and 2020. The purpose of this national evaluation was to examine the impact and outcomes of the HSE NCS Counselling in Primary Care Service (CIPC) across Ireland. Evaluations of this type are essential to help ensure service-wide quality improvement. This report details the research approach, methodology, data collection methods, clinical outcomes and other relevant research findings pertaining to this significant national research. Key learning outcomes and recommendations for the further development of the service are identified.

National Evaluation - Phase 1

The CIPC National Evaluation study examines the impact and outcomes of CIPC across Ireland.

Phase 1 of the evaluation was conducted in the HSE South East region in 2015. The initial phase of study assessed the research approach, methodology, data collection methods and reported clinical outcomes for this area. Counselling was found to be effective for the majority of those who participated in Phase 1 of this study. Key learning outcomes and recommendations were identified from this phase of the evaluation which informed procedures for the rest of the national evaluation (CIPC National Research Group, 2018).

To provide a full and complete picture of the effectiveness of counselling across the Republic of Ireland, the data gathered from Phase 1 are included in the following report.

CIPC national evaluation aims and objectives

This national study aims to provide a comprehensive description of CIPC in terms of client outcomes (both short and longer term), to examine psychotropic medication prescription patterns as well as to provide feedback from key stakeholders regarding their experiences of the service (i.e., clients and GPs).

Encompassing all HSE areas, this study provides a comprehensive account of the first national evaluation of a primary care counselling service and addresses the following areas:

- Effectiveness of counselling;
- Effectiveness of counselling at 6- and 12-month follow-up;
- An evaluation of psychotropic medication prescription patterns for clients attending counselling;
- Evaluation of GP satisfaction with the CIPC service;
- Evaluation of client satisfaction with the CIPC service.

Research questions addressed by this study:

1. Is CIPC effective?

a. What is the impact of counselling on client symptoms of psychological distress?
b. What factors predict recovery and improvement?
c. How does counselling impact client risk?
d. What is the impact of counselling on client quality of life, work, and social functioning?
e. What factors influence change in counselling?
f. Does age impact clinical outcomes in counselling?

2. How effective is CIPC: Do the effects of counselling last?

a. What is the effect of counselling on clinical outcomes 6 and 12 months later?
b. What is the effect on client quality of life 6 and 12 months after counselling?

3. Are medication prescription patterns impacted by CIPC counselling?

a. Are there changes to the rates of psychotropic medication as prescribed by clients' GP after counselling has ended?
b. What do changes in prescription patterns tell us about clinical outcomes from counselling?

4. What do GPs say about CIPC?

a. What are GP views of the CIPC model of service?
b. How do GPs view the impact of CIPC on GP practice?
c. What are GP views about the impact of counselling on patients?

5. What is the experience of clients who attend CIPC?

a. How satisfied are clients with the accessibility of the CIPC service?
b. What are client perceptions of counselling effectiveness?
c. How do clients view the benefits of counselling?
d. How satisfied are clients with their counsellor?
e. What is the relationship between client satisfaction with counselling and clinical outcomes?

1.7 Ethics, confidentiality and consent

1.7.1 Ethical approval process

This study is the first national evaluation of CIPC. In the absence of a single national HSE ethics body ethical approval was required from each HSE area before data collection commenced. For two HSE areas where ethical approval was not available due to the absence of a Regional Ethics Committee, concomitant approval was granted by the HSE National Director of Mental Health (Appendix 1).

As this project was conducted in collaboration with the School of Psychology, Trinity College Dublin (TCD) following a grant received from the Irish Health Research Council, ethical approval was also sought and received from TCD School of Psychology Ethics Committee in March 2016 (Appendix 1).

1.7.2 Participant consent

Full and informed consent was provided by all participants in the study. All clients who presented to CIPC for initial assessment during the data collection period were provided with information about the evaluation, data collection and consent processes before being invited to take part in the research.

During the initial assessment session counsellors/therapists discussed the evaluation project with all potential participants and outlined:

- The purpose of the research;
- The consent process including a client's right to refuse participation;
- The implications of their participation;
- The voluntary nature of participation and their right to withdraw at any point;
- The confidentiality of the data provided;
- Reassurance on the implications of non-participation i.e., that their attendance at CIPC and psychological treatment would not be affected by their decision to participate in the study or not.

1.7.3 Evaluation of psychotropic medication prescriptions

In accordance with the WMA Declaration of Helsinki - Ethical Principles for Medical Research 2008 protocols, separate and explicit consent for the examination of participants' psychotropic medication prescription data was also sought from study participants.

1.7.4 Confidentiality and data protection

All data collection processes, data storage, transfer and usage methods were conducted in accordance with the WMA Declaration of Helsinki - Ethical Principles for Medical Research 2008 and were submitted for review by the Office of the Data Protection Commissioner who reviewed and approved the processes as outlined. As the General Data Protection Regulations (EU GDPR) was introduced during the study, all research processes were reviewed to ensure compliance with the General Data Protection Regulations.

2 CIPC counselling: Is it effective? Clinical outcomes post counselling

2.1 Literature review

2.1.1 The prevalence of common mental health disorders

Common mental health disorders (CMHDs) such as anxiety and depression are recognised as a leading cause of disability worldwide and a major contributor to the overall global burden of disease (Global Burden of Diseases, Injuries, and Risk Factors Study, 2019; Disease and Injuries Collaborators, 2020; WHO, 2021), impacting physical health, social relationships and general functioning (Chisholm et al., 2016; Furber et al., 2015; Singla et al., 2017). In 2019, depression was the second-leading cause of disability globally, and anxiety ranked eighth, both being the most common types of mental health disorders (Santamauro et al., 2021) The global prevalence of depressive and anxiety disorders further increased during 2020. The COVID-19 pandemic led to a stark rise in depressive and anxiety disorders globally in 2020, with an additional 53.2 million and 76.2 million cases of anxiety and major depressive disorders worldwide (Santamauro et al., 2021).

CMHDs account for 25% of all health related disability (Vos et al., 2017), higher than cancer or coronary heart disease (Hewlett, 2015). Within the EU it is estimated that 38% (164.8 million) of the population experience mental health difficulties each year with depression affecting 30 million people (Wittchen et al., 2011). Anxiety and depression combined cost the global economy more than €823 billion every year in lost productivity (The Lancet Global Health, 2020). Irish studies indicate prevalence rates of 10–12% for psychological distress including depression and anxiety (Doherty et al., 2008; Walsh & Duffy, 2018).

Most mental health difficulties can be dealt with in primary care without referral to specialist mental health services (Department of Health [DOH], 2006). Vision for Change (VFC) recommended “all individuals should have access to a comprehensive range of interventions in primary care for disorders that do not require specialist mental health services” (DOH, 2006, p. 61) including increased access to psychological therapies and availability of mental health professionals in primary care. “Advancing the Shared Care Approach between Primary Care & Specialist Mental Health Services” (HSE, 2012), a guidance document which followed VFC emphasised timely access to psychological therapies and recommended a stepped care approach to be developed to effectively address MHD prevalence. Despite service developments, evidence of their effectiveness and demand from service users (HSE, 2021), access to psychological therapies remains inequitable (Mental Health Reform, 2021).

2.1.2 The evidence for counselling and psychotherapy

The effectiveness of counselling and psychotherapy for addressing a wide range of psychological difficulties is now widely accepted (APA, 2012; Carr 2007; Norcross & Wampold 2011). A clear evidence base exists that psychological therapies are effective for common mental health disorders such as anxiety and depression (APA, 2012; Emmelkamp et al., 2014; Wampold & Imel, 2015) and are, as, or more, effective than medication (Campbell et al., 2013; Cuijpers et al., 2013; Norcross & Wampold, 2011; Roth & Fonagy, 2005; Zarbo et al., 2017) with higher rates of treatment retention and more enduring effects (Cuijpers et al., 2013).

In 2012 the American Psychological Association adopted as policy the resolution of ‘Recognition of Psychotherapy Effectiveness’ which demonstrated not only the significant effect of psychotherapy across different diagnoses (including depression and anxiety), but also that psychotherapy outcomes tend to last longer than psychopharmacological treatments and require less additional treatments. The APA resolution concluded that psychotherapy should be included in health care provision as ‘an established evidence-based practice’ (American Psychological Association, 2012). Similarly in the UK, psychological therapies are recommended as the first line treatment for common mental health disorders

(National Institute for Health & Clinical Excellence, 2011; WHO, 2015) and are recognised as one of the most important interventions contributing to a reduction in the global burden of these disorders (Emmelkamp et al., 2014). This position is reflected in Ireland's national Mental Health Policy, Sharing the Vision (2020). This policy proposes a continuum of mental health service provision where "…all service elements… should include access to talk therapies as a first-line treatment option for most people who experience mental health difficulties" (DOH, 2020, p. 47).

The effectiveness of counselling and psychotherapy is long established following research conducted over many decades in randomised control trials (e.g., Corney & Simpson, 2005; Elkin et al., 1989; Hemmings, 1997; Van der Lem et al., 2012). Meta-analysis, which allows the amalgamation and summarizing of results of various studies leant further support to the effectiveness of psychotherapy (Melchert, 2016; Munder et al., 2019). Such meta-analytic reviews have included studies demonstrating that counselling compared with usual GP care was effective in the short term (Bower & Rowland, 2006) and that brief counselling was effective for mixed anxiety and depression (Cape et al., 2010).

Studies in primary care settings using practice-based research approaches have also demonstrated the effectiveness of counselling and psychotherapy. Sawchuk et al. (2018) reported outcomes of a five-site, primary care psychotherapy programme ($n = 2{,}772$) and found post therapy scores were significantly better than at assessment. Practice-based meta-analytic studies have also supported the assertion that short-term therapy is effective in reducing the symptoms associated with depression and anxiety related problems (Cahill et al., 2010).

The effectiveness of counselling is often statistically described using an 'Effect size' calculation.[1] Recent studies have reported medium to large post-therapy effect sizes for psychological therapies. For example, a U.S. based primary care counselling service study found effects of $d = 0.50$-0.68 (Sawchuk et al., 2018), a meta-analysis of 10 primary care studies in the UK indicated an average effect size of $d = 1.3$ (Cahill et al., 2010), and a Norwegian study reported an effect size of $d = 1.1$ (Knapstad et al., 2018). Norcross and Wampold (2011) found that patients receiving psychological therapy were 79% better off than those without treatment. An Irish review of evidence found psychotherapy alone/in combination with other treatments is effective for mental health disorders in adults and children (Carr, 2007).

The improving access to psychological therapies programme (IAPT) provides psychological therapies across England and has been positively evaluated (Clark et al., 2009). Initially focussed on provision of psychological therapy for anxiety and depression, IAPT has expanded to include a wider range of therapies with greater focus on specific client groups (ethnic minorities, older adults, adults with physical health conditions and children) (Bradley & Drapeau, 2014; Clark, 2018; Clark et al., 2009). Richards and Borglin (2011) assessed the impact of the IAPT stepped care programme over a two-year period. Of the 5,717 patients assessed during the study period the largest effect sizes were observed for those completing treatment for depression (Cohen's $d = 1.24$) and anxiety ($d = 1.21$). Recovery rates were also substantial with 47% of clients showing reliable and clinically significant improvement.

2.1.3 Service-user preference for counselling and psychotherapy

Service user preference for psychological therapies is well established with a clear preference for psychological therapies over medication for treatment of common mental health difficulties (APA, 2012; Holmes et al., 2018; McHugh et al., 2013; Swift et al., 2011). Swift et al. (2013) found that 75% of patients preferred psychotherapy to address depression rather than medication.

Irish services users have also consistently demanded access to psychological therapies (Department of Health, 2006; Mental Health Reform, 2017) yet often have difficulty accessing treatment. Consultations conducted as part of the development of *A Vision for Change* (2006) highlighted the need for greater access to psychological or 'talk' therapies. Listening exercises, surveys and face-to-face consultations with service users, family members and carers undertaken by HSE mental health services (Mac Gabhann et al., 2010; Mental Health Commission, 2011; Mental Health Reform, 2009; O'Feich et al., 2019) have consistently identified a need for greater access to talking therapies. These reports have found in the absence of talking therapies, there was an over-reliance on medication, need for greater choice of treatment and existence of

[1] Effect size measures describe the magnitude (size) of the difference between different groups (e.g., receiving different therapeutic approaches), or for the same group before counselling and after counselling. A commonly used and reported effect size is Cohen's d. where 0.2 is considered a 'small' effect size, 0.5 a 'medium' effect size and 0.8 or more, a 'large' effect size. This measure is reported in many studies investigating the effectiveness of counselling delivered in primary care.

barriers to access including waiting lists (HSE, 2021). A national survey found just 10% of those experiencing mental health difficulties accessed treatment (Doherty et al., 2008). A country-wide consultation with services users of mental health services highlighted difficulties accessing psychological therapies and a need for non-medical treatment options (Mental Health Reform, 2009).

For most Irish adults, GPs are the first point of contact when a mental health issue arises (Cullinan et al., 2016; Hughes et al., 2010); they are also the main gatekeepers referring for treatment (Cullinan et al., 2016). Restrictive eligibility criteria, long waiting times and limited treatment choices have impeded access to psychological therapies (MHR, 2017). In the absence of psychological options, GPs may have to rely on psychotropic medications (Grace et al., 2012; OCFH, 2017) despite best practice guidance (National Institute for Health and Clinical Excellence, 2011) and international recommendations (WHO, 2017a).

Meta-analytic studies indicate medication and psychological therapies achieve comparable outcomes for depression and anxiety (Driessen et al., 2010; Gonçalves & Byrne, 2012; Roshanaei-Moghaddam et al., 2011), yet antidepressants remain the most frequent treatment for depression (Cipriani et al., 2018) with consumption of antidepressants doubling in OECD countries between 2000 and 2015 (OECD, 2018). Recent studies have questioned the efficacy of antidepressants (Aherne et al., 2017; Hengartner, 2017) with concerns expressed about potential harm from antidepressant use (Hengartner, 2017) and questions regarding increases in antidepressant prescriptions which have not translated into measurable public health benefits (Hengartner, 2017).

Patient preference is important for guiding treatment decisions. Evidence shows better clinical outcomes associated with provision of patient-preferred treatments (Mergl et al., 2011; Swift et al., 2011; Williams et al., 2016). Practice guidelines indicate that where there is no evidence for one treatment option being superior to another, patient preference should determine the treatment selected (APA, 2006; Williams et al., 2016). Given the efficacy of talk therapies for the treatment of CMHD and patient preference for psychological interventions, counselling and psychotherapy should be the treatment of choice and access should be improved to enable patients receive their preferred treatments (APA, 2012).

Treatment utilisation patterns however show a substantial increase in antidepressant prescriptions (Hengartner, 2017; McHugh et al., 2013;) despite poor adherence to such medications (Bambauer et al., 2007). Further, trends show a reduction in patients receiving psychological therapies for common mental health difficulties despite evidence of patient preference, efficacy and cost effectiveness (Béland et al., 2011; McHugh et al., 2013). Limited access to evidence-based psychological therapies is identified as contributing to the preponderance of medication-based treatments for anxiety and depression (Hengartner, 2017; McHugh et al., 2013).

This situation is also evident in Ireland where concerns have been raised about medication prescription levels for mental health difficulties (Cadogan et al., 2018; Conway-Lenihan et al., 2016; Schomerus et al., 2006). Benzodiazepines are still commonly prescribed in Ireland, often for extended durations (Cadogan & Ryder, 2015; Cadogan et al., 2018). Ireland ranks highest amongst OECD countries for chronic benzodiazepine use amongst adults aged over 65 (OECD, 2018). Conway et al. (2016) argue that prevention and alternative treatments such as counselling and psychotherapy are necessary to reduce spend on prescription drugs. Limited availability and lack of access to talk therapies has however led to a reliance on medication-based treatments for mental health difficulties in Ireland (Grace et al., 2012; Mental Health Reform, 2017; OCFH, 2017; Vitale et al., 2015) despite national policy (DOH, 2020), best practice guidance (e.g., National Institute for Health & Clinical Excellence, 2011) that psychological therapies should be the first line treatment for common mental health disorders, international recommendations (WHO, 2017a) and patient preference (Baumeister, 2012; McHugh et al., 2013).

2.1.4 Cost effectiveness of psychological therapies

Investment in psychological therapies can yield significant economic savings, through increased productivity, reduced absenteeism (Dezetter & Briffault, 2015; LSE, 2006) and reduced use of general medical services (Candilis & Pollack, 1997; Simon & Katzelnick, 1997). Research suggests that psychotherapy is likely to be a more cost-effective intervention in the long term than medication which is more costly when premature termination and non-adherence to treatment regimens are considered (APA, 2012). Altmann et al. (2016) examined a sample of 22,294 patients experiencing common mental health disorders who were provided with psychotherapy. The authors found that direct health care costs were reduced on average by 10%, hospitalisation days by 27%, and work disability days by 41%.

Cost-benefit analysis has also demonstrated that psychological therapies provided a good return on investment. A cost-benefit analysis of the improving access to psychological therapies programme in the UK demonstrated a return on investment of £1.75 for every £1 invested (Laynard et al., 2007). Dezetter et al. (2013) estimated the cost-benefit ratio of provision of psychological therapies for common mental health difficulties in France and found that psychological therapies were cost effective in the short and long term with a positive impact on health, quality of life, productivity with indirect positive effects on somatic disorders. Dezetter's analysis that every €1 invested in psychological therapies yielded €1.95 in savings (Dezetter et al., 2013). Similarly, a Canadian study of cost effectiveness of psychological therapies for depression showed a decrease in health service and societal costs (Dezetter & Briffault, 2015). Vasiliadis et al. (2017, p. 902) found that increasing access to psychological therapies for patients with depression yielded an average of $2 in savings to society for every $1 spent and was associated with reduced mortality and increased productivity. Together these studies demonstrate that psychological therapies don't just provide good value for money, but also help to reduce use of other health services and contribute at a societal level in terms of improved productivity etc.

2.1.5 Conclusion

There is a high prevalence of common mental health disorders which impact significantly on individual and global health, internationally and in Ireland. The evidence for psychological therapies as effective treatments for common mental health difficulties is widely accepted with psychological therapies viewed as the first line treatment of choice. Psychological therapies are generally preferred by service users and are cost effective.

The development of CIPC has been a welcome addition to the range of mental health service provision in Ireland, offering access to psychological therapies for the adult population who hold a GMS card. While the effectiveness of primary care counselling has been established in other jurisdictions, it has not been assessed at a national level in Ireland to date.

2.2 Method

2.2.1 Sampling procedure

In keeping with the practice-based research approach, no inclusion or exclusion criteria were implemented in the construction of the sample for this study. Most clients who attended for an initial assessment and completed a pre-therapy questionnaire CORE OM 34 form during the research data collection period were invited to participate in the research. In a small number of cases, participation in the research was deemed unsuitable for clinical reasons.

2.2.2 Study participation

During the period of data collection for this study, CIPC received 14,156 referrals (Table 1).

Just 21% of referrals were screened as inappropriate as they were ineligible based on age [the referred client was under 18 years] GMS status [the referee did not have a valid GMS card or the reason for referral was outside the remit of the CIPC service]. A total of 37.6% of referrals did not progress to assessment stage because referees did not complete the mandatory opt-in process.

Overall, 5,762 clients completed assessments during the study. Of these, 84% (*n* = 4,838) were accepted for counselling and invited to participate in the study. A total of 2,965 (61.3%) consented to take part. For 37 participants, their IDs were duplicates or invalid and these were removed from the sample, leaving 2,928 participants with valid consent.

2.2.3 Data collection areas and collection periods

Data was collected from all 10 CIPC services which provide counselling across each of the 9 HSE Community Health areas. For this study CHO Area 8 was divided into two service areas (CHO 8 Midlands and CHO 8 Cavan Monaghan/Louth Meath). Data collection took place over 3 phases - Phase 1 began in CHO area 5 between May and August 2015. This pilot phase of the study has been reported on previously (CIPC National Evaluation Research Group, 2018). This was followed by three-month collection periods in Areas 3 and 7 (July-September 2016) and Area 6 (June-August 2017). Following the completed roll-out of a national, centralised electronic client management system by September 2017, which enabled electronic recording of client outcome measures, it was possible to extend the data collection period in the remaining areas to allow for collection of a larger participant sample. Thus, the final phase of data collection for all remaining areas (1, 2, 4, 8 Midlands, 8 CM/LM and 9) began in February 2018 and continued for a 12-month period.

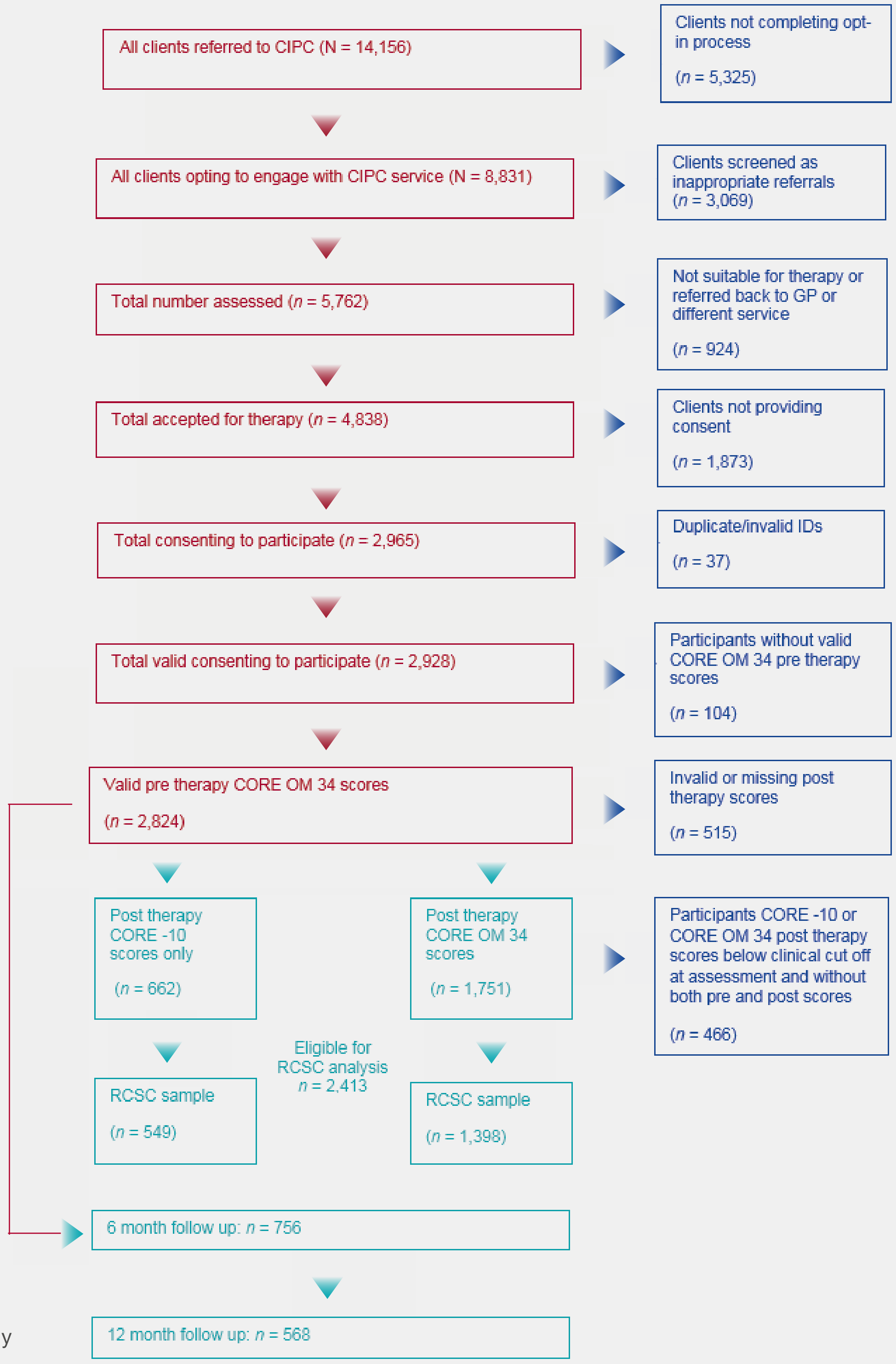

Figure 2.

CONSORT diagram of study participants

Follow-up data were gathered at 6 and 12 months between February 2019 and February 2020 in all CHO areas except for CHO Area 5.

Client participation rates are calculated based on the percentage of clients seen for assessment and accepted for counselling during the data collection period who also consented to take part in the research (Table 1). CHO area participation rates varied between 50% and 81.2%. National percentage participation rates were calculated based on the number of clients who consented to participate in the research from the overall sample (*N* = 2,965).

Table 1. Participation rates by CHO area

National CHO area data collection area & periods, total number of assessment completed, accepted for therapy & clients consented to participate, research participation rates nationally and by CHO Area & weighted contribution % to national participation rate.

			N			Reearch participation (%)		
CHO Area	**Data collection period (months)**		**"Assessments completed"**	**"Accepted for therapy"**	**"Consented to participate"**	**National rate**	**CHO Area rate**	**"Weighted % contribution to national total"**
1	12	Donegal, Sligo & Leitrim	1005	811	468	15,6	57,7	9,93
2	12	Galway, Mayo & Roscommon	402	362	173	5,9	47,8	9,63
4	12	Cork & Kerry	1108	995	522	17,1	52,5	10,08
8MD	12	Laois, Offaly, Longford & Westmeath	522	467	347	11,9	74,3	9,68
8LM	12	Meath, Louth, Cavan & Monaghan	827	657	420	14,3	63,9	9,82
9	12	Dublin North & Dublin North City	1042	788	640	21,7	81,2	10,71
5	4	Waterford, Wexford Kilkenny, Carlow & South Tipperary	293	219	122	4,2	54,8	9,69
6	3	South Dublin, South East Dublin & East Wicklow	153	153	103	3,5	67,3	9,73
3	3	Limerick, Clare & North Tipperary	200	200	77	3,2	38,5	9,79
7	3	South West Dublin, Kildare & West Wicklow	210	186	93	2,6	50	9,74
Total			**5762**	**4838**	**2965**	**100**		

2.2.4 Measures

During the period of data collection for this study, CIPC received 14,156 referrals (Table 1).

Psychological measures

Three clinical questionnaires were used in this study and the effects of counselling on clients' level of distress was measured using the Clinical Outcomes in Routine Evaluation - Outcome Measure (CORE OM 34: Evans et al., 2002). This measure was already in routine clinical use by the CIPC service. Clients' perceived level of functional impairment was measured using the Work and Social Adjustment Scale (WSAS: Mundt et al., 2002) and the Health Related Quality of Life (HRQOL-4: Centers for Disease Control and Prevention, 2000) was used to assess physical and mental health as a quality of life measure.

The additional clinical measures introduced specifically for use during the study, i.e., HRQOL-4 and WSAS were selected based on their high levels of reliability, validity and user acceptance. Further, their brevity made them more amenable for use by counsellors/therapists as part of the complete therapeutic and client outcome monitoring process.

Counsellor/therapists' subjective ratings of clients' presenting issues and end-of-therapy data were also included in some analyses. These data were collated using the CORE Therapy Assessment Form and the CORE End of Therapy Form. All study measures, client demographic and clinical profile forms are included in Appendices 2 A-F.

CORE system measures

The CORE OM 34

The CORE OM 34 is a 34-item global measure of distress and used extensively in clinical settings across primary and secondary services in Ireland, the UK and Europe (CORE System Group, 1998; Mellor-Clark, 2006). High completion rates in primary care counselling service settings (Barkham, 2005) attest to its usefulness as a brief measure in primary care settings. Good levels of discrimination between clinical and non-clinical populations, internal reliability (i.e., consistent within itself as a measure), test-retest stability (i.e., it is consistent over time), sensitivity to change and convergent validity (i.e., the degree to which it corresponds with other theoretically related measures) are reported (Evans et al., 2002).

The CORE OM 34 comprises 34 items addressing 4 domains: subjective well-being (4 items), symptoms (12 items), functioning (12 items) and risk (6 items). Items are scored on a five-point scale from 0 to 4 (*'Not at all', 'Only occasionally', 'Sometimes', 'Often', and 'All or most of the time'*). 17 items focus on low-intensity problems (e.g., 'I feel anxious/nervous'), 17 on high-intensity problems (e.g., 'I feel panic/terror'). Eight items are scored positively (Appendix 2A).

The CORE OM 34 was selected for use in this study because it is the primary measure of psychological distress used for assessment and outcome measurement in the CIPC service. Further, the measure is standardised throughout CIPC, making comparisons of outcomes between services using this measure more straightforward.

The CORE-10

The CORE-10 is a shortened version of the CORE OM 34 and comprises 10 items. Each item was selected from the 10 item clusters on the CORE OM 34, (1) subjective well-being, (2) anxiety, (3) depression, (4) physical, (5) trauma, (6) general functioning, (7) close relationships (functioning); (8) social relationships (functioning), (9), risk to self, and (10) risk to others. Each item is scored on a 5-point scale ranging from 0 (*'not at all'*) to 4 (*'most or all the time'*). The clinical score is calculated by adding the response values of all 10 items (Minimum score 0, Maximum score 40) (Appendix 2B).

The CORE-10 has been validated as having good internal reliability (α = .90) and the score for the CORE-10 correlated with the CORE OM 34 at .94 in a clinical sample and .92 in a non-clinical sample. It is considered an acceptable and feasible instrument to use with people presenting with common mental health problems in primary care settings (Barkham et al., 2013).

The CORE OM measures sit within a wider system designed to aid the evaluation of service quality and outcomes which also includes the practitioner completed Therapy Assessment and End of Therapy Forms which are fully described in section 2.2.4.

Functional and social impairment and quality of life measures

The Work and Social Adjustment Scale (WSAS)

The Work and Social Adjustment Scale (WSAS: Mundt et al., 2002) is a simple and reliable measure of impairment in functioning. It assesses the impact of a person's mental health difficulties on their ability to function in terms of work, home management, social and private leisure, personal or family relationships (Mundt et al., 2002).

The WSAS has been demonstrated as a reliable and valid measure of impairment in functioning due to specific problems (Zahra et al., 2014). Studies indicate strong psychometric properties for the WSAS and support its broader use in clinical research (Mundt et al., 2002). The WSAS has been shown to be concurrently valid (i.e., it corresponds with other established scales measuring the same construct) and its brevity is positively regarded by patients (Zahra et al., 2014). The measure correlates with severity of depression and some anxiety symptoms.

The WSAS comprises five items scored on a nine-point scale ranging from 0 = *Not at all* to 8 = *Very severely* (Appendix 2C). Participants are asked to indicate how much their psychological problem impairs their ability to do day-to-day activities in their lives in the areas of work, home, leisure and relationships.

The health related quality of life measure

The Health Related Quality of Life (HRQOL: Moriarty et al., 2003) measure is used to assess perceptions of health status and activity limitation (Hagerty et al., 2001). The HRQOL-4 scale is a component of the Behavioral Risk Factor Surveillance System employed by the Centre for Disease Control in the U.S. It has been validated as measuring distinct mental and physical health components (Hjermstad et al., 1998) and is shown to be a reliable measure of physical and psychological status (Moum, 1998). Additionally, the construct validity of the HRQOL-4 measure has been demonstrated in primary care populations in Sweden (Alfredsson, 2002), Canada

(Ounpuu et al., 2000) and Puerto Rico (National Center for Chronic Disease Prevention and Health Promotion, 2002).

The HRQOL-4 measure consists of four questions relating to 1) self-rated general health (physical and mental) rated 1 = *Excellent* to 5 = *Poor*, 2) client-rated number of days when their physical health and 3) mental health were not good, and 4) the number of days when activity was limited because of poor physical or mental health (Appendix 2D). These responses are analysed to generate an estimation of "healthy" and "unhealthy" days as perceived by clients during the 30-day period prior to the questionnaire being administered. Differences in the number and proportions of reported mentally and physically unhealthy days between pre and post counselling are reported, as well as over the longer term at 6 and 12 months after counselling has ended.

Using the number of self-reported mentally unhealthy days at the various time points, the overall proportions of clients experiencing "frequent mental distress" can be calculated. This is defined as 14 or more days during the previous 30 days when their mental health was not good. Differences in the number and proportions of clients who experienced frequent mental distress between pre and post counselling and over the longer term at 6 and 12 months after counselling ended were also calculated.

CORE therapy assessment form

The Therapy Assessment Form (TAF) is a practitioner-completed form (Appendix 2E). It captures service related information including demographic data i.e., age, sex, employment status and ethnicity and location of counselling, referrer type, assessment, previous attendance with the service as well as attendance at other services. Clinically relevant information is also gathered including reason for referral, type and level of severity of presenting problems as assessed by the counsellor/therapist. In addition level of risk as determined by the counsellor/therapist is captured. Client coping strategies are also recorded. Once complete, the counsellor/therapist indicates assessment outcome.

CORE end of therapy form

The end of therapy (EOT) form is completed at the end of counselling (Appendix 2F). The EOT form captures post-therapy information that allows data from the client completed CORE OM 34 to be seen in context. It includes type, mode and frequency of counselling, session attendance; therapy model; a review of presenting problem severity, risk and how therapy ended (i.e., planned or unplanned ending). Perceived benefits of therapy are also assessed.

2.2.5 Therapist training and participation

To ensure a standardised and consistent approach to the evaluation, a training session was conducted by the researcher and local CIPC Clinical Coordinator with the counsellors/therapists in each CIPC service area prior to beginning data collection. Training sessions were supported by written documentation outlining the purpose and scope of the evaluation.

Training focussed on familiarising counsellors/therapists with the administration of additional clinical measures and supporting counsellors/therapists to integrate the evaluation process into their clinical practice.

A total of 171 counsellors/therapists submitted data to the national evaluation.

2.2.6 Client invitation procedure

Prior to attending for initial assessment, CIPC clients were contacted by phone or letter and informed that an independent evaluation of the service was occurring and that their counsellor/therapist would discuss this during their initial assessment. It was stressed to clients that they were free to take part or not and that their involvement in the study or not would not impact their treatment in any way.

During the client's initial assessment meeting, the evaluation study was outlined. Clients were provided with an information sheet (Appendix 3A) about the study and invited to participate. Written consent was obtained from those who wished to participate (Appendix 3B). Clients were informed that by consenting they would be contacted 6 and 12 months after completing their counselling to give them the opportunity to provide follow-up data. Clients were also given the option to participate in a separate aspect of the study to examine their psychotropic medication prescriptions pre and post counselling. Clients who opted to participate in this part of the study completed a separate consent form (Appendix 3C).

2.2.7 Administration of measures

The CORE OM 34, HRQOL-4 and WSAS questionnaires were administered by CIPC counsellors/therapists during the initial assessment session and the final agreed session with clients. A total of 79.5% of counsellors/therapists also administered CORE 10 questionnaires during ongoing counselling with some clients as part of their routine clinical practice in addition to pre and post CORE OM 34 questionnaires

In routine practice CIPC counsellors/therapists conduct an in-depth clinical assessment with all clients during their initial appointment. This assessment comprises a detailed exploration of current presenting issues, past mental and physical health history and familial and social context. It also includes an assessment of client readiness and motivation for counselling and an identification of counselling goals. During this assessment process, the clinical outcome measures are administered with the client. The CORE TAF is completed by the counsellor/therapist following the initial assessment session. The CORE EOT Form is completed by the counsellor/therapist at the conclusion of counselling.

The CORE OM 34 contains a 6-item risk scale which may indicate that a client is presenting with a risk of harm to themselves and/or others. All CIPC counsellors/therapists are trained to routinely follow up with clients when a risk item is scored to assess level of risk and to take appropriate steps necessary to manage any presenting risk.

2.2.8 Data entry

CORE OM 34, TAF, EOT, WSAS and HRQOL-4 questionnaire data were entered on the CORENET system by the counsellor/therapist or where possible, by the individual client if a tablet or laptop was available. In some cases, paper versions of questionnaires were completed, and the data was inputted into the CORENET system following the session.

Pre and post counselling CORE OM 34 and CORE-10 completion rates

Of the 2,928 clients who consented to participate in the study, 96.5% (*n* = 2,824) completed valid CORE OM 34 pre-therapy clinical outcome questionnaires. Sixty-four participants (2.2%) were recorded as completing the questionnaire items related to the CORE 10 questionnaire and data were missing for 1.3% (*n* = 40).

Regarding post counselling questionnaire completions – 59.8% (*n* = 1,751) completed post counselling CORE OM 34 questionnaires and 22.6% (*n* = 662) completed CORE 10 forms. Data were missing or invalid for 17.6% (*n* = 515) of the consenting participants. For the calculation of reliable and clinically significant change (RCSC: described in detail), the sample was delineated into those participants with valid pre and post counselling CORE OM 34 and CORE – 10 questionnaires and who scored above or below clinical cut-off (Figure 2).

2.3 Results

2.3.1 Who gets referred to CIPC?

Profile of participants

Age

Of the overall sample (*n* = 2,928), age data were available for 98.2% (*n* = 2874) of participants. The mean age of participants in the evaluation was 42.5 years (age range 18-89). The most represented age in the sample were between 36 and 45 (25.6%, *n* = 750). Figure 3 shows a full breakdown by age category.

Gender

A total of 73.7% of participants (n = 2,157) were female and 24.5% were male (*n* = 717). No information on gender was available for 54 participants (1.8%).

Employment

Over twelve and a half percent of clients were recorded as *Unemployed and seeking work*, while 31.9% indicated they were *Employed*. 8.3% did not have corresponding data for this category.

Ethnicity

Over 74% of the sample were identified as *white Irish*, 11.2% were from *Any other white background*. No data was provided for 10% of participants (Appendix 4).

2.3.2 Source of referral to CIPC

Of the overall sample (*n* = 2,928), data indicating who referred the client were available for 95.8% (n = 2,806) of participants. A total of 90% (*n* = 2,634) of all study participants were referred to CIPC by their GP. Other primary care team professionals, including physiotherapists, dietitians, social workers, occupational therapists and surgery practice nurses comprised 5.1% of referrals (*n* = 150). Figure 4 outlines the profile of referral agents for study participants.

Previous contact with the CIPC service

Data indicating whether participants had previously attended the CIPC service (or not) was available for 68% (*n* = 1,988) of the overall sample (*n* = 2,928). Of this group, 80.2% were first attenders (*n* = 1,595), 18.1% (*n* = 359) were attending for a second episode, and 1.7% (*n* = 33) were attending for a third. One client was recorded as attending for their fourth episode.

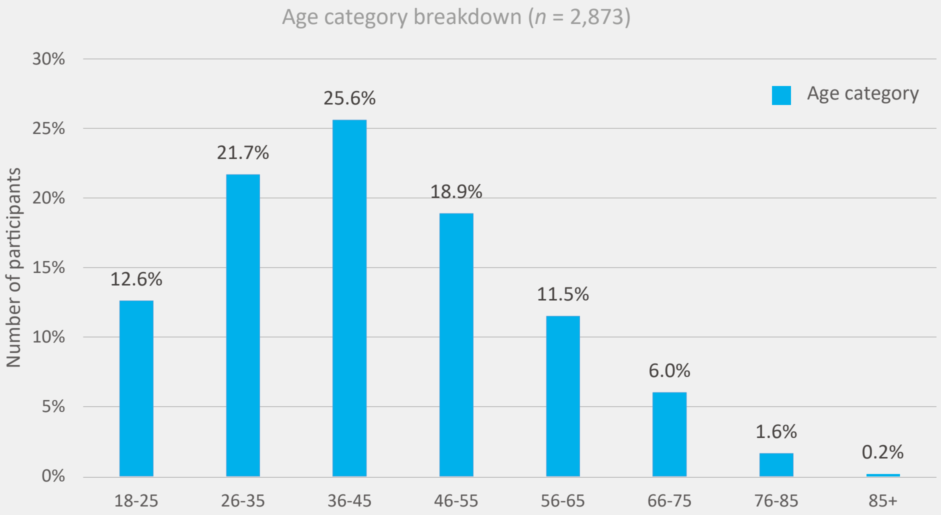

Figure 3. Participant age category breakdown by number

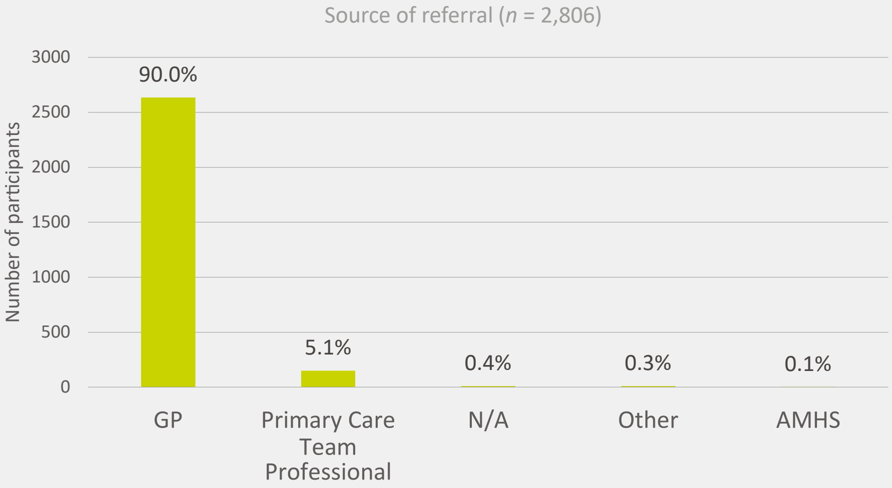

Figure 4. Breakdown of the sources of referral

Client use of psychotropic medication

Of the overall sample (*n* = 2,928), 43.3% (*n* = 1,267) of participants were identified as in receipt of psychotropic medication prescriptions before beginning their counselling. More than a third, 38.5% (*n* =1,127) were identified as being prescribed a single type of medication, 4.6% (*n* = 135) were prescribed two types of medication and five participants (0.2%) were prescribed three types of psychotropic medication.

Over three-quarters of the sample who were identified as being prescribed psychotropic medications reported taking antidepressants (*n* = 1,072). Anxiolytics or hypnotics accounted for the prescriptions of 21% of participants, and 3% (*n* = 39) reported being prescribed anti-psychotics (Figure 6).

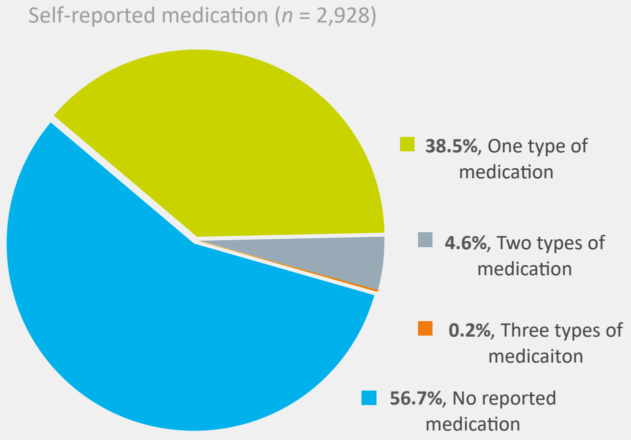

Figure 5. Proportions of self-reported medication prescriptions

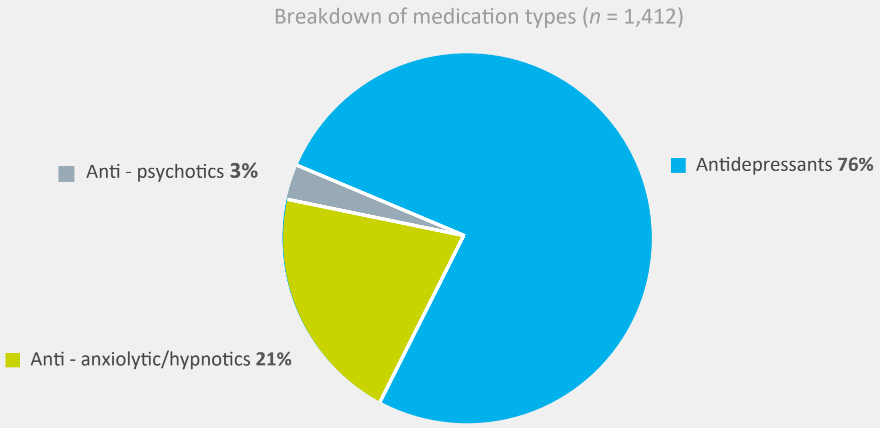

Figure 6. Breakdown of self-reported medication

2.3.3 How long do people wait for CIPC?

Waiting times are calculated from date of referral to date of first assessment appointment. Data to calculate waiting times were available for 99.6% of clients who took part in the evaluation (*n* = 2,916). A total of 31.8% of participants (*n* = 930) waited less than 12 weeks to be seen. Twenty-four percent (*n* = 702) waited between 13 and 17 weeks, while 44% (*n* = 1,284) waited 17 weeks or more (Figure 7).

2.3.4 Why do people seek counselling with CIPC?

The main problems client present with at assessment are recorded on the TAF by the counsellor/therapist. Most participants presented with more than one problem with which they required help. The most identified presenting problem was anxiety which was recorded for 81.1% of participants (*n* = 2,375). A total of 59.7% reported depression as a major reason for seeking help (*n* = 1,747). Nearly half of all clients (45.5%) were assessed as presenting with interpersonal issues and 38.4% reported self-esteem issues (*n* = 1,125).

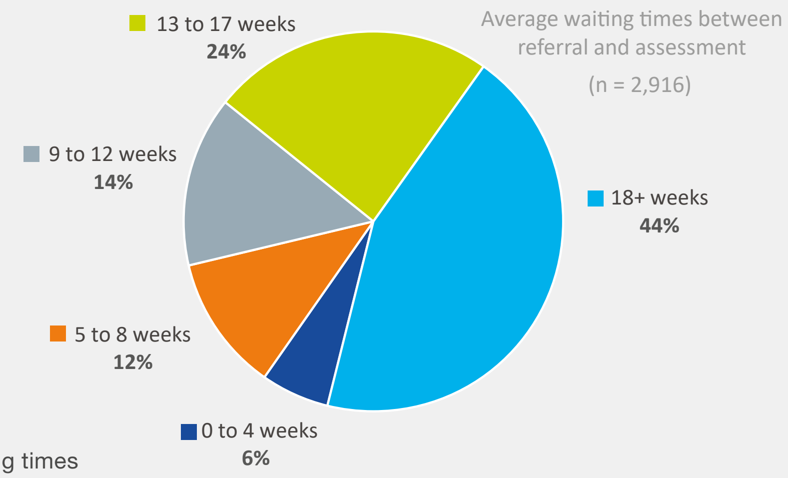

Figure 7. Participant waiting times

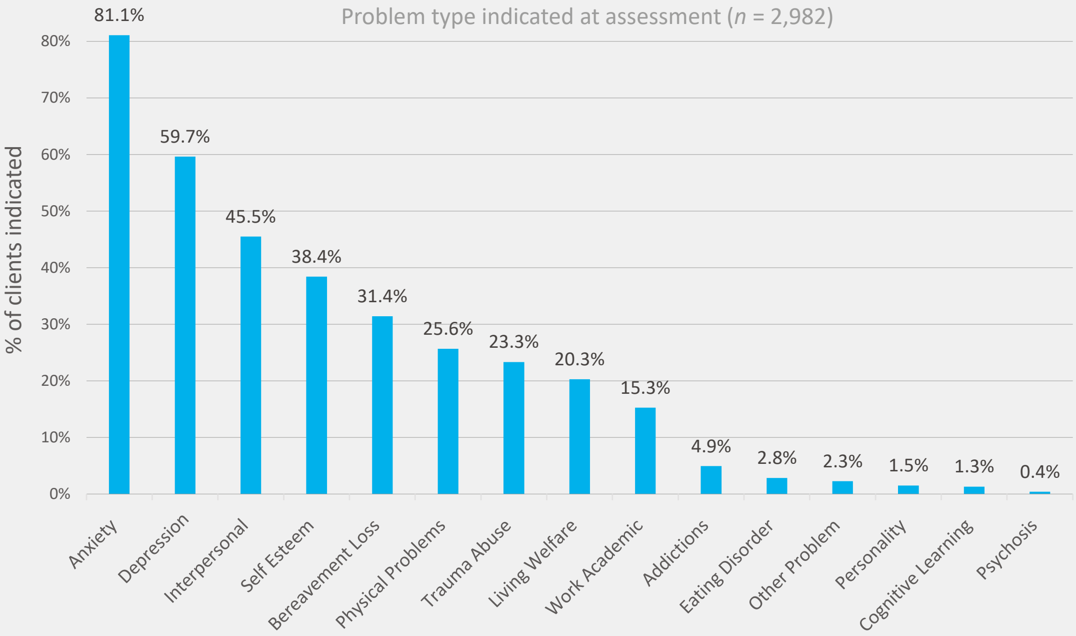

Figure 8. Proportion of presenting problems (of the total n) at assessment

Bereavement and physical problems, accounted for 31.4% and 25.6% of presenting problems respectively (*n* = 920, *n* = 751)(Figure 8).

Severity and duration of most common presenting problems in CIPC

In addition to the type of problems causing distress, the level of severity of each presenting problem was recorded on the CORE TAF by the counsellor/therapist.

Problems were scored 1 if it was *"causing minimal difficulty"*, 2 for *"causing mild difficulty"*, 3 for *"causing moderate difficulty"* and 4 for *"causing severe difficulty"*.

Cross tabulation of problem severity and duration was examined for the two main problems with which clients presented, i.e., anxiety and depression (Figures 9 and 10).

Level of severity and corresponding duration of depressive symptoms was recorded by counsellors/therapists for 49.7% of clients (*n* = 1,454). Counsellors/therapists recorded depression as causing a moderate level of difficulty for 41.7% of clients (*n* = 606), a mild level of difficulty was recorded for 36.4% of clients, while minimal and severe levels were recorded for 11% and 10.9% (*n* = 160) and (*n* = 159) of clients, respectively.

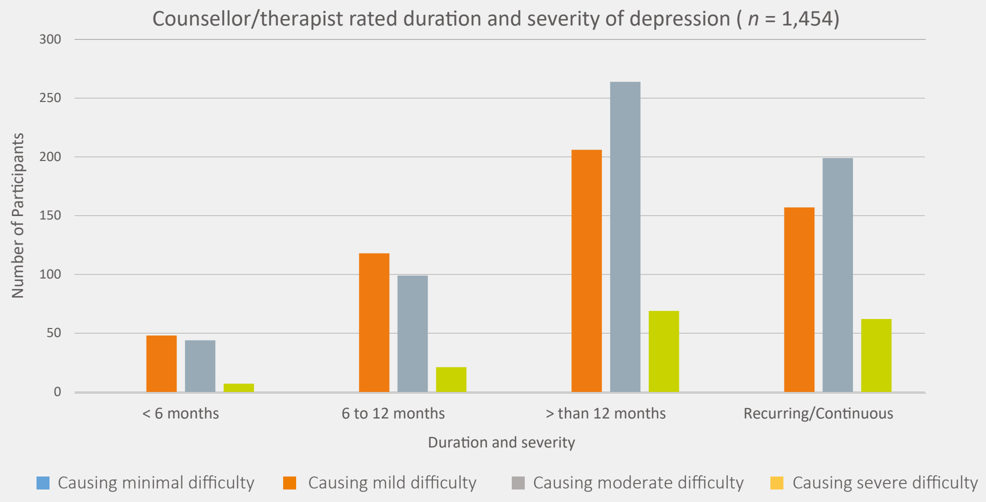

Figure 9. Relationship between severity and duration of therapists rated depression

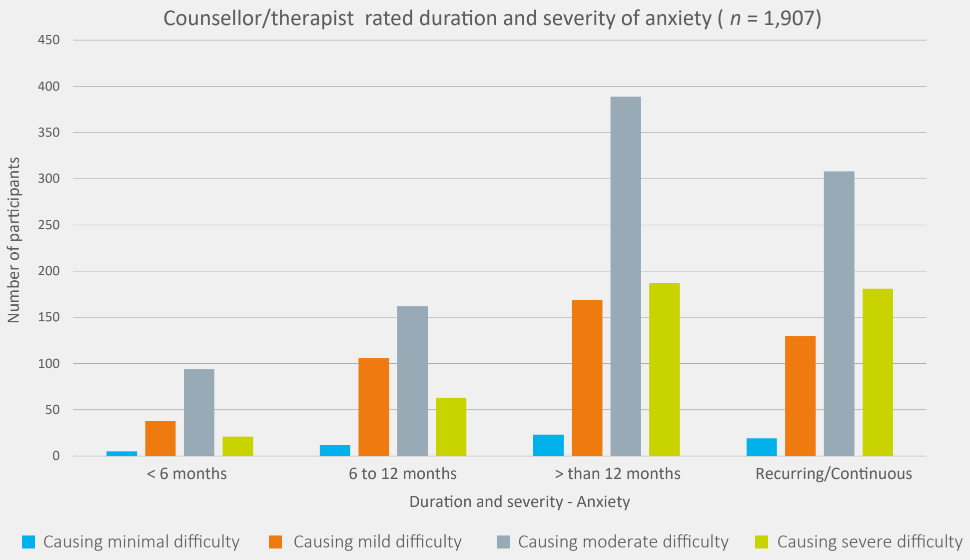

Figure 10. Relationship between severity and duration of therapists rated anxiety

Just 7.7% (*n* = 112) of clients reported as suffering from their depressive symptoms for a period of 66 months or less to their counsellor/therapist. Approximately 19.1% (*n* = 278) for 6 to 12 months, 41.5% of clients were recorded as having experienced symptoms for a period of more than 12 months (*n* = 603) and 31.7% indicated symptoms had persisted on a recurring or continuous basis (*n* = 461).

Therapist rated severity and duration of anxiety

A similar relationship and pattern of results were observed between the severity and duration of anxiety and stress-related symptoms (Figure 10). Data were available for 65.1% of clients (*n* = 1,907).

2.3.5 What therapeutic approaches are practiced in CIPC?

Number of therapeutic approaches undertaken with clients

Counsellors/therapists indicated the type and frequency of counselling undertaken with each client on the CORE EOT form. For most clients, multiple therapeutic approaches were utilised in counselling. Specifically, 21.7% (*n* = 634) of clients experienced two types of therapeutic approach and 17.8% (*n* = 521) experienced three types. A total of 19.8% (*n* = 579) were indicated as receiving four or more different types of therapeutic approach. Data indicates that for 24.2% of participants a single type of therapy approach was utilised (*n* = 707). Data was missing or invalid for 487 participants (16.1%; 0.5% respectively)(Figure 11).

Type of counselling approaches undertaken

Counsellors/therapists have the option to indicate a therapeutic approach undertaken with each client and the majority reported utilising more than one. This means that the percentages of therapy types undertaken for all clients combined exceeded 100% for the overall sample of participants (*n* = 2,928).

From the overall sample (*n* = 2,928), therapeutic approach was reported for 91.3% of participants (*n* = 2,674). The most common approach utilised was person centred therapy, indicated in 64.5% of cases (*n* = 1,725). Integrative therapy was used with 58.6% of cases (*n* = 1,568). Supportive therapy was the next most common approach, 40.8% (*n* = 1,092). Figure 12 shows a full breakdown of therapeutic approaches utilised by counsellors/therapists.

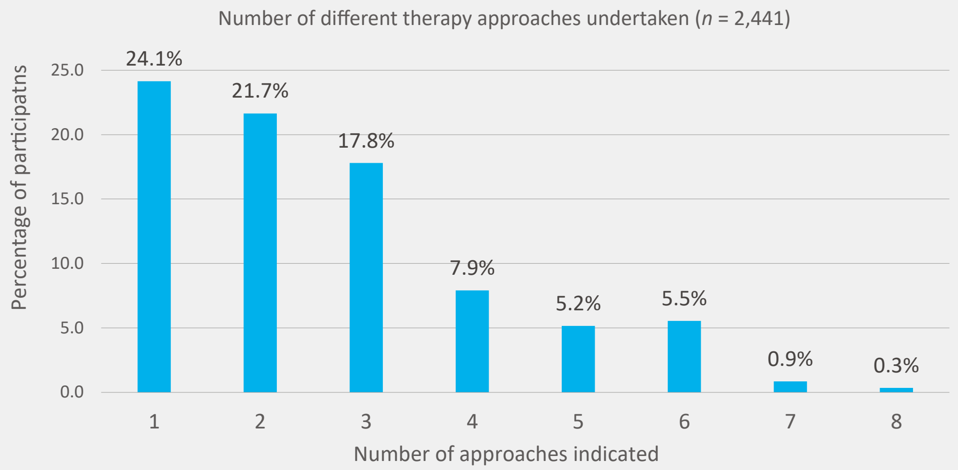

Figure 11. Number of therapy approaches undertaken by counsellors/therapists

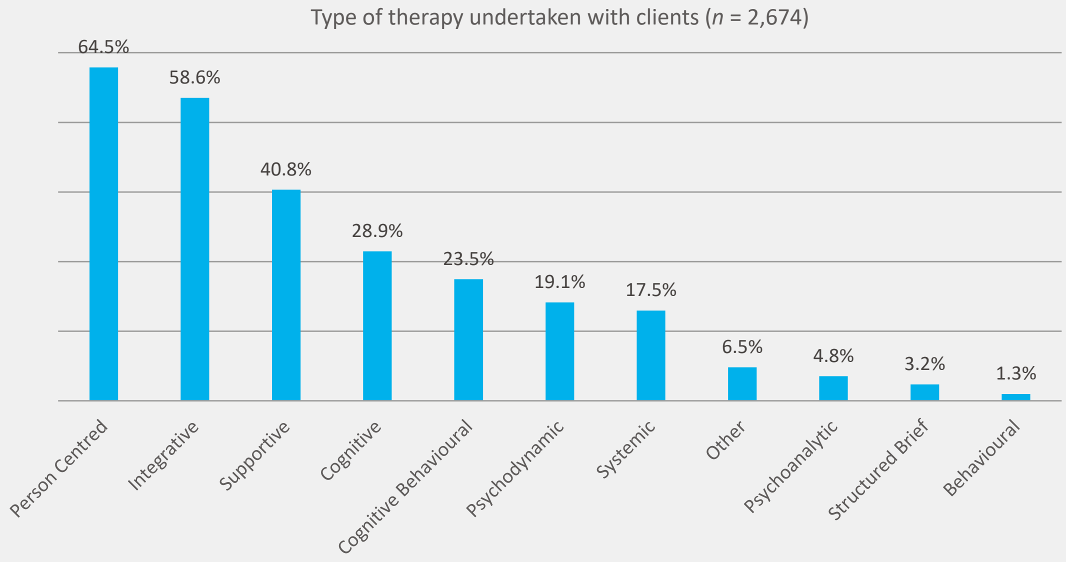

Figure 12. Percentages of the types of therapy undertaken by counsellors/therapists

Use of single versus versus multiple therapy approaches

Counsellors/therapists were categorised as belonging to one of two groups: 'always/sometimes utilising multiple therapy approaches' or 'never using multiple therapy approaches' based on responses indicated on the EOT Form. These results showed that 88% (*n* = 117) of counsellors/therapists employed multiple therapy approaches. Just 12% (*n* = 16) of counsellors/therapists employed a single therapeutic approach.

2.3.6 How long do clients attend CIPC?

Of the overall sample (*n* = 2,928), data indicating the number of sessions attended was available for 94.2% of participants (*n* = 2,757). The number of sessions attended ranged from 1 (131 participants) to 23 (2 participants). The average number of sessions attended was 7.2 (median 8). Just 23.2% of participants attended nine sessions (*n* = 680), while 14.2% attended eight sessions (*n* = 415). No data was available for 5.8% of clients (*n* = 171) (Figure 14).

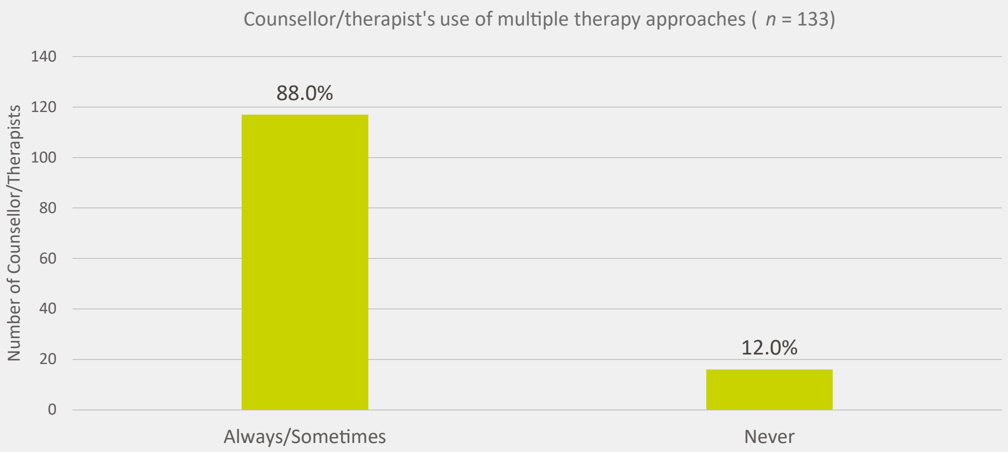

Figure 13. Counsellors/therapists use of single or multiple therapy approaches

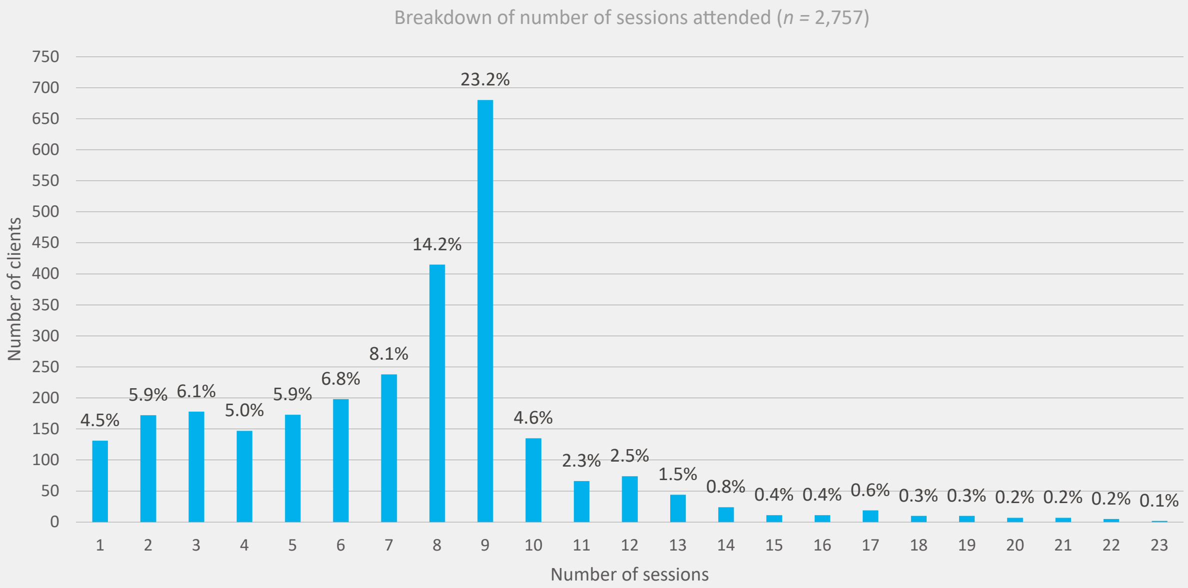

Figure 14. Breakdown of average number of sessions attended

2.3.7 Is CIPC effective? Analysis of clinical outcomes

Proportion of clients scoring above clinical cut-off on CORE OM 34

The clinical cut-off[2] point employed in this study was 1.00 on the primary outcome measure the CORE OM 34. Of the overall sample (*n* = 2,928), 82.1% (*n* = 2,373) of participants were above this clinical cut-off point at the pre counselling stage (Figure 15).

Impact of counselling on client symptoms of psychological distress (CORE OM 34)

A detailed breakdown of pre and post counselling questionnaire completion rates is outlined in Appendix 4A. Analysis of the data for pre to post counselling comparison was conducted based on pairwise deletion (available-case analysis). There was a 58.4% (*n* = 1,710) rate of completion for both pre and post counselling CORE OM 34 questionnaires. Only those participants with valid pre and post counselling CORE OM 34 data were included in pre to post change analyses.

A paired samples t-test was conducted to evaluate the impact of counselling on participants CORE OM 34 scores. There was a statistically significant decrease in CORE OM 34 scores from the start to end of counselling from a mean average of 1.55 (*SD* = .60) to a post therapy mean average of 0.85 (*SD* = .60) (*n* = 1,710, *p* <.001), mean reduction of 0.70 (Figure 16).

Effect size was calculated in accordance with the method described by Cohen (1988). A large effect size of 1.20[3] was associated with the impact of counselling.

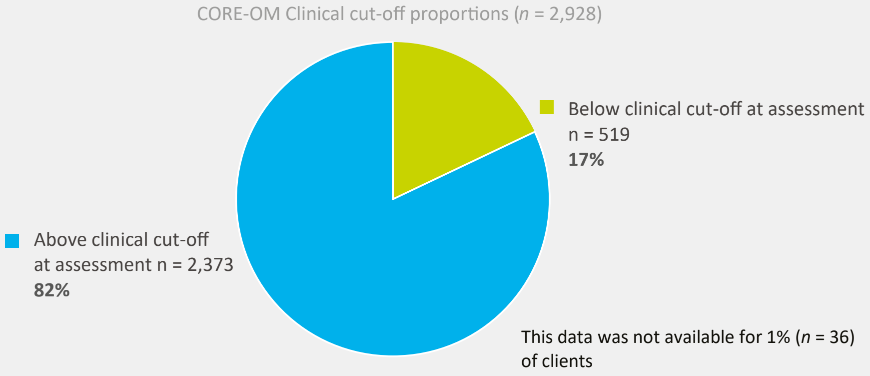

Figure 15. Percentages of participants above and below clinical cut off on the CORE OM 34

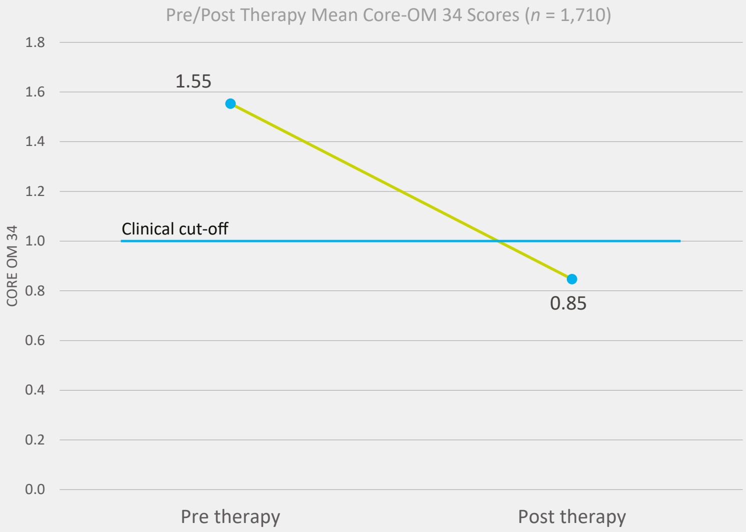

Figure 16. CORE OM 34 pre- to post-counselling change

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[2] Clinical cut-offs are statistically derived points which differentiate between clinical and non-clinical populations. If a client scores above the clinical cut-off point, this indicates that their score is more representative of a clinical population.

[3] Small effect size 0.20; moderate effect size 0.50; large effect size > 0.80. (Cohen, 1988)

2.3.8 How many clients improved & recovered?

Reliable and clinically significant change (RCSC) refers to the amount of change observed from scores on a measure, in this case, the CORE OM 34 measure. The change between pre and post therapy scores must be significant enough to infer that it was because of counselling rather than chance or error that accounts for the change (reliability). In addition, the amount of change must be of a magnitude whereby a client's CORE OM 34 score moves from within the range of the clinical population to that of the general population (improvement). Both reliability and significant (improvement) criteria must be met for a client to be considered as having achieved reliable and clinically significant change (recovery) (Appendix 5).

1,398 clients were eligible for RCSC analysis (47.8% of the overall sample *n* = 2,928) i.e., those clients who scored above clinical cut-off at assessment and for whom there was a valid pre and post CORE OM 34 score.

A majority (72%) (n = 1,003) of clients demonstrated either recovery or improvement. More than half (56.4%) of clients achieved recovery (*n* = 787), 15.5% significant improvement (*n* = 216) in CORE OM 34 scores after attending CIPC. Just 27.2% of clients showed 'no reliable change' i.e., change in their scores was less than the required level to move them from the clinical to the non-clinical range (*n* = 379) and less than 1% (*n* = 13) of clients who completed pre and post CORE OM 34s demonstrated deterioration in clinical outcomes (Figure 17).

2.3.9 How did counselling impact client risk?

Pre-post counselling comparison of risk on core OM 34

Clients were considered 'at risk' when they scored 1 on two or more of the risk items or 2 on one or more of the risk items of the CORE OM 34 (Appendix 6). Pre and post counselling comparisons were made between the groups of participants indicated as being 'at risk' and those for whom risk was not present. Pre and post therapy risk data was available for 51.4% (*n* = 1,506) of the overall sample.

Before counselling, 26.7% (*n* = 402) of participants scored 2 or higher on the risk items sub-scale. Post counselling this proportion reduced to 8.5% (*n* = 128) (Figure 18). A McNemar test using binomial distribution indicated this was a statistically significant difference.

2.3.10 What is the impact of counselling on client quality of life?

HRQOL-4: General health

Before commencing counselling, 4.3% (*n* = 22) of participants reported that their general health (i.e., combined physical and mental health) was excellent. This number rose to 7.7% (*n* = 39) by the EOT. Similarly, the number of clients who considered their general health to be very good increased by the end of counselling (from 80 to 133 clients). There was a slight increase in the number of clients reporting their general health as good, up from 38.3% to 40.3% (*n* = 195 – 205 respectively)(Figure 19).

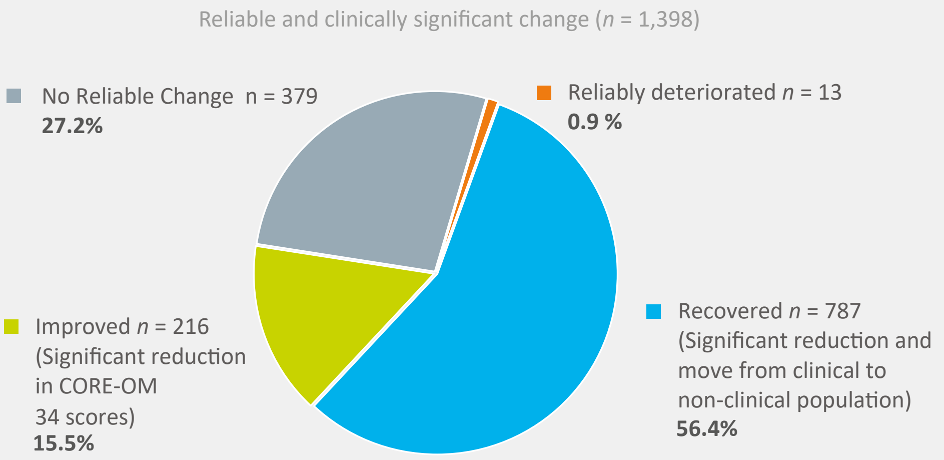


Figure 17. Proportions of RCSC, improvement, no reliable change and deterioration

In terms of clients' general health deteriorating, the number of participants rating their general health as fair, dropped from 29.1% to 19.1% (148 to 97 clients) and this trend was repeated in the number of clients who felt their general health was poor – dropping from 64 to 34 clients between pre and post counselling.

A Wilcoxon signed-rank test showed that these changes were significant - participants' pre counselling test ranks were significantly lower than their post counselling test ranks (*T* = 16364, *z* = -10.571 *p* < .001).

Number of mentally and physically unhealthy days & activity limitation

A paired t test showed that the average number of days clients reported feeling mentally unhealthy before counselling dropped by 46.2%, an average of 8.3 days (from 17.9 to 9.6 days). This was statistically significant (*t* = 16.477, *df*= 420, *p* = <.001, one-tailed) and resulted in a large effect size of 0.91.

Physically unhealthy days also reduced significantly after counselling from 12.5 to 9.2 days, a reduction of 3.2 days on average (*t* = 6.208, *df* = 409, *p* = <.001, one-tailed). Effect size 0.34.

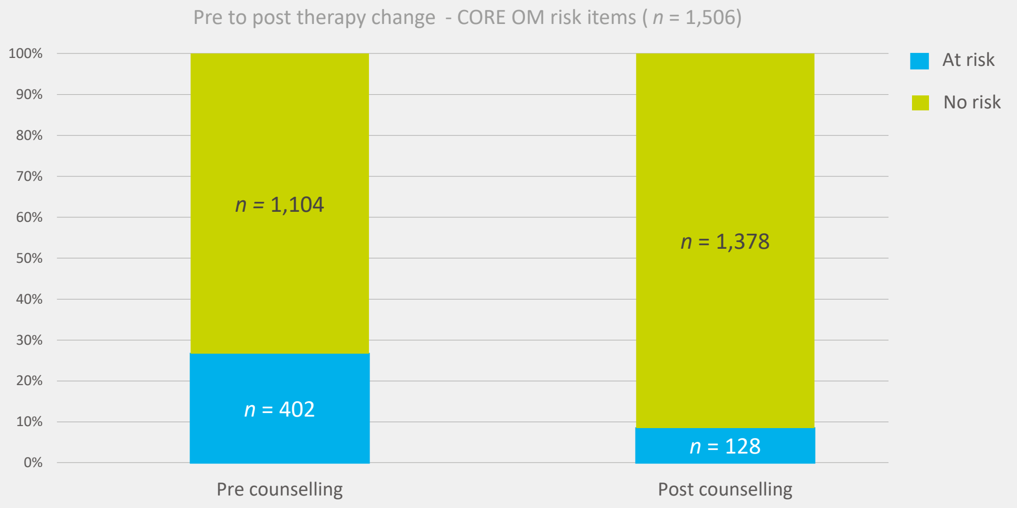


Figure 18. Pre- to post-counselling risk change using CORE OM 34 risk items

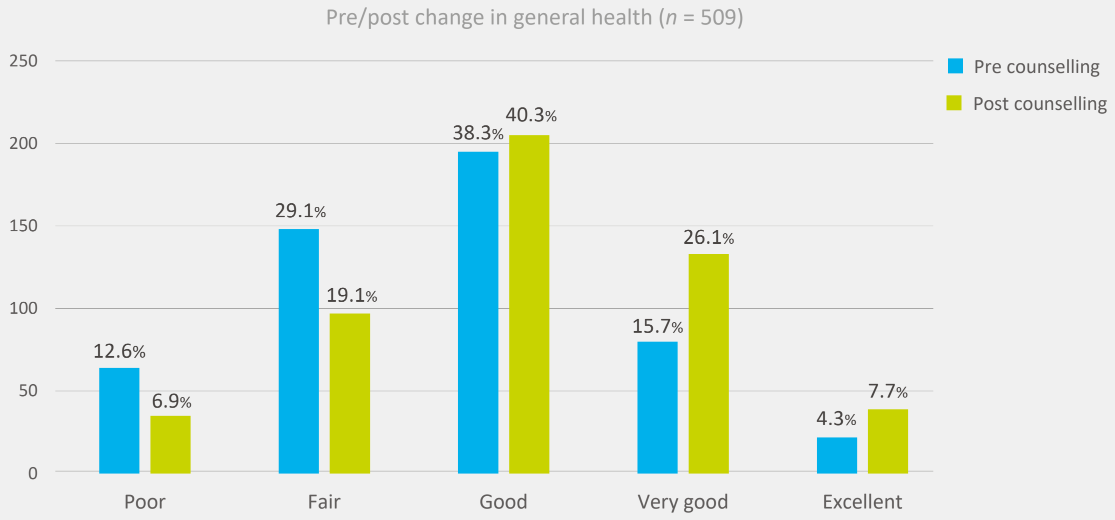


Figure 19. Pre- to post-counselling change in HRQOL-4 general health

The number of days participants reported their normal activity being limited due to their mental and/or physical problem was significantly less by the end of counselling reducing by an average of 4.3 days (*t* = 9.550, *df* = 433, *p* = <.001, one-tailed). Effect size 0.47 (Figure 20).

Frequent mental distress

A comparison of pre and post proportions of clients experiencing Frequent Mental Distress (defined as mental health reported as not good for 14 or more days in the past 30 days) was conducted and showed large reductions after counselling Figure 21).

Before counselling, 68.9% (*n* = 392) of the sample for whom pre and post data were available, reported experiencing Frequent Mental Distress. Post counselling this had reduced to 29.3% (n = 172).

Predictors of frequent mental distress

Age, sex, waiting time, number of sessions attended and pre counselling CORE OM 34 score were analysed to examine their association with frequent mental distress as measured on the HRQOL-4. These factors were entered into a binary logistic regression model. Results showed that of these factors pre counselling CORE OM 34 score and waiting time were significant predictors of frequent mental distress. Pre therapy CORE OM 34 scores increased the log odds of suffering frequent mental distress by a factor of 7.07 (Appendix 7).

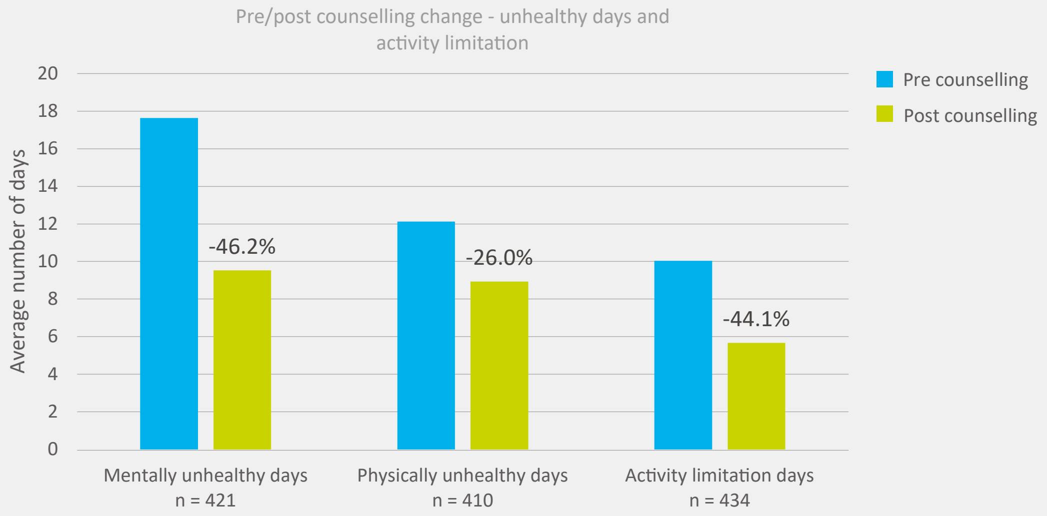


Figure 20. Pre- to post change for mentally unhealthy days, physically unhealthy days and activity limitation days

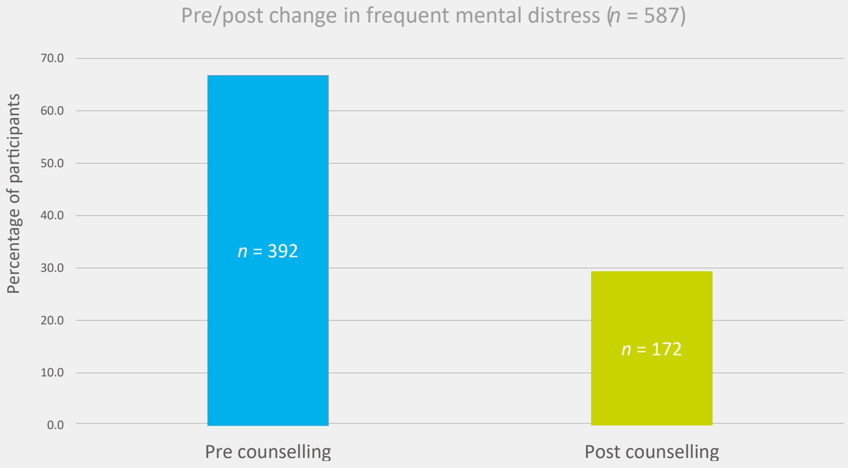


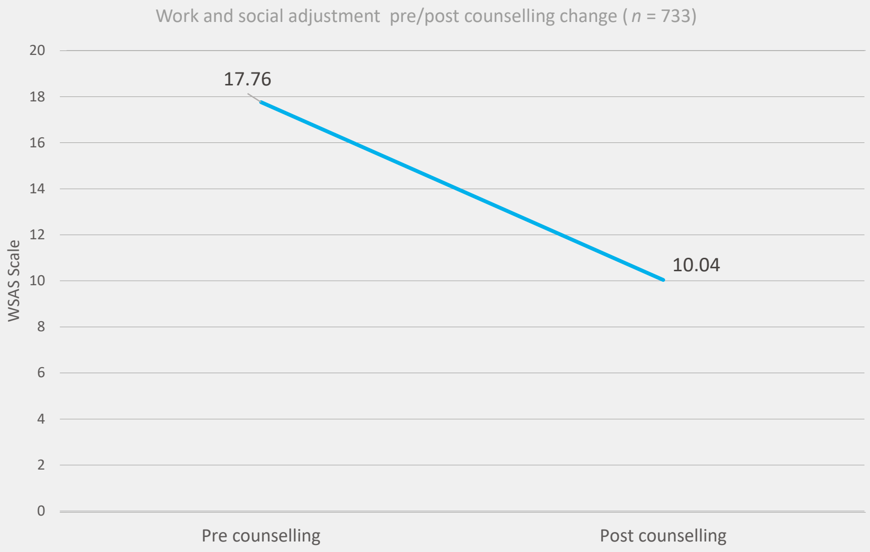
Figure 21. Pre- to post-counselling change in frequent mental distress

The impact of counselling on work and social functioning: WSAS

According to Mundt et al., (2002), a reduction rate of 2 standard errors of measurement (i.e., 8 points on the WSAS) is the minimum that should be considered clinically significant change in a sample of clients receiving psychological treatment in a primary care context (Zahra et al., 2014). The proportion of participants who achieved clinically significant change using this criterion was 43.6% (*n* = 320) (Figure 22).

Figure 22.

Pre- to post-counselling change in WSAS scores



2.3.11 What factors influence change in counselling?

Factors predicting recovery

Additional analyses were conducted to evaluate how the following factors effected clients' likelihood of improving in a reliable and clinically significant way i.e., RCSC.

Gender: There was no statistical difference between male and female clients in terms of those that achieved (χ^2 (1, n = 1,983) = 2.001, p = .157) .

Factors considered important were included in a binary logistic regression model using the enter method and RCSC membership (Yes/No) as the dependent variable:

- Number of weeks waiting to be seen for assessment
- Pre counselling CORE OM 34 score (severity measure)
- Pre counselling risk score
- Number of sessions attended
- Type of counselling ending [planned or unplanned]
- Previous contact with the CIPC service.

A total of 1,037 participants were included in the analysis and the full model significantly predicted RCSC group membership. Between 4.9% and 6.6% of the total variation in RCSC group membership was explained by the model (Table 2).

Number of weeks waiting: Waiting time for assessment and CORE OM 34 risk levels were not significant predictors of whether participants achieved RCSC.

Pre counselling CORE OM 34 score (severity measure): For every 1 unit increase in pre-counselling CORE OM 34 scores the likelihood of achieving RCSC decreased by a factor of 0.50.

Number of sessions attended: For every session attended, the odds of achieving RCSC decreased by a factor of achieving RCSC by a factor of .94.

Symptom severity and number of sessions attended

A Pearson product-moment correlation was conducted to determine the relationship between pre counselling CORE OM 34 scores and the number of sessions attended. There was a strong, positive correlation between CORE OM 34 scores at assessment and the reported number of sessions attended by clients. This correlation was statistically significant (*r* = .143, *n* = 2,413, *p* = .001), indicating that higher levels of symptom severity were associated with attendance for more counselling sessions.

Previous contact with CIPC: Being a previous client of the service was associated with decreasing log odds of achieving RCSC, albeit weakly by a factor of 0.76

Type of ending: Having a planned ending to counselling was strongly associated with the log odds likelihood of achieving RCSC by a factor of 3.4.

Factors predicting deterioration

Factors involved when clients' symptoms worsened, i.e., reliably deteriorated were also analysed. The same factors used to assess RCSC group inclusion, see above, were included in a binary logistic regression model using Reliably Deteriorated (Yes/No) as the dependent variable. A total of 1,037 participants were included in the analysis and the full model significantly predicted RCSC group membership (Table 3).

The only factor found to have a significant association was type of counselling ending. Having an ***unplanned ending was strongly associated with an increased likelihood of reliably deteriorating***. Results showed a strong association by a factor of 7.7 (Table 3).

2.3.12 How does age impact counselling outcomes?

Age related analyses – pre to post outcomes (CORE OM 34, WSAS and HRQOL-4)

A Pearson correlation analyses was conducted to determine whether there was any relationship between age and clients' pre counselling CORE OM 34, WSAS or HRQOL-4 scores. This helped to indicate whether there were any relationships in the data between age categories and symptom severity, social and occupational functioning and periods of time when participants' mental and /or physical health was not good before beginning counselling.

A series of one-way and mixed repeat measure ANOVAs were then conducted to assess for significant changes between pre and post counselling in CORE OM 34, WSAS and HRQOL-4 scores. Three effects were examined in these analyses: time, age category and the interaction of time by age category.

CORE OM 34 outcomes – Age differences

Of the overall sample (n = 2,928), age data were available for 98.1% (n = 2,873) of participants. Data was missing

Table 2. Relationships between predictors and outcome for RCSC

Logistic regression table with number of weeks waiting, pre therapy CORE OM, pre counselling risk, number of sessions attended, planed versus unplanned endings and previous client of the service as predictors of client RCSC achievement

						95% CI for odds ratio	
Variable	B	SE	Wald	p	OR	LL	UL
Number of weeks waiting (between referral and assessment)	-0.009	0.005	2.679	0.102	0.991	-0.981	1.002
Pre therapy CORE OM score (initial severity of symptoms)	-0.691	0.142	23.610	0.000	0.501	0.379	0.662
Pre counselling risk score	-0.004	0.029	0.017	0.897	0.996	-0.942	1.054
Number of sessions attended	-0.057	0.020	8.628	0.003	0.944	0.909	0.981
Planned or unplanned ending	1.219	0.169	52.006	0.000	3.383	2.429	4.711
Previous client of the service	-0.281	0.140	4.050	0.044	0.755	0.574	0.993
Constant	0.937	0.287	10.689	0.001	2.552		

Note. B = values for the logistic regression equation for predicting the dependent variable from the independent variable (in log-odds units), SE = Standard Error, Wald = used in conjunction with the p value to indicate usefullness of predictor variable, OR = odds ratio (i.e. the odds of achieving RCSC for one state of a predictor over the odds of achieving RCSC over the opposite state of a predictor), LL = lower limit, UL = upper limit.

for 1.8% of participants (n = 54). Pre and post age and CORE OM 34 data were available for 81.5% (n = 2,373) of the overall sample (Figure 23).

There were significant differences between the group in terms of CORE scores pre-counselling. Preliminary analysis showed a negative correlation between age and pre-counselling CORE OM 34 scores: r(2,835) = -.147, p = .005) which indicated that, on average, older participants in the sample were more likely to record less severe CORE OM 34 scores at assessment.

Higher severity was generally associated with younger age at time of assessment for counselling.

Mixed ANOVA results (Appendix 10) showed a significant change in CORE OM 34 scores between pre and post counselling. There were also significant differences between some of the age categories and between some age categories over time.

In terms of differences in pre to post clinical outcomes, analysis indicated that by the end of counselling those in the 66–75 year old age category showed a statistically significant greater level of improvement than all younger age groups younger than 56 years old (Appendix 10A).

HRQOL-4 outcomes – Age differences

Increased symptom severity in the form of overall distress, higher levels of impairment in the areas of work and social functioning and longer periods of time when clients were reporting being mentally unhealthy were all associated with clients in the younger age categories.

The reverse was true of those clients reporting periods when their physical health was not good, with longer periods associated with clients in the older age categories. (Appendix 11A)

These findings are in line with CORE OM 34 data which identified that younger clients were more likely to have more severe CORE scores prior to counselling.

Number of mentally unhealthy days

On average, as participants in the sample got older, the number of days they felt that their mental health was not good decreased (Appendix 11). There was no statistically significant difference in the number of mentally unhealthy days reported between the different age categories before or after counselling (Figure 23).

Table 3. Relationships between predictors and outcome for reliable deterioration

Logistic regression table with number of weeks waiting, pre therapy CORE OM, pre counselling risk, number of sessions attended, planed versus unplanned endings and previous client of the service as predictors of client's reliable deterioration

						95% CI for odds ratio	
Variable	B	SE	Wald	p	OR	LL	UL
Number of weeks waiting (between referral and assessment)	0.006	0.015	0.154	0.694	1.006	-0.977	1.036
Pre therapy CORE OM score (initial severity of symptoms)	-0.795	0.448	3.150	0.076	0.452	-0.188	1.086
Pre counselling risk score	0.003	0.095	0.001	0.974	1.003	-0.833	1.208
Number of sessions attended	0.066	0.053	1.539	0.215	1.069	-0.962	1.187
Planned or unplanned ending	2.046	0.398	26.419	0.000	7.739	3.547	16.888
Previous client of the service	0.139	0.393	0.125	0.723	1.149	-0.532	2.481
Constant	-3.492	0.866	16.255	0.000	0.030		

Note. B = values for the logistic regression equation for predicting the dependent variable from the independent variable (in log-odds units), SE = Standard Error, Wald = used in conjunction with the p value to indicate usefullness of predictor variable, OR = odds ratio (i.e. the odds of achieving RCSC for one state of a predictor over the odds of achieving RCSC over the opposite state of a predictor), LL = lower limit, UL = upper limit.

Number of physically unhealthy days

Results of a Pearson correlational analysis indicated that as participants got older, the number of days they felt their physical health was not good increased (Appendix 11B).

WSAS outcomes – Age differences

Of the overall sample (n = 2,928), pre counselling WSAS and age category data were available for 73.1% (n = 2,141) of participants. Pre and post age and WSAS data were available for 24.6% (n = 719) of the overall sample.

A Pearson correlational analysis showed a negative relationship between age and clients' pre counselling WSAS scores $r(2{,}141) = -.053$, $p = .015$. This indicated that on average, as participants in the sample got older, their WSAS scores at assessment also presented as less severe (Figure 24).

This was confirmed through an ANOVA [$F(7, 2{,}133) = 4.154$, $p < .001$].

2.3.13 The importance of endings: Planned versus unplanned

Counsellors/therapists indicated how counselling ended for each of their clients on the EOT form choosing either planned or unplanned ending.

Of the total sample (n = 2,928), 67.9% (n = 1,989) of clients were recorded by their counsellor/therapist as ending their counselling in a planned way. Approximately 28% (n = 819) of clients were recorded by counsellors as ending in an unplanned way. Data were missing for 4.1% (n = 120) of clients (Figure 25).

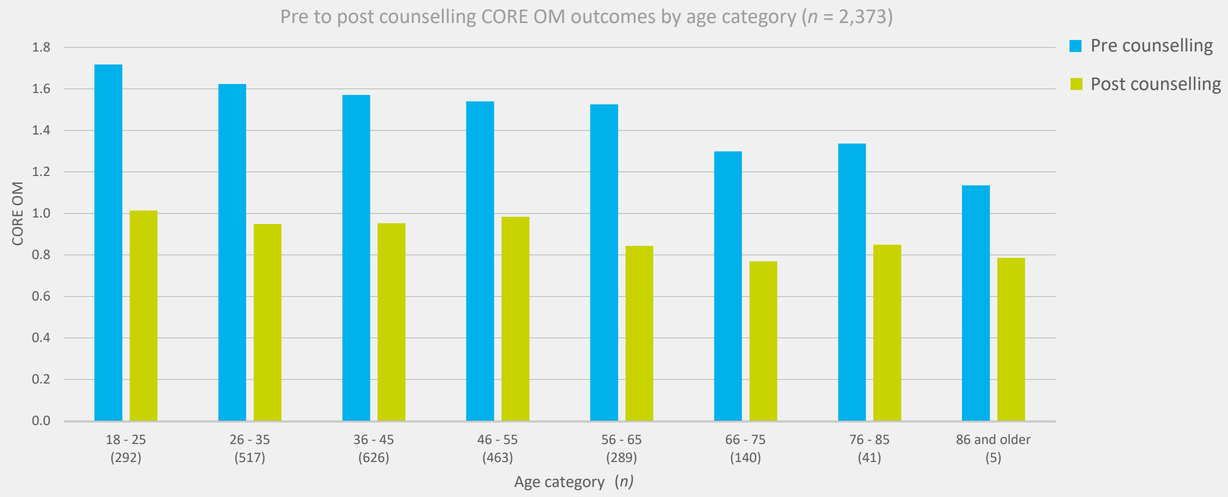


Figure 23. Pre- to post change in CORE OM 34 scores by age category

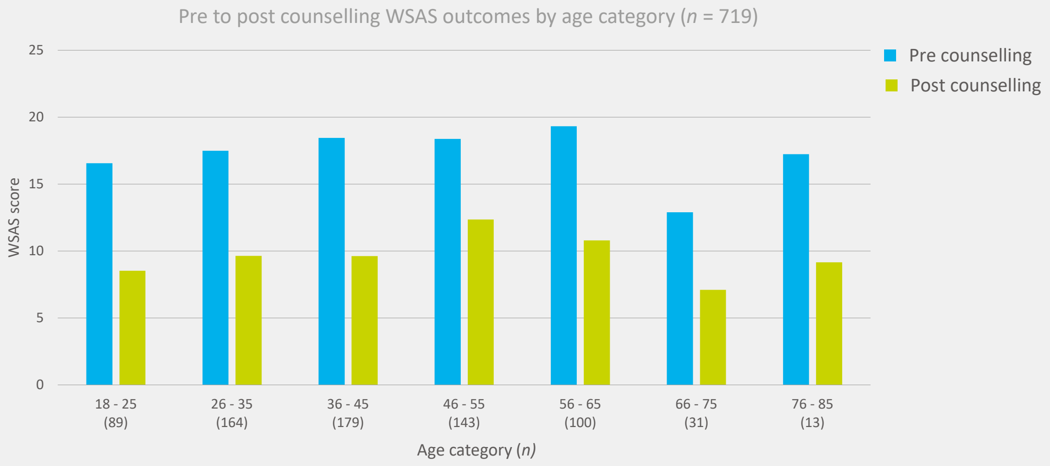


Figure 24. Pre- to post change in WSAS scores by age category

Planned ending types were further categorised as: Planned from the outset; Agreed at some point during counselling; Agreed ending during a session prior to the pre-agreed final session (Figure 25).

Unplanned endings are defined as "…a unilateral decision initiated by the client alone." (Connell et al., 2006). In this study they were categorised as endings which occurred because the client: declined counselling when offered a place; did not attend for initial assessment; discontinued counselling prior to the agreed number of sessions; stopped attending and was uncontactable; did not attend/cancelled sessions offered.

Symptom severity, number of sessions and type of ending

A binary logistic regression analysis was performed which examined the probability of a client having a planned or unplanned ending based on the initial severity of their symptoms and the total number of sessions attended.

Results indicated that those with higher CORE-OM 34 scores before counselling were more likely to have an unplanned ending (Appendix 9).

Results showed that with each additional session attended clients were more likely to have a planned ending (an increase of one session in the total number of sessions attended was associated with an increase in the odds of having a planned ending by a factor of 1.8).

Differences between clients with planned and unplanned endings for those who completed the CORE OM 34 questionnaire

As reported in Figure 25, 67.9% (n = 1,989) of clients were recorded by their counsellors/therapists as ending their counselling in a planned way and 28% (n = 819) of clients were recorded by counsellors as ending it in an unplanned way.

There was no significant difference between males and females in terms of type of ending i.e., male to female clients X^2 (1, N = 2,752) = 2.112, p = .146). In addition, the number of clients scoring above clinical cut-off did not differ for those who had a planned or unplanned ending stage X^2 (1, N = 2,772) = 1.123, p = .289).

There was no difference in pre counselling symptom severity between clients with planned endings (M = 1.56, SD = .608) or those clients who had an unplanned ending to their counselling (M= 1.60, SD = .604), t(2770) = -1.556, p = 0.120), as indicated by the CORE OM 34.

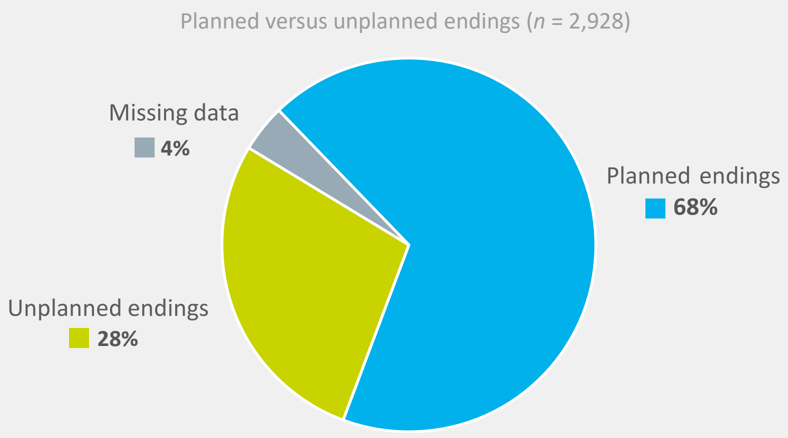


Figure 25. Overall proportions of planned versus unplanned endings

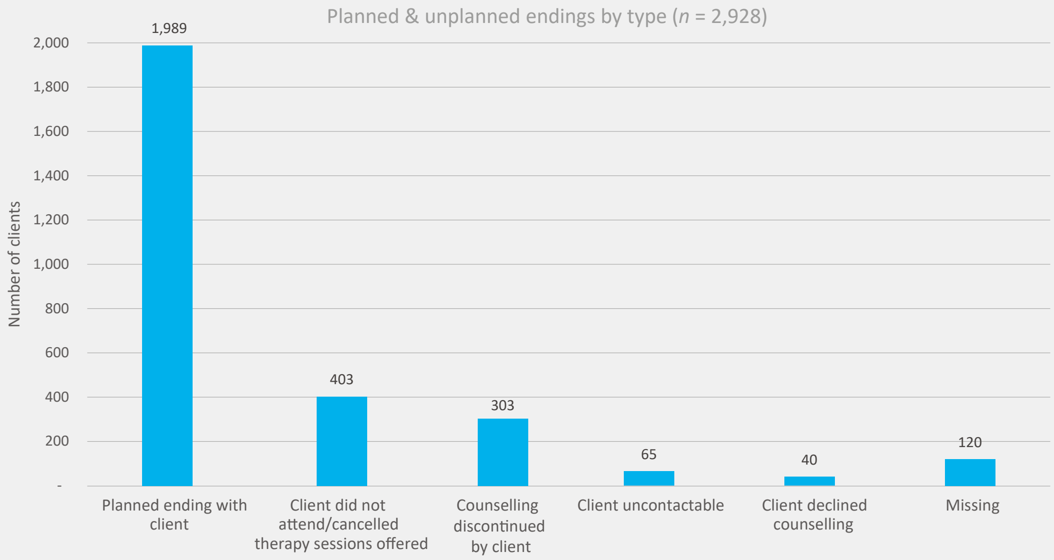


Figure 26. Proportions of therapy ending type[4]

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[4] The following categories are omitted from the chart due to small numbers: Client cancelled therapy sessions offered (*n* = 3), Referral to external service (*n* = 1), Significant pattern of non-attendance (*n* = 3), Client did not attend initial assessment (*n* = 1).

Statistically significant differences were observed between those with planned versus unplanned endings in terms of:

- **Age:** Those who had unplanned endings were an average of 4.1 years younger (M = 39.6, SD = 14.659) than those clients who had a planned conclusion to their counselling (M = 43.66, SD = 14.448), t(2751) = 6.711, p< .001).
- **Number of sessions:** Clients with unplanned endings attended for a shorter time and for less sessions than those who concluded their counselling contracts, attending on average 4.1 sessions. While those who finished their course of counselling availed of an average of 8.6 sessions, t(2724) = 36.910, p < .001).
- **Level of improvement**: There was a significant difference in the amount of improvement shown on pre to post CORE OM 34 scores by those who completed in a planned way compared with those who had an unplanned ending. Those who completed counselling improved significantly more (M = -0.70, SD = 0.615), t(2363) = -9.471, p < .001) than those with unplanned endings (M = -0.39, SD = 0.665) (Appendix 8).

2.3.14 What were the outcomes for clients who discontinued?

Secondary analyses of outcomes and RCSC - CORE – 10 scores only

Further analysis was undertaken in relation to clients who ended their counselling in an unplanned way (Discontinued group) for whom a CORE-10 measure was available at their last attended session (n = 662).

To generate pre counselling scores for this group of participants, scores from the corresponding 10 items on the CORE OM 34 questionnaire completed during the assessment session by these clients were extracted and mean scores calculated using the process described in the CORE-10 user manual (Appendix 2B).

For these analyses, participants were considered as having an unplanned ending if the counsellor/therapist recorded either Client did not attend/cancelled therapy sessions offered or Counselling discontinued by client. Over half (53.6%) (n = 355) of clients were recorded as having an unplanned ending and 43.4% (n = 287) had planned endings. Data were missing for 3% (n = 20). Of this group, 312 clients had data available for analysis.

Comparison of clinical outcomes for clients who completed counselling and clients who discontinued:

The clinical outcomes for clients who completed counselling (N = 1712) and those clients who discontinued for whom CORE-10 data was available were analysed (N = 312) (Table 4).

Clinical outcomes and type of ending

Pre/post CORE OM 34 and where applicable CORE-10 scores are reported in addition to counselling effect sizes generated for each group. The proportion of clients recovered in each group (i.e., those demonstrating RCSC), as well as those showing improvement and deterioration are reported.

Results demonstrate that a significantly higher proportion of clients who completed counselling and had a planned ending (i.e., episode completers), achieved reliable and clinically significant change (56.4% demonstrated recovery) compared to the group of clients who discontinued abruptly (29.1% demonstrated recovery). In addition, those who completed counselling showed a significantly greater effect associated with counselling (ES = 1.20) than the discontinued group (ES= 0.70) as well as a greater reduction in psychological difficulties pre to post counselling as measured on the CORE OM 34 and CORE-10 (Table 4).

2.4 Discussion

2.4.1 Counselling is effective

This study demonstrated that counselling was effective in reducing psychological distress for the majority of CIPC clients. There was a statistically significant decrease in CORE OM scores after counselling with a large effect size (Cohen's d = 1.2) demonstrated when counselling was provided.

A total of 82% of participants were assessed as above the clinical cut-off point on the CORE outcome measure at the start of counselling. This indicates that their difficulties were in the clinical range in terms of level of severity of psychological difficulties. This is in line with other studies examining the effectiveness of counselling and therapy (Gibbard & Hanley 2008; Gyani et al., 2013; Knapstad et al. 2018).

Anxiety and depression were the main presenting problems identified by clients at time of referral, as would be expected given that these difficulties are the most common mental health difficulties identified in the Irish general population (Doherty et al., 2008).

Table 4. Pre/post counselling effect sizes and recovery rates for main and subsamples of interest

Effect sizes, recovery, improvement and deterioration rates and pre and post counselling CORE OM 34 and CORE - 10 scores for Episode Completors (using CORE OM 34) and participants with Unplanned Endings (using CORE - 10)

	Core OM				Reliable and clinically significant change				
	n	Pre counselling	Post counselling	ES	n*	"Recovered %"	Improvement %	Deterioration %	No reliable change %
Episode completors (CORE OM 34)	1.712	1.55	0.85	1.20	1.398	56.4	71.9	0.9	27.2
Discontinued (CORE - 10)	312	1.79	1.30	0.70	258	29.1	42.7	8.5	48.4

Note. Episode completors = Assessed participants with valid pre and post counselling CORE OM 34 scores and who ended their counselling in a planned way, i.e. completed planned number of sessions. Discontinued (CORE-10) = participants indicated as ending counselling in an unplanned way, ending type = client did not attend/cancelled therapy sessions offered or counselling discontinued by client and with extrapolated pre counselling CORE-10 therapy scores from pre therapy CORE OM 34 scores and valid CORE-10 post therapy scores
*Only those above the CORE OM clinical cut off (i.e.1.00) can be included in RCSC analysis

Following counselling, 70% of participants (n = 2,037) experienced a reduction in their psychological distress (reflected in CORE OM 34 scores). A total of 72% of clients demonstrated either 'recovery' or 'reliable improvement'. 'Recovery' refers to clients who demonstrated reliable improvement, **plus** movement from a CORE score typical of a 'clinical' population to a score typical of the general population – 56.4% of clients in this study. 'Reliable improvement' indicates a decrease in psychological distress levels beyond that expected if they had not received any intervention – i.e., counselling (15.5% of clients). These results compare favourably with previous research among adults treated with psychotherapy under naturalistic conditions in the community [like this study] which showed that fewer than 30% achieve reliable improvement (Hansen et al., 2002; Schneider et al., 2020).

Table 5 gives a detailed comparison of CIPC outcome results with those of similar UK counselling services including IAPT.[5] Services are compared in terms of approaches used, how change was measured, effect sizes and the level of recovery and improvement. The CIPC study demonstrated comparable outcome effect sizes and similar proportions of clients achieving RCSC, reliable change or deterioration.

Similar increases in the well-being of people attending primary care counselling and psychological services are also documented across Nordic countries and the US. For example, in Sweden, Werbart et al. (2013) reported an overall effect size of *d* = 0.83 (*n* = 175) using the Global Severity Index (GSI) in a primary care setting where, like CIPC, counsellors utilised three main approaches: cognitive-behavioural (CBT), psychodynamic and integrative/eclectic psychotherapy. A Norwegian study, Knapstad et al. (2018), reported an RCSC rate of 69% (*n* = 663) along with an effect size using the PHQ-9 of *d* = 1.09. A recent US study reported that 53% of clients indicated reliable change with effect sizes of *d* = 0.51 on the PHQ-9 and *d* = 0.57 on the GAD-7 (Sawchuk et al., 2018). CIPC results broadly replicate reported improvements in the mental well-being of people attending counselling as reported in these studies.

Table 5. CIPC national evaluation results compared to similar services in the UK, Scandinavia and the USA

Comparison of CIPC study RCSC rates and effect sizes with those from other practice based studies

Study name and year of publication	Country	Therapy approach	Measure(s)	RCSC N	RCSC rate % (n)	Overall improved rate %	Effect size N	Effect size	Effect size calculation
CIPC National Evaluation	**Ireland**	**Mixed**	**CORE-OM**	**1398**	**56**	**72**	**1712**	**1,20**	**(Pre-Post)/ Pre SD**
Gyani et al 2013 (IAPT)[a]	UK	CBT	PHQ-9 GAD-7	19395	40	64	-	-	-
Cahill et al. 2010bc	UK	Mixed	CORE-OM	10842	56	74	10842	1,19	N/A
Barkham et al 2012	UK	Mixed	CORE-OM	10397	57	72	11651	1,91	(Pre-Post)/ Pre SD
Knapstad 2018	Norway	CBT	"PHQ-9 GAD-7"	663	69	-	864	"1.13 1.04"	(Pre-Post)/ Pre SD
Sawchuk et al. 2018	USA	CBT	"PHQ-9 GAD-7"	"464 489"	-	"55 53.3"	1372	"0.51 0.57"	Unknown
Werbart 2013	Sweden	Mixed	SCL-90	175	35	51	175	0,83	(Post-Pre) / SD pooled

Note. All effect size Ns are study samples meeting the following criteria: valid pre and post data returned and participants attended at least two sessions. RCSC Ns are those meeting the same criteria, but excluding participants below the respective clinical cut-offs at pre treatment.
a Reported RCSC and ES rates are reported as combination rates in this study.
b These are aggregated results of a meta analysis and excludes a single study which contributed over 50% of the overall data.
c RCSC rate is mean rate accross all seven primary care only studies included in the meta-analysis
RCSC, Clinical and Reliably Significant Change; CORE-OM, Clinical Outcomes in Routine Evaluation; PHQ-9, Patient Health Questionnaire; GAD-7, Generalised Anxiety Disorder scale, Symptom Check List-90; SCL-90.
- Not reported or unable to determine using data reported in the study

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[5] IAPT – Increasing Access to Psychological Therapy is the NHS primary care counselling service which delivers counselling and therapy across England.

While most clients that attend counselling and psychotherapy services improve, psychological therapies have the potential to do harm as well as good. In this study, 1% of participants (n = 13) showed deterioration in CORE OM 34 scores over the course of counselling with CIPC. Gyani et al. (2013) reported a deterioration rate of 6.6% in global distress after their one-year evaluation of the IAPT service in the UK. Rates of deterioration should however be considered in the context of deterioration rates for those who do not receive counselling; Beck et al. (2015) reported a deterioration rate of 13% for their waiting list control group who were not in receipt of counselling or psychotherapy.

2.4.2 Attendance at CIPC reduces suicide risk

In this study more than one quarter of participants (26.7% (n = 402)) were identified as at risk of harm at the start of counselling. At the end of counselling this number had reduced to 8.5% (*n* = 128), a statistically significant reduction indicating that counselling was effective in reducing risk where it presented. This is in line with international research which identifies that counselling and psychotherapy are effective in reducing suicidal behaviour (Méndez-Bustos et al., 2019; Sudak & Rajalakshmi, 2018).

A systematic review of the literature demonstrates the effectiveness of psychotherapeutic interventions in the management and reduction of suicide risk and behaviour (Méndes-Bustos et al., 2019). Cognitive Behavioral Therapy (CBT), Dialectical Behavioral Therapy (DBT) and specifically directed problem solving strategies have been identified as particularly effective in reducing risk (Calati & Courtet, 2016; Weinstein et al., 2018).

A Danish study examining the impact of short-term counselling which focussed specifically on reducing self-harm and suicide found that it was effective in averting future suicide attempts in a group identified as high risk. In addition the researchers found that these benefits were sustained over the long term, with 26% fewer suicide attempts and deaths by suicide in the 5 years after counselling amongst the group who had received counselling compared with the group who had not (Erlangsen et al., 2015).

Research has also identified the importance of addressing suicide risk directly in counselling as part of suicide risk prevention strategies (Sudak & Rajalakshmi, 2018). This approach to risk prevention is integrated into CIPC practice. All CIPC counsellors are required to complete suicide risk prevention training and risk assessment is a key element in the comprehensive assessment conducted by counsellors at the outset of counselling. The findings from this study demonstrate the effectiveness of CIPC counselling in reducing risk amongst clients who attend the service.

2.4.3 Counselling improves client quality of life

Quality of life is a broad ranging concept incorporating a persons' physical health, psychological state, level of independence, social relationships, and relationship with their environment (Evans et al., 2007; Quilty et al., 2003). People with psychological difficulties are more vulnerable to diminished health related quality of life because of common mental health disorders which increase vulnerability to health conditions such as heart disease, diabetes mellitus due to the impact of stress on quality of life (Skevington & McCrate, 2012). In addition, common mental health disorders such as an anxiety and depression are associated with increased use of general medical services (Candilis & Pollack, 1997; Simon & Katzelnick, 1997) as well as increased absenteeism and reduced productivity in the workplace (Dezetter et al., 2013). Effective treatment of psychological difficulties can yield significant economic benefits due to savings from reduced absenteeism and increased productivity from those treated returning to employment (Dezetter & Briffault, 2015; London School of Economics, 2006).

Attendance for counselling with CIPC had the effect of improving participants' perceptions of both their general and psychological health. Results showed they were spending less time suffering the day-to-day negative consequences of their psychological difficulties.

Results demonstrated significantly lower levels of distress, both statistically and clinically in a substantial proportion of participants post therapy as measured using the HRQOL-4 and WSAS. Significantly less impairment was reported by most participants in functional ability. Clients also demonstrated significant improvement in their general health after counselling as measured on the HR-QOL. Specifically there was a significant increase in the overall number of days clients felt their general health was excellent and very good, along with significant decreases in the number of days their general health was fair or poor following

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[5] IAPT – Increasing access to psychological therapy is the NHS primary care counselling service which delivers counselling and therapy across England.

counselling. Significant decreases were also reported by clients in the number of physically and mentally unhealthy days they experienced, as well as the number of days their activity was limited due to the problems with which they had attended the CIPC service. There was no significant difference in the number of mentally unhealthy days between different age categories.

A good level of congruence was observed between the outcomes of both the HRQOL-4 scale and the CORE OM 34 with increasing levels of distress as indicated by pre counselling scores being accompanied by increasing numbers of days when participants felt their mental health was not good.

The WSAS assesses the impact of a person's mental health difficulties on their ability to function in terms of work, home management, social and private leisure, personal or family relationships (Mundt et al., 2002). Study participants showed significant improvement in their WSAS scores with 43.6% achieving clinically significant levels of change.

Results from the HRQOL-4 and WSAS are significant as they demonstrate the positive impact counselling has on client quality of life and ability to return to tasks of daily living which can be severely impacted by psychological difficulties such as depression and anxiety, Shih and Simon (2008). Savings to the economy from improvements in quality of life are also significant in financial terms given the cost of lost productivity arising from psychological difficulties (The Lancet, 2020).

These treatment gains arising from CIPC counselling have important implications not just for the day to day life of clients, but also in terms of direct and indirect savings to the Irish State arising from reduced use of other health care services, improved population health and greater productivity in the workplace. Several international studies have demonstrated the potential savings associated with counselling and therapy outcomes (e.g., Dezetter et al., (2013); Vasiliadis et al., 2017). Psychological therapies are shown to be cost effective in the short and long term with a positive impact on health, quality of life and productivity yielding indirect savings of up to €1.95 for every €1 invested in psychological therapy services (Dezetter et al., 2013). Outcomes are also associated with reduced mortality in the population (Vasiliadis et al., 2017, p 902) and reductions in direct health costs and hospitalisation Altmann et al. (2016) because of effective psychological therapy provision.

Eligibility to access CIPC is currently limited to adults who hold a general medical card, which are granted to assist those on low incomes to meet the cost of health care. The intention in limiting access to CIPC to those with medical cards at the time of its establishment was to ensure access for those with limited financial resources who were most vulnerable to psychological difficulties. Research has consistently demonstrated that lower socio-economic status is associated with reduced access to care, poorer health outcomes, and increased mortality and morbidity with the impact of these effects increasing with age (McMaughan et al., 2020). The findings from this study demonstrate that as a national service receiving an average of 17,000 referrals per year from adult medical card holders, CIPC is making a significant contribution to improving the health of those in the Irish population most vulnerable to poorer health outcomes as well as to the Irish economy through improved general health and productivity.

2.4.4 Age impacts severity of reported psychological distress

Increased symptom severity in the form of overall distress, higher levels of impairment in the areas of work and social functioning and longer periods of time when clients were reporting being mentally unhealthy were all associated with clients in the younger age categories.

Pre-counselling symptom severity in terms of CORE OM 34 scores varied significantly between different age groups however higher severity was generally associated with younger age at time of assessment for counselling. Longer periods of poor physical health were more associated with clients in the older age categories.

This pattern of age differences in psychological distress is consistently reported in the research literature (Drapeau et al., 2014). Jorm et al. (2005) reported that psychological distress generally declined across the age range of 20-64 years with differential exposure to risk factors cited to explain some age group differences. Variations in psychological distress and other health problems during adulthood are associated with differential exposure to specific risk factors (Jorm et al., 2005; Schieman et al., 2001). Risk factors commonly associated with psychological distress include low educational level (Brault et al., 2012; Caron & Liu, 2011; Jorm et al., 2005), marital status (Brault et al., 2012; Caron & Liu, 2011; Jorm et al., 2005) and unemployment (Brault et al., 2012; Jorm et al., 2005).

2.4.5 Importance of timely access to counselling to reduce reliance on psychotropic medication

A total of 43.3% of participants were recorded as taking some form of psychotropic medication at the start of counselling. Of this group 76% reported being prescribed antidepressants, and 21% reported being prescribed anxiolytics. This finding affirms previous reports and studies which express concern about the reliance on medication based treatment for common mental health difficulties in Ireland (Grace et al., 2012; MHR, 2017; OCFH, 2017; Vitale et al., 2015)

Research indicates comparable outcomes for medication and psychological therapies in the treatment of anxiety and depression (Dreissen et al., 2010; Goncalves & Byrne, 2012). There is clear patient preference for talk therapy treatments for such common mental health disorders (Baumeiser, 2012; McHugh et al., 2013) yet antidepressants remain the most frequent treatment for depression (Cipriani et al., 2018) with a pattern of increasing use across OECD countries (OECD, 2018). This despite concerns about prescription levels for mental health difficulties (Cadogan et al., 2018; Conway Lenihan et al., 2016), potential harm from antidepressant use and absence of public health benefits (Hengartner, 2017).

The level of prescription amongst CIPC clients and the fact that most clients reported experiencing difficulties for more than 12 months prior to attendance underlines the importance of timely access to CIPC to reduce the requirement for reliance on medication to address psychological difficulties.

2.4.6 CIPC counselling approaches are tailored to client needs

Common therapeutic factors, (e.g., therapeutic alliance, clear rationale for the problem and a belief in the treatment method) (Greenberg, 2012), are considered responsible for most of the change across all forms of therapy (Wampold & Imel, 2015). Research also indicates that clients are less likely to drop out of therapy, and show better outcomes if their therapeutic preferences are accommodated (Swift et al., 2019). CIPC service policy does not prescribe the use of specific therapeutic approaches but relies on a comprehensive assessment of the client's presenting difficulties by counsellors/therapists and utilisation of therapeutic approaches most appropriate to client assessed needs.

Findings from the current study showed that most counsellors (88%) utilised multiple approaches with clients. Nine separate types of therapeutic approach were identified by counsellors/therapists during the current study. Person-centred, integrative and supportive therapies collectively accounted for 61% of all therapy types utilised with participants during the study. The most utilised therapy approaches were person centred, integrative and supportive. Cognitive and cognitive behavioural approaches were the next most used approaches.

These results confirm international research findings which typically indicate similar outcomes across different therapeutic approaches (Wampold & Imel, 2015). Further, they evidence the client-centred model of service provided by CIPC shown in counsellor/therapist flexibility and competence at providing a therapeutic approach tailored to individual client needs and preferences as they present for treatment.

2.4.7 Impact of ending on counselling outcomes: The importance of planned endings

Results of meta-analytic studies consistently indicate that dropout rates are far less for psychological therapies than for pharmacotherapy – the discontinuation rate in pharmacotherapy is 1.76 times higher than in psychotherapy (Swift et al., 2017). This underlines the importance of offering psychological therapies as a first-line treatment for many psychological disorders as effective treatments will only work if clients are willing to engage in them (Greenberg, 2016; Leichsenring et al., 2016). Large scale meta-analyses indicate that one-fifth (21.9%) of clients dropped out of psychotherapy prematurely (Fernandez et al., 2015; Swift & Greenberg, 2012; Swift et al., 2017). Higher rates of premature termination have been reported in studies using naturalistic research designs (Swift & Greenberg, 2012) with higher dropout rates expected in 'real world' clinical settings (Swift et al., 2017) such as CIPC. One study in the UK identified dropout rates of between 38% and 58% for primary care counselling services in the UK (Connell et al., 2006). CIPC had a dropout rate of 32% with 68% of participants in this study achieving a planned ending to their counselling.

Predictors of dropout are categorised in terms of treatment based, patient or therapist factors (Swift & Greenberg, 2012). Treatment-based predictors associated with premature termination include non-predefined duration of the intervention, non-manualised treatments and university-based programmes. In one study, 5.7% of dropout variance was explained by therapist characteristics (Zimmerman et al., 2017) such as level of experience, training and skills (Swift

& Greenberg, 2012). Patient factors associated with dropout include low level of education and lower age (Swift & Greenberg, 2012) though findings are not consistent (Altmann et al., 2018). The quality of the therapeutic alliance (Roos & Werbart, 2013) is also linked with premature termination.

Studies have consistently found that clients who drop out report more dissatisfaction (Knox et al., 2011) and poorer clinical outcomes (Cahill et al., 2003; Lampropoulos, 2010; Swift et al., 2009) compared with those who complete counselling. The CIPC study found that twice as many clients who had planned endings achieved reliable and clinically significant change compared with those who had unplanned endings. Clients with unplanned endings were on average of younger age (3.5 younger on average) and attended for a shorter duration, completing on average less than 75% of the number of sessions than those with planned endings. These findings are consistent with the literature which shows higher rates of drop out in those of younger age (Swift & Greenberg, 2021). While pre-counselling severity levels as measured using the CORE were not different to a significant degree, clinical outcomes were. Those who completed the full course of counselling [on average 7 sessions] achieved significantly higher levels of improvement than those who had an unplanned ending, who were seven times more likely to deteriorate.

The impact of therapeutic approach on client dropout has also been explored. Swift and Greenberg (2014) conducted a meta-analysis comparing drop out rates for different therapeutic approaches. They found that integrative therapy was associated with the lowest rates of dropout from therapy. This makes sense given the nature of integrative therapy which aims to respond to the distinctive individual needs of each client considering their affective, behavioural, cognitive, and physiological functioning as well as spiritual beliefs (Zarbo et al., 2016). As previously noted, CIPC counsellors/therapists utilised a range of therapy approaches depending on client needs, and integrative therapy was one of the most applied therapeutic approaches.

The findings from this study indicate that client dropout rates from CIPC are less than those reported in the literature for similar practice-based studies (Swift et al., 2017). Research has shown that clients who receive information about the expected length of therapy were significantly less likely to dropout than those who do not (Swift & Callaghan, 2011). The CIPC model of service is clearly defined, clients are offered up to 8 sessions of counselling which is outlined in the contract of counselling agreed at the outset, it is possible that having a predefined counselling contract (Swift & Greenberg, 2012) may contribute to achieving a high proportion of planned endings for CIPC clients. Further research is needed to establish direct association with ending type however at a practice level this finding provides support for the importance of having a clear contract of counselling duration agreed with the client at the outset of treatment.

The nature of endings raises significant implications for practitioners given that counselling is more effective where a planned ending is achieved. Those who dropout of counselling often have more severe symptoms at the start of counselling [though this was not found in the current study] and are more likely to have poorer clinical outcomes (Saxon et al., 2009) . This was replicated in the current study with those clients who had unplanned endings showing significantly less improvement after counselling.

Planned endings in counselling/therapy are also associated with greater cost savings. Altmann et al. (2018) found a significant reduction in annual inpatient costs, and reduced number of work days lost due to disability, for patients who concluded therapy in a planned way. Thus, the importance of monitoring progress and ending type at an individual practitioner as well as at a service level is clear. The findings in this study highlight the importance of clients completing the counselling contract and the need to support counsellors to identify those clients more at risk of dropout and to achieve planned endings with such clients. Evidence based strategies identified as helpful in reducing dropout include strengthening client hope, enhancing client motivation to change and fostering the therapeutic alliance (Swift & Greenberg, 2015).

Research has shown that clients are more likely to complete their treatment if they receive information early on about their expected treatment duration (Swift & Callahan, 2011). Outcome monitoring is recommended to determine optimal treatment length for individual clients and has been shown to reduce dropout from counselling and psychotherapy in clinical practice (Lambert & Shimokawa, 2011). CIPC utilises the CORE system measures to evaluate clinical outcomes. The CORE-10 is a short form measure which can be administered every session which is used in CIPC clinical practice by some CIPC counsellors. To what extent this measure is used to routinely monitor and inform clinical practice e.g., when a client is at risk of dropout was not the focus of the current study. The extent to which this practice contributes to sustaining clients in therapy is not clear. At a practice level it is recommended that consideration be given to the systematic introduction of outcome monitoring in CIPC to optimise planned endings. In addition it would be beneficial for the CIPC to routinely gather data on type of counselling ending as a measure of service effectiveness.

2.4.8 Questionnaire completion rates

Pre and post therapy completion rates for the primary measure - CORE OM 34 in this study were 96.5% and 59.8%, respectively. Post therapy rates are high in comparison to similar services in the UK where completion between 83% and 39% were obtained for pre and post questionnaire completion (Bewick et al., 2006).

The completion rates of pre and post counselling for the WSAS (74.3% and 27.1%) and HRQOL-4 (70.2% and 25.9%) questionnaires were considerably lower. Factors contributing to this may have been that 819 (28% of the total group of participants) had unplanned endings and did not have an opportunity to complete the WSAS or HQROL as these measures were only administered at the final session. These measures were also additional to those used in routine clinical practice by CIPC counsellors/therapists and may have been perceived as placing an extra administrative burden on counsellors/therapists who acted as a barrier to their implementation. This issue has been noted in other studies (Hatfield & Ogles, 2004). Review of completed measures at an earlier stage in the research process by the research project team could have identified this problem.

It is possible some counsellors/therapists did not perceive that the types of measures used could capture the unique characteristics or processes of change which occur in the therapeutic relationship (Roth & Fonagy, 2006) which impacted on compliance with the administration of these additional measures.

These factors would benefit from additional exploration given their potential impact on use of routine outcome measures in the CIPC service.

2.4.9 Generalisability of study results

Just 24.9% of study participants were male and 75.1% were female; this profile is representative of the population who typically attend CIPC. As outlined above, there were minor statistical differences between the profile of research participants in terms of age, number of weeks waiting to begin therapy and the number of sessions attended. These differences were not large enough to affect meaningful change. Gender breakdown, employment and ethnicity groups, proportion of clients above or below cut-off level and pre therapy symptom severity (CORE OM 34) closely reflect that of the overall cohort of clients who attended the service over the course of the study. Hence study outcomes presented here should generalise well to the larger population of clients who attend CIPC.

Most (85%) of participants were from white Irish backgrounds. The number of participants from other ethnic backgrounds was consistent with the proportion that generally attend the CIPC service. Participation in the study for clients attending the service for whom English is not their first language and who require an interpreter participation in the study was challenging as the CORE OM 34, WSAS and HRQOL-4 are not available in all languages. This meant that the participant group was weighted toward those who had English as their first language or a sufficient level of English to enable them to give informed consent and complete the study measures.

CIPC has noted that it is increasingly accessed by clients for whom Ireland is not their country of birth. To ensure CIPC is an equitable and inclusive service it is important to make it accessible for those who do not have English as their first language through making referrers and clients aware that interpreters can be provided where necessary and by ensuring that key service literature is translated into other languages.

2.4.10 Conclusion

The findings from this study demonstrate that CIPC counselling is effective in addressing common mental health difficulties with positive outcomes reported for most clients who attend. CIPC counselling also shows a positive impact on overall general health as well as improving day-to-day functioning and quality of life.

Given the prevalence of common mental health difficulties and their impact, as well as the psychological, societal and economic cost of such conditions, the case for expanding CIPC is evident. This requires the concomitant resources to ensure CIPC continues to provide a timely and effective service.

In line with the HSE corporate plan objectives to prioritise early interventions and improve access to person-centred mental health services, CIPC should be regarded as the treatment of choice for clients presenting with common mental health difficulties who require tailored psychological interventions.

3 How effective is CIPC? Do the effects of counselling last?

3.1 Literature review

3.1.1 Counselling effectiveness one year on: Clinical outcomes after counselling has ended

The relationship between psychotherapy outcomes and the length of treatment gains is becoming an increasingly important service related question. Cairns (2014) found that the less impact therapy has on the client the more likely they will seek additional help resulting in higher costs in the long run. Despite the importance of clarifying the enduring effects of counselling, studies which assess the psychotherapy outcomes beyond treatment termination are rare (Flückiger et al., 2014).

The most common follow-up periods found in the literature tend to be for periods between 4 and 12 months after therapy has ended (Davis et al., 2008). A 2011 meta-analysis comparing usual GP care, other psychological and psychosocial interventions and medication with counselling for patients with mental health and psychosocial problems in primary care in the UK found that counselling performed no better than usual GP care in the long term in four studies included in the review (Bower et al., 2011). However, a more recent meta-analyses of 46 RCTs of long-term effectiveness by Karyotaki et al. (2016), which examined acute phase psychotherapy for depression in adults found that the psychotherapy group performed better than control groups on all positive outcomes combined (recovery, remission, partial remission, response, and reduction in depression severity), as well as on quality of life measures at a follow-up of 6 months or longer.

In terms of studies conducted from a practice-based perspective, Davis et al. (2008) conducted a long-term evaluation of brief, time-limited counselling. CORE OM 34 questionnaires were completed by participants (*n* = 58) during assessment, immediately after counselling and 30 months after ending. Results showed that mean CORE OM 34 scores were significantly reduced between the beginning of counselling and immediately after counselling. There was also a significant statistical difference between CORE OM 34 scores when counselling ended and 30 months later, although the effect was small in real terms. Between post counselling and follow-up there was an increase in the number scoring above the clinical cut-off, from 29% to 31%.

The current study is one of few that investigates the longer term outcomes of counselling in a practice-based setting as measured by the CORE OM 34, at 6- and 12-month follow-up.

There are also clinical considerations for the Counselling in Primary Care service that underpin the rationale for the current study. To provide a service to as many individuals as possible in a timely fashion, CIPC operates a policy of not offering a second counselling episode until 6 months after completion of the client's first counselling episode.

The results of the current study will help to inform whether this clinical practice is efficacious, i.e., whether clinical gains made during a first episode of counselling are generally sustained at 6 and 12 months. This information can guide the service in prioritising service resources for maximum benefit.

3.2 Method

3.2.1 Participants

Table 6 shows the number of CORE OM 34 questionnaires sent and returned to each CIPC service that participated in the follow-up study. Follow-up questionnaires were not sent to a small number of clients for various reasons such as a client was deceased during the research period. Decisions not to send follow-up questionnaires were taken on a case-by-case basis in each area.

Overall, the demographic profile of participants for whom follow-up data were available at 6 and 12 months was identical to that observed in the main sample (Table 7).

Table 6. 6- and 12-month CORE OM 34 questionnaire returns by CHO area[6]

Breakdown of six and 12 month CORE OM questionnaire returns by CHO area

CHO	6-month follow-up invitations sent	6-month follow-up invitations returned	% returned	12-month follow-up invitations sent	12-month follow-up invitations returned	% returned
1	449	133		464	121	
2	307	51		147	26	
3	17	22		21	-	
4	676	151		486	132	
6	102	37		102	38	
7	20	28		20	-	
8MD	333	94		337	86	
8LM	615	104		387	76	
9	569	138		563	89	
Total	3088	758	24,5	2527	568	22,5

[6] CHO 5 was part of an initial pilot phase of the evaluation and did not participate in follow-up.

Table 7. 6- and 12-month follow-up sample demographic information

Follow-up participation gender and age breakdown information

		Six month follow up *(n = 758)*					12 month follow up *(n = 568)*				
Demographic	Category	Mean age	Min-max	*n*	%	Missing %	Mean age	Min-max	*n*	%	Missing %
Age		46.1	18-25	740		2.4	45.6	18-85	568		2.6
	18-25			61	8				62	10.9	
	26-35			117	15.4				76	13.4	
	36-45			192	25.3				137	24.1	
	46-55			159	21				122	21.5	
	56-65			131	17.3				105	18.5	
	66-75			67	8.8				41	7.2	
	76-85			13	1.7				10	1.8	
	85+			-	-				-	-	
Gender	Male			172	22.7				149	26.2	
	Female			568	77.3				419	73.8	

3.2.2 Measures

CORE OM 34, WSAS and HRQOL-4 measures were sent to participants with instructions for self-administration and a self-addressed stamped envelope for return of the questionnaires to their local CIPC office.

3.2.3. Procedure

All clients who consented to participate in the study also agreed to participate in the follow-up study.

All clients who completed an assessment and were accepted into counselling were included in the follow-up study. This included clients with planned and unplanned counselling endings. Clients were sent the follow-up pack by their local CIPC office 6 months and 12 months after the date of their last counselling session. Packs included instructions for completion and a self-addressed stamped envelope to return the questionnaires. All returned follow-up data were input directly into the CORENET system for analyses.

A risk management protocol was developed by CIPC research group to respond to elevations on the risk scale of the CORE OM 34 questionnaires received by post. All returned follow-up questionnaires were screened by the CIPC Coordinator for risk before being entered on the CORENET database for analysis. Clients were contacted by phone/letter where clinical risk was identified with recommendations to contact their GP and/or the service as appropriate (Appendices 17 A–C for risk management protocol letters). This resulted in a small number of clients re-attending the CIPC service. This protocol was in place for the duration of the study.

3.2.4 Missing data analyses

As with many practice-based longitudinal studies, a significant amount of follow-up questionnaires were not returned, resulting in data that was not available for subsequent analyses. However, there are statistical techniques that can be implemented to estimate and enter missing values in these types of data sets (see Dong & Peng, 2013). Multiple imputation (MI) is generally agreed to be the most robust method for longitudinal data (Sinharay et al., 2001; Sterne et al., 2009; West, 2001). MI was used for each of the measures reported on below. Outcomes for participants in the data set using MI strongly reflected those in the data set for which data were available. The MI results and process used in this study are fully described in Appendix 12.

3.3 Results

3.3.1 Questionnaire completion rates

Questionnaire completion rates were 25.9% and 19.4% at 6 and 12 month follow-up respectively for CORE OM 34 questionnaire. Rates for the HRQOL-4 and WSAS questionnaires were similar, ranging between 22.7% and 24.2% for 6-month follow-up and 14.1% and 15.4% at 12-month follow-up (Table 8).

Table 8. Questionnaire completion rates for CORE OM 34, HRQOL-4 and WSAS measures at 6- and 12-month follow-up time points

Questionnaire completion rates at pre and post counselling

	Pre counselling		Post counselling		6-month follow-up		12-month follow-up	
Measure	*n*	%	*n*	%	*n*	%	*n*	%
CORE OM	2887	98.6	2413	82.4*	758	25.9	568	19.4
HRQOL								
Question 1	2068	70.6	772	26.4	673	23.0	421	14.4
Question 2	2065	70.5	765	26.1	699	23.9	413	14.1
Question 3	2082	71.1	775	26.5	667	22.8	414	14.1
Question 4	2012	68.7	729	24.9	664	22.7	416	14.2
WSAS	2176	74.3	793	27.1	709	24.2	451	15.4

* Inclusive of valid CORE 10 questionnaire post counselling scores

3.3.2 Clinical outcomes: CORE OM 34: Long-term change in symptom severity

Questionnaire completion rates were 25.9% and 19.4% at 6 and 12 month follow-up respectively for CORE OM 34 questionnaire. Rates for the HRQOL-4 and WSAS questionnaires were similar, ranging between 22.7% and 24.2% for 6-month follow-up and 14.1% and 15.4% at 12-month follow-up (Table 8).

Long-term outcomes using observed data points

A total of 336 client had complete data for all four time points required to conduct a repeated measures ANOVA (with Greenhouse-Geisser correction due to the violation of sphericity) (Figure 27). This showed that mean CORE OM 34 scores differed significantly between time points [$F(2.899, 971.133) = 123.962$, $p < 0.001$]. Post hoc tests using the Bonferroni correction revealed that CORE OM 34 scores reduced by an average of .65 between pre and post counselling from 1.47 to 0.82 on the scale, then increased by an average of .31 between post counselling and 6 months later and (0.82 to 1.13) and finally increased very slightly again between 6 to 12 months after counselling by an average of .03 (1.13 to 1.16) (all differences $p < 0.001$).

The graph below (Figure 27) supports the statistical analysis suggesting that average CORE OM 34 scores between pre and post counselling decreased and then increased again between post therapy and 6 months later. A slight increase in scores was observed between 6 and 12 months after counselling had ended. While overall benefit in the form of decreased levels of psychological distress were experienced by participants between pre and post therapy, this benefit decreased somewhat 6 months after therapy had ended, with a slight additional loss of benefit occurring subsequently. Importantly, the overall benefit of counselling from pre to 12 months follow up was supported by a paired sample t-test which determined there was a significant difference between clients' average COREOM scores before attending CIPC and 12 months later ($M = 0.31$, $SD = .70$); $t(561) = 10.61$, $p < .001$).

3.3.3 The impact on client quality of life 6 and 12 months after counselling

WSAS – Long-term outcomes

Work and social adjustment questionnaire scores indicated significant decreases in the severity of impairment from pre to post counselling – with a drop in scores from 17.4 to 10.9. This was followed by an increase between post counselling and 6 months later to 13.8. A slight decrease to 12.2 was observed 12 months after counselling had ended (Figure 28).

HRQOL-4

Observable data were available at all four time points for 44 participants who reported a significant decrease in the number of days they felt mentally unhealthy before

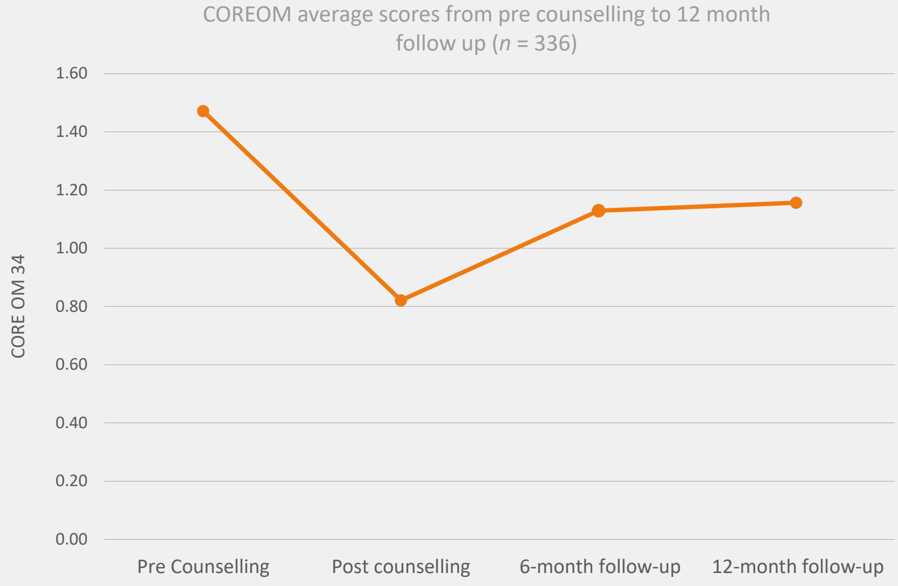


Figure 27. CORE OM 34 pre, post, 6- and 12-month outcomes using observed data

counselling (14.2 days in the previous month) and 12 months after counselling had ended (10.5 days) (Figure 29). This was also borne out in statistical analysis (*t* = 2.282, df= 44, *p* = .027, two-tailed).

The number of days between pre and post counselling when they felt mentally unhealthy reduced by an average of 4.8 days in the previous 30. The level of reduction declined to 1.3 days and 0.4 days at 6 months and 12 months follow-up, respectively. This resulted in an average of 10.5 days when participants felt mentally unhealthy 12 months after counselling. This is still well below the pre counselling average of 14.2 days however it was not a statistically significant difference (*t* = -.613, df= 64, *p* = .542, one-tailed).

In terms of the number of days participants felt their physical health was not good, a slightly different picture emerged over the longer term after counselling. Before counselling the average number of days in the previous month that participants reported their physical health was not good was 11.4. This dropped to 6.6 days immediately after counselling but increased 6 months later to 10.8. Interestingly, between 6 months and 12 months after counselling had ended, they reported another drop in the average number of days to 9.3.

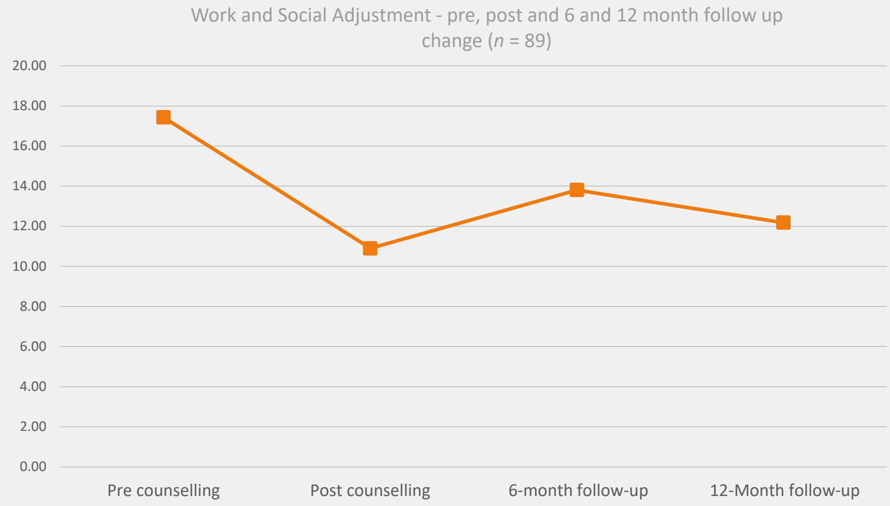


Figure 28. Work and social adjustment at pre, post 6 and 12 months using observed data

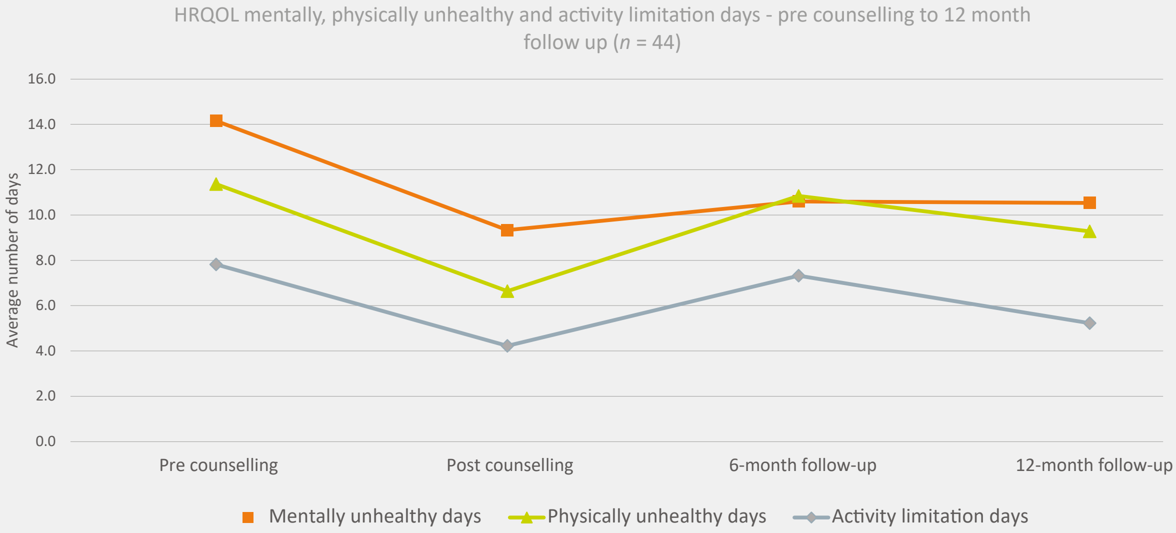


Figure 29. HRQOL-4 mentally and physically unhealthy and activity limitation at pre, post 6 and 12 months

Finally, the number of days that participants felt that their activity was limited due to their mental and physical problems followed a similar pattern to that of physically unhealthy days. Dropping from a pre counselling rate of 7.8 to 4.2 days post counselling, this number increases again 6 months later to 7.3 days. Between 6 and 12 months post counselling there was a decrease of between 2.1 days to 5.2 days.

3.4 Discussion

3.4.1 The effects of counselling last even after it ends

Studies examining the effectiveness of psychotherapy over the long term are not commonly undertaken, a fact highlighted by those attempting to conduct meta-analyses in this area (Cuijpers et al., 2016). Reasons for this include difficulty gathering robust sequential data for a large enough number of individual participants and threats to the generalisability of the results (Caruana et al., 2015).

This evaluation is one of the few follow-up studies measuring psychological distress, self-perceived quality of life and psychological status of participants. Analyses showed that 12 months after counselling ended the effect of counselling for participants was still significant in terms of reduced psychological distress, reductions in the time they felt unwell (mentally and physically) and that they continued to experience less impairment to their social and occupational activities than they had prior to counselling.

The results of studies that have examined change over a longer term in the real world context of primary care services, outcomes have been comparable with those found in this evaluation. Baker et al. (2002) reported that improvements found three months after counselling ended continued over the course of the following 18 months. They suggest that counselling may have facilitated participants to resolve key issues in their lives and provided them with the emotional tools helping them to cope for an extended period after counselling ended.

A more recent meta-analyses of RCTs investigating the long-term effects of psychotherapy found psychotherapy outperformed control groups at 6 months and 12 months post-randomisation (Karyotaki et al., 2014, 2016), though effects significantly decreased with longer follow-up periods. While a decrease in effectiveness was also observed in this evaluation, the overall benefit as measured by the primary outcome measure (i.e., the CORE OM 34) remained statistically significant up to 12 months later.

Other results from meta-analyses of RCT studies examining change over follow-up periods of at least 6 months after short-term psychotherapy have not found that effects lasted (Bower et al., 2011). This may be explained by their focus on defined effects in highly stratified groups of participants. As Barkham et al. (2008) notes, the primary focus of an RCT is on extending understanding of change in psychotherapy through identification of causal mechanisms in tightly controlled settings in homogenous groups, as opposed to practice based studies, such as this where service and client related factors are examined with the view to understanding their behaviour in real world conditions (Barkham et al., 2008).

To date, access to the CIPC service has been limited to patients who hold a General Medical Services (GMS) card. Eligibility for a GMS card is generally based on incomes status, with those over 70 and individuals in certain other socio-economic/health categories qualifying automatically. The aim of the scheme being to support those in most difficult financial circumstances to access health care (HSE, 2014). In the US, Sadock et al. (2017) conducted a study on the effectiveness of primary care counselling on a population who they described as vulnerable due to limited resources and low socioeconomic status. They found support for the effects of counselling for up to 18 months following counselling for this cohort. The outcome of the current CIPC study highlights the importance of providing effective counselling with lasting effects to ease the burden of mental health difficulties in vulnerable sections of the community.

3.4.2 Improvement in functioning sustained

The WSAS results in this study found a significant improvement in functioning was sustained for participants up to 12 months after counselling. A recent study of the effectiveness of Prompt Mental Health Care (PMHC) in the Norwegian mental health care system used the same measure (i.e., WSAS) and found that levels of work impairment were substantially reduced up to 12 months after treatment ended for those experiencing mild to moderate depression and anxiety (Knapstad et al., 2020). Substantial long-term reduction of work impairment, as reported in this current study, is potentially highly significant in economic terms. Mental health difficulties are estimated to cost €11 billion each year to the Irish economy “much of which is related to lost productivity in the labour market.” (MHR, 2018). The finding that attendance at Counselling in Primary Care can help to reduce impairment at work long-term, and consequentially improve productivity indicates the potential cost-effectiveness of a national primary mental health care service, such as CIPC.

3.4.3 Relapse prevention

The results of the current study demonstrated a significant improvement in CORE OM 34 scores for participants from before they attended CIPC and 12 months later (p <.001). Participants are reporting significantly lower levels of distress one year later, which points to the enduring positive impact of counselling. There is, however, a noticeable difference in the level of improvement immediately after counselling ended and 6 and 12 months later . This finding is echoed in those of other studies. Kupfer (1991) reported that approximately half of all patients treated for a first episode of depression relapsed. Ali et al. (2017) reporting on an IAPT service in the UK found that the majority (79%) relapsed within the first 6 months after treatment. And given that 60% of participants presented to the CIPC service for the first time with symptoms of depression, it is not surprising that there was a decrease in the improvements made for some participants after counselling ended.

In relation to this finding, any interventions which could promote the maintenance of the significant gains made in counselling are important to consider. Studies where 'booster' or 'maintenance' sessions are provided after counselling ended, show better treatment results when compared with studies that did not provide any further sessions (Karyotaki et al., 2016; Miranda et al., 2009). Richardson and Reid (2006) report on relapse prevention for depression in their study on a group CBT programme for older adults. They recommended top-up sessions as part of a relapse prevention plan (Richardson & Reid, 2006, p. 65). Further research on the utility of 'booster' sessions in maintaining counselling improvement is recommended. The CIPC service could consider a study piloting the provision of 'booster' sessions to identify the client presentations where this may be most clinically beneficial and to consider whether this would impact re-referrals to the service for further counselling episodes.

The findings in this study which showed significant clinical gains in comparison to pre-therapy are sustained at 6 and 12 months for most clients lends support to the CIPC practice of not offering a second counselling episode until 6 months after completion of the first. The ability to predict which clients are at increased risk of 'relapse' or unable to sustain gains made during counselling would be of great benefit to counselling service providers, policymakers, service funders and GPs (Moriarty et al., 2020). The identification of clients vulnerable to relapse when they present to either a GP or counselling service may be achieved using a combination of prognostic factors to produce multivariable prognostic models. Such risk prediction tools are increasingly recommended by policymakers (Riley et al., 2019) and could be explored for use by CIPC to help ensure maximum benefit is achieved by the service.

3.4.4 Episodic model of service

CIPC follows an episodic service model designed to provide counselling as required over the course of an individual's life-span. Re-referral to the service for different presenting issues arising at different life stages is clinically appropriate. The service aims to respond promptly to these presentations and to offer the client the support and intervention needed to facilitate them to effectively negotiate periods of increased stress.

The understanding by referrers, such as GPs that clients' presenting issues are appropriate for this model of time-limited counselling is crucial. Clients with a significant trauma history, for example, require a different level of psychological therapy and are less likely to sustain progress from a short-term primary care counselling service (Cloitre et al., 2012). It is often, only during an initial episode of primary care counselling however that such a history may be acknowledged or disclosed. Referral for more appropriate intervention such as that provided by the HSE NCS CAPA service, for adults who have experienced childhood abuse can be facilitated.

Further exploration of the utility of 'booster' sessions, risk prediction models of relapse and increased communication with GPs and other referrers about suitability for CIPC could mitigate the need for some re-referrals and ensure that clients access the most appropriate service for their needs in the timeliest manner. This would help improve clients overall experience of service and ensure the most efficient use of service resources.

3.4.5 Participation rates and generalisability of findings

Participation rates at the follow-up phases in this study were less than those observed in other studies conducted in practice-based and real-world-primary care environments. Baker et al. (2002) reported questionnaire return rates of 32.5% at 6 months and

22.8% at 12 months after counselling; compared with 25.9% and 19.4% found in this study. Some studies have reported much lower participation levels over the longer term, e.g., Ray-Sannerud et al. (2012) received only 10% (*n* = 70) of the total questionnaires sent to participants between 1.5 and 3 years after completing their counselling. While attrition during this study was a factor, follow-up data represented a satisfactory proportion of and similarity with the major characteristics of the overall participant sample which allowed interpretation of the results with a moderate degree of confidence they are generalisable to the overall CIPC population.

The dearth of studies available regarding the long-term effect of counselling underscores the importance of the longitudinal outcome results produced by this evaluation.

4 Counselling and medication prescription: What the scripts tell us

4.1 Literature review

Meta-analytic studies indicate that medication and psychological therapies achieve comparable outcomes for depression and anxiety (Driessen et al., 2010; Goncalves & Byrne, 2012; Roshanaei-Moghaddam et al., 2011), yet antidepressants remain the most frequent treatment for depression (Cipriani et al., 2018), with consumption of antidepressants doubling in OECD countries between 2000 and 2015 (OECD, 2018). Antidepressant use in Europe rose by approximately 20% between 2000 and 2010 (Gusmão et al., 2013) and from 7.7% in the period 1999–2002 to 13.2% in the period 2015–2018 in the USA (Brody & Gu, 2020). Figures from the Irish literature have displayed similar trends of increasing antidepressant use. The number of GMS cardholders prescribed antidepressants almost doubled between 2008 and 2018 (O'Donnell, 2019). A recent study of antidepressant prescribing in two Irish GP practices found a rise in antidepressant medication over the study period, 2016 to 2020 (McCool et al., 2021). This has been exacerbated by the impact of the pandemic with the Primary Care Reimbursement Service (PCRS) recording a 30% increase in the prescription of antidepressants in December 2020 compared to the previous year (Crowley & Hughes, 2021 p. 19). Despite the well documented side effects of long-term antidepressant use (Andersohn et al., 2009; Moret et al., 2009; Reid & Barbui, 2010), their prescribing term typically endures for a year or longer (Johnson et al., 2012).

Previous research has highlighted a high prevalence of mental health disorders among young Irish adults, with anxiety disorders being one of the most common types reported (Cannon et al., 2013). An analysis of general practitioner (GP) records in Ireland identified that approximately 75% of mental health cases involved those aged less than 65 years. In most cases, patients were treated with medication (81%) (O'Doherty et al., 2020).

Recent studies have questioned the efficacy of antidepressants (Aherne et al., 2017; Hengartner, 2017) with concerns expressed about potential harm from antidepressant use (Hengartner, 2017). Additionally, increases in antidepressant prescriptions have not translated into measurable public health benefits (Hengartner, 2017).

4.1.1 Impact of counselling on prescribing practice

Despite evidence that has shown psychotherapy to be as effective as pharmacotherapy in the short term treatment of depression, and more effective in the longer term (Leichsenring et al., 2016), the literature regarding the impact of counselling on prescribing practice is limited and at times inconclusive with methodological difficulties making comparisons between studies problematic. For example, Nettleton et al. (2000) found no relationship between counselling and medication use while Bower and Rowland (2006) reported a positive association, demonstrating a reduction in medication use for patients who had attended counselling.

In relation to prescribing rates, Simpson et al. (2003) investigated the effect of employing counsellors in GP premises on the psychotropic drugs prescribed and referral rates to mental health services. While they found no statistically significant effect on the volume of prescribing rates, there was an indication that practices where counsellors were employed for four or more years had lower patterns of medication prescription amongst clients attending counselling.

Sreeharan et al. (2013) in the UK used longitudinal time-series analyses to investigate the impact of the establishment of IAPT (Improving Access to Psychological Therapies) services on antidepressant prescribing rates in primary care pre and post establishment of IAPT. Antidepressant prescribing rates had been increasing at a rate of 10% per year prior to 2008 and the roll-out of IAPT. The study found no significant impact on this rate associated with the establishment of IAPT services over the course of the study (2008–2011).

Bridges et al. (2019) examined therapy outcomes for three different groups: patients whose treatment did not include pharmacotherapy, patients who had no change in medication during therapy i.e., they were already taking a psychotropic medication and continued to take the medication at the same dose for the duration of therapy and patients who initiated or had an increase in psychotropic medication concurrent with initiating their therapy. They found no post therapy difference in outcomes between the three groups and all groups improved to a comparable degree. However, patients who were prescribed medication or had an increase in medication during the trial were significantly more likely to drop out of counselling prematurely.

4.1.2 Cost offset

'Cost-offset' is a term used in health economics which refers to savings made associated with a reduction in health service utilisation due to another intervention. In the context of counselling it can be applied to situations where utilisation of other services, including prescribing of medications, can be shown to decrease because of counselling provided because of changes in patients' mental health, social functioning, or need for care (Wight & Fiedler, 1989). Meta-analytic evidence has shown that counselling provided by on-site therapists working in primary care in the UK can contribute to cost-offset in terms of reductions in consultation rates, psychotropic prescribing, and mental health referrals (Harkness & Bower, 2009). This is particularly relevant to the Irish context given that in 2016 the government spent over €44.4 million on antidepressant medications alone. The impact of the pandemic has further increased this spend. Data from the Irish Public Care Reimbursement Service (PCRS) demonstrates a further escalation in both prescribing frequency and total drug expenditure in 2020 in comparison with 2019 (HSE, 2020).

4.1.3 Over-reliance on medication

In Ireland, GPs have acknowledged an issue with prescribing patterns of psychotropic medication, and some have sought to address it (Grace et al., 2012). It is acknowledged that in the absence of accessible psychological therapies there can be an over-reliance on medication (Cadogan et al., 2021). Grace et al. (2012) reported on a GP-led quality improvement initiative intended to reduce prescription of benzodiazepine and Z-drugs (i.e., non-benzodiazepines that offer similar benefits) in their GP practice. An audit was carried out to identify all patients in receipt of regular prescriptions for benzodiazepine and Z-drugs. All such patients were invited for an appointment to discuss their prescriptions. The letter sent to patients also highlighted the benefits of reducing/stopping their intake and contained additional information advice on how to do so. Finally, a specific policy to guide GPs in the practice on safer benzodiazepine prescribing was also put in place. After 3 months,70% of the 137 patients contacted had their medication reviewed. 40% had agreed to a dose reduction and 8% had stopped their medications completely. Of those who reduced, the average reduction was 50% of their starting dose. This highlights the benefit of focusing on psychotropic use and of including patients in decisions regarding their treatment.

A 2019 study suggested that approximately 65% of patients have never discussed the idea of stopping the use of antidepressant medications. Likewise, 48% of patients did not have their antidepressant medications frequently reviewed with their general practitioner (Read et al., 2019). This highlights the need for ongoing communication and frequent reviews with health care practitioners (McCool et al., 2021).

A recent study by Walshe (2021) explored the effectiveness of primary care interventions on reducing or discontinuing benzodiazepine/Z-drug use (BZRA) compared with usual care. The authors conclude that brief interventions delivered in primary care settings are more effective than usual care at reducing and discontinuing BZRA use. A gradual dose reduction approach must be specific to the individual to prevent rapid dose reduction, which has implications for withdrawal and can hinder patient success. Developing a personalised approach is important to address this problem.

Surveys of antidepressant users suggest 30–50% have no evidence-based indication to continue but coming off antidepressants is often difficult due to fears of relapse, withdrawal and a lack of psychological treatments (Kendrick 2020).

4.1.4 Study objectives

One of the primary reasons for the establishment of the HSE Counselling in Primary Care Service was to provide GPs and patients with an alternative treatment option to medication for mild to moderate psychological difficulties as GPs are often the first point of contact for people with mental health conditions (HSE, 2012; Wittchen et al., 2003). Consequently, one of the goals of the CIPC National Evaluation was to consider how patterns of psychotropic medication prescription were impacted by the CIPC service.

This study of prescribing patterns is exploratory in nature. We sought to work with both GPs and consenting clients to collect and examine psychotropic medication prescribing data with a view to establishing if changes in psychotropic medications could be observed for clients who attended counselling. Importantly, the review could only examine prescription statuses as recorded by GPs through the surgery management software systems. There is no implication that this reflects accurately psychotropic medication consumption, or compliance by patients with the advice given to them by their GP regarding their psychotropic medication.

4.2 Method

4.2.1 Consent

The invitation to participate in the CIPC National Evaluation comprised two discrete parts; firstly all clients who presented for assessment were invited to consent to take part in the overall service evaluation examining the effectiveness of counselling provided by CIPC. Secondly, in line with ethical requirements, separate consent was sought from all participating clients to allow CIPC to request details of their psychotropic medication prescriptions from their GP (Appendix 3C for consent form) for up to 6 months after their counselling ended. Written requests for medication prescription reports were sent to the GPs of consenting clients.

4.2.2 Participants

The overall sample comprised all clients who provided explicit consent to participate in this element of the evaluation and for whom data files were received from their respective GPs. Not all files received were valid or usable and details of exclusion criteria are described in Figure 30.

4.2.3 Materials

All GPs of clients who provided explicit consent to participate in the psychotropic medication data collection process were sent a request for medication data by post. This included instructions on how to extract the relevant data from their respective GP management software packages. Reports for participants were generated from within one of two integrated practice management software options; Socrates GP™ or HealthOne™ patient record and practice management systems (Appendix 13). Custom CIPC medication data reports were developed for each software platform. This followed a process of consultation between the CIPC study researcher and Clanwilliam Health, a health care technology and services company which owns and operates both Socrates GP™ and HealthOne™.

To support GP participation, this study was endorsed by the Irish College of General Practitioners (ICGP) who agreed to provide GPs with 1 CPD credit for return of mediation data reports.

4.2.4 Procedure

Prior to requesting medication data reports, several efforts were made to inform as many GPs as possible about the research study and planned data collection process. The evaluation research group disseminated the results of the Phase 1 study to GPs through local communication channels. In addition, Phase 1 results were reported in an article about the research along with an invitation for GPs to participate in the medication submission process. This invitation appeared in the September 2018 print and online versions of the monthly GP magazine - *Forum*.

A pilot study was conducted in one CHO area to assess data collection methods for medication data. Based on feedback and an evaluation of the learning outcomes of this pilot study the medication data collection method was revised and the final process for obtaining the data from GPs was implemented as described.

Eight CIPC services participated in this part of the study (two services did not take part in this section of the study, the service which had completed the pilot data collection process and the CHO 5 service which completed phase 1 of the study which did not include a medication data study phase).

Each CIPC service maintained a list of clients who consented to participate in the medication data phase of the study. All GPs for these clients were written to with details of the study. A copy of the relevant client consent form to release medication data and detailed instructions on how to extract the relevant medication data from their respective GP management software packages was included.

Requests for all medication data were sent by post. Reports generated by GPs were returned to the relevant CIPC Coordinator or CIPC researcher via HealthMail, a secure email service of the HSE, managed by eHealth Ireland in line with GDPR guidelines. Where GPs did not respond to the first request two further follow-up contacts were made by email and/or phone encouraging return of the requested data.

4.2.5 Analytical approach

A total of 1,212 individual medication reports relating to 192 clients were returned for analysis (Figure 29). The objective of the analysis was to describe changes in participants' psychotropic prescription status as recorded by their GPs for the period 6 months prior to counselling, during counselling and 6 months after they had finished counselling with CIPC. Reports generated by GPs using their respective surgery management software packages (i.e., Socrates™ or HealthOne™) returned several different results depending on the status of client prescriptions:

1. *"Discontinued or Stopped"* referred to prescriptions for the named drug which ceased on the corresponding date for that entry
2. *"New or Prescribed"* referred to prescriptions for the named drug which commenced on the corresponding date for that entry

3. *“Re-prescribed”* referred to continuation of the prescription for the named drug on the corresponding date for that entry

Each change in prescription entry status of *Stopped* or *Discontinued* was cross-referenced with the date counselling ended to determine if the change occurred before counselling began, within the period that counselling took place or during the 6-month period after each client ended their counselling. It was common that prescriptions were *stopped* or *discontinued* on a particular date to be *re-prescribed* on the same date. For the sake of this analysis these changes were not considered as discontinuations in prescriptions status.

Increases and decreases in the amount of medication prescribed were determined by recording dosage levels as baseline amounts in the 6 months prior to each participant beginning their counselling or the first recorded prescription after this period, whichever occurred first.

Differences in these baseline dosage amounts were compared with any changes observed during the counselling period and in the 6 months after counselling ended.

4.3 Results: Are medication prescription patterns impacted by CIPC counselling?

Of the 5,025 clients who attended assessment during the research period, 2,101 opted to participate in the psychotropic medication data phase of the study. A total of 1,212 patient medication requests were sent from 9 CIPC services to GPs. Prescription records were returned which related to **192** clients, a return rate of 15.8% (Figure 30).

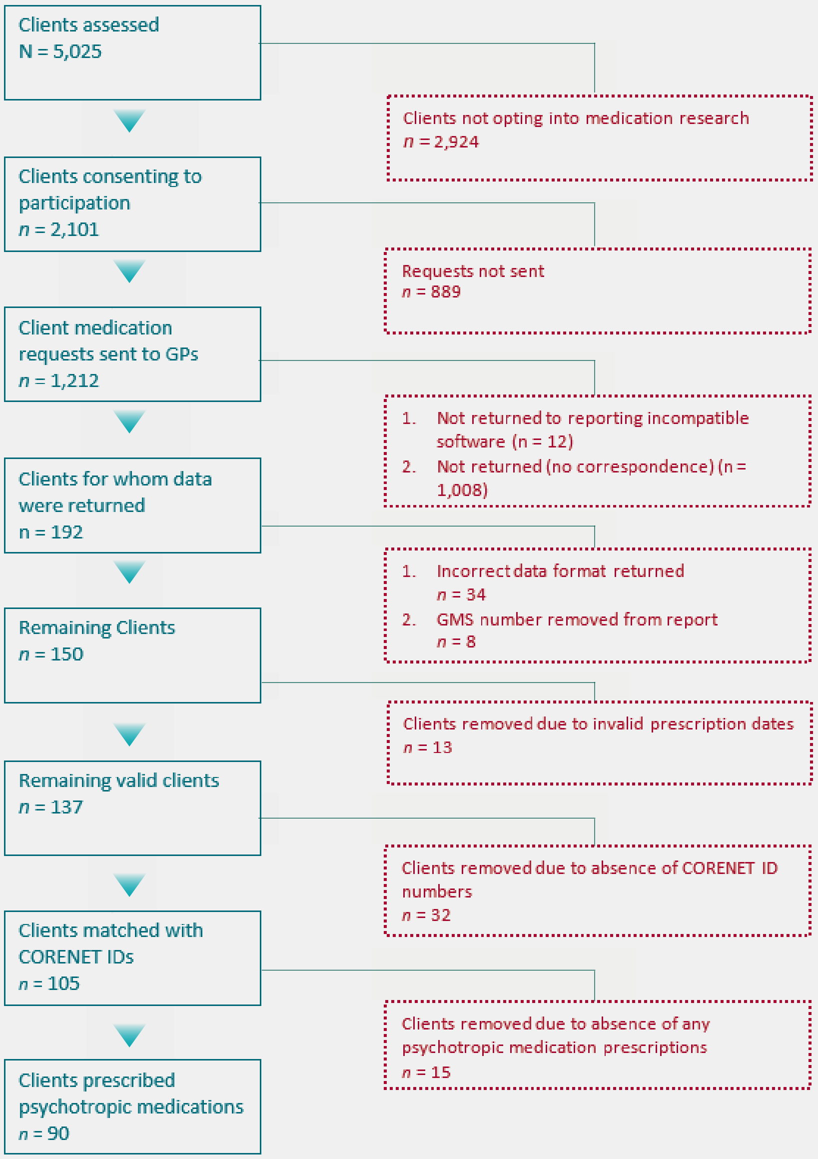


Figure 30.
CONSORT diagram showing research participation, inclusion and exclusion of participants based on returned data

Of the 192 clients for whom prescription data were returned, a number were excluded from subsequent analysis (Figure 30). Just 34 records were returned in unusable format. Eight returns had no GMS number so could not be matched with client IDs to determine counselling end date. Thirteen clients were removed from analysis as their records related to periods outside of the research period. Thirty-two records were excluded as there was no corresponding client ID.

Data for 105 clients were matched with their corresponding IDs and of these 90 clients were prescribed psychotropic medications and included in analyses.

4.3.1 Participant demographics - gender, age, employment and ethnicity

The mean age of participants involved in the examination of psychotropic medication prescribing analyses was 46.9 years (range 23-84). The majority (70%) were female (*n* = 63), 30% were male (*n* = 27).

In total, 26.7% were recorded as *Employed* (*n* = 24), while 21.1% indicated they were *long-term sick*, *disabled or on benefits* (n = 19), 14.4% as *homemaker not working or actively seeking work* (n = 13), 12.2% as *unemployed and seeking work* (n = 11) and 8.9 % did not have corresponding data for this category. Over 63% of the sample reported being *white Irish* (*n* = 57) and 13.3% as from *Any other white background* (*n* = 12)(Table 9).

Gender breakdown and employment status mirrored the proportions found in the main study sample (Figure 31).

The pattern of attendance regarding the average number of sessions reported for sample of participants in the psychotropic medication prescribing sample (*n* = 90) closely mirrored that of the overall national sample in the study (N = 2,757) (Figure 32).

Table 9. Demographic information for psychotropic medication prescription participants

Demographic	Category	Mean Age	Min - Max	*n*	%	Missing %
Age		*46.9*	*23-84*	*90*	-	-
Gender	Male	48.4	25-84	27	30.0	-
	Female	46.3	23-75	63	70.0	-
Employment Status						8.9
	Employed			24	26.7	
	Unemployed and seeking work			11	12.2	
	Student			3	3.3	
	Long Term Sick, Disabled or Benefits			19	21.1	
	Homemaker not working or actively seeking work			13	14.4	
	Not receiving benefits and not working or actively seeking work			2	2.2	
	Unpaid voluntary work, not working or actively seeking work			1	1.1	
	Retired			9	10	
Ethnic Origin						17.8
	White Irish			57	63.3	
	Any Other White background			12	13.3	
	Black, or Black Irish - African			1	1.1	
	Black, or Black Irish - any other Black background			1	1.1	
	Asian, or Asian Irish - any other Asian background			1	1.1	
	Other including mixed background			2	2.2	

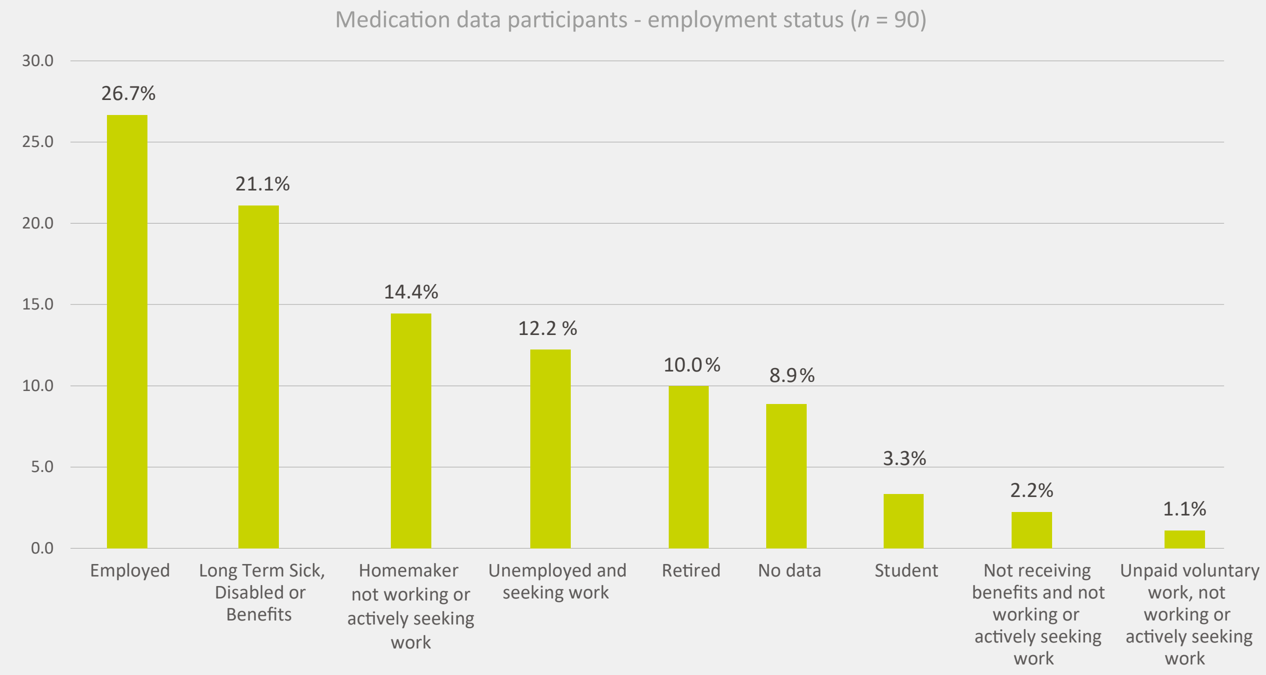


Figure 31. Medication data participants breakdown of employment status

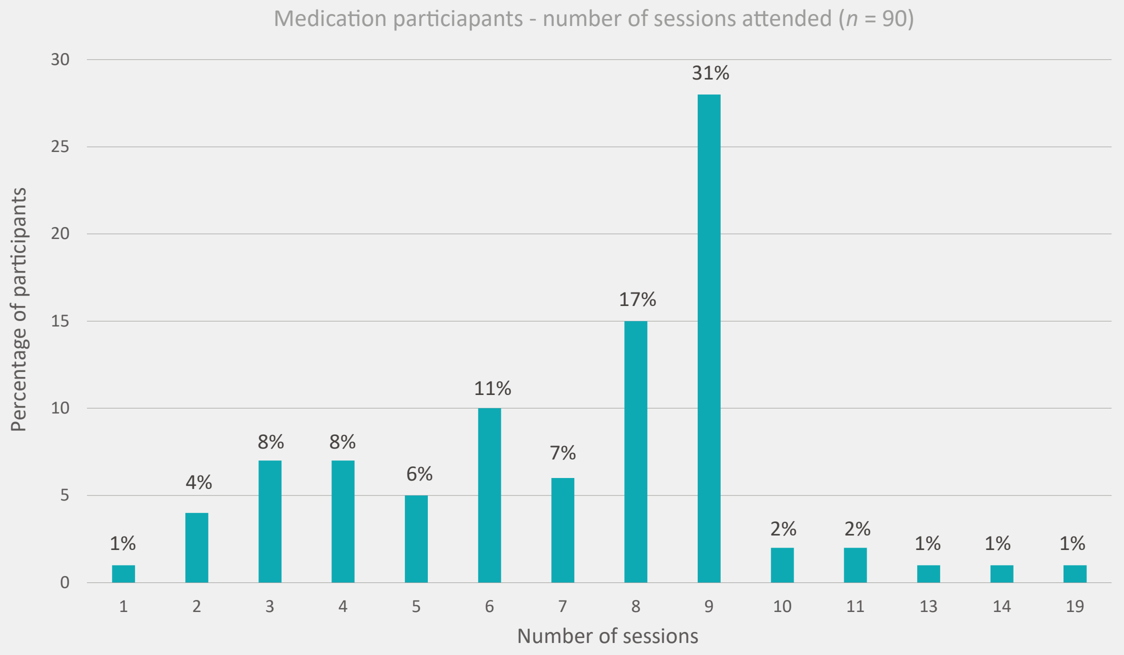


Figure 32. Breakdown of number of sessions attended by participants in the psychotropic medication prescription analysis

4.3.2 Planned versus unplanned endings

The participants involved in the psychotropic medication prescription analysis exhibited a higher rate of planned endings to their counselling than those participants in the main sample – 76% versus 69% respectively.

4.3.3 Breakdown of prescribed drug classes

Over half of all participants in the sample (53.3%) were prescribed antidepressants. 41.1% had prescriptions for anti-anxiolytics and the remainder for either sedative/ hypnotic or opioid analgesics (Figure 33).

Major drug types prescribed

Four drug types accounted for most of all prescriptions issued (47.8%): Alprazolam, Diazepam, Amitriptyline and Sertraline (Figure 34).

4.3.4 Description of prescribing patterns

There was variation throughout the sample in the number of psychotropic prescriptions before counselling began, during counselling and in the 6 months after counselling ended (*n* = 90). The average number of prescriptions per participant was 3 before attending counselling and after range from 0–5.

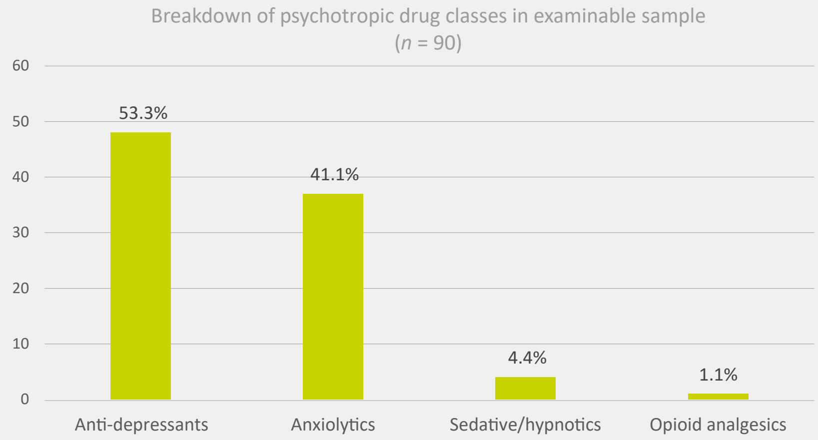


Figure 33. Breakdown of psychotropic drug classes

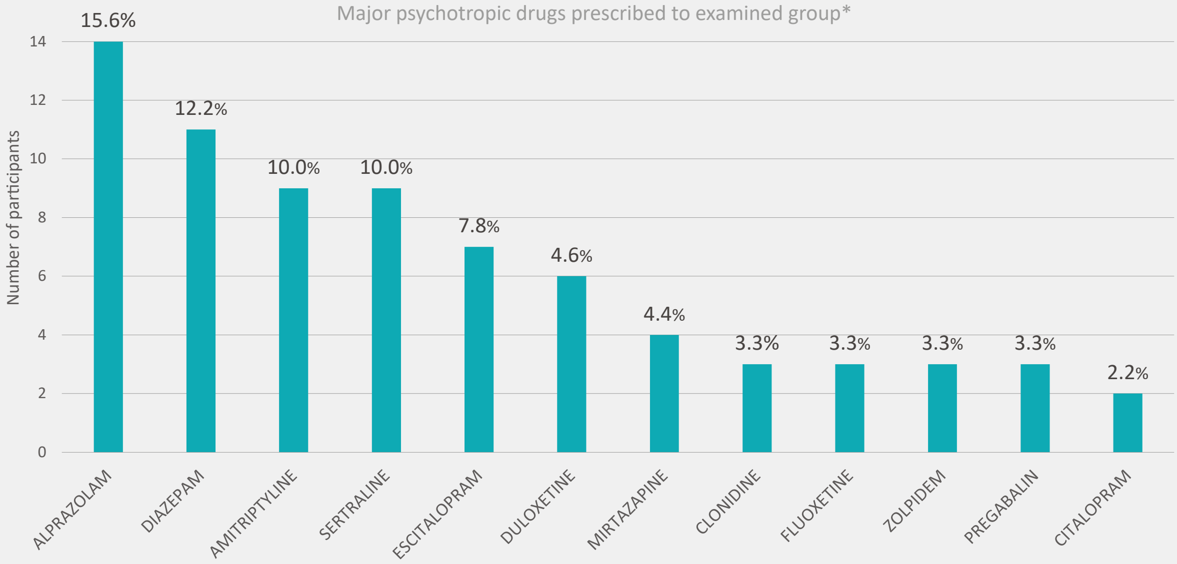


Figure 34. Breakdown of major psychotropic drug types[7]

[7] Participants with single allocations (n = 12) were omitted from this chart

4.3.5 Summary of prescription change status

Over half (57.8%) (*n* = 52) clients reported no change in the number or the status of their existing prescriptions over the study period i.e., they remained on the same class of medication with no change in dosage.

Of the remaining 38 clients, the following changes to prescription status were indicated during and/or after attending counselling with CIPC (Figure 35):

- 3.3% of clients (*n* = 3) stopped/discontinued their psychotropic medication prescriptions completely
- 6.7% of clients (*n* = 6) reduced the overall number of their psychotropic medication prescriptions
- An additional 5.6% (*n* = 5) decreased the dosage of their psychotropic medication
- 4% (*n* = 4) increased the dosage of their psychotropic medication
- 1% (*n* = 1) of clients indicated both an increase in overall number of prescriptions and medication dosage
- 12% of clients (*n* = 11) had prescriptions for psychotropic medication introduced during the study period
- 8.8% (*n* = 8) clients had an increase in the total number of prescriptions.

4.3.6 What do changes in prescription patterns tell us about clinical outcomes from counselling?

Comparison of CORE OM 34 scores pre, post and 6 months after counselling between participants showing no change, improvement and dis-improvement

To further investigate differences in medication prescription patterns and attendance at counselling participants were categorised into one of three groups which were suitable for analysis, i.e., for whom data were available at all three time-points.

This constituted 31% (*n* = 28) of the total medication sample:

- Unchanged: those whose prescription status remained unchanged over the course of the study (17.7%, *n* = 16)
- Increased/commenced medication: those whose number of prescriptions or dosages increased or began during the study (7.7%, n = 7)
- Decreased/Stopped: those whose number of prescriptions or dosages decreased or stopped (5.5%, n = 5).

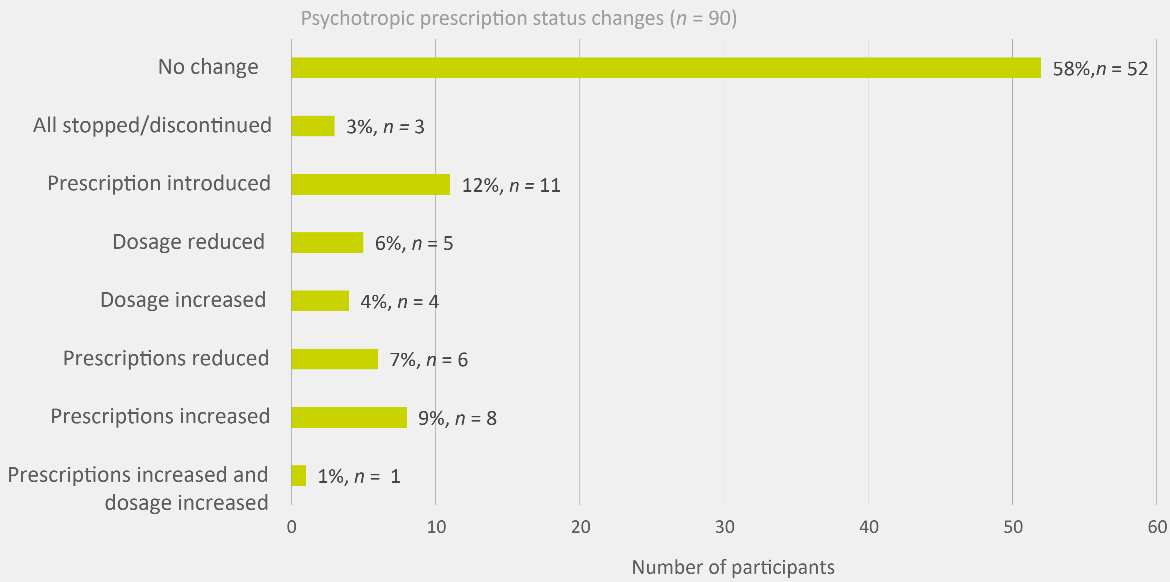


Figure 35. Distribution of participants with changes to psychotropic prescription changes (n = 90)

Mixed ANOVA results showed a main effect for TIME, $F(2,24) = 10.969$, $p < .001$, $\eta_p^2 = .478$ on CORE OM 34 scores between pre counselling and 6 months after counselling ended. Estimates for average CORE OM 34 scores across **all** prescription change class categories at pre, post and 6 months after counselling were 1.43 (SE = .137, 95% CIs: 1.145] [1.711]), .80 (SE = .121, 95% CIs: [.541] [1.038]) and 1.25 (SE = .200, 95% CIs: [.836] [1.658]) respectively. This suggests that average CORE OM 34 scores for all three prescription change classes differed significantly between pre, post and 6 months after counselling, following the pattern of change ended as shown in Figure 36.

There was no significant effect of prescription change classes on CORE OM 34 scores: $F(2, 24) = 0.136$, $p = .874$, $\eta_p^2 = .011$, with participants in all three prescription change classes showing no significant differences between them in terms of change in CORE OM 34 scores across pre, post and 6 months after counselling. Meaning the group differences in CORE OM 34 scores averaged across time were not significantly different between the prescription change class groups. The test of the interaction between the grouping variable, i.e., Change class and time was also non-significant, $F(2,4) = 0.735$, $p = .572$, $\eta_p^2 = .056$.

A visual inspection of the CORE OM 34 scores before and after counselling ended and 6 months later shows some differences of potential interest from a clinical perspective. All three groups made significant gains (i.e., reductions) in improvement in their level of psychological distress while attending counselling (i.e., between pre and post counselling).

Figure 36 also shows a difference in severity of symptoms between the three groups 6 months after counselling. CORE OM 34 scores for those in the Decreased/Stopped group increased but remained **below the clinical cut-off** level of 1.00. The Status Unchanged group shows an increase in scores to levels above clinical cut-off which was a pattern evident in post to 6 month change for participants in the main sample (i.e., Chapter 3, p. 64, $n = 336$).

Of note, those clients for whom medication was introduced or dosage increased during counselling demonsrated CORE OM 34 scores which were **higher** 6 months after they ended counselling than when they began, i.e., they deteriorated.

Further analysis was conducted to consider whether there was any relationship between medication change group membership and type of ending to counselling (planned versus unplanned), age and gender. No statistically significant relationships or differences were found between medication change groups on any of these the factors.

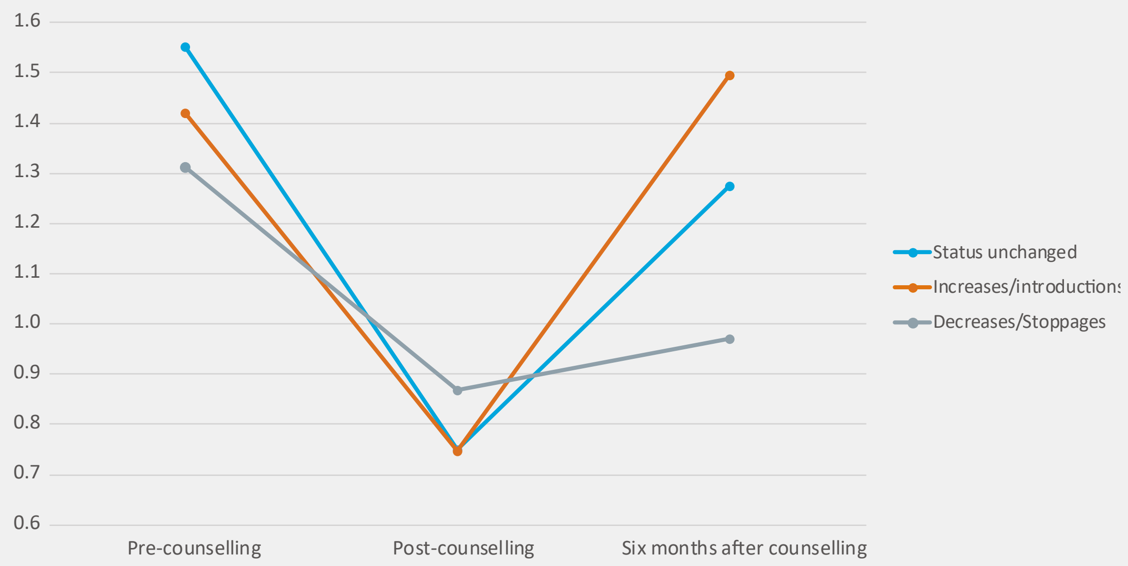


Figure 36. CORE OM 34 severity change between three change class groups: Status unchanged, increases/introductions and decreases/stoppages at pre, post and 6 months after counselling

4.4 Discussion

This phase of the CIPC national evaluation was an exploratory study, the purpose of which was to examine psychotropic prescription records to consider the pattern of medication prescription before, during and in the 6 months after attendance at CIPC counselling. As outlined, prescription of psycho-tropics, in particular antidepressants, is rising (Crowley & Hughes 2021; McCool et al., 2021; O'Donnell 2019) despite their effectiveness for treating common mental health disorders such as anxiety and depression being questioned (Hengartner, 2017). This study sought to identify what if any impact counselling had on prescription patterns for psychotropic medications for clients who attended CIPC.

4.4.1 Increased prescribing of psychotropic medications is a global health concern

The prescribing of psychotropic medication is an issue of real concern to mental health services globally with increases in antidepressant use recorded in the USA (Brody & Gu, 2020) to 13.2% by 2018 (Pratt et al., 2017) and Europe (Gusmão et al., 2013). In Ireland the number of GMS cardholders prescribed antidepressants almost doubled between 2008 and 2018 (O'Donnell, 2019) with further increases noted during the pandemic (Crowley & Hughes 2021; McCool et al., 2021). This despite concerns about the side effects of long-term use of antidepressants (Andersohn et al., 2009; Moret et al., 2009; Reid & Barbui, 2010) which have been well documented as the prescribing term typically endures for a year or longer (Johnson et al., 2012); as well as the significant impact of withdrawal problems (Davies & Read, 2018) and poorer outcomes associated with long-term use (Royal College of Psychiatrists, 2019).

Some research has recommended counselling and psychotherapy in combination with antidepressants as superior to either intervention alone, however this research is now being questioned. Indeed, the assumption that antidepressants and psychotherapy are more effective together has not been proven (Guy et al., 2019). Research indicates that antidepressants may yield no clinically significant benefits over placebos (Hengartner & Plöderl, 2018; Ioannidis, 2008; Kirsch & Jakobsen, 2018). In addition psychotherapy has been found to have comparable effects to medication for depression and anxiety (Cuijpers et al., 2013) be as effective as pharmacotherapy in the short-term treatment of depression and more effective in the longer term (Leichsenring et al., 2016).

4.4.2 Relationship between counselling and medication prescription patterns

There is limited research examining the relationship between counselling/psychotherapy and medication prescription patterns and what research there is remains inconclusive. Bower and Rowland (2006) found an association between counselling and a reduction in medication use, Nettleton et al. (2000) found no such relationship. More specifically in relation to prescribing rates, Simpson et al. (2003) investigated the effect of employing counsellors at GP premises on the psychotropic drugs prescribed and referral rates to mental health services. Although they found no statistically significant effect on the volume of prescribing rates overall, there was evidence of lower rates of psychotropic medication prescription for clients attending counselling where counsellors had been employed for more than 4 years.

What is known is that decisions about whether to prescribe psychotropic medications for psychological difficulties are influenced by many factors including likely response to treatment, patient preference and adherence, availability and accessibility of alternatives to medication treatment as well as cost (O'Donnell et al., 2017).

This study found that for the group of clients for whom an examination of prescriptions could be conducted (n = 90) there was no change to prescriptions for most clients (57.8%). Possible reasons for no change include client fear of reducing/terminating medication. GP perception that medication in conjunction with counselling is preferable, which is a strong assumption in the research literature as outlined above, client reluctance to terminate medication use due to fear of side effects, fear of symptoms returning (Scholten et al., 2020). GP confidence in distinguishing withdrawal effects from depression relapse also impacts decision making (Read et al., 2020). A total of 68% of the doctors in this UK study indicated they would like more training on the common effects associated with tapering of dosage. As a result, patients were more likely to remain on psychotropic medications for longer durations (Read et al., 2020).

In addition GP opinions on antidepressants may impact prescribing behaviour. Kelly et al. (2021) found that Irish GPs reported being less likely to cease antidepressant medication prescriptions for two subgroups, those with long-term depression and those who were elderly (Kelly et al., 2021).

For some clients in this study, medication prescriptions or dosage increased (26.7%). When compared with the group of clients who showed reduced medication prescriptions, this group was observed to have more severe scores before counselling and the most severe scores 6 months following counselling. This may indicate that CIPC may not have been the most appropriate service for the level of psychological difficulties they were experiencing in the first place. The CIPC service is intended for those with mild to moderate psychological difficulties, but the service regularly receives referrals from clients with complex difficulties. Due to the lack of other psychological support services CIPC is often the most accessible option. For some of these clients a successful outcome may be to help them engage in more intensive interventions e.g., from the community mental health service which may contribute to decisions regarding medication prescription.

Just 16% of clients in this part of the study were observed to have a total cessation of medication prescriptions, reduced number of psychotropic prescriptions or reduction in the dosage of their psychotropic medication. Clients in this group (for whom pre post and follow-up outcome data were available) were more likely to have less severe CORE OM 34 scores at the start of counselling and while the reduction in symptoms was somewhat less than the other two groups during counselling, the level of change which was maintained was greater, with this group of clients remaining below the clinical cut-off point for psychological difficulties 6 months after counselling had concluded. This group of clients had similar levels of psychological distress compared to the general population immediately after counselling and in the 6 months after it ended.

Again it is interesting to consider what role, if any, counselling played in decisions to reduce or cease prescription of medication. It is possible that improvement in client well-being was a contributory factor in this decision making. These results must be interpreted with awareness that the sample for whom data was available is small and results cannot be broadly generalised as a result.

Findings from this part of the study are in line with responses to the survey of GPs, perceptions and experiences of the CIPC service (Chapter 5). This survey found that 49% of GPs agreed that CIPC had contributed to a reduction in prescription of psychotropic medications. Findings demonstrated in similar studies elsewhere such as that by Schafer et al. (2009) who found that GPs perceptions of reduction in medication prescription were associated with availability of counselling for patients.

4.4.3 Factors influencing prescribing patterns

The results from this study could be an indication of the longer term benefits of counselling and therapy whereby counselling facilitated some clients to re-evaluate their relationship with medication, especially when, as shown by Harkness and Bower (2009) and Rowe et al. (2012) prescribing rates can be reduced when there is collaborative communication between GPs and counsellors, which also involves the client. This is particularly pertinent when it is considered that approximately 65% of patients have never discussed the idea of stopping the use of antidepressant medications with their GP and 48% of patients did not have their antidepressant medications frequently reviewed with their general practitioner (Read et al., 2019).

There is a growing sense of disquiet about the rising tide of prescribing for mild to moderate mental health difficulties such as anxiety and depression. An important consideration arising from this exploratory study is whether better communication between GPs, patients and the CIPC counsellor could impact on prescribing patterns. Enhanced communication across all stakeholders could start an important conversation about psychotropic medications and facilitate collaborative and informed treatment decisions for patients. The results yielded in this study demonstrating that 16% of clients' psychotropic prescriptions in the sample ceased or reduced in dosage in the aftermath of attending counselling with the CIPC service, leave us with many questions that require further exploration.

The relationship between the patient and their GP is an important factor in patient decisions about their health care. In a study that examined the GP-patient relationship, Henninger et al. (2019) showed that when patients are confronted with what they believe to be a medical emergency, the quality of the relationship with the GP is one of the main determinants of whether they consult their GP rather than an emergency department.

Evidence from the research indicates that the decision to stop taking psychotropic medication is a complex one where both GP and patient fears can impact successful termination (Eveleigh et al., 2019). Even when continued use is not recommended by a doctor many patients are reluctant to stop (Eveleigh et al., 2019). Fear of recurrence of depression or relapse is one of the most significant factors that impacts patient decisions to cease long-term use of antidepressants (Eveleigh et al., 2019).

It is important therefore to consider how the GP–patient relationship might impact on decision making about psychotropic prescription. The Irish study conducted by Grace et al. (2012) demonstrated a positive impact on psychotropic prescription reduction and cessation following communication from GPs to their patients. Eveleigh et al. (2019) recommend that it may be helpful for GPs to be aware of their patient's fears and expectations surrounding psychotropic medication use and cessation.

CIPC also has a role to play in encouraging and facilitating clients to begin a dialogue with their GP regarding their mental health treatment options. It may be helpful for CIPC counsellors to have additional training in psychopharmacology to facilitate greater understanding of psychotropic medications which would be useful in informing such conversations.

In addition, enhanced communication between CIPC counsellors and GPs regarding medication prescription would also be helpful. Simpson et al. (2003) demonstrated that in the longer term, GP prescribing rates for patients reduced when counsellors were working closely with GPs. This suggests that trust between GPs and counsellors is an important factor for positive communication. Further consultation between CIPC counsellors and GPs may be required to enhance relationships and build trust. The CIPC discharge summary which is sent to referring GPs could also be reviewed considering the importance of collaborative communication. A more detailed progress summary may be useful for GPs in the decision-making processes regarding further mental health interventions with patients who have attended CIPC, including the prescribing/reduction or cessation of psychotropic medication. The importance of improving coordination of care with the client at the centre of decision making cannot be underestimated.

4.4.4 Lack of alternatives

In considering whether attendance at counselling impacts GP prescribing rates, the evidence presented in this study demonstrates that 16% of patients had a discontinuation or reduced their psychotropic prescriptions during or following their attendance of CIPC. Consideration of these results in the context of other research that highlight barriers to psychotropic prescription reduction or cessation is important. Lasserre et al. (2010) have highlighted concerns regarding psychotropic medication prescription, in particularly the consequences of adverse outcomes, patient safety, and health care costs. They conclude that a mismatch exists between GPs' intent (91%) and practice (27%) in relation to reduction or cessation of psychotropic prescription in adults over 65 years. In their study, GPs identified the barriers to reduction or cessation of medication as patient refusal and the absence of local psychotherapy services.

Lack of available psychotherapy services has similarly been cited as a barrier by Irish GPs. The ICGP's 'Submission to the Joint Committee on Health on Prescribing Pattern Monitoring and the Audit of Usage and Effectiveness Trends for Prescribed Medications', argued that "prescribing rates of antidepressants reflect a lack of psychological therapies and a lack of social therapies and resources in society" (2018, p. 4). While CIPC is a 'welcome development' (MHR, 2017) in terms of increased access to talking therapies it is currently limited to those with medical cards. "Limited public (free) access to psychosocial services disproportionately affects those without ability to pay and forces an increased use of medication options" (Murphy et al., 2018, p.4). Would universal access to counselling help to reduce these barriers and impact GP prescribing behaviours in Ireland?

A recent Swedish study examining GP attitudes and behaviour towards psychotropic drug prescribing in primary care found that GPs were overwhelmingly in favour of using psychotherapy rather than psychotropic drugs for mild to moderate mental health issues (Svensson et al., 2019). The high availability of psychotherapy in Swedish primary care makes referral to counselling a viable option. Internationally, however, a scarcity of psychotherapy services is often a significant factor contributing to high levels of prescribing of psychotropic drugs at primary care level. It is noteworthy that 89% of respondents in the CIPC National Evaluation GP satisfaction survey agreed that CIPC should be expanded and made available to non-GMS patients. Furthermore, 85% of GPs indicated that they had patients who would have benefited from counselling but whom they had not referred to CIPC, citing the eligibility criteria (which require patients to hold a valid GMS card) as well as long waiting times as the main barriers to accessing counselling.

Another factor which may impact on GP decisions regarding prescription of psychotropic medication is level of accessibility of CIPC in terms of waiting times for counselling. Results from the national GP survey show that 63% of GPs were dissatisfied with the length of time patients had to wait for counselling. Qualitative comments from GPs referred specifically to the impact of waiting times and highlighted the fact that medication was often the only option in the absence of counselling (see page 99). Further research is needed to examine the links between GP dissatisfaction with waiting times for counselling and prescribing patterns.

4.4.5 Study limitations

This was an exploratory study and as such was limited in scope. The sample of clients represents only those who consented to participate in the review of medications for whom data was returned. The return rate from the overall number of requests for medication data was low, pertaining to just 15.8% of patients for whom these data were requested. Challenges involving doctors and GPs in research are well documented (Husin et al., 2020; VanGeest et al., 2007) with response rates to participate in research remaining generally static despite increasing evidence of strategies to improve involvement (Creavin et al., 2011). Research has highlighted some of the reasons for GP non-participation as including time constraints, burden of administrative work (Kaner et al., 1998); concerns about patient confidentiality, scepticism about the applicability of research (Rosemann & Szecsenyi, 2004) as well as lack of interest (Tong et al., 2018). Research that places greater demand on doctors' time and resources is associated with more significant challenges in achieving a response (Husin et al., 2020). This could certainly be a factor in the current study which required GPs to run an additional report on patient data and return it to the researcher. The role of administrative staff in filtering letters and requests has also been highlighted as contributing to low response rates from GPs (Scott et al., 2011). In a systematic review VanGeest et al. (2007) identified that endorsement by a professional association increased GP response rate to research surveys. Use of monetary and non-monetary incentives as well as telephone/email contact prior to the research and reminders has also helped improve response rates (Groenewegen et al., 2016).

This study utilised a number of these methods to optimise GP participation including endorsement by the Irish College of General Practitioners as well as incentives in the form of CPD credits for participation and use of reminders. Despite these measures the return rate remained low. It is possible that some GPs did not return the data requested as they did not have the software available to run the necessary reports (a small percentage of GP practices do not use Socrates™ or HealthOne™). The level of response does mean however that caution should be exercised when generalising these results to the population of patients in primary care counselling who are prescribed psychotropic medication. Further research with a longer timeframe and a larger population is needed for definitive results.

4.4.6 Conclusion

Gaining an understanding of the relationship between counselling outcomes and prescribing of psychotropic medications in Ireland is important. It would help to ensure the most appropriate interventions for clients and to inform the clinical guidance to GPs in balancing pharmacotherapy and psychotherapy options in the treatment of psychological problems. In addition it would facilitate a greater understanding of the potential cost savings that are possible from increased investment in psychotherapeutic interventions.

A total of 16% of patient's psychotropic prescriptions decreased or ceased following attendance for counselling with CIPC. This has important implications when considering the future direction of mental health service scope and design. The economic as well as social implications are significant with the potential cost offset in reducing the spend of psychotropic medication and investing in expansion of counselling services, so they are available to all citizens, requiring urgent consideration. The WHO's Mental Health Action Plan 2013-2020 includes as one of their four objectives: the provision of comprehensive, integrated mental health and social care services in community-based settings. The presence of CIPC certainly offers GPs in Ireland an alternative to psychotropic prescription. However there are factors, such as a) the restricted access to non-GMS patients b) underinvestment leading to lengthy waiting times for counselling in some areas, and c) the need for more effective communication strategies, which require further attention and consideration.

The need for equity of access to counselling services for all Irish citizens is clear and has important implications for policymakers in contemplating the expansion of CIPC to non-GMS patients and investment to meet the demands of the service. The potential for cost-offset associated with investment in counselling is significant given these study findings, especially when the level of investment to date in CIPC is compared with the spend on psychotropic medication.

5 Counselling and GP satisfaction: What GPs say about CIPC

5.1 Literature review

A significant proportion of visits to Irish GPs concern mental health issues with GPs being the first point of contact when a mental health issue arises for most Irish adults (Cullinan et al., 2016; Hughes et al., 2010). People in Ireland appear more willing to contact a GP about mental health issues than specialist mental health services. The Health Research Board's National Psychological Well-being and Distress survey found that almost 90% of respondents were willing to contact a GP about a mental health issues while only 48% were willing to contact a psychiatrist (Doherty et al., 2007).

Bagayogo et al. (2018) examined barriers for GPs delivering care to patients with mental health issues. A key barrier was lack of timely access to mental health professionals. A mixed methods survey evaluating GPs' mental health service provision needs in a HSE Local Health Office Area found that 24% of GPs reported that they restricted referrals due to excessively long waiting times, while 12% did so because of a lack of confidence in services (Ni Shiothcháin & Byrne, 2009).

Schafer et al. (2009) found high levels of satisfaction amongst GPs with patient outcomes from primary care interventions. A total of 82% of those interviewed stated that the patients they referred did not subsequently require referral to secondary services. GPs reported valuing the service and referring significant numbers of patients to it. Half of GPs felt the service had led to reduced prescribing. Satisfaction with communication with the counsellor was linked with perceptions of how clinically useful that service was to their patients.

An evaluation of the HSE North East Primary Care Counselling Pilot project included a survey of GPs regarding their experience of using the service and perception of outcomes for clients referred. GPs indicated satisfaction that the service reduced stigma for patients referred, waiting times were short and that access to counselling was straightforward (MHR, 2013). GPs also identified benefits in terms of a reduction in patient attendance for GP consultation and in changes to levels of medication prescribed for those who attended counselling (Ward, 2007).

More recently, GP perceptions of the CIPC service have been evaluated in the Republic of Ireland in an independent study by Rafferty and Bradley (2019). Qualitative interviews conducted with GPs identified that CIPC "positively influenced how [mild to moderate] issues are managed within the community". GPs felt having CIPC as a referral option for patients with mild to moderate mental health problems had led to a reduction in referrals to community mental health services. Access and eligibility was a concern, with more than 50% of those interviewed commenting that access to the service should be extended beyond GMS patients to include those with GP visit card holders.

Understanding general practitioners' perceptions of psychological therapy services at primary care level is a key part of any robust service evaluation. As CIPC's largest referral group, GP perceptions are integral to evaluating the quality and effectiveness of its model of service.

Challenges involving doctors and GPs in research is well documented (Husin et al., 2020; VanGeest et al., 2007) and have been discussed previously in this report. Key factors influencing doctors' decisions to complete surveys are the cost of their time; perception of how results will be used and GP perception of survey relevance (VanGeest et al., 2007).

Research that places greater demand on doctors' time and resources is also associated with more significant challenges in achieving a response (Husin et al., 2020). In addition, the role of administrative staff in filtering letters, calls etc. to GPs to protect their time has been found to contribute to lack of participation in research (Scott et al., 2011).

The internet is increasingly considered an efficient means for conducting surveys including for surveying physicians (Braithwaite et al., 2003). Potential efficiencies include savings on time, postage, and printing costs (Cobanoglu et al., 2001).

In a large, multi-country study in primary care that combined a survey among GPs and a linked survey among patients that visited their practice (the QUALICOPC study) Groenewegen et al. (2016) recorded a 7% participation rate for Irish GPs. The authors noted that the context of each country impacted on response rates and identified higher participation rates amongst countries with predominantly salaried GPs.

5.1.1 Study aim

This study aimed to evaluate the perceptions and experiences of GPs who referred to the CIPC service to inform the National Evaluation of CIPC. For pragmatic reasons, this part of the study utilised an online survey methodology, which is shown to be an effective way of gathering these data (Braithwaite et al., 2003).

5.2 Method

5.2.1 Participants

Participants in this part of the national evaluation were GPs, locums and registrars in GP practices who referred to CIPC and/or were on the GP mailing list administered by HSE Primary Care Leads with responsibility for liaison with GPs.

5.2.2 Development of survey measure

The GP satisfaction survey was developed by the CIPC research group with the aim of gathering GPs opinions about aspects of the CIPC service. Survey items were developed in consultation with members of the Irish College of General Practitioners who considered them for relevance and suitability. In addition feedback was obtained from a sample of GPs regarding its content prior to online distribution.

The survey comprised two sections:

1. Views on the CIPC model of service - operational and administrative aspects of CIPC
2. Views regarding the impact on patients because of attending CIPC

Quantitative responses are scored on a 5 point Likert scale with an option to enter qualitative responses for certain items (Appendix 14).

5.2.3 Procedure

GPs were invited to participate in an online survey of their experiences of the CIPC service. Invitations to complete the survey were sent by post or via Healthmail, a secure clinical email service provided by the HSE to all GPs (Appendix 15).

5.2.4 Data collection and analysis

The GP survey was hosted on a GDPR compliant survey website - SurveyLegend™. All respondents received the same email link and were restricted to complete the survey only once. Participation in the survey was anonymous.

The survey was open for a period of 6 weeks after which access was closed. After this time all valid responses to items were downloaded for analyses within the HSE network as an MS Excel™ spreadsheet and the response frequencies reported as proportions of the overall total for each item.

5.3 Results

5.3.1 Response rate

A link to complete the survey online was distributed to 2,192 individual GPs across all HSE areas. In addition, hard copy invitations were issued to some GPs. 378 responses to the survey were recorded. This resulted in an overall response rate of 17.2%.

5.3.2 Description of respondents

Most (98%) (*n* = 372) of respondents identified as “Practice GPs”, while four respondents described themselves as “GP Registrars” and two as “Locums”.

Three-quarters of respondents were located outside of the Dublin area (Figure 37).

A total of 99% (*n* = 368) of respondents stated that they had referred at least one patient to the CIPC service at some point in the past. Just 5 respondents indicated that they had never referred into the service.

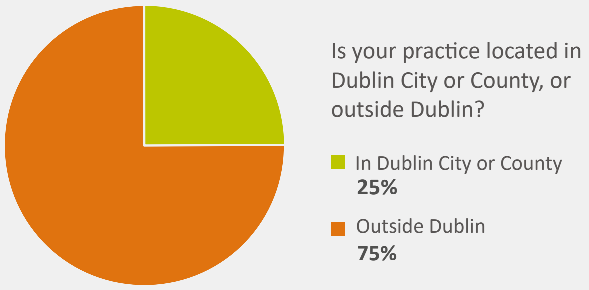


Figure 37. Proportion of participating GPs located in/outside Dublin City or County

5.3.3 GP views of the CIPC model of service

Q1 - Please indicate your level of satisfaction with the clarity of the referral criteria.

Approximately 59% of GPs were either satisfied or very satisfied with the clarity of the referral criteria, while 19% expressed dissatisfaction with this aspect of the service (Figure 38).

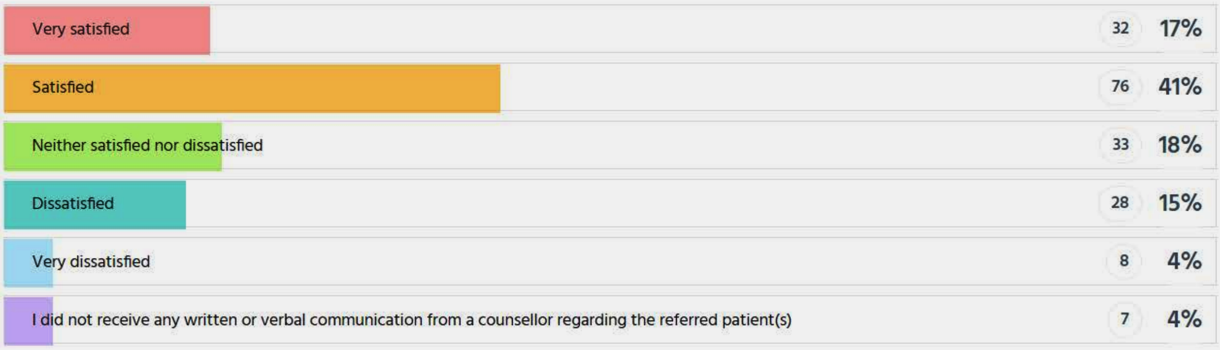


Figure 38. GP level of satisfaction with the clarity of the referral criteria

Q2 - Please indicate your level of satisfaction with the procedure for referring patients to counselling.

While 44% were either satisfied or very satisfied with the procedure for referring patients to counselling, 39% expressed dissatisfaction with this process (Figure 39).

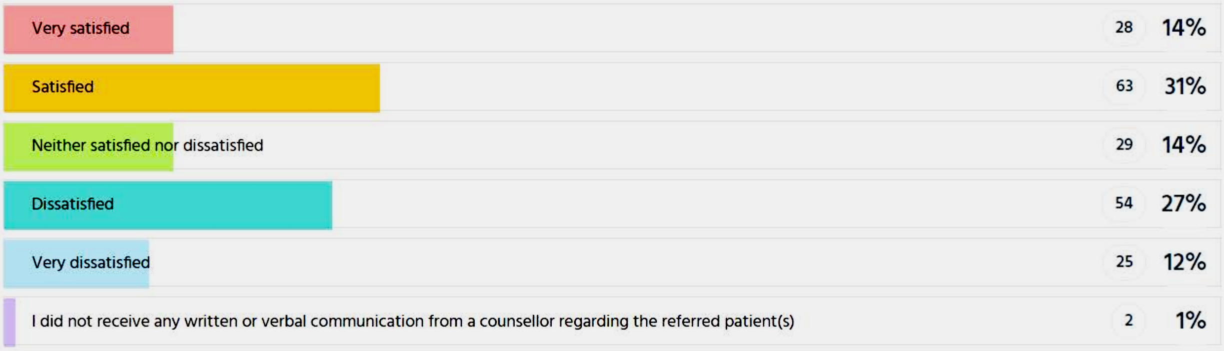


Figure 39. GP level of satisfaction with the procedure for referring patients to counselling

Q 3 - Please indicate your level of satisfaction with the length of time patient(s) had to wait for their counselling to begin.

Just 18% of GPs were satisfied with the length of time patients had to wait for their counselling to begin, 63% were not (Figure 40).

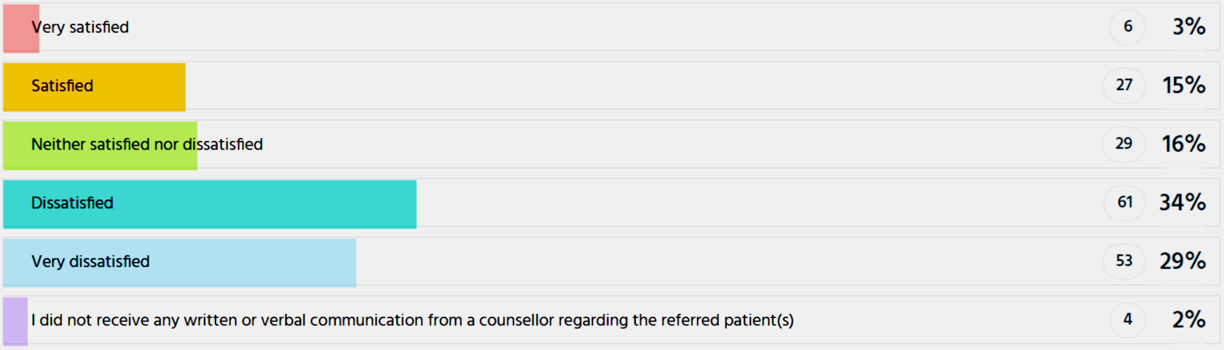


Figure 40. GP level of satisfaction with the length of time patient(s) had to wait for their counselling to begin

Q 4 - Please indicate your level of satisfaction with the service opt-in system.

Half (50%) expressed satisfaction with the system provided for patients to opt-in to counselling. However, 37% were either dissatisfied or very dissatisfied (Figure 41).

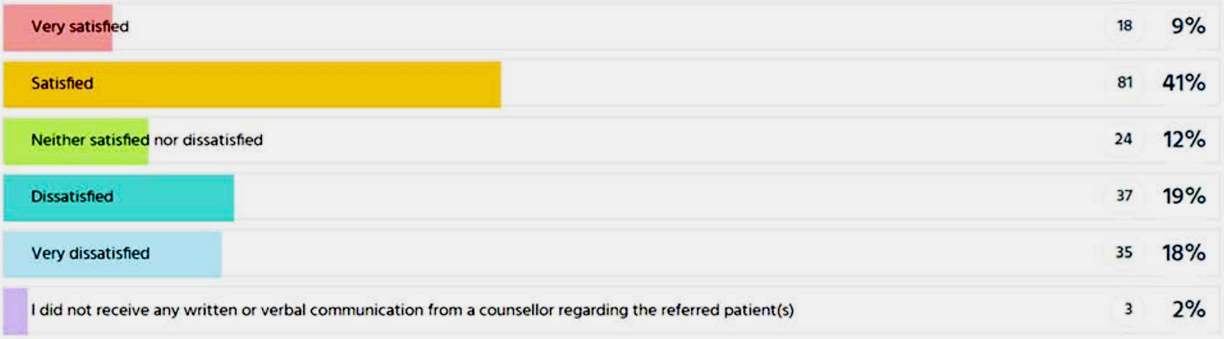


Figure 41. GP level of satisfaction with the service opt-in system

5.3.4 CIPC impact on GP practice

Q 5 – The availability of the CIPC service for referrals has reduced referral to Adult Mental Health Services.

Over half (54%) of GPs believed that the availability of the CIPC service reduced referral to adult mental health services, while 31% thought this to be false or somewhat false (Figure 42).

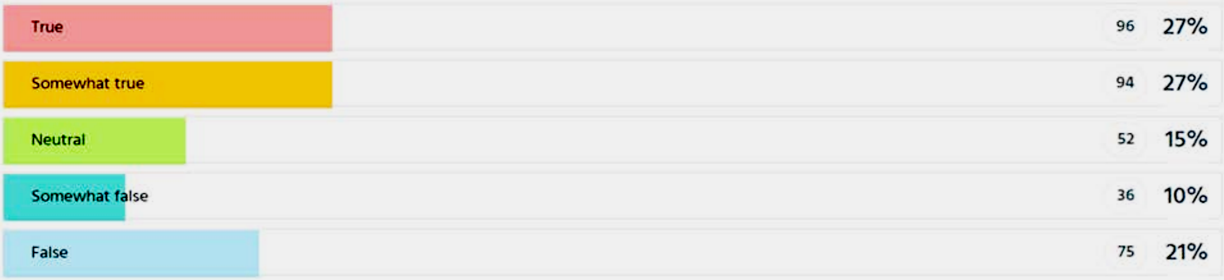


Figure 42. Availability of the CIPC service and reduction of GP referral to Adult Mental Health Services

Q 6 – Impact of CIPC on patient attendance for GP consultation

Almost half (47%) of GPs believed that level of patient attendance for GP consultation was impacted by attendance at counselling (Figure 43). Of the 47% who believed that patient attendance for GP consultation was impacted in any way by attendance at counselling, 92.7% said that attendance had been reduced or the purpose of visits had changed. (Figure 44).

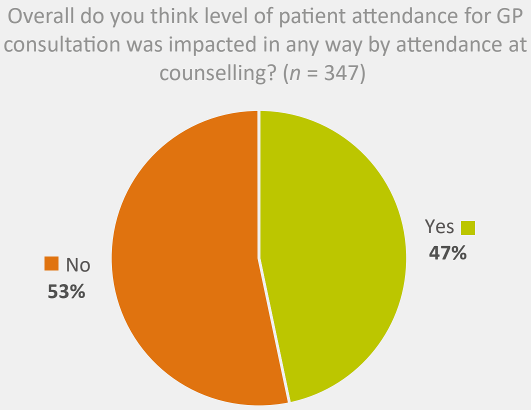


Figure 43. Relationship between the level of patient attendance for GP consultation and attendance at counselling.

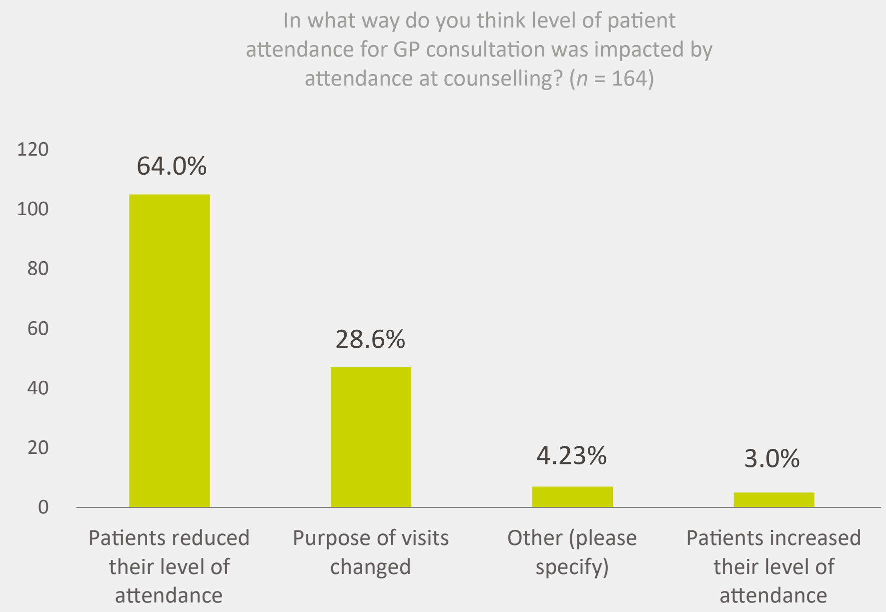


Figure 44. Types of change in GP consultations after attendance at counselling

Q 7 - CIPC is currently available only to GMS patients. It should be made available on the same basis to non-GMS patients.

Most (89% of) respondents agreed that CIPC should be made available on the same basis to non-GMS patients as it currently is to GMS card holders (Figure 45).

Figure 45. Proportions of GPs agreeing/disagreeing that CIPC should be made available on the same basis to non-GMS patients.

Q 8 – Are there patients you think would benefit from counselling but did not refer to the CIPC service?

When asked if there were patients whom they thought would benefit from counselling, who had not been referred to CIPC, 86% said 'Yes', while 14% said 'No' (Figure 46).

When asked to give reasons why they did not refer patients who could have potentially benefitted from attending CIPC, most GPs selected more than one response. Hence, the overall number of reasons for non-referral was greater than the number of GPs who responded. Non-eligibility for GMS card holder status was the main reason cited as non-referral to CIPC – 31.5% (Figure 47).

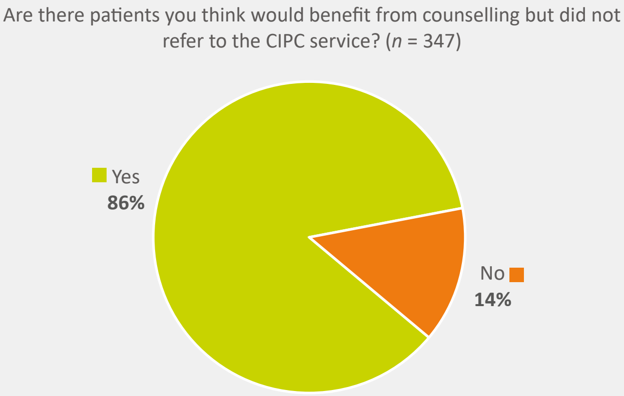
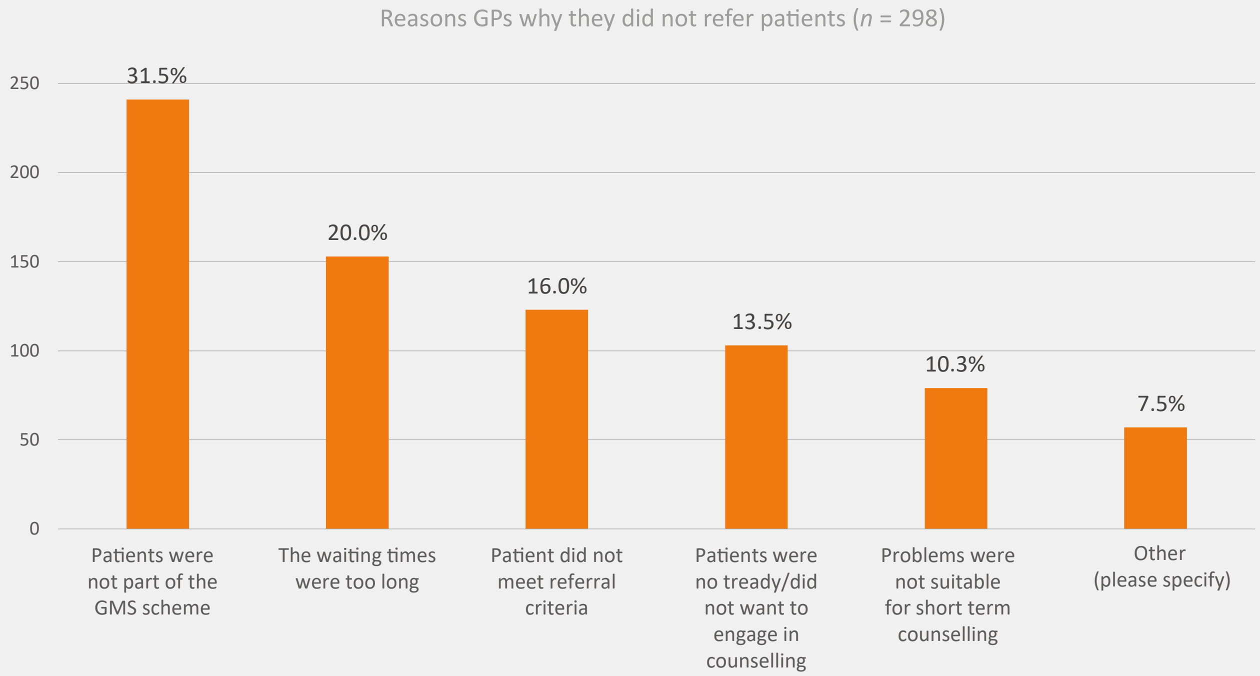


Figure 46. Proportions of GPs who did/did not refer patients whom they thought would benefit



Note – Overall n refers to the number of GPs who responded, while the percentages are derived from the total number of times each available reason was selected by those GPs.

Figure 47. Proportions of GPs with reasons for non-referral of patients

5.3.5 GP views of the impact of CIPC counselling on patients

Q 9 - CIPC is an effective treatment strategy for patient(s) with mild to moderate psychological difficulties.

Most (80% of) GPs agreed that CIPC is an effective treatment strategy for patients with mild to moderate psychological difficulties (Figure 48).

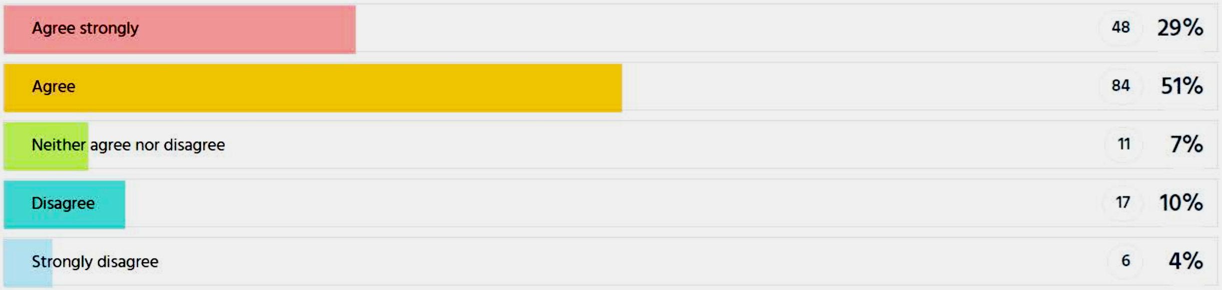


Figure 48. GPs’ perceptions of CIPC as effective strategy for patients

Q 10 - Overall patients who attended CIPC benefited from counselling.

Most (79%) agreed that patients who attended CIPC had benefited from the counselling they had received (Figure 49).

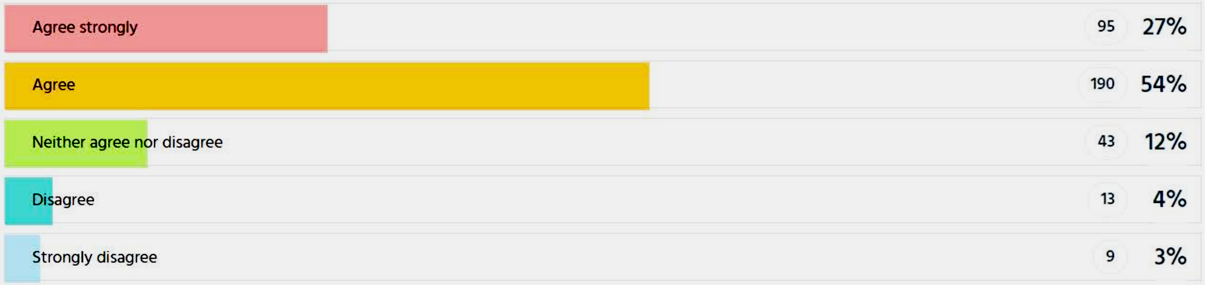


Figure 49. GPs’ perceptions of the benefit for the patients who attended CIPC

Q 11 - For those patients referred, CIPC has contributed to a reduction in prescription of psychotropic medications.

Less than half (49%) agreed that for those patients referred, CIPC has contributed to a reduction in prescription of psychotropic medications (Figure 50).

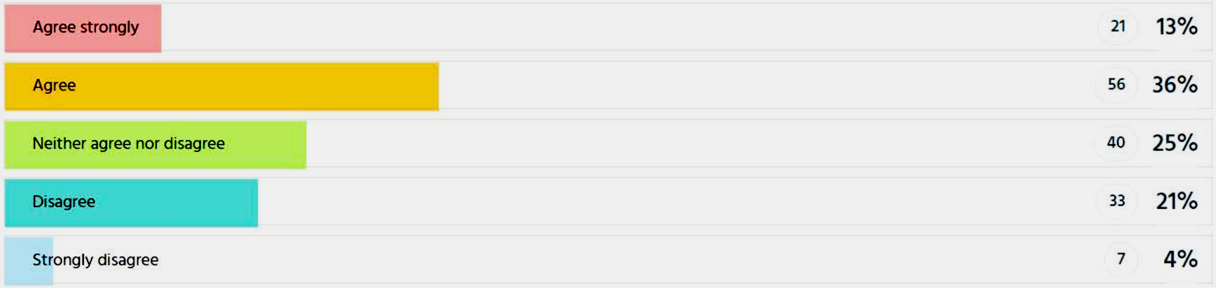


Figure 50. GPs’ perceptions of impact of CIPC on psychotropic prescription prescribing rates

5.3.6 In their own words: Qualitative feedback from GPs

A total of 67% of all GPs who responded (253) provided qualitative feedback about CIPC.

Generally, GPs were positive about the quality of the service provided:

“Eight sessions is perfect and I see huge changes in patients’ well-being after attending. They learn coping strategies and are better prepared for life’s stresses when they occur in the future.”

Three key themes were identified from GP qualitative feedback:

1. Views on the CIPC referral and opt-in process
   - The need to develop an electronic referral option via email or health mail
2. Experience of and perception of waiting times
3. Requests to extend availability of CIPC beyond those who have a GMS card
   - Including recommendations to extend eligibility criteria in terms of the nature of problems that can be referred to CIPC

5.3.7 GP views of the CIPC referral and opt-in process

Of the areas GP expressed dissatisfaction with the opt-in process was highlighted. Once a client is referred to CIPC by their GP they are asked to phone to opt in to activate the referral. The following comment reflects GP views of the opt-in system:

“Opt-in system is confusing and puts some more vulnerable patients off, they lack the confidence to actively engage with opt-in system.”

Some GPs stated they felt limited by the referral criteria for CIPC:

“Broaden the scope of problems.” [accepted for referral]

The procedure for referral was highlighted in the qualitative feedback with 10% of comments referring to the need for an e-referral option to be made available.

“Make e-referral available, and/or accept referrals from the GP software.”

5.3.8 GP views on waiting times

Many GPs chose to comment on their experience of waiting times for the CIPC service:

“Great service, waiting times too long puts me off referring.”

“Excellent service which badly needs mores resourcing to reduce waiting times. Given a choice between reducing waiting times and increasing coverage to Non-GMS, I would prioritise reducing waiting times.”

The impact of growing demand for the service on waiting times for CIPC was highlighted in the feedback:

“It is an excellent service and patients’ feedback has been very positive. Initially the waiting time was short but as the service has become busier and demand is higher it is a longer wait for patients.”

5.3.9 Need to expand eligibility criteria and availability of CIPC

A fifth (20%) of GPs who commented recommended that CIPC be expanded to enable non GMS patients to access the service:

“The program works and patients derive benefit from it. The fact that it is only for GMS patients greatly limits its availability. If the service was expanded to all patients it would lessen referrals to the Mental Health secondary care services.”

GPs highlighted the consequence of not having the option of counselling available for patients who don’t have a GMS card including medication and unnecessary referral to CMH services:

“Service is not open to non GMS patients. Private counselling can be expensive and unfortunately not many can afford it. In some cases I end up having to prescribe medication as people can’t afford counselling, yet I know psychology would be the best treatment option for the patient.”

“Great service, patients really benefit. Especially helpful for dysthymic patients and elderly patients for whom counselling also affords a chance to feel listened to”.

“Would be delighted if I could offer this service to non GMS - would significantly reduce cost to state for medications and secondary referrals.”

The rationale for expanding eligibility criteria for accessing CIPC was framed in terms of the potential for reducing use of other secondary care services:

"They have to be referred to the CMHT unnecessarily from a clinical point of view in order to access any psychological support."

"Very good service needs more funding takes a lot of pressure off the mental health service and is often more helpful. Very impressed."

The following quote from one GP summarises the main themes which emerged from qualitative feedback:

"1. Easier opt-in procedure: if we could refer via healthmail, instant referral, and patient could make opt-in phone call sooner. 2. Shorter waiting time. 3. Open to non GMS patients."

5.4 Discussion

The aim of this phase of the CIPC National Evaluation Study was to explore GP perceptions and experiences of using the CIPC service. A total of 378 GPs responded to the invitation to participate, a response rate of 17.2%. This rate of response is in line with that expected for online surveys (Scott et al., 2011) and surveys of physicians internationally (VanGeest et al., 2007). It exceeds that recorded for Irish GPs in a multi-country survey of GPs which recorded a participation rate of just 7% for Irish GPs (Groenewegen et al., 2016). Low response rates do however have the potential for response bias. The distribution of responders in this survey which reflects that of referrers to CIPC indicates that the sample was broadly representative of those GPs who refer to CIPC.

5.4.1 Benefits of counselling

This study highlighted consistently positive messages from GPs in relation to their experience of the CIPC service. Approximately 79% of GP respondents agreed that patients who attended CIPC benefited from counselling and that CIPC is an effective treatment strategy for patients with mild to moderate psychological difficulties. These findings mirror those identified by Rafferty and Bradley (2019) in a qualitative study conducted with GPs in the South of Ireland who noted "Counselling in Primary Care is an effective service for the treatment for mild to moderate mental health issues at a primary care level" (Rafferty & Bradley, 2019, p. 875).

Over half (54%) of respondents in the current study reported that the availability of the CIPC service has reduced referral to adult mental health services, a finding also evident in the study conducted by Raffertyand Bradley (2019) who reported that GPs found "CIPC to have brought about a reduction in the need to refer some patients on to psychiatric services when they can be adequately managed within the community". Rafferty and Bradley (2019, p. 872) also reflected this opinion.

Almost half of the of GPs surveyed (49%) agreed that CIPC has contributed to a reduction in prescription of psychotropic medications a finding which reflects that of Schafer et al. (2009) who found that GPs perceived a reduction in medication prescription associated with availability of counselling for patients. This finding was also highlighted in a survey of GPs engaged in the NE Primary Care Counselling Project which predated the development of CIPC (Ward, 2007).

These views were also reflected in the qualitative comments from respondents and reflects the findings from Rafferty and Bradley (2019). Participants in their qualitative study stated that CIPC contributed to a reduced rate of referral of their patients to secondary care mental health services. This highlights an important role played by the CIPC service in reducing the cost and burden on specialist mental health services.

5.4.2 Dissatisfaction with referral process and waiting times

Results from this survey highlighted GP dissatisfaction with some aspects of the CIPC service with 39% of GPs expressing dissatisfaction with the referral process and qualitative comments, highlighting a preference for access to online referral. This finding reflects that reported by Rafferty and Bradley (2019) who identified that "the [CIPC] referral process should be made available to be carried out online; saving time and resources both for GPs and administrative staff" (Rafferty & Bradley, 2019, p. 874)

Like previous studies of Irish GPs (Ni Shiothcháin & Byrne, 2009; Rafferty and Bradley, 2019), dissatisfaction with waiting times was highlighted by GPs in this study. Waiting times for CIPC vary across the country depending on demand. A total of 63% of GPs in this survey expressed dissatisfaction with CIPC waiting times. Increased waiting times negatively impact GP referral behaviour with many GPs not referring when waiting times become too long. One GP in the current study captures this problem succinctly: "Waiting times have become unacceptably long - I no longer refer patients for this reason". CIPC was developed with the intention of offering easy access to time limited psychological support. The challenge of waiting times will need to be addressed if there is to be future expansion of CIPC beyond those currently eligible.

5.4.3 Positive impact of CIPC on service utilisation

Results of this survey highlight areas for service improvement as well as policy change including the need to review service eligibility which is currently limited to GMS Cardholders. This limitation has been highlighted in several national policy documents including Sláintecare (2017) which highlighted an overdependence on medication and acute services for addressing MH issues and recommended that counselling in primary care be extended to the whole population (OCFHC, 2017, p. 60; Appendix 1:1). More recently the updated mental health policy *Sharing the Vision* (DOH, 2020) also highlighted the need for increased access to talking therapies in primary care.

GPs in the current survey support these recommendations. A total of 89% of respondents to the CIPC survey agreed that CIPC should be extended and made available to non-GMS patients. This finding was also highlighted in the study conducted by Rafferty and Bradley (2019) who found that 50% of the GPs they interviewed commented that access to CIPC service should be extended.

Most of GP respondents (85%) indicated that they had patients who would have benefited from counselling but whom they had not referred to CIPC. The two main reasons cited for non-referral included eligibility criteria which require patients to hold a valid GMS card as well as long waiting times

GPs recognise the impact of a CIPC expansion in terms of increased demand and the possibility of longer waiting times. The need to invest in CIPC to support such expansion was highlighted. The benefits of an expanded CIPC service were clearly identified by many GPs. Just over half (54%) expressed the view that availability of CIPC contributed to a reduction in referrals to Adult Mental Health Services, whilst 49% of respondents shared the view that CIPC had contributed to a reduction in prescription of psychotropic medication because of access to counselling. In addition 47% of GPs indicated that client attendance at CIPC had impacted on patient attendance with most of these highlighting reduced frequency of GP consultations. The cost offset for the health service of an accessible CIPC service is strongly supported by these findings.

The need to invest in service infrastructure and adequately resource CIPC is essential if the called for service expansion beyond GMS cardholders is to be realised. Without such investment increased demand for the service will result in significantly longer waiting times meaning the service becomes inaccessible and unable to offer early intervention for mental health difficulties. There is also the very real impact on service users who in the absence of access to psychological therapy are most likely to be prescribed medication as highlighted by one GP: *"Counselling input if done on time would have alleviated need for medication and helped them far more than medication alone."*

GPs are aware of this dilemma, one GP commented that if expansion were to result in increased waiting times his preference would be to retain existing eligibility criteria.

Concerns have also been expressed by CIPC service managers regarding service infrastructure and limited capacity to expand in line with Sláintecare's recommendations (HSE NCS, 2018).

5.4.4 Conclusion

This survey of GPs clearly demonstrates their perception of the value and effectiveness of CIPC in addressing mild to moderate mental health difficulties which present in primary care. GPs highlighted the referral process as an area that requires improvement. Provision of e-referral would greatly enhance GP experience of the service and increase service efficiency.

It is recommended that the CIPC service implement an electronic referral system to facilitate easier referral by GPs.

However GPs also highlighted the continued inequity of access to CIPC which remains limited to GMS cardholders. Long waiting times were highlighted as the other key barrier to access. There was a clear consensus amongst survey respondents that CIPC should be expanded. The need for additional investment to ensure that expansion of CIPC does not further reduce access in terms of longer waiting times was highlighted.

It is recommended that consideration is given to expanding eligibility of the CIPC service beyond medical card holders. Such expansion should be sufficiently resourced to prevent the unintended consequence of increased waiting times.

GPs commented on the positive impact of CIPC for the health service in terms of reduced utilisation of specialist mental health services and reduced prescription of medications. On the whole GPs are satisfied with the CIPC service and see positive benefits for their patients in terms of how counselling has helped to address their mental health difficulties.

"This service has been a massive needed breakthrough, the only lifeline of counsellor offered to patients who can't afford it. I am a huge fan. ….We need more schemes like CIPC. Some of my patients have improved beyond belief and I have been hand holding them for years."

6 | The voice that matters most: What do clients say about CIPC?

6.1 Literature review

6.1.1 The importance of service-user feedback

Service user feedback of experience using health care services is recognised as a key indicator of service quality and an essential source of data to inform quality improvement and improve service delivery (Fortin et al., 2018; Raleigh et al., 2015). Systematic review of the literature highlights the main sources of service user dissatisfaction with service experience as waiting times, factors associated with communication and access to information (Säilä et al., 2008; Siponen & Välimäki, 2003) with dissatisfaction often arising because of a discrepancy between expectations and services received (Avis et al., 1997).

Gilbert (2006, p. 119) considers the importance of service user feedback:

> *"If we want to know how a person feels, we must begin by acknowledging the fact that there is one and only one observer stationed at the critical point of view …she is the only person who has even the slightest chance of describing 'the view from in here', which is why her claims serve as the gold standard against which all other measures are measured."*

Methods such as patient surveys have been used in service planning initiatives across the HSE. For example, the HSE, in conjunction with the Health Information and Quality Authority (HIQA) and the Department of Health, developed the National Patient Experience Survey to identify patient's priorities and improve experiences in acute public hospitals in Ireland (Health Information & Quality Authority, 2017). Vitale et al. (2013) examined service users' experiences of receiving multidisciplinary care in the community and found an over-reliance on the medical model of treatment. Participants reported having little involvement in making decisions about their treatment. The experiences of service users engaging with mental health services in Ireland has also been explored. The report on listening meetings held with mental health service users and family members (HSE, 2016) reiterated a demand for enhanced access to and choice of talking therapies.

Assessing service users' perspectives on their experiences of counselling, especially in publicly provided services is recognised as an important element of mental health services research internationally (Kilbourne et al., 2018). Lambert (2007) investigated service users' perceptions of counselling over time. The results indicated that a clear sense of the likely duration of therapy at the outset was important to clients. Waiting times also emerged as an important theme. Cross-sector communication between health care services was considered important to alleviate feelings of "being lost in the system". Overall service users reported experiencing positive change both during and after counselling.

Service user satisfaction is key to ensuring delivery of a quality service and is linked with positive outcomes . Such feedback is important for informing the development of service policy and practice. Studies on mental health service user experiences have identified the relationship with mental health practitioners as key to helping or hindering recovery from severe mental distress. Feelings of trust, continuity and involvement in decision-making have all been highlighted (Bacha et al., 2020; Denhov & Topor, 2012; Ljungberg et al., 2016). The centrality of the therapeutic relationship as a key factor contributing to psychological change and positive outcomes from counselling and psychotherapy is also well documented in the literature (Norcross & Wampold, 2011).

A core value of the HSE National Counselling Service, which established CIPC, has always been to listen to client experiences. Client perspectives on their counselling experience have been sought since the inception of the service. The first NCS national evaluation aimed to assess client experience of attending counselling with particular emphasis on service quality, accessibility and client-centred delivery. High levels of client satisfaction with the effectiveness of counselling and the importance of client experiences of the counselling relationship in achieving positive outcomes were identified (Leigh et al., 2003).

6.1.2 Study aims

This phase of the National Evaluation Study sought to explore client perceptions of their counselling experience with CIPC across the country. Key areas explored included client experience of service accessibility, client perceptions of their counsellor and their perception of the effectiveness of counselling.

6.2 Method

6.2.1 Participants

Data from 1,322 client satisfaction forms received between 16 April 2015 and 5 February 2019 were analysed. The sample of questionnaires analysed is representative of the national CIPC client population.

6.2.2 Measures

The Client Satisfaction Survey utilised by the CIPC service for this evaluation was an updated version of that originally developed for the evaluation of client experiences by the NCS (Leigh et al., 2003). The original questionnaire was developed in consultation with service users, support organisation representatives, counsellors/therapists and NCS administrative staff.

The Client Satisfaction Survey (Appendix 16) comprises 4 main sections including:

- Client demographics
- Views on the CIPC service
- Views on counselling provided
- Contact with the GP and other health professionals.

Design of the measure incorporates key elements which explore the strength of the therapeutic alliance between client and their counsellor/therapist. Therapeutic alliance is a significant factor associated with positive outcomes in counselling and psychotherapy (Wampold, 2015). The client satisfaction survey encompasses three main elements: therapeutic bond including trust in the counselling relationship and experience of feeling heard and understood, agreement about the goals of therapy, and agreement about the tasks of therapy (Bordin, 1979; Wampold, 2015). Satisfaction with the therapeutic approach adopted by the counsellor (Ardito & Rabellino, 2011; Duncan et al., 2003) has also been identified as an important factor associated with developing a positive therapeutic alliance.

The main data type requested in each section of the questionnaire is quantitative with qualitative data also allowed as a response to several questions. All quantitative responses are included in the analyses for this study. Detailed analysis of the qualitative data is the subject of a further study. Qualitative comments provided by clients on the satisfaction questionnaires are used to illustrate the quantitative findings.

6.2.3 Procedure

As per CIPC policy, all clients who attend the CIPC service are invited to complete a Client Satisfaction Survey (CSS) when counselling has ended. Clients were given the CSS by their counsellor/therapist at the end of the final session or received the form by post. Completed forms were returned to the local CIPC office using a self-addressed stamped envelope which had been provided by the service.

For this element of the study, the CSSs analysed were those returned during the primary outcome data collection period in each of the respective CHO areas.

6.2.4 Data analysis

Response totals for all Client Satisfaction Survey items are reported in their raw form. Responses to each question were inputted to a data base for analysis.

CSS data was matched to participating clients' corresponding outcome data for a subsample of the questionnaires returned. The relationship between CSS and outcome data were analysed for this subsample.

Unless otherwise stated, all raw proportions of responses are reported for the overall sample (N = 1,322). Where the total of all responses is less than 1% for any question this may be omitted from graphical representations of the data to save space. These are reported as footnotes.

6.3 Results

6.3.1 Who responded?

Data was received from 1,322 clients of whom 77.5% of participants were female and 22.5% male. Most clients who responded were aged 36–45. For a full breakdown of age categories see Figure 51.

Most (91.9%) of clients who returned surveys attended an assessment session plus at least one counselling session.

6.3.2 How satisfied are clients with the accessibility of the CIPC service?

Information received before opting into the CIPC service

Over 72% of clients said that they received information about the service from their referrer (Figure 52).

The opt-in process

Referrals to CIPC are activated when a referral form is received, and the client phones the service to opt in for counselling. Opt-ins are recorded by an answering machine or administrative personnel. Of the sample, 57.9% spoke to a member of CIPC service when opting in.

Over 92% (n = 1218) of clients were satisfied or very satisfied with the process of opting into the CIPC service (Figure 53).

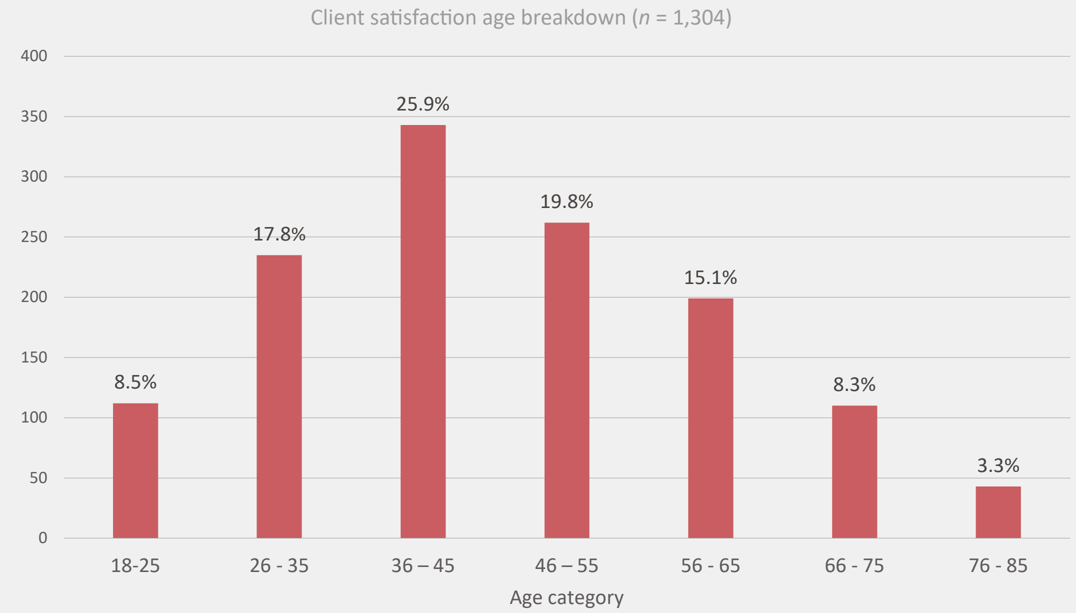


Figure 51. Age breakdown of participants in the client satisfaction study[8]

[8] No age data for 18 clients

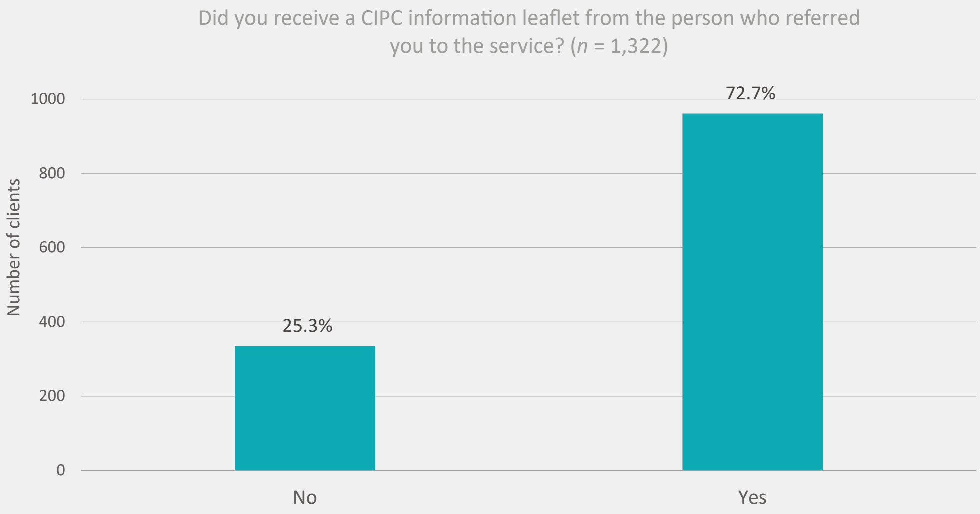


Figure 52. Proportion of participants who received CIPC information from their referrer

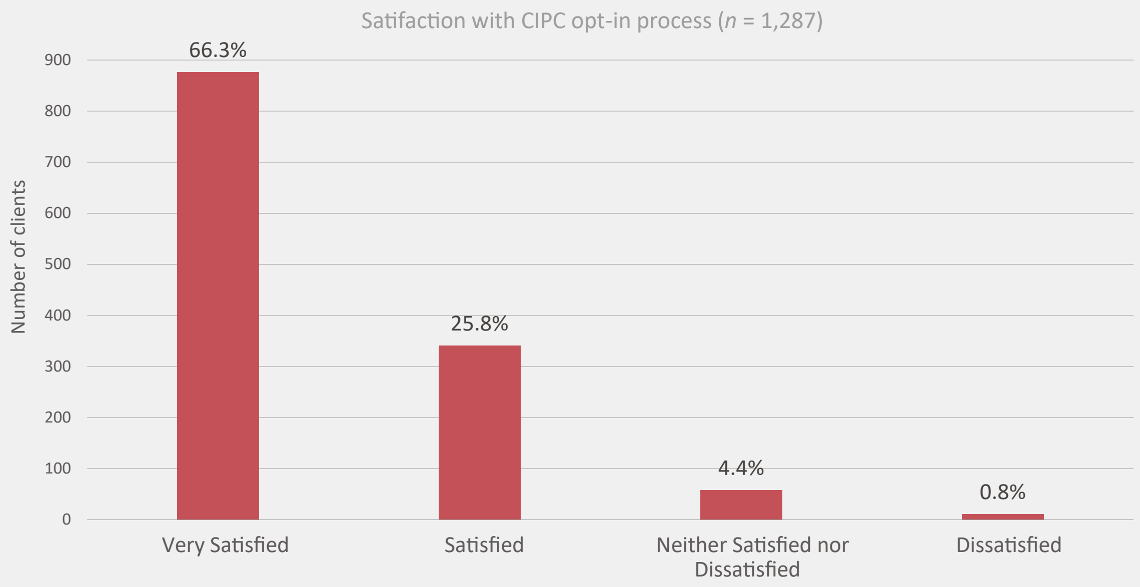


Figure 53. Proportion of client satisfaction with CIPC opt-in process.

Client satisfaction with waiting time for first appointment

Approximately 55.6% (*n* = 735) of clients were satisfied or very satisfied with the length of time waiting between opting in and their first appointment (i.e., assessment) (Figure 54). A significant proportion of clients expressed dissatisfaction with this aspect of the CIPC service (25.6%).

“Fantastic service. It has made a huge difference. Only complaint is the 2-month waiting time for 1st appointment.” CIPC Client

Time and date of assessment appointment offered

CIPC aims to be a flexible service and where possible offers clients a choice of location and times for an appointment. More than 50% of clients (*n* = 735) were very satisfied with the time and date of the assessment session they were offered, with a further 38.5% (n = 509) saying they were satisfied (See Figure 55).

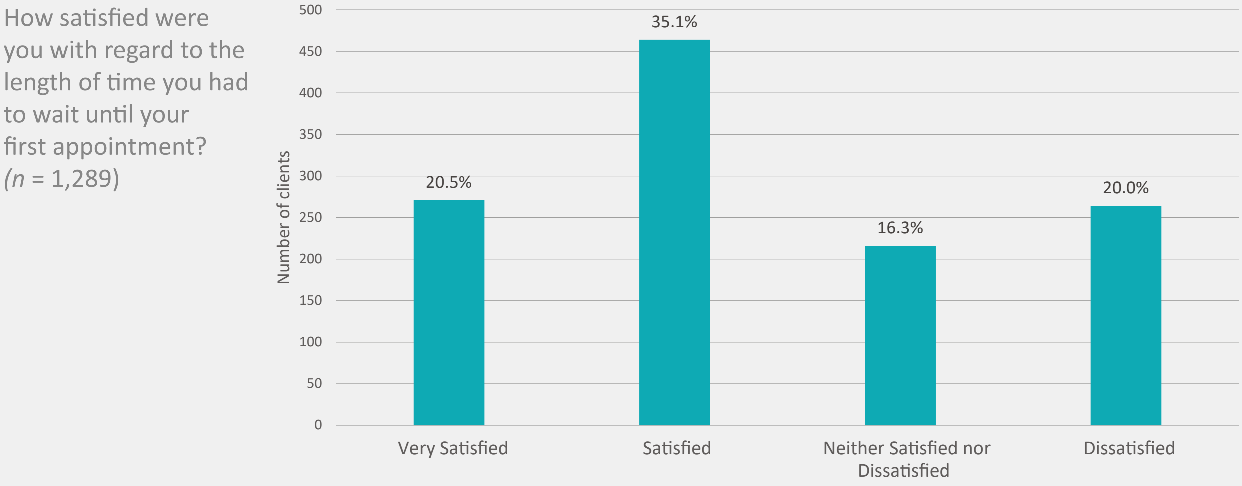
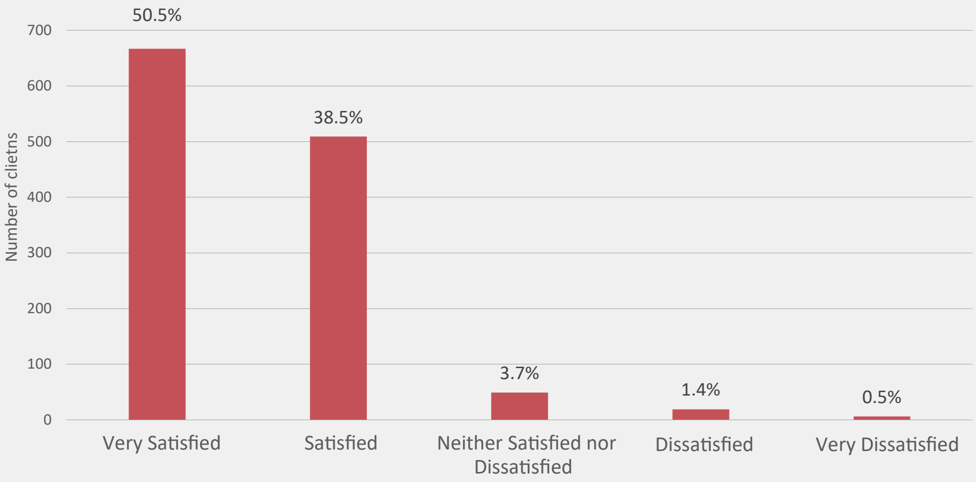


Figure 54. Proportion of client satisfaction with time waiting for first appointment

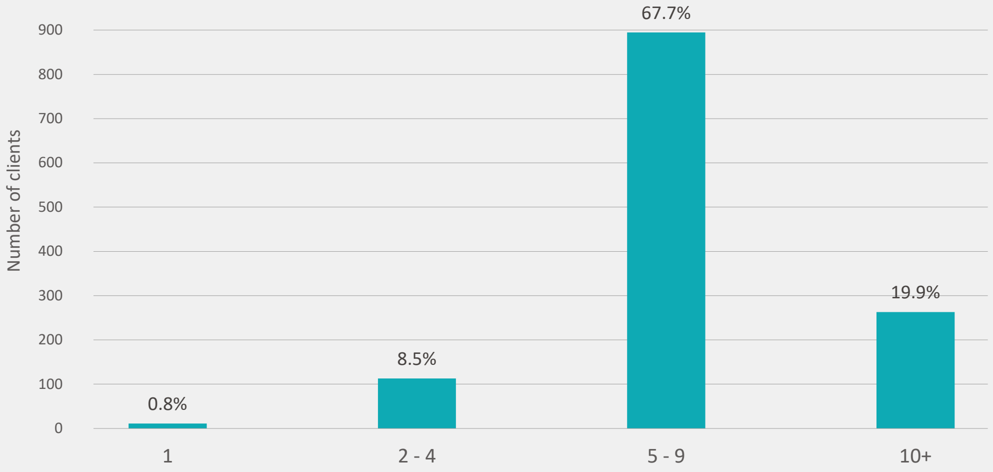


How satisfied were you with regard to the time and date of your appointment? (*n* = 1,250)

Figure 55. Proportion of client satisfaction with time and date of first appointment

Number of sessions attended

Most clients (67.7%) attended between five and nine counselling sessions in addition to their initial assessment (Figure 56).



In addition to your initial assessment, how many sessions did you attend? (*n* = 1,282)

Figure 56. Number of sessions attended

Satisfaction with number of sessions offered

Clients were also invited to comment on their level of satisfaction with the number of sessions offered. Satisfaction ratings with the number of sessions offered to clients was high, with over 80% reporting being very satisfied or satisfied (Figure 57). A total of 60 participants did not provide a response to this item. Just 6.4% of clients (*n* = 130) reported being dissatisfied or very dissatisfied. Of those who were satisfied with the number of sessions offered 77.% attended up to 8 sessions and 19.5% attended 10 + sessions.

Of the overall sample (n = 1,262) regardless of expressed level of satisfaction with the number of sessions offered, 266 clients indicated they would have preferred more counselling sessions. Analysis of the number of sessions attended by these responders (n = 266) indicated that

78% attended up to 8 sessions and the remaining 22% attended 10 + sessions which was in line with the number of sessions offered to clients who did not specifically state a desire for more counselling sessions.

“I understand that there has to be a limited amount of sessions.
However I feel that ten or twelve sessions would have been of more benefit.”
CIPC Client

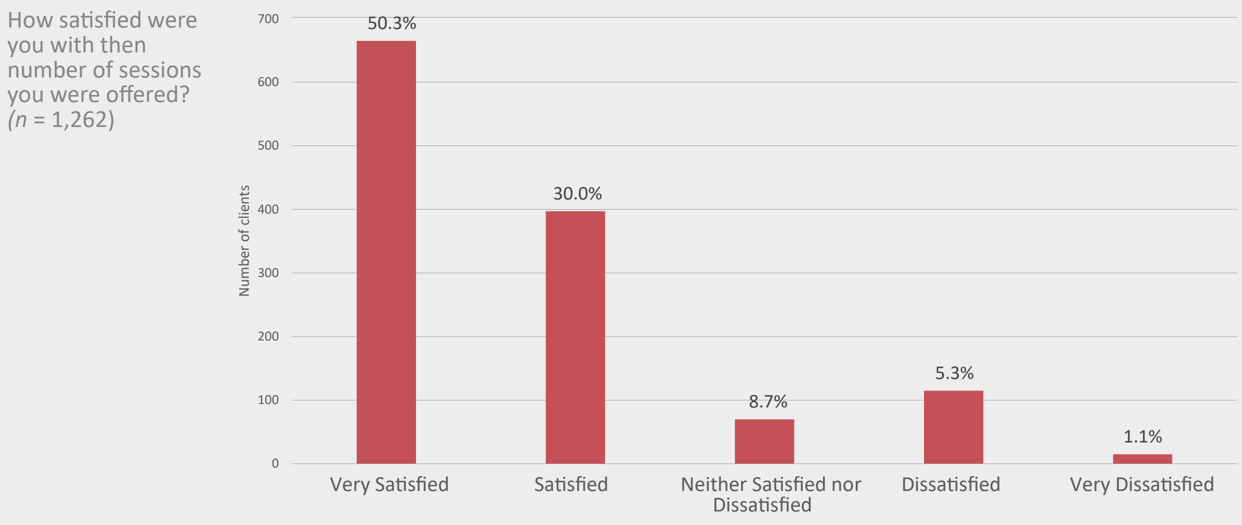


Figure 57. Proportion of client satisfaction with number of sessions offered

Suitability of counselling location

In terms of how clients felt about the location at which their counselling took place, most were satisfied or very satisfied with the convenience, privacy and suitability of the location (Figure 58) (combined rates of satisfied and very satisfied of 95.3%, 95.8% and 93.1%, respectively).

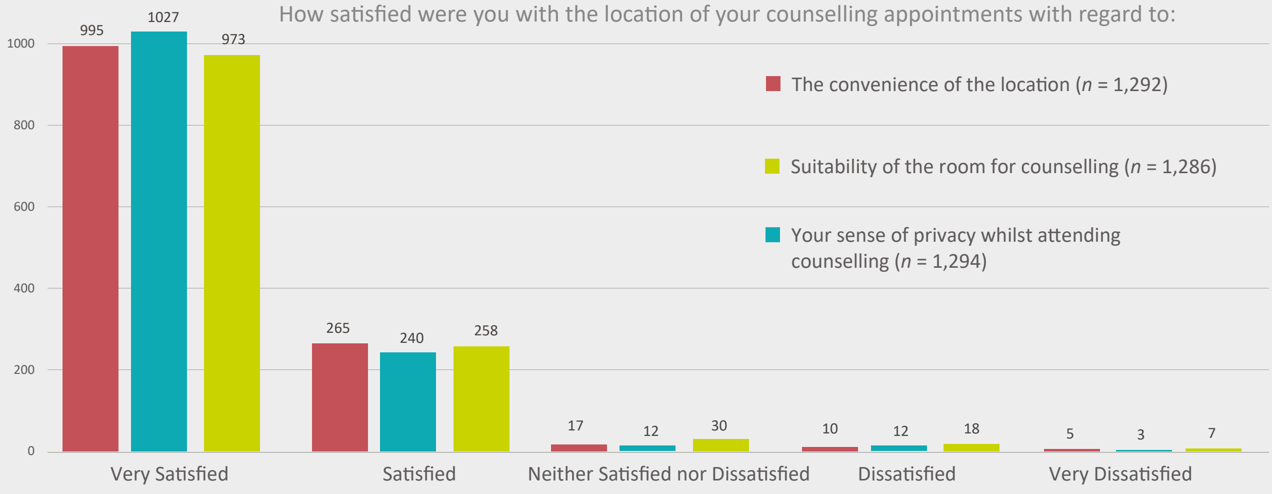


Figure 58. Proportion of client satisfaction with convenience, sense of privacy and suitability of the room in which they attended counselling

6.3.3 What are client perceptions of the effectiveness of counselling?

The perception of the effectiveness of counselling among clients was very high. 91.5% (*n* = 1,210) believed their counselling to be very effective or effective for the problem for which they had sought help in CIPC (Figure 59). Just 1.7% (*n* = 22) felt their counselling was either ineffective or very ineffective.

How effective was counselling in helping you to deal with the difficulties that led you to seek counselling in the first place?
(n = 1,289)

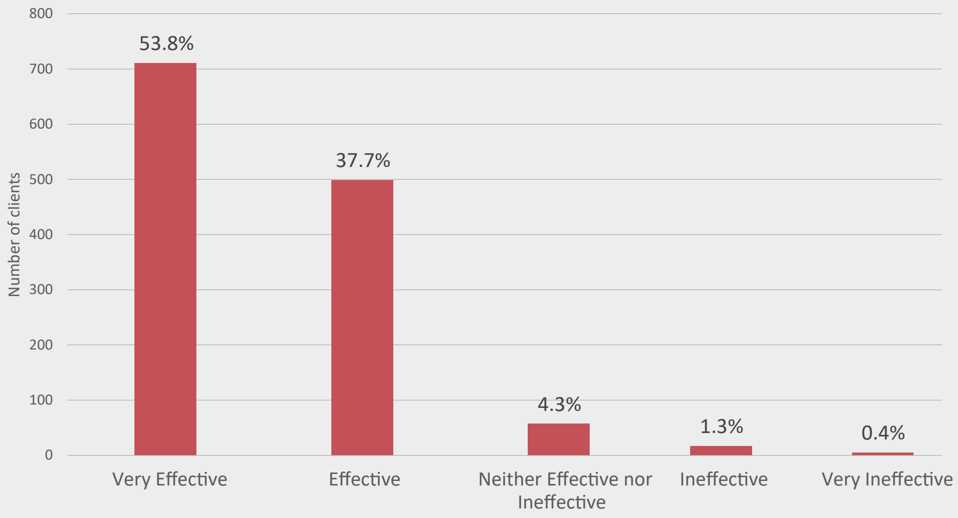


Figure 59. Proportion of client perception of the effectiveness of counselling

“This is an excellent service. I really don’t know where I would be without it. The reason I am so late in sending this in is that I’ve started a new job and I could not see myself doing that 6 months ago. I felt if there was more availability to services like this it would very much reduce the cost and overcrowding in hospitals + doc surgeries. All my physical symptoms went when my mind felt better.” CIPC client

6.3.4 How do clients view the benefits of counselling?

Most (95.8%) (*n* = 1,267) of clients indicated that they had benefited from counselling. 3.3% (*n* = 43) thought they had not (Figure 60). Data were missing for 0.9% (*n* = 12) of clients.

Overall do you feel that you benefited from counselling?(*n* = 1,310)

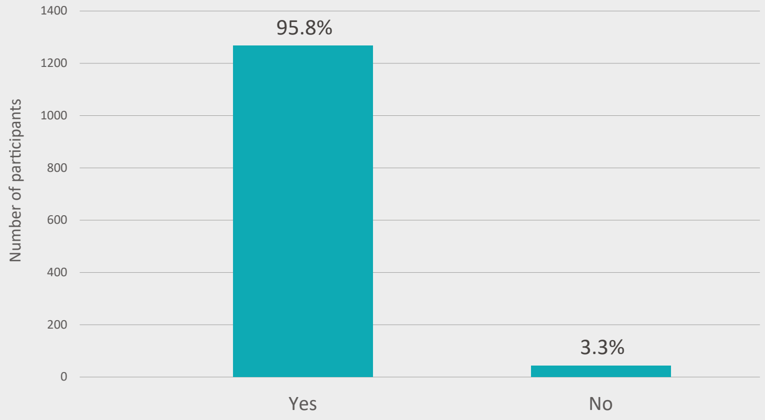


Figure 60. Proportion of client perception of the benefit of counselling

Type of perceived benefit gained from counselling

Clients were asked to indicate the way in which they felt counselling had benefited them from a list of choices. More than one choice could be selected (Figure 61).

Managing feelings and dealing with stress were the two main benefits, selected by 67.9% (*n* = 898) and 64.3% (*n* = 850) of clients respectively. 63.9% (*n* = 845) and 60.1% (*n* = 805) of clients identified feeling better about themselves and having better coping skills because of attending counselling in CIPC. A breakdown of the proportions of the remaining benefits are provided in Figure 61.

A small proportion of clients indicated a decline in certain areas. Just 3.3% (*n* = 43) indicated there had been no change in the problems for which they were seeking help and 0.6% (*n* = 8) stated their problems had gotten worse.

"Thank you so much for this service. I was in a dark, scary place regarding my mental health. My counsellor helped me more than words can describe. I feel more confident, happier & feel like I can handle anything that life throws at me. I was nervous beginning counselling but as soon as I met my counsellor, she made me feel so comfortable & at ease. I truly believe counselling has changed my life for the better." CIPC Client

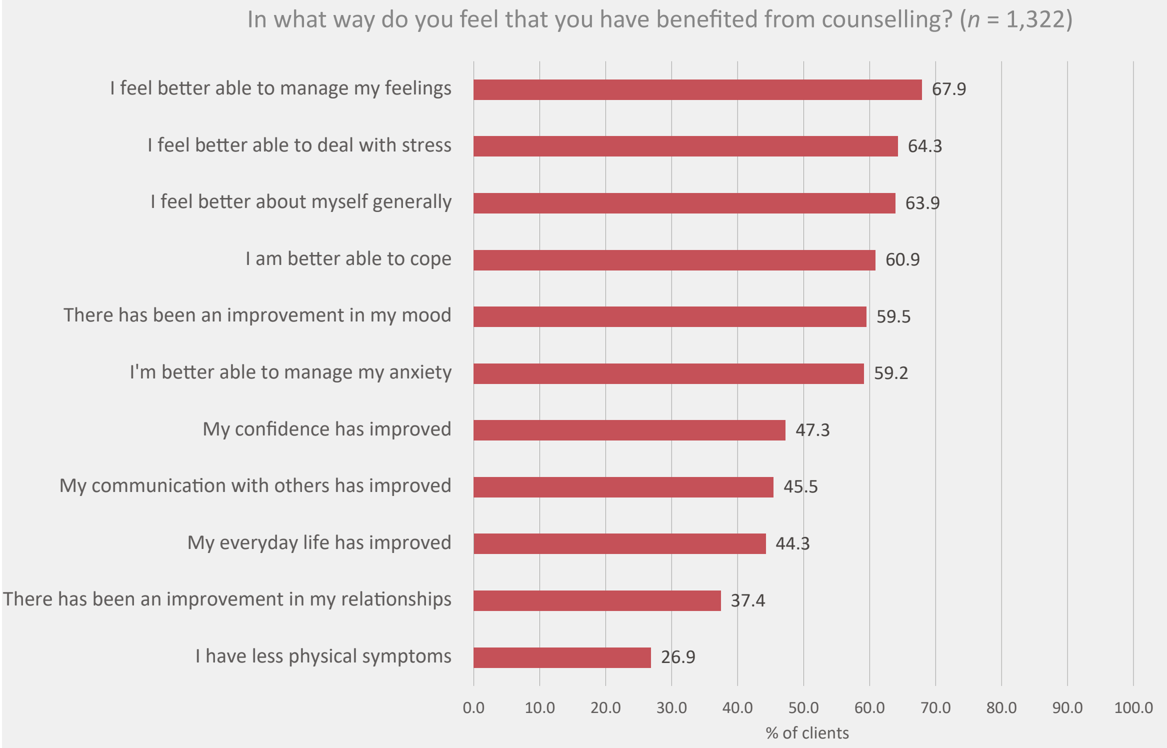


Figure 61. Proportion of client perceptions of the types of benefit derived from counselling

6.3.5 How satisfied are clients with their counsellor?

Clients were asked about their satisfaction levels in relation to their counsellors' ability to listen, understand and work with the important issues in their lives.

Ability to listen

The majority, 97.2%, were very satisfied or satisfied with their counsellor's ability to listen and understand them (Figure 62).

Figure 62. Client satisfaction — counsellor's ability to listen

Ability to work with them on the important issues in their lives

Most (94%) were very satisfied or satisfied with their counsellor's ability to work with them on the important issues in their lives (Figure 63).

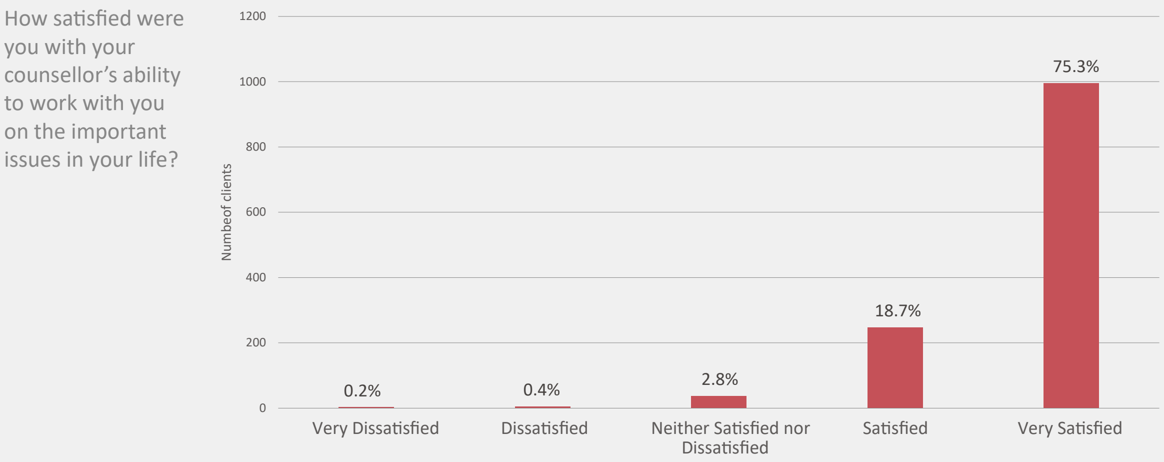


Figure 63. Client satisfaction – counsellor's ability to work with the client

Ability to adopt a therapeutic approach that suited them

In terms of their counsellor's ability to adopt a therapeutic approach that suited them, 91.7% expressed either being very satisfied or satisfied (Figure 64).

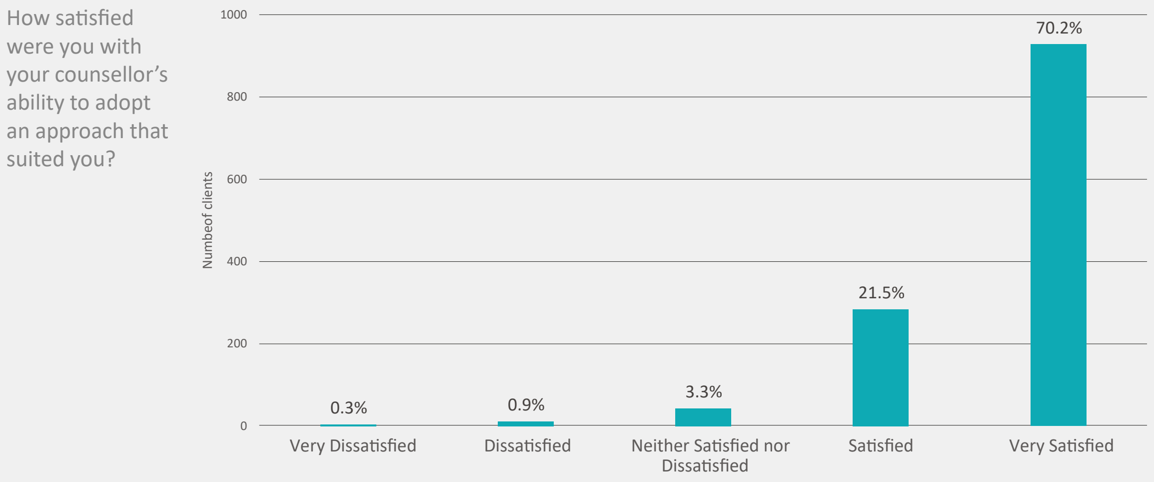


Figure 64. Client satisfaction - counsellor's ability to adopt a therapeutic approach individualised for the client

Ability to respect their confidentiality

A large majority of clients expressed a high level of satisfaction with their counsellor's ability to respect their confidentiality; 96.4% expressed being either very satisfied or satisfied (Figure 65).

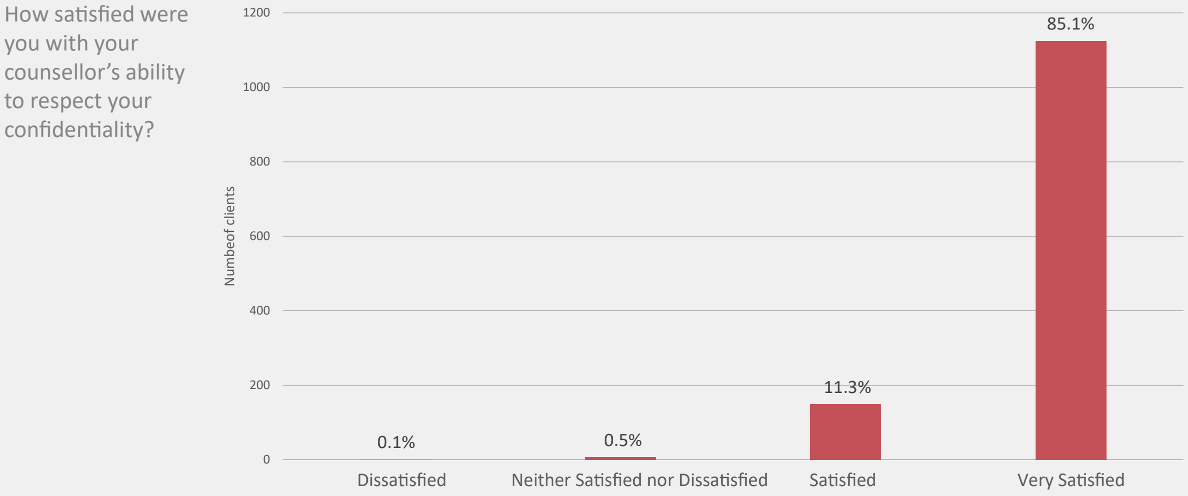


Figure 65. Client satisfaction – counsellor's ability to respect clients' confidentiality

Ability to help them resolve the difficulties that brought them to counselling

While there was a large proportion of clients who were either very satisfied or satisfied with their counsellor's ability to help them resolve the difficulties that brought them to counselling, 88.6%, just over 6% were neither satisfied not dissatisfied and 1.8% expressed being either dissatisfied or very dissatisfied (Figure 66).

"I had a very positive experience with this service. I made huge progress in a short space of time. My counsellor helped me to deal with issues that I have struggled with all my life." CIPC Client

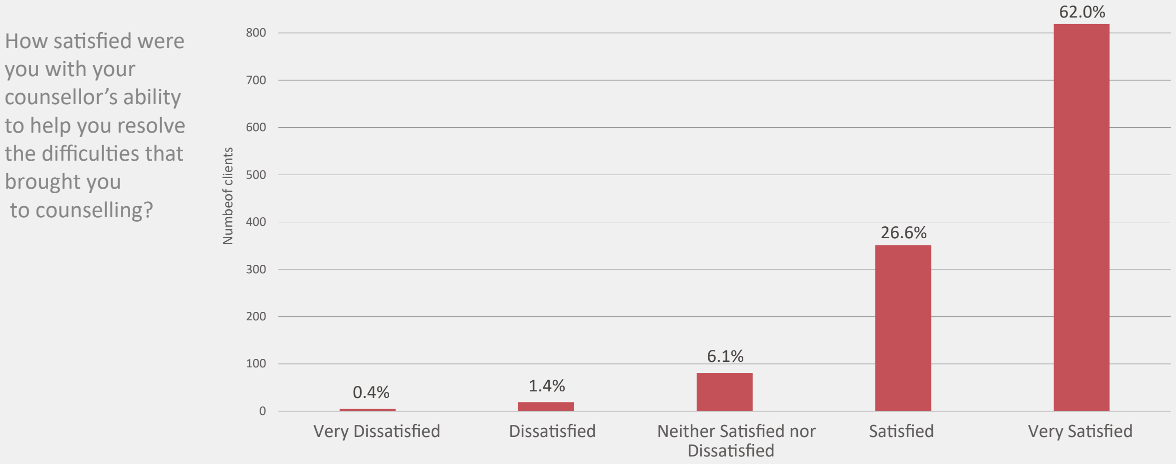


Figure 66. Client satisfaction — counsellor's ability to help resolve presenting issues

Ability to help them learn to cope with future problems

When asked about their counsellor's ability that helped them learn to cope with future problems; 86.6% of clients expressed being either very satisfied or satisfied. 7.3% of clients were neither satisfied nor dissatisfied and 1.4% were dissatisfied or very dissatisfied (Figure 67).

"In general, counselling was a really positive experience. I have learned to cope with my issues and my everyday life. I feel that the sessions have gave me so much courage to improve my life and I am very happy about it."

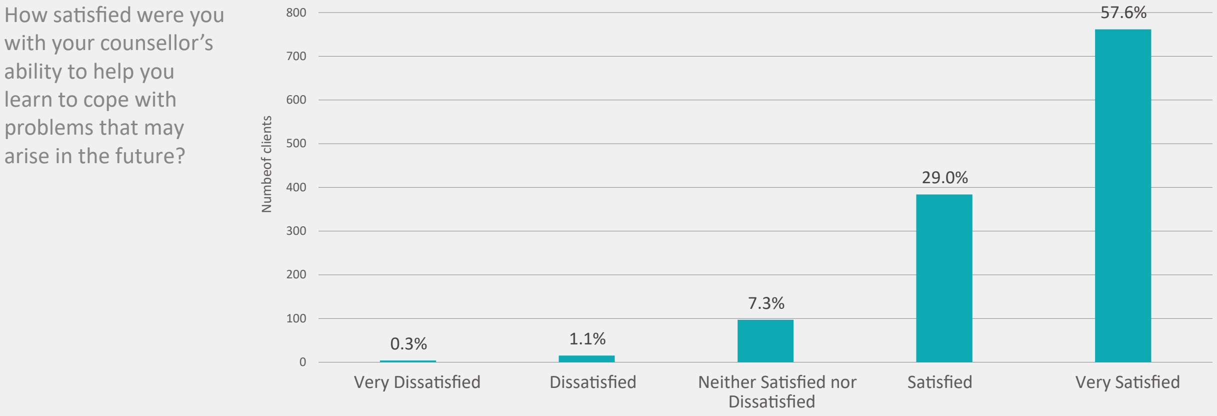


Figure 67. Client satisfaction — counsellor's ability to help clients learn coping skills

Ability to create a trusting one-on-one relationship

Their counsellor's ability to create a trusting one-on-one relationship was rated as very satisfactory or satisfactory by 93.5% of clients (Figure 68).

"Initially I was dubious about attending counselling but after a couple of sessions I could see the benefit from it. I was able to form a trusting relationship with my counsellor." CIPC client

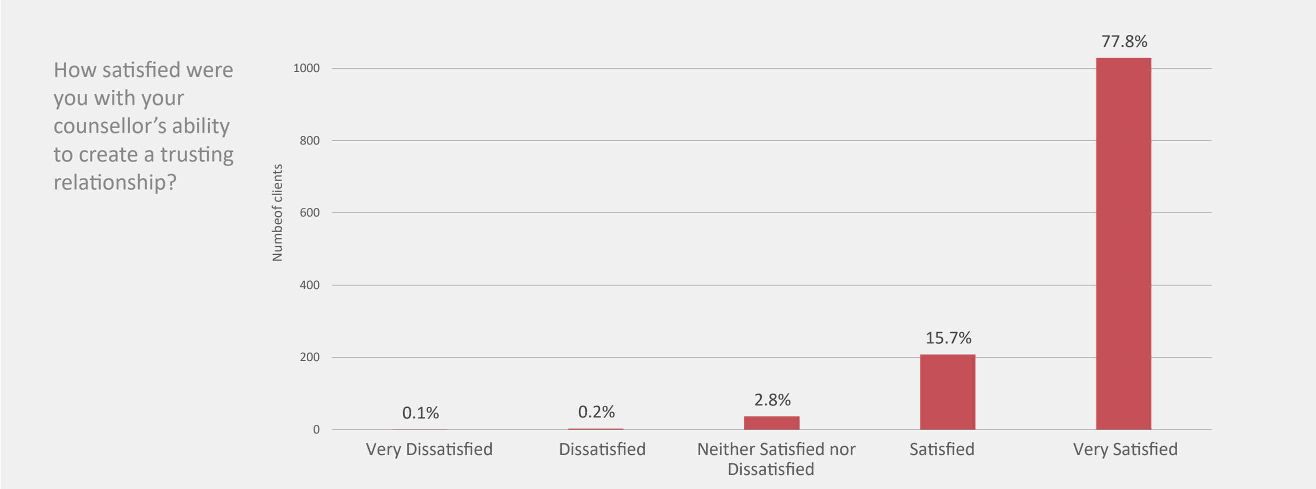


Figure 68. Client satisfaction — counsellor's ability to create a trusting relationship

Would clients recommend their counsellor to friend/family member?

The majority (92.3%) of clients identified that they would recommend their counsellor to a family member or friend. While 5.6% of clients did not respond to this question, 2.1% said they would not recommend their counsellor (Figure 69).

"Overall I feel that the CIPC is a great service & would highly recommend as I felt it helped me to grow as a person & to figure out what was best for me & how to do it. I feel happier in myself, more than I have felt in months."

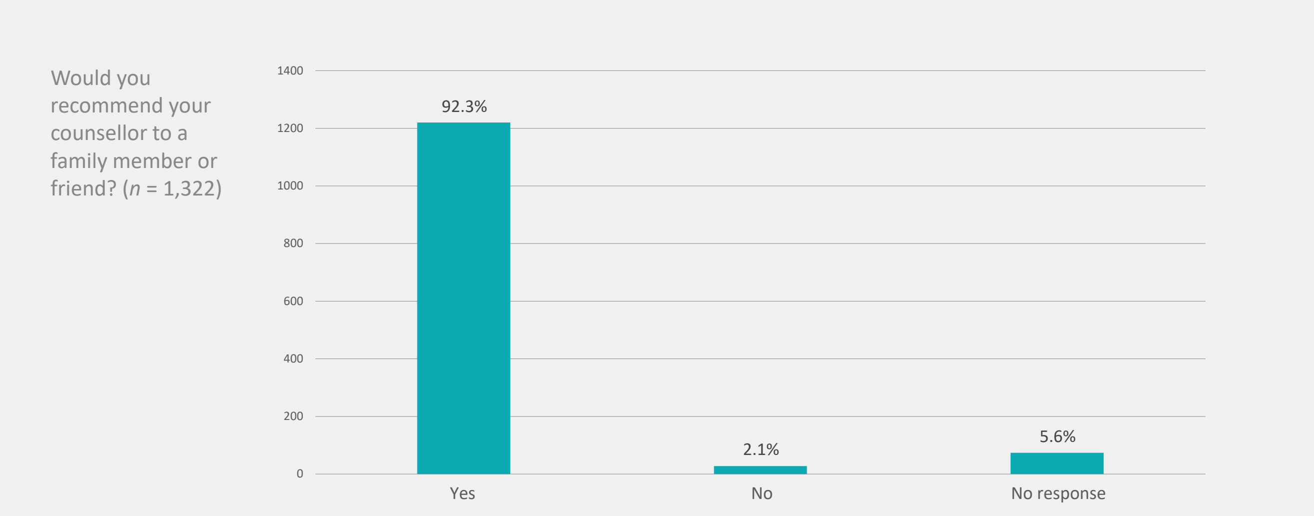


Figure 69. Proportion of clients recommending their counsellor

Onward referrals

When asked if they had been referred to or attended any other professionals in relation to their psychological health since attending CIPC, 226 (17%) clients provided details of the services to which they had been referred. Of those who responded, 59 indicated they were referred to a psychiatrist or other mental health team member. Forty three clients were referred to longer term counselling with the NCS.

How did counselling end?

Clients were asked about how they ended their counselling with CIPC. Clients selected from a list of options a single reason that best represented the reason they ended their counselling (Figure 70).

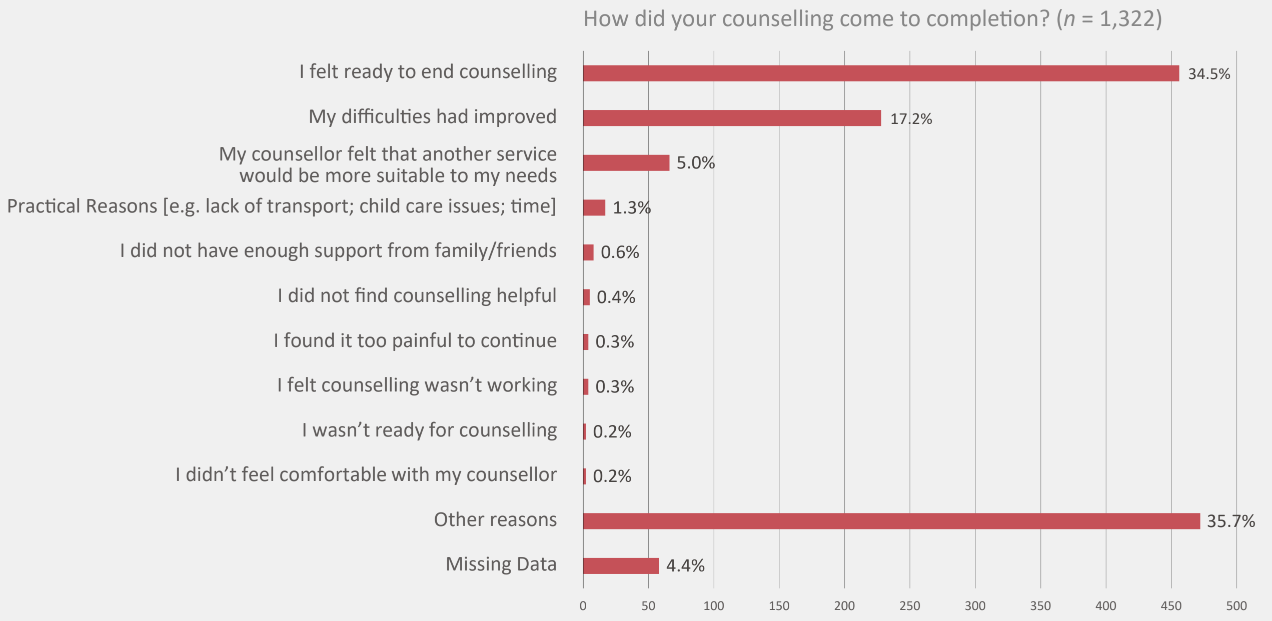


Figure 70. Reasons for ending of counselling

A total of 34.5% (*n* = 456) of clients felt they were ready to end their counselling at the time that they did, while 17.2% (*n* = 228) reported that their difficulties had improved. Five percent (*n* = 66) reported that their counsellor felt that a service other than CIPC would better suit their needs at that time.

Just 1.3% of clients ended their counselling for practical reasons such as lack of transport, childcare issues or time related problems. The remaining 2% of predefined reasons for the ending of counselling were spread among clients who, found counselling too painful, or reported a lack of support from family and/or friends, that counselling wasn't working, or they had not been ready to begin in the first place. A small number of clients (*n* = 5) reported that they did not feel comfortable with their counsellor or felt counselling was not helpful.

Finally, 4.4% of clients did not provide a reason why their counselling ended.

'Other' reasons for ending counselling

A relatively large proportion of clients - 35.7% (*n* = 476) selected 'other reasons' for ending counselling and provided qualitative data about how their counselling came to an end. These qualitative responses were analysed, and the main themes identified, most responses related to the overall length of therapy provided (Table 10).

6.3.6 What is the relationship between client satisfaction and clinical outcomes?

Analysis of the relationship between clinical outcomes on the CORE OM 34 and client levels of satisfaction with different aspects of the service was conducted to investigate if there were any significant correlations. This information may give an indication of how a client's experience of various aspects of the counselling service impacted on their overall clinical outcomes from counselling.

Table 10. "Other"reasons counselling ended as indicated by participants in client satisfaction analysis

Breakdown of main themes in "other" reasons for ending counseling		
The overall length of therapy provided	*N*	%
1 - Allocated number of sessions reached	269	56.5
2 - Allocated number of sessions reached but wanted more counseling	71	14.9
3 - Had enough sessions and therapy was successful	57	12.0
4 - Therapy was unsuccesful	12	2.5
5 - Other reasons	34	7.1

Analytical approach

Pre and post counselling CORE OM 34 data was available for 241 (18.2%) participants who returned a Client Satisfaction Survey. The relationship between CORE OM 34 scores and client satisfaction questions were analysed and the Pearson's r coefficient is reported.

A pre/post difference in CORE OM 34 scores was calculated for each of the 241 participants – a larger reduction indicates more improvement and vice versa. The average difference in the reduction in CORE OM 34 scores between clients who expressed satisfaction and those who were dissatisfied with their counselling experience was calculated using an independent t test to assess statistical significance.

This subsample of 241 participants was comparable with the overall sample. An independent t test showed no significant difference between those for whom CORE OM 34 pre and post and satisfaction data were available (n = 241) and the main group of respondents (n = 1,081) in terms of their demographic status, pre-therapy symptom severity, average number of sessions attended or medication use.

Waiting times and pre-therapy symptom severity

Analysis showed that the longer clients waited for an initial assessment session, the worse their symptoms were when they attended (as measured by the CORE OM 34). Results of the Pearson correlation indicated that there was a significant negative association between the item: "How satisfied were you with regard to the length of time you had to wait until your first appointment?" (*1 = Very dissatisfied to 5 = Very satisfied*) and their pre-counselling CORE OM 34 score $r(245) = -.167$, $p = .009$.

Clients who expressed being less satisfied with the length of time they waited for an assessment were also shown to have waited longer in real terms. This highlighted that their perception of the length of time they waited was associated with lower satisfaction. Results of the Pearson correlation indicated that there was a strong and significant negative association between the item "How satisfied were you with regard to the length of time you had to wait until your first appointment?" and actual number of weeks spent waiting $r(245) = -.202$, $p < .001$.

Counsellor/therapist abilities and relationship to client change

Of the eight questions dealing with client satisfaction with aspects of counsellors' abilities, five questions were shown to be statistically significantly related to the amount of reduction in clients' symptoms.

These were:

- Satisfaction with counsellor's ability to work on the important issues in clients' lives
- Counsellors helping resolve clients' difficulties that brought them to counselling
- Counsellors helping clients to learn coping strategies for future problems
- Counsellors' ability to adopt an approach that suited the individual client
- Counsellors' ability to create a trusting relationship.

All the above were positively correlated with the amount of improvement clients demonstrated, i.e., higher satisfaction with counsellor/therapist abilities was associated with greater improvement in clinical outcomes (Table 11).

Table 11. Correlations between counsellor abilities and client satisfaction

Correlation between Clients' CORE OM pre to post counselling score difference and Counsellor/Therapists' abilities (significant results only)			
How satisfied were you with your counsellor's ability to...	**Pearson's *r***	***p***	***n***
Work with you on the important issues in your life?	-.165*	0,012	229
Adopt an approach that suited you?	-.166*	0,012	232
Help you resolve the difficulties that brought you to counselling?	-.149*	0,023	231
Help you learn to cope with problems that may arise in the future?	-.156*	0,019	227
Create a trusting relationship?	-.192**	0,003	231
** Correlation is significant at the 0.01 level (2-tailed).			
* Correlation is significant at the 0.05 level (2-tailed).			

The most significant relationship to changes in clients' distress levels was satisfaction with counsellors' ability to create a trusting relationship. $r(230) = -.19$, $p = .002$.

Questions related to client satisfaction with the counsellors' ability to listen to and understand clients and the level of communication between counsellors and clients' GPs, were not significantly correlated with the level of change in clients' pre/post CORE OM 34 scores.

Counselling outcomes and client perception of benefit of counselling

There was a significant difference in counselling outcomes between those who perceived they had benefitted from counselling (M = -.67, SD = .581) and those who did not (M = -.23, SD = .701)(t = -2.478, p = .014).

While clients who expressed dissatisfaction with counselling still demonstrated change in pre and post CORE OM 34 scores (an average reduction in CORE OM 34 scores of .23), their level of improvement was significantly less than for those who expressed satisfaction with counselling – this group demonstrated an average reduction of .68 in their CORE OM 34 scores.

6.4 Discussion

Overall client feedback regarding the CIPC service as indicated by the results of the CIPC Client Satisfaction Survey show that most clients who attended counselling were satisfied with the service that they received and believed that counselling was effective or very effective in helping them to address their difficulties (92%) .

These results highlight several important themes in relation to client experiences:

1. Accessibility of the CIPC service
2. Clients' perception and experience of waiting times
3. Clients' perception of counselling effectiveness and
4. Clients' experience of the end of counselling.

6.4.1 Accessibility of the CIPC service

In the original design of the CIPC service model, the 'opt-in' process was established as an indicator of motivation for counselling and to support active client agency in the decision to attend counselling and address their emotional and psychological issues. In this survey, the opt-in process received a high satisfaction rating from clients with over 92% being very satisfied or satisfied with the process. This offers support to the rationale that the 'opt-in' process reflects a client's motivation in relation to attending counselling . Feedback from GPs [see Chapter 5] indicated that some have reservations about the value of the opt-in process, with many commenting that it may act as a barrier or disincentive to patients engaging in counselling. This perception is not borne out by the feedback from the clients. From a service resource perspective, the opt-in process is an important resource management tool as it serves to identify those clients who are not motivated or interested in attending counselling thereby reducing the number of unattended sessions. Opt-in systems are routinely used in counselling, psychotherapy and mental health services and are associated with improved attendance and reduced waiting times (Jenkins et al., 2014; Woodhouse 2006).

The CIPC model of service delivery was designed to provide access to counselling at primary care level, counselling is provided in local communities in primary care centres, or easily accessible counselling centres. Across the 26 counties in Ireland, counselling is now delivered in over 240 such locations. Feedback from clients shows these locations provide an excellent fit for clients with ratings of over 90 to 95% satisfaction with the convenience, privacy, and suitability of counselling location. These results support the policy of co-locating the delivery of psychological and mental health services alongside other primary care health services in terms of reducing stigma and promotion of positive and proactive mental health care.

CIPC aims to provide a flexible service in relation to times and dates of appointments and where possible these are negotiated with the client by telephone. This is reflected in client responses with over 88% reporting satisfaction with this aspect of service delivery.

6.4.2 Client perceptions and experience of waiting times

Most clients were satisfied or had no opinion about the length of time they had to wait between being referred to the service and attending their first assessment appointment (75.4%), a significant proportion (25.6%) did express dissatisfaction.

Increasing waiting times for counselling are an indicator of how supply for the service is overtaken by demand. Demand has increased year on year for the CIPC service. In relevant studies elsewhere, time spent waiting for an initial assessment has been associated with non-attendance and poorer outcomes (Marshall et al., 2016) and was found to be a negative aspect of clients' experience which can lead to decreased motivation, increased physical health risks, and increased risks to self and others (Brown et al., 1989; Mind, 2010; Wenger & Rosenbaum, 1994). Findings from a previous National Counselling Service Client Satisfaction Survey of clients attending in 2009, found that waiting for seven months or longer impacted clients' overall satisfaction ratings of the service, with level of dissatisfaction after that time increasing (Reddan, 2011).

Feedback from some CIPC clients in this survey referenced experiencing the waiting period as difficult, such as "*waiting time was very long"* and *"only complaint is the 2 month waiting time for first appointment*". The following comment aptly illustrates the relationship between waiting and escalating distress: *"…I had a long wait time from the time of applying for counselling to the time of beginning the sessions, and in that time I became very hopeless about my difficulties being helped*". There were also suggestions that the service could improve communication with clients about waiting times, e.g., "I *had to ring to make sure I was still on the list. Approx. waiting time should be communicated*".

In this study, the results found that clients' CORE OM 34 scores at first appointment, indicating levels of distress being experienced, were correlated with the length of time they waited. Clients' perception of that waiting time was also related to the actual length of time. When clients wait longer for their first counselling appointment, their levels of clinical distress increase and they become more dissatisfied the longer they must wait. As the demand for the CIPC service continues to increase, capacity to respond will be impacted with longer waiting times a natural consequence. It is imperative that CIPC is provided with sufficient resources to meet the growing demand and need for the service to reduce the impact on clients that arises from significant waiting times.

6.4.3 Client perceptions of counselling effectiveness

Client satisfaction with the effectiveness of the counselling provided by CIPC was 91.5%. This is in line with other studies such as the IAPT service in England. Kuhn (2011) reported a 97% client satisfaction rating though the number of clients in that study was significantly smaller (n = 67). Proctor and Hargate (2013) in a study of IAPT services found that 98% of clients were either vary satisfied or satisfied with therapy received (n = 235).

In line with national and international research relating to psychological presentations at primary care level (O'Doherty et al., 2020; Shepardson et al., 2020; Titzler et al., 2020), the CIPC Clinical Outcome Study (see Chapter 2) reported depression and anxiety as the most common presenting problems for clients attending. The results of the CIPC client satisfaction survey demonstrates that clients perceived counselling as a highly effective intervention in addressing such difficulties with 59.2% and 59.5% of respondents indicating that counselling had been effective in addressing feelings of anxiety and depression respectively. A total of 67.9% of clients indicated that counselling had been effective in helping in helping them to address their feelings generally.

Client qualitative comments also reflected their overall experience of counselling and the benefit they derived from attending for example:

- *"I truly believe that counselling has changed my life for the better"*
- *"My experience of counselling really helped me...I felt the whole experience was beneficial overall, very glad I did it."*
- *"I had a very positive experience with this service. I made huge progress in a short space of time".*

Better clinical outcomes associated with client satisfaction

Clinical outcomes are also impacted by client perceptions and experience of counselling. Results comparing clients' perceived benefit from counselling with their clinical outcome scores demonstrated that there was greater clinical improvement for client's who expressed satisfaction with counselling overall. It is interesting to note that clients who expressed dissatisfaction with counselling still experienced a significant reduction in their clinical distress as rated by CORE OM 34, however this was at a lower level than for those clients who expressed satisfaction with the service. This raises implications for practice in terms of encouraging greater exploration with clients during counselling of how they are experiencing the process. The CIPC service could benefit from the introduction of alliance measures such as Session Rating Scale (Duncan & Miller, 2003) to provide counsellors/therapists with concurrent client feedback on client experience of the counselling process along with clinical outcome data. In addition clinical outcome data could be captured more frequently by consistent use of the CORE-10 in each session. This would provide the opportunity for counsellors to use feedback to adjust how they are working with a client which could potentially improve both the client experience, and consequently clinical outcomes.

Analysis of client feedback about their counselling experience indicate that counselling is perceived by clients as improving their overall emotional and mental health. Clients reported additional benefits from counselling relating to emotional and psychological functioning, self-esteem, improvements in how to manage feelings (67%), improved ability to deal with stress (64%) and feeling better about self (64%). These findings underline the positive impact counselling can have, which goes beyond a reduction in symptoms of anxiety or depression. A substantial number of clients also reported experiencing improvements in their communication with others and overall relationships with others (45 % and 38% respectively).

Trust in counselling relationship linked with positive outcomes

Previous research has consistently demonstrated the importance of the availability of supportive and confiding relationships as a protective factor in promotion of positive mental health and the lack of such relationships as a significant risk factor for the development of depression, anxiety and suicidality (Teo et al., 2013; Wang et al., 2018). It is a very welcome finding that CIPC clients report benefits from counselling that can aid them in fostering and maintaining healthy coping strategies for the future with over 86% reporting that they were satisfied with their counsellors' ability to help them learn to cope with future problems.

"I feel more confident, happier and feel like I can handle anything that life throws at me. With a lot of help and practice I feel I am ready to face my problems however hard or difficult."

Clients of the CIPC service reported very high levels of satisfaction with the counsellor's ability to listen and work with them on their issues in general. Previous research into the 'common' factors that underlie effectiveness in counselling have stressed the importance of the therapeutic alliance in determining a large proportion of the impact of therapy (Norcross & Wampold, 2011.) Meta-analytic reviews have demonstrated the importance of therapeutic alliance for predicting therapeutic change and achieving positive outcomes (Horvath et al., 2011; Soto 2017). Clients in this study expressed very high levels of satisfaction with their counsellors' ability to create a trusting relationship (93%), with their ability to work on important issues (94%), their ability to help resolve their presenting difficulties (88%) and ability to adopt a therapeutic approach that suited them (92%). All these facets of the therapeutic alliance are important in achieving positive therapeutic outcomes.

Individual client comments highlighted the importance of the therapeutic relationship in the improvements that they made:

"My counsellor helped me more than words can describe. I was nervous beginning counselling but as soon as I met my counsellor, she made me fell so comfortable and at ease… My counsellor helped me to deal with issues that I have struggled with all my life."

Analysis of clinical symptoms on CORE OM 34 and client's experience of the counselling relationship identified the aspects of the therapeutic relationship which were significantly related to reduction in symptoms. Of these, client satisfaction with the counsellor's ability to create a trusting relationship showed the strongest and most significant association with a positive outcome from counselling. This is further evidence that the creation of a positive and trusting therapeutic alliance is at the heart of positive change in counselling.

The CIPC service requires a high level of both academic qualification and substantial period of clinical experience to be attained before counsellors/therapists begin working for the service. Counsellors/therapists are expected to be able to offer a range of therapeutic interventions to clients. The CIPC model of therapy emphasises the paramount importance of the therapeutic alliance as an agent of change and of 'fitting' the therapeutic approach used to the clients presenting needs. Results of the client satisfaction survey support this aspect of the CIPC service model in tailoring interventions and approaches to clients reflected in the positive impact of the focus on the therapeutic relationship.

6.4.4 Client experiences of the end of counselling

Clients were asked about any onward referrals since ending with CIPC and it was observed that 17% (*n* = 226) of clients reported being referred to additional services after attending CIPC. These included a range of services, such as secondary mental health care, addiction services, or longer term counselling within the NCS for experiences of childhood abuse. This result indicates that for some clients, CIPC plays a role in identifying additional needs and supporting access to other relevant services by provision of information, onward referral, or recommendations to the GP. This communication and integration between services in a client-centred way is at the heart of Sláintecare (2017) and the current mental health strategy 'Sharing the Vision' (Department of Health 2020).

6.4.5 Client views on the number of sessions offered

CIPC provides a time-limited model of counselling, with most clients offered up to 8 counselling sessions after their initial assessment. There is some degree of flexibility in this model, based on clinical need, as evidenced by the result from the Clinical outcome study (see Chapter 2) that 14.5% attended 10 or more sessions. The use of outcome monitoring systems has been shown to reduce premature termination in practice (Lambert & Shimokawa, 2011). Use of the CORE 10 questionnaire on a session by session basis in CIPC would support the service in making clinical decisions about when additional sessions may be required.

Results in relation to the numbers of sessions attended by clients and their satisfaction with same indicates a substantial minority (just over 20%) were not satisfied with the number of sessions they received. Most of these clients indicated they would have preferred more counselling appointments.

Client comments in relation to the number of sessions that they received also highlights the variability of how the time-limited model is experienced:

- *"I feel the amount of sessions offered should be adapted to each person. I felt I may have benefitted from more"*
- *"I would have like a few more sessions"*
- *"I needed less counselling appointments but it's nice to know you have some sessions left in case something goes wrong again"*
- *"My sessions were finished. I did what I needed to do so I was pleased with myself"*
- *"I am happy with what I got. It was just right for me"*

Results in relation to the client experiences of the end of counselling indicates that over 50% felt ready to end, or that their difficulties had improved. An additional 5% indicated it was because they had enough counselling sessions and their difficulties had improved. Twenty percent indicated that their counselling ended because they had completed their contract (i.e., reached the number of therapy sessions agreed at the outset).

A total of 20% of clients cited several reasons for ending, some of which related to practical issues preventing or interfering with their ability to attend such as lack of transport or childcare. During the COVID-19 pandemic the Counselling in Primary Care Service expanded its service provision to include telehealth – through provision of structured telephone counselling (STC) and online video counselling (OVC). These options, when clinically appropriate, help to address some of the practical issues which can prevent clients accessing the service such as transport difficulties. The integration of telehealth provision to the CIPC service will help to ensure that in the future more clients can engage and complete counselling with CIPC than was possible during the period when the Client Satisfaction survey was conducted.

Almost 6% of the total responses indicated that the client had reached the allocated number of sessions and wanted more counselling. In contrast approximately 3% gave responses indicating that they ended counselling because they did not feel it was helping them. Results from studies on counselling and psychotherapy consistently report that some clients do not benefit (Lambert, 2013) so it is not surprising that a proportion would choose to end for this reason. Results of the client satisfaction survey found that while the time-limited model of counselling provided by CIPC matched the client level of need in most cases there are some clients for whom more sessions are preferable or required. The CIPC service model has the capacity to be flexible and responsive to these needs. Identification of which clients would benefit most from additional sessions would be enhanced by the introduction of consistent session by session measurement. This would help to ensure optimum use of counselling sessions keeping in mind the need to respond in a timely manner to those clients waiting for counselling.

6.4.6 Conclusion

CIPC is beneficial to clients

In summary the findings from the CIPC client satisfaction survey tell us that clients find CIPC very effective and beneficial. They demonstrate that clients experience that their presenting issues have been addressed in a professional manner by counsellors who are trusted and effective in addressing difficulties in a caring, confidential manner which is tailored to meet individual needs.

The findings also indicate areas where some clients were less satisfied. Suggested improvements to the service currently provided include reductions in waiting times and improved communication at the point of referral about expected waiting times. In addition it has been identified that a proportion of clients would prefer more counselling sessions than are offered. Review of practices in relation to how the option for flexibility in number of sessions is assessed would be beneficial.

Study findings also indicate that a proportion of referrals to CIPC are of individuals who require a medium to longer term counselling contract. In these cases the CIPC service supports individuals to seek onward referral to secondary or specialist services as appropriate. In so doing, CIPC often provides a positive first therapeutic experience which facilitates many clients to engage with other mental health services that they may not have accessed without the intervention of CIPC.

While direct client feedback identified areas that CIPC needs to improve on, comments from clients also highlighted the significant ways counselling has been of benefit:

"I found counselling to be everything. More than I expected. My therapist was so sincere. I felt so at ease and comfortable. This truly is a significant part of my life that I will always remember & appreciate as it helped me overcome so much…This should be offered to anyone & everyone before being prescribed medication." CIPC Client

7 Evidence of CIPC from the real world: What have we learned? Conclusions and recommendations

7.1 Real world research: The value of practice-based evidence

Despite the sizable evidence base for counselling and psychotherapy, there remains a significant gap between the availability of effective psychological therapies and the delivery of such interventions in the community (Committee on Developing Evidence-Based Standards for Psychosocial Interventions for Mental Disorders, Board on Health Sciences Policy & Institute of Medicine, 2015). It is argued that until efficacy and effectiveness studies include treatment conditions that resemble practice in the real world, it is difficult to draw conclusions from existing data that can meaningfully affect clinical practice (Cook at al., 2017).

Challenges associated with an evidence based practice approach to counselling and psychotherapy include concerns about the generalisability of the findings, given that the conditions and characteristics of randomised controlled treatment outcome research *versus* those of real-world clinical practice differ significantly. Many studies under-represent minority populations, clients with co-morbid conditions or exclude participants with psychosocial stressors. In actual practice, most clients experience these stressors and may have multiple presenting issues. There is a need for research which examines the effectiveness of counselling in real world settings that take these complexities into account (Cook et al., 2017).

Meta-analytic studies of randomised controlled trials, which are considered the 'gold standard' in terms of the level of evidence and ability to generalise results to particular patient populations (Kabisch et al., 2011), have demonstrated that patients who receive counselling and psychotherapy tend to have moderately better outcomes than usual GP care or other controls (Wampold et al., 2017). Many RCT studies however are conducted under highly controlled conditions, applying manualised treatments, to carefully selected study participants which are not reflective of clinical practice. In addition RCT type research designs are problematic to implement in real world counselling services due to the divergent nature of their aims versus the realities of normal service operations (Ammerman et al., 2014), particularly when evaluating psychotherapeutic intervention outcomes (Speer, 1998).

There remain fundamental differences between the requirements and objectives of RCTs, pragmatic effectiveness studies and studies gathering practice-based evidence (Cartwright, 2007; Leichsenring, 2004). This situation has led to a paucity of information on whether psychological treatments are generally effective once implemented on a large scale in public mental health and primary care settings. In recognising this need CIPC took a practice based approach to this research. Studies such as the CIPC national evaluation study are required to inform the literature and clinical practice about the impact and effectiveness of counselling in public health service provision.

Practice-based studies focus on routine data collection from clients in usual health settings (Castonguay et al., 2013). Typically this means large data sets as such studies include all service users. This allows for a more flexible approach and the inclusion of participants from under-represented groups in the population not typically accessible in RCT research (Barkham et al., 2010). Additionally, psychological treatments are delivered in usual service locations and are not manualised. Practice based studies such as this one are therefore more reflective of the type of therapy normally practiced by clinicians.

Barkham and Margison (2007) define the process of gathering practice based evidence as *an integration of clinical expertise, service level experience together with evidence derived from practice in routine clinical settings. The CIPC* National Study incorporates these elements and applied them using the framework developed by Barkham et al. (2010)(See Chapter 1).

CIPC was established as a service for mild to moderate psychological difficulties however clients with a diverse range of difficulties which vary in terms of complexity, severity and duration are regularly referred. A practice based approach to evaluating the impact of the service was therefore important to reflect the client population who avail of CIPC counselling. Clinical outcomes measures form part of how the CIPC service is routinely delivered, this was a key enabler for the current study. As a 'real world' research study all clients who opted to participate were included. In practice this meant that the study sample also included those who did not complete their counselling and for whom complete post-counselling results are not available. This impacted the overall findings but reflects the true picture of counselling in practice.

The CIPC National Evaluation study is the first practice based national study of its kind by a counselling service in Ireland to evaluate service provision and clinical outcomes for clients. It provides a baseline for benchmarking service performance as well as contributing learning to the wider field of counselling provision. This will serve to improve service delivery to clients and benefit service policy and development.

The CIPC National Evaluation Research study demonstrates the value and power of practice based research and routine evaluation in clinical practice. The importance of research and evaluation to ensure achievement of best mental health outcomes is a key principle of Sharing the Vision (2020). The framework offered by this study provides a model which could be generalised to other health and social care services across the HSE. It is recommended that the NCS continue to integrate research into practice and to promote the development of practice based research across all aspects of the service in order to continue to improve service quality for clients.

7.2 CIPC is an effective, life-changing service

"Counselling has changed my life for the better I can handle anything that life throws at me"

Almost 3,000 CIPC clients (2,965) consented to take part in the National Evaluation study, a participation rate of 61%. Those who took part were similar in profile to clients who attend the service on a regular basis that is most were female (75% of all participants) with an average age of 42 indicating that the sample was representative of CIPC clients. Over 85% of participants were from white or white Irish backgrounds, broadly reflective of the general population of CIPC clients.

Anxiety and depression are the most common mental health difficulties identified in the Irish general population according to GPs (Doherty et al., 2008). This was evident in the current study with 81.1% of participants identified by counsellors/therapists as having trouble with anxiety and 59.7% reporting depression as a major reason for seeking help. Most clients experienced moderate or severe levels of these problems.

Prior to counselling, 26.7% of clients were identified as displaying self-harm or suicide risk indicators. This reduced significantly with counselling intervention. Post counselling scores indicated a reduction to 8.5%, a clinically and statistically significant improvement.

Counselling with CIPC was effective in addressing the problems clients presented with to a significant degree. At the start of counselling 81% (*n* = 2,373) of those who participated in the study scored above the clinical cut off for psychological difficulties. After counselling **72% (*n* =1,003) of participants demonstrated either improvement or recovery.** Effect size was calculated to determine the impact of CIPC counselling, this found that counselling was effective in reducing psychological distress and had a large effect, i.e., ES = 1.20.

Results from additional measures used to assess work and social adjustment and client rated physical and mental health, (the WSAS and HRQOL-4), demonstrated a similar pattern of positive change indicating improvement in client physical and mental health and quality of life because of counselling. Participant scores demonstrated improvement in levels of distress with significantly less impairment reported by most participants in functional ability following counselling. According to the HRQOL-4, significantly lower numbers of mentally and physically unhealthy days were reported (8.3 and 3.2 days average reduction respectively) along with better perceptions of overall health and higher levels of activity for clients at the end of counselling.

A total of 68% of clients had a planned ending to their counselling contracts. Clients who achieved planned endings were far more likely to have a better clinical outcome. There was a significant difference in the amount of improvement shown for those who completed counselling in a planned way compared with those who had an unplanned ending. Clients who had unplanned endings attended on average 50% fewer counselling sessions and were seven times more likely to show deterioration in clinical symptoms.

Feedback from clients through the CIPC Client satisfaction survey supports these clinical outcome findings. Clients reported high levels of satisfaction with the service they received and 92% of those who gave feedback indicated that counselling was effective or very effective in helping them to address their difficulties.

These findings were further supported by GPs, 80% of whom considered that counselling was beneficial to their patients and effective in dealing with their psychological difficulties. This was further reflected in the many qualitative comments provided by GP respondents. In addition it is noteworthy that 89% of GPs who responded to the CIPC National GP satisfaction survey agreed that CIPC should be expanded and made available to non-GMS patients. The level of demand for CIPC was reflected in the finding that 85% of GPs who answered the survey stated they had patients who would have benefited from counselling but whom they had not referred to CIPC citing the eligibility criteria which require patients to hold a valid GMS card as well as long waiting times as the barriers to accessing counselling.

> *"Great service, patients really benefit. Especially helpful for dysthymic patients and elderly patients for whom counselling also affords a chance to feel listened to.*
>
> *Would be delighted if I could offer this service to non GMS - would significantly reduce cost to state for medications and secondary referrals."*
> *CIPC Client*

In summary these findings tell us is that counselling is very effective. Most clients who availed of counselling with CIPC experienced improvement in both mental and physical health; their mental well-being improved, they felt less distressed and were able to return to their day-to-day activities.

Given the prevalence of common mental health disorders (WHO, 2017b), their impact on physical health, social relationships and general functioning (Chisholm et al., 2016; Furber et al., 2015; Singla et al., 2017) as well as the psychological, societal and economic cost of such common mental health disorders (Dezetter et al., 2013) the potential for CIPC to positively impact the mental and physical health of the Irish population is evidenced in the findings of this report.

CIPC is clearly an effective service which achieves positive outcomes for clients with additional benefits for overall physical and mental health. These findings are endorsed by clients directly as well as by GPs and support the case for expansion of CIPC eligibility beyond those who hold a General Medical card.

Achieving a planned ending yields significant benefits for clients, with better clinical outcomes from counselling far more likely for those clients who complete their counselling contract.

It is recommended that CIPC introduce a process for identifying clients at risk of drop out and develop additional supports to optimise client engagement in counselling.

7.3 Counselling has lasting benefits

Direct benefits of counselling gains are maintained: Significant improvements from counselling last long after it ends

Follow-up studies are an important source of information about a service's long-term impact. Research examining the long-term effect of counselling have demonstrated that regardless of the type of therapy clients receive in the primary care context, most improve, and improvements tend to last for a period of at least three months (Davis et al., 2008; Karyotaki et al., 2016). CIPC contacted participants at 6 and 12 months after counselling to examine whether improvements had been sustained. Findings showed that while the size of the improvement clients experienced by the end of counselling had reduced at follow up, clients remained significantly better at 6 and 12 months, than they had been prior to counselling. A similar pattern was found in client reports regarding their overall physical and mental health. Client improvements following counselling were sustained even a year after counselling had concluded.

Indirect benefits of counselling: CIPC helps to reduce the burden on other services

The benefits of the CIPC service extend beyond individual patients and have the potential to reduce demand on other services such as GP time and adult mental health services. This was the view of GPs surveyed for this study, 54% of whom expressed the view that the availability of the CIPC service had reduced referrals to adult mental health.

The following comment from a CIPC client captures this succinctly:

"This is an excellent service. I really don't know where I would be without it. I've started a new job and I could not see myself doing that 6 months ago. I feel if there was more availability of services like this it would very much reduce the cost and overcrowding in hospitals."

7.4 What clients think: Service-users' experience of CIPC

"I had a very positive experience with this service. I made huge progress in a short space of time. My counsellor helped me to deal with issues that I have struggled with all my life."

To gather a holistic picture of how CIPC counselling impacted service users, a client satisfaction survey was conducted as part of the research study. 1,322 clients responded. Results show clearly that clients who attended have a positive experience of CIPC. The majority (96%) of clients reported that counselling was beneficial and consider that it helped to improve their mood and address their problems including how to manage their feelings and cope with stress. These findings underline the positive impact that counselling can have, which goes beyond symptom reduction.

A key aim of counselling is to facilitate clients to gain skills or strategies which can be generalised to new situations in the future. Client feedback indicates that this was achieved for most clients. A majority (86%) of participants reported being satisfied with their counsellors' ability to help them learn to cope with future problems:

"The counselling helped me understand more about myself and helped me to cope better with anxiety and stress. To manage better with different situations before they got worse."

Clients expressed very positive views about the counsellor they attended, with high levels of satisfaction with counsellors/therapists' ability to listen (97%), respect their confidentiality (96%) and work on the important issues in their lives (94%).

"I felt so supported and listened to, my counsellor helped me respect and value myself again."

The findings also indicated areas where CIPC can improve. A quarter (25%) of clients identified the need for improvements in waiting times as well as communication at the time of referral about expected waiting times. Some clients indicated a preference for more counselling sessions than were offered.

The CIPC model of service provides for up to 8 sessions in addition to the initial assessment appointment. Findings from the study identified that participants attended an average of 7 sessions. Number of sessions varied, ranging from 1 to 23 sessions, reflecting how counsellors/therapists tailored counselling to the needs of the client. This reflects the reality of clinical practice and the importance of clinical judgement to allow for extensions to the counselling contract in response to client need when required. The option to extend counselling contracts when clinically indicated allows the service to be flexible and responsive to client need whilst also maintaining a clear model of service necessary to ensure effective use of resources and timely access for most clients. Client feedback indicated some clients would have preferred more counselling sessions. Identification of which clients would benefit most from additional sessions would be enhanced by the introduction of consistent session by session measurement. This would help to ensure optimum use of counselling sessions keeping in mind the need to respond in a timely manner to those clients waiting for counselling.

The study found that some clients who were referred to CIPC required more intensive intervention than is appropriate for a short-term counselling service. CIPC offers a positive therapeutic experience which facilitates many of these clients to subsequently engage with other mental health services which they may not have accessed otherwise. Counsellors/therapists actively support such individuals to seek onward referral to other secondary or specialist services where appropriate. Attendance at CIPC helps to improve client trust of other health services such as mental health and acts as a bridge to services they require.

Qualitative feedback provided by clients highlighted the need for CIPC to improve its waiting times and its communication with clients while they are waiting: *"A very valuable service - Extremely helpful to me. However waiting time was very long"*.

Enhanced communication with clients while on the waiting list could help to reduce distress, increase engagement with other services while waiting and possibly reduce waiting times and dropout rates. It is recommended that CIPC develop a greater focus on communication with clients who are waiting for example through regular telephone communication. In addition consideration should be given to provision of self-directed online interventions to clients on the waiting list. A recent HSE digital mental health initiative, the SilverCloud Health online CBT programme, may help to address this need. CIPC is currently participating in the roll-out of this programme.

It is recommended that CIPC implement a strategy for communication with clients who have been waiting longer than 2 months. Clients on the waiting list should be provided with information about other support options that can be availed of while waiting.

It is recommended that CIPC develop an agreed service standard in relation to waiting times to maximise timely access for service users. As a demand led service with finite resources waiting list management is an ongoing challenge. CIPC needs to ensure that all available resources are used to optimal effect.

The direct role of long waiting times in exacerbating the impact of psychological difficulties has been highlighted in this study. The potential for CIPC to prevent the development of more severe psychological difficulties requiring more costly tertiary interventions is clear. In line with the core service delivery principles of Sharing the Vision which aims to reduce the prevalence and severity of mental health difficulties through early intervention (DOH, 2020, p. 95), future resource allocation decisions should take account of CIPC's essential role in implementing these key objectives.

7.5 "I felt heard for the first time" - Quality of counselling relationship is key

A substantial body of research has examined what makes talk therapies effective. The therapeutic alliance is one of the key factors which determines the impact of counselling and therapy (Norcross & Wampold, 2011). Clients in this study expressed very high levels of satisfaction with their counsellors/therapists' ability to create a trusting relationship (93%), work on important issues (94%), help resolve their presenting difficulties (88%) and to adopt a therapeutic approach that suited them (92%). These factors all form part of the therapeutic alliance and are essential to achieving positive therapeutic outcomes.

A key element in the counselling relationship is the counsellor/therapist's capacity to attune to the needs of the client and to work on the issues which the client considers to be of importance. This highlights the need to be flexible and to ensure that therapeutic approaches are tailored to client needs. This study demonstrated that clients experienced positive counselling relationships which facilitated counselling to be effective. In addition, 88% of counsellors/therapists employed multiple therapy approaches in their work with clients, a concrete indicator of the counsellor/therapist's capacity to adapt to client's presenting needs.

As outlined in Chapter 2 there was a significant association between client satisfaction with the counsellor's ability to create a trusting relationship and a reduction in clinical symptoms. This is further evidence that the creation of a positive and trusting therapeutic alliance is at the heart of positive change in counselling.

"After a couple of sessions I could see the benefit from it. I was able to form a trusting relationship with my counsellor."

For clients the therapeutic relationship is key to change, this requires trust, as well as flexibility and responsiveness to client needs. The CIPC service requires a high level of academic qualification and substantial clinical experience before counsellors/therapists begin working with the service. Counsellors/therapists are expected to offer a range of therapeutic interventions depending on client needs. The CIPC model of therapy emphasises the importance of the therapeutic alliance as an agent of change and of ensuring that the therapeutic approach used is appropriate to the presenting needs. Study results demonstrate the success of this model in tailoring interventions and approaches to client needs and the positive impact of counselling arising from the focus on the therapeutic relationship.

7.6 Commitment to routine evaluation maximises results

A total of 68% of participants in this study achieved a planned ending to their counselling. This is higher than the average reported in large-scale meta-analyses, which report higher dropout rates in 'real world' settings (Swift et al., 2017) and studies using naturalistic research designs (Swift & Greenberg, 2012). For example, Connell et al. (2006) reported an average premature dropout rate of 50.1% across 31 different primary care services in the UK.

Predictors of dropout are categorised in terms of treatment based, patient or therapist factors (Swift & Greenberg, 2012). Treatment-based predictors associated with premature termination include non-predefined duration of the intervention, non-manualised treatments and university-based programmes. In one study, 5.7% of dropout variance was explained by therapist characteristics (Zimmerman et al., 2017) such as level of experience, training and skills (Swift & Greenberg, 2012). Patient factors associated with dropout include low level of education and lower age (Swift & Greenberg, 2012) though findings are not consistent (Altmann et al., 2018). Quality of the therapeutic alliance (Roos & Werbart, 2013) is also linked with premature termination.

Findings from the CIPC National Evaluation study indicate that client dropout rates from CIPC are less than those reported in the literature. In considering the possible factors that might be associated with a high level of planned endings it is worth noting that the CIPC model of service specifies a clear duration for counselling contracts. Clients are offered up to eight sessions of counselling which is outlined in the contract of counselling agreed at the outset. It is possible that this may contribute to achieving a high proportion of planned endings though further research is needed to establish a direct association with ending type. At a practice level however, this finding provides support for the importance of having a clear contract of counselling duration agreed with the client at the outset of treatment.

The nature of endings raises significant implications for practitioners given that counselling is found to be more effective where a planned ending is achieved. Positive counselling outcomes are more associated with planned endings in primary counselling services (Clark et al., 2018) a finding replicated in the current study which found that clients with planned endings had a greater likelihood of achieving reliable and statistically significant change. The importance of monitoring the counselling contract and ending type at an individual practitioner as well as at a service level is clear. The need to support counsellors/therapists to achieve planned endings with clients is highlighted. Evidence based strategies identified as helpful in reducing dropout include strengthening client hope, enhancing client motivation to change and fostering the therapeutic alliance (Swift & Greenberg 2015), all of which can be incorporated into clinical practice when it is identified that there is the potential for dropout. Use of session by session feedback supports identification of clients where drop out may be a risk.

Timely access to counselling is important not just for a positive service user experience but also crucially at a clinical level. Findings from this study showed that the longer a client experienced psychological difficulties, the more severe those difficulties were likely to be at time of attendance for counselling. Referral at an early stage in the development of psychological difficulties and timely access to counselling are both crucial to prevent development of more severe psychological difficulties.

This study found that ending type, severity of presenting issues and duration of psychological difficulties prior to counselling all influenced counselling outcome. The longer clients waited to attend counselling the more likely they were to score in the severe range in terms of their presenting issues. The more severe their clinical scores the more likely they were to have an unplanned ending and the less likely they were to achieve reliable and clinical change.

These findings tell us that clients need to be seen sooner in the development of their difficulties to increase the likelihood that they will stay for the full course of counselling and have the greatest chance of achieving more positive outcomes.

> These findings highlight the importance of early referral to CIPC and timely access to counselling. Routine evaluation allows for these factors to be monitored and responded to particularly client risk of dropout.
>
> It is recommended that CIPC enhance its routine monitoring of client outcomes and improve consistency of session by session feedback to reduce the risk of client dropout.

7.7 In the absence of counselling, medication is often the only option

Internationally, research has highlighted a mismatch between GP intent and practice when it comes to cessation of psychotropic medication with one of the most significant barriers to achieving cessation identified as the lack of access to counselling and psychotherapy (Lasserre et al., 2010).

Lack of available counselling and psychotherapy services has similarly been cited as one of the reasons that psychotropic medicines continue to be prescribed by Irish GPs. The ICGP's 'Submission to the Joint Committee on Health on Prescribing Pattern Monitoring and the Audit of Usage and Effectiveness Trends for Prescribed Medications', reported that 'prescribing rates of antidepressants reflect a lack of psychological therapies and a lack of social therapies and resources in society' (2008, p.4).

Would universal access to counselling impact on GPs prescribing behaviours in Ireland? A Swedish study suggests this might be the case. Svensson et al. (2019) examined GP attitudes and behaviour towards psychotropic drug prescribing in primary care and found that GPs were overwhelmingly in favour of using psychotherapy rather than psychotropic drugs for mild to moderate mental health issues. Timely access to quality services were a requirement.

A majority (86%) of GPs who responded to the CIPC GP survey identified that there were patients whom they felt could benefit from counselling but whom they did not refer. The most common reason being that they did not hold a GMS card and were not eligible for the CIPC service. Qualitative feedback provided by GPs highlighted the limited options available to those patients who do not hold GMS cards: ***"In some cases I end up having to prescribe medication as people can't afford counselling, yet I know it would be the best treatment option for the patient".*** A total of 89% of GPs who responded to the survey agreed that CIPC eligibility should be expanded beyond medical card holders.

The presence of CIPC offers GPs in Ireland an alternative to psychotropic prescription for psychological difficulties. However some issues need to be urgently addressed if CIPC is to expand and provide a meaningful alternative to medication. There needs to be an expansion of the current eligibility beyond GMS patients and significant investment to address lengthy waiting times in some areas and ensure a timely response if demand increases.

The impact of waiting times for counselling on GP decisions to prescribe psychotropic medication also requires consideration. Results from the CIPC evaluation of GP satisfaction found that 63% of GPs were dissatisfied with the length of time patients had to wait for counselling. Qualitative feedback from some GPs cited waiting times as a reason for not referring and indicate that medication is often the only alternative available. This was succinctly expressed by one GP:

"A good service when patients get to it - waiting list is far too long to be truly of benefit. Antidepressant medications tend to be used while waiting for CIPC"
GP respondent

This comment is reflected in this national evaluation which showed that 43.3% (n = 1,267) of participants reported being in receipt of psychotropic medication prescriptions at the time they started counselling, a finding which reflects the research highlighted above and the negative impact of waiting times for clients.

This study also incorporated an examination of psychotropic prescription records for the purpose of determining whether attendance at counselling was followed by any change in prescription activity within a 6-month period following the end of counselling. Approximately 16% of clients were observed to have a reduction/cessation of their psychotropic medication prescriptions in the 6 months after counselling ended. While this sample was small, it highlights the potential for cost offsets from reduced spend on psychotropic medication and improvement in client quality of life because of investment in an expansion of CIPC, as well as the indirect positive social benefits supports from such an expansion.

These findings are promising particularly when considered alongside responses from the GP Satisfaction Survey which identified that 49% of GPs perceived that CIPC had contributed to a reduction in prescription of psychotropic medications to clients who attended counselling. This finding is in line with Schafer et al. (2009) who found that GPs perceived a reduction in medication prescription associated with availability of counselling for patients.

Demand for equity of access to counselling services in Ireland is clear (Department of Health, 2020; Mental Health Reform, 2017; Sláintecare 2017). There is now a need to translate policy into practice. This requires appropriate investment in psychological therapies including CIPC. Some of this funding could be secured if there was a rebalancing of the spend on psychotropic medications particularly when we consider that, "Limited public (free) access to psychosocial services disproportionately affects those without ability to pay and forces an increased use of medication options" (Murphy et al., 2018, p. 4).

Given the potential for adverse outcomes, patient safety issues, and additional health care costs arising from medication usage (Davies & Read 2018; Kendrick 2020; Lasserre et al., 2010) the value of investment in, and expansion of, the CIPC service to reduce psychotropic medication usage is obvious. Additional investment in counselling has the potential for positive impacts on overall health, reduced drug dependence and improved quality of life. Further examination of the link between waiting times for counselling and prescribing patterns is warranted.

It is recommended that consideration be given to expand eligibility for the CIPC service beyond GMS cardholders. This should be done on a phased basis, with any expansion targeting those who hold a doctor visit only card in the first phase of expansion. Any expansion of service should be contingent on provision of adequate additional resources and infrastructure to ensure it does not impact on timely access.

The negative impact of long waiting times for CIPC is clear from the results of this study including a worsening of client symptoms, the potential for poorer engagement in counselling, and the potential for increased use of medication. It is therefore recommended that CIPC develop an agreed national strategy to ensure timely access to counselling with a process for managing waiting lists to ensure they do not extend beyond 3 months.

7.8 Support earlier identification and referral to counselling

A significant proportion of participants reported experiencing their psychological difficulties for a period greater than 12 months (22.7% of those who reported depression and 29% of those with anxiety), or on a recurring or continuous basis prior to starting counselling. It was clear from the findings in this research that the longer a problem was present before the start of counselling, the more likely the client was to have more severe levels of difficulty and to achieve less significant improvement. The corollary was also true, those clients who waited a shorter period before being referred achieved more improvement, were more likely to complete the course of counselling and to have a planned ending. This indicates a need to encourage referral to CIPC at an earlier stage in the development of psychological difficulties.

There are additional benefits, beyond those that accrue to the individual client, when planned endings are achieved. Planned endings in counselling/therapy are also associated with greater cost savings. Altmann et al. (2018) found a significant reduction in annual inpatient costs, and reduced number of work days lost due to disability, for patients who concluded therapy in a planned way.

Results of meta-analytic studies consistently indicate that clients are less likely to drop-out of psychological therapies than they are to discontinue pharmacotherapy. The discontinuation rate in pharmacotherapy is 1.76 times higher than in psychotherapy (Swift et al., 2017). This further underlines the importance of offering psychological therapies as a first-line treatment for psychological disorders as effective treatments will only work if clients are willing to engage in them (Greenberg, 2016; Leichsenring et al., 2016).

Research has shown that clients are more likely to complete their treatment if they receive information early on regarding likely treatment duration (Swift & Callahan, 2011). Outcome monitoring is recommended to determine optimal treatment length for individual clients and has been shown to reduce drop out from counselling and psychotherapy in clinical practice (Lambert & Shimokawa, 2011). CIPC utilises the CORE system measures to evaluate clinical outcomes. The CORE-10 is a short form measure which can be administered every session, and which is used in CIPC clinical practice. To what extent this measure is used to routinely monitor and inform clinical practice e.g., when a client is at risk of dropout, was not the focus of the current study as such the extent to which this practice contributes to sustaining clients in therapy is not clear. This is an area which could be usefully explored in the future.

There are several recommendations for clinical practice arising from these findings:

- Earlier identification of psychological difficulties and earlier referral to CIPC would be of benefit to clients. It would increase the likelihood of a positive outcome from counselling. It is recommended that CIPC consider a programme of engagement with key stakeholders to educate on the importance of early identification of psychological difficulties and referral to CIPC where appropriate.
- Development of a standardised discharge summary at the end of counselling could help improve feedback to GPs and increase awareness of the benefits of counselling.
- Clients who have CORE scores in the moderate or severe range should be identified at the outset of counselling for additional support to reduce the risk of drop out.
- The CORE-10 should be implemented on a session-by-session basis in CIPC to enable feedback to counsellors/therapists on counselling progress. This will help to identify clients at risk of drop out and support counsellors/therapists to achieve planned endings in so far as possible.
- Consideration should be given to introducing a therapy alliance measure to further support engagement in counselling, prevent drop out and improve clinical outcomes.

7.9 Enhance GP, counsellor and client communication

Many GPs referred to the absence of an e-referral option for CIPC.

> *"Online referral from within our GP software would be more efficient for GPs - healthlink referral facility exists for practically all other referrals." -*
> *GP respondent*

Developing an e-referral system would be of benefit to both referral agents and the CIPC service.

It is recommended that an e-referral process be set up and implemented across all CIPC services.

Referrals to CIPC are activated when a referral form is received, and the client phones the service to opt in for counselling. Opt-ins are recorded by an answering machine or administrative personnel. In this study 58% of clients reported that they spoke to a member of CIPC service when opting in. Just 37% of GPs who participated in the GP survey indicated dissatisfaction with the CIPC opt-in system. Many also commented on this system in their qualitative feedback perceiving it as an additional barrier for potential clients. This dissatisfaction was not reflected in client feedback, as over 92% (n = 1218) reported being satisfied or very satisfied with the process of opting into the CIPC service.

The opt-in is a measure of client motivation – it requires the client to decide to contact the service and to actively decide to engage in counselling. The opt-in process was established to ensure best use of counselling appointments. Approximately 30% of clients do not contact the service to opt in following referral from their GP. Counselling appointments are not offered to clients who do not opt in.

The questions raised by GPs are valid and warrant further investigation as little is known about the clients who do not opt in to CIPC. In addition variation in how the opt-in system is operated between different CIPC services was noted with some services texting/writing to clients to inform them of the referral and inviting them to opt in.

CIPC should review its current opt-in procedures and consider standardising these processes in so far as possible with a view to minimising any potential barriers to client access. In addition, consideration should be given to communicating with GPs about the purpose of the opt-in system.

There is growing concern about increased rates of prescribing for mild to moderate mental health difficulties such as anxiety and depression (Rowe et al., 2012). An important consideration arising from this research study in particular the phase which explored medication prescription patterns is whether better communication between GPs, patients and the CIPC counsellor could impact on prescribing patterns. Enhanced communication across all stakeholders has the potential to start an important conversation about psychotropic medications and to facilitate collaborative and informed treatment decisions for patients. The results yielded in the medication part of this study (See Chapter 4) demonstrated that 8.9% of client's psychotropic prescriptions ceased in the months following counselling with the CIPC service. This is a useful area for future research.

Research indicates that approximately 65% of patients have never discussed the idea of stopping antidepressant medication use with their GP and that 48% of patients did not have their antidepressant medications regularly reviewed by their GP (Read et al., 2019). Eveleigh et al. (2019) recommend that it may be helpful for GPs to be aware of their patient's fears and expectations towards psychotropic medication use and cessation. Grace, Rowe and Cullen's (2012) Irish study demonstrated a positive impact on psychotropic prescription reduction and cessation following communication from GPs to their patients. CIPC counsellors undoubtedly have a role in facilitating clients to begin a dialogue with their GP regarding their medication and mental health treatment options. Additional training for CIPC counsellors in psychopharmacology would be useful in informing these conversations.

Simpson et al. (2003) demonstrated that in the longer term GP prescribing rates for patients reduced when counsellors were working closely with GPs. This infers that trust between GPs and counsellors is an important indirect factor in outcomes for clients and patients. Greater communication between CIPC counsellors and GPs may be required to enhance relationships and build trust. At a practical level there is scope to improve communication from CIPC counsellors to clients' GPs following the client's discharge from counselling.

A CIPC progress summary for GPs is recommended at discharge to support decision-making processes around further mental health interventions including the prescribing of psychotropic medication whether that be continuation, change in dosage, or cessation. This would help to facilitate more integrated, co-ordinated care planning with the patient.

7.10 Conclusion

"I truly believe counselling has changed my life for the better."

The CIPC National Evaluation Research Study was an ambitious project. It attempted to address several questions including whether counselling is effective and if so, for how long. It considered the views of its key stakeholders – those who use the service and those who refer. Finally it sought to explore psychotropic medication prescription patterns during and after attendance for counselling with CIPC.

The results of this study as laid out in Chapters 1 to 6 show that counselling as provided by the CIPC service in Ireland is clinically and cost effective for most clients referred. Importantly results demonstrated that the effect of counselling lasts beyond the counselling contract with positive impacts on mental health and physical well-being for up to one year after counselling. Clients are overwhelmingly positive about their experience of counselling, how it benefits them as well as their satisfaction with the counsellors they attended. GPs perceive CIPC to be a worthwhile service, with clear benefits for individual clients as well as indirect positive effects on their practice in terms of reduced demand on GP time, the possibility of reduced likelihood of medication prescription and less likelihood of referral to secondary mental health services.

CIPC has achieved the objectives it was set when first established nationally. The key challenge now is how to develop CIPC and ensure an accessible, equitable, sustainable and effective service into the future. Some of the key elements required to address this challenge are outlined below.

One message clearly expressed by GPs, a key stakeholder, was the need to secure equity of access primarily through **expansion of the service beyond medical card holders**. To expand CIPC requires investment and planning. Consideration may need to be given to phased expansion for example to extend the service in the first instance to doctor visit card holders. A caveat to this development, also expressed by GPs was that such expansion cannot be at the expense of increased waiting times.

With increased resources, many more people could benefit from CIPC. There is a need to develop and expand referral pathways into CIPC, for example for clients who no longer need the intensive intervention offered by secondary mental health services.

In line with one of the key objectives of Sláintecare to achieve integrated service provision, CIPC provides an early intervention mental health service delivered in primary care (OHCHC, 2017). **CIPC needs to be supported and prioritised by ongoing investment, financial and infrastructural** (e.g., through access to appropriate accommodation) from both Mental Health and Primary Care.

Sharing the Vision (2020) the national policy for mental health services recommends that prompt access to counselling should be available "for those who need it" (DOH 2020, p.98). This study has shown that access within a reasonable time frame is not just a matter of convenience but directly impacts client outcomes from counselling. Those who wait longer demonstrate poorer outcomes from counselling. **Waiting times need to be reduced and access time optimised.**

This highlights the **need for increased resources to maintain shorter waiting times, ensure equity of access and outcome effectiveness.** A national standard waiting time that does not exceed 3 months should be introduced to manage access to the service. CIPC needs to be adequately resourced to ensure this standard can be maintained.

This study highlighted areas where effectiveness could be improved in terms of service delivery and clinical practice. The research clearly identified the increased benefits in terms of clinical outcomes that accrue from planned endings to counselling. This also highlighted the need to focus on client progression through counselling. It is recommended that the practice of **routine outcome monitoring be introduced across CIPC.** This would include session by session rating as well as use of a measure of therapeutic alliance. This is essential to reduce unplanned endings as the results demonstrate that the client's rating of the therapeutic relationship was the factor that is most predictive of a positive outcome from counselling.

Sláintecare and Sharing the Vision both emphasise the importance of early intervention. There is evidence that

CIPC outcomes were significantly better, in terms of reduced distress and symptoms as well as engagement in counselling, the earlier in the development of psychological difficulties that a referral was made. **Earlier intervention will be supported by improved communication between CIPC and GPs** and other stakeholders as well as increased awareness of the benefits of CIPC and when to refer. Development of a standardised discharge summary at the end of counselling could help improve feedback to GPs and increase awareness of the benefits of counselling thus encouraging earlier referral and intervention.

CIPC depends on its skilled and flexible workforce who have demonstrated their capacity to respond to the individual needs of those referred. As the service approaches its 10th anniversary in 2023, there is a need to **develop a comprehensive workforce strategy that will ensure that CIPC has the human resources necessary to maintain quality service provision into the future.**

CIPC adjusted quickly and effectively to the challenges of COVID-19, embracing telehealth from the outset and ensuring minimal disruption to service delivery. While face-to-face interventions remain central to how CIPC is provided, telehealth in the form of structured telephone counselling and online video counselling has enabled CIPC to improve its accessibility. **Maintaining a blended approach to service delivery into the future essential** to ensure ease of access to CIPC by as many clients as possible.

It is essential that CIPC remain flexible, responsive and open to new developments. By listening to our service users, CIPC will continue to evolve and adapt, supporting clients to change their lives for the better.

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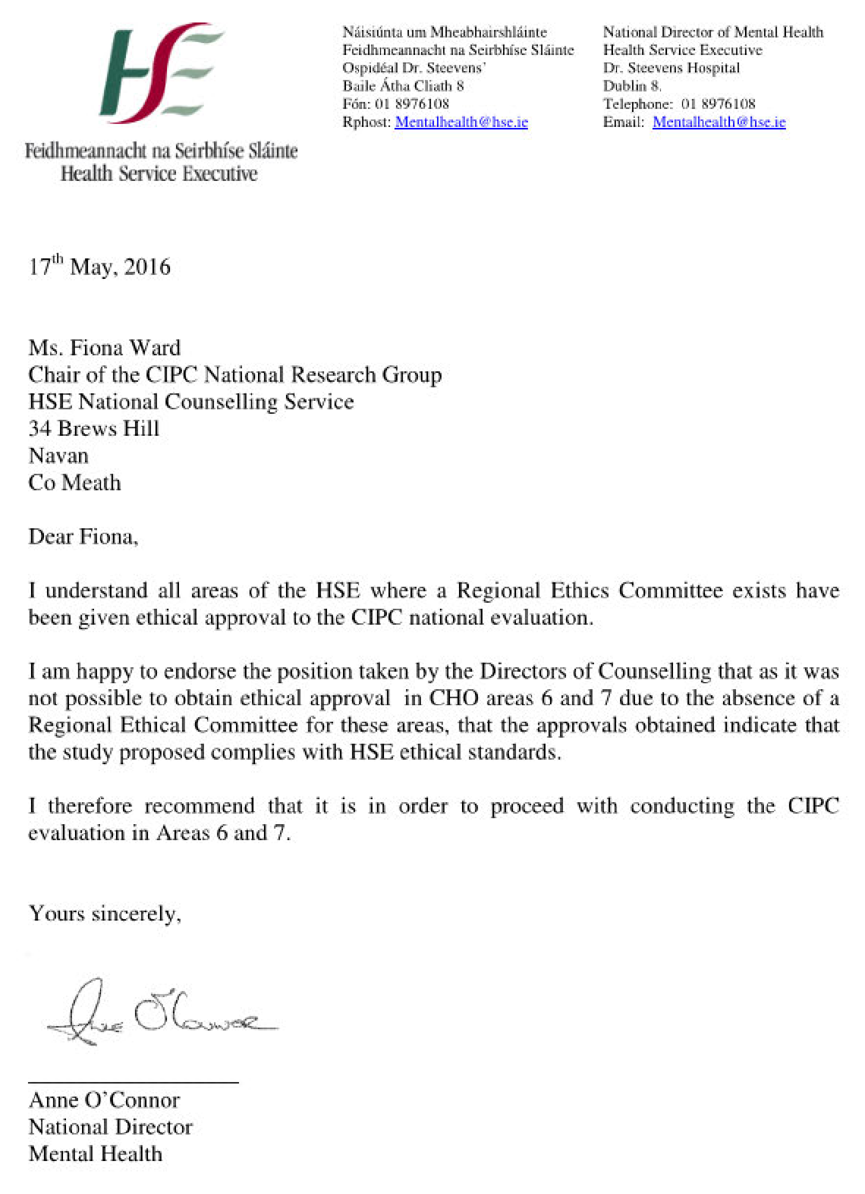
Appendix 1 Ethical approval documentation



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Náisiúnta um Mheabhairshláinte
Feidhmeannacht na Seirbhíse Sláinte
Ospidéal Dr. Steevens'
Baile Átha Cliath 8
Fón: 01 8976108
Rphost: Mentalhealth@hse.ie

National Director of Mental Health
Health Service Executive
Dr. Steevens Hospital
Dublin 8.
Telephone: 01 8976108
Email: Mentalhealth@hse.ie

17th May, 2016

Ms. Fiona Ward
Chair of the CIPC National Research Group
HSE National Counselling Service
34 Brews Hill
Navan
Co Meath

Dear Fiona,

I understand all areas of the HSE where a Regional Ethics Committee exists have been given ethical approval to the CIPC national evaluation.

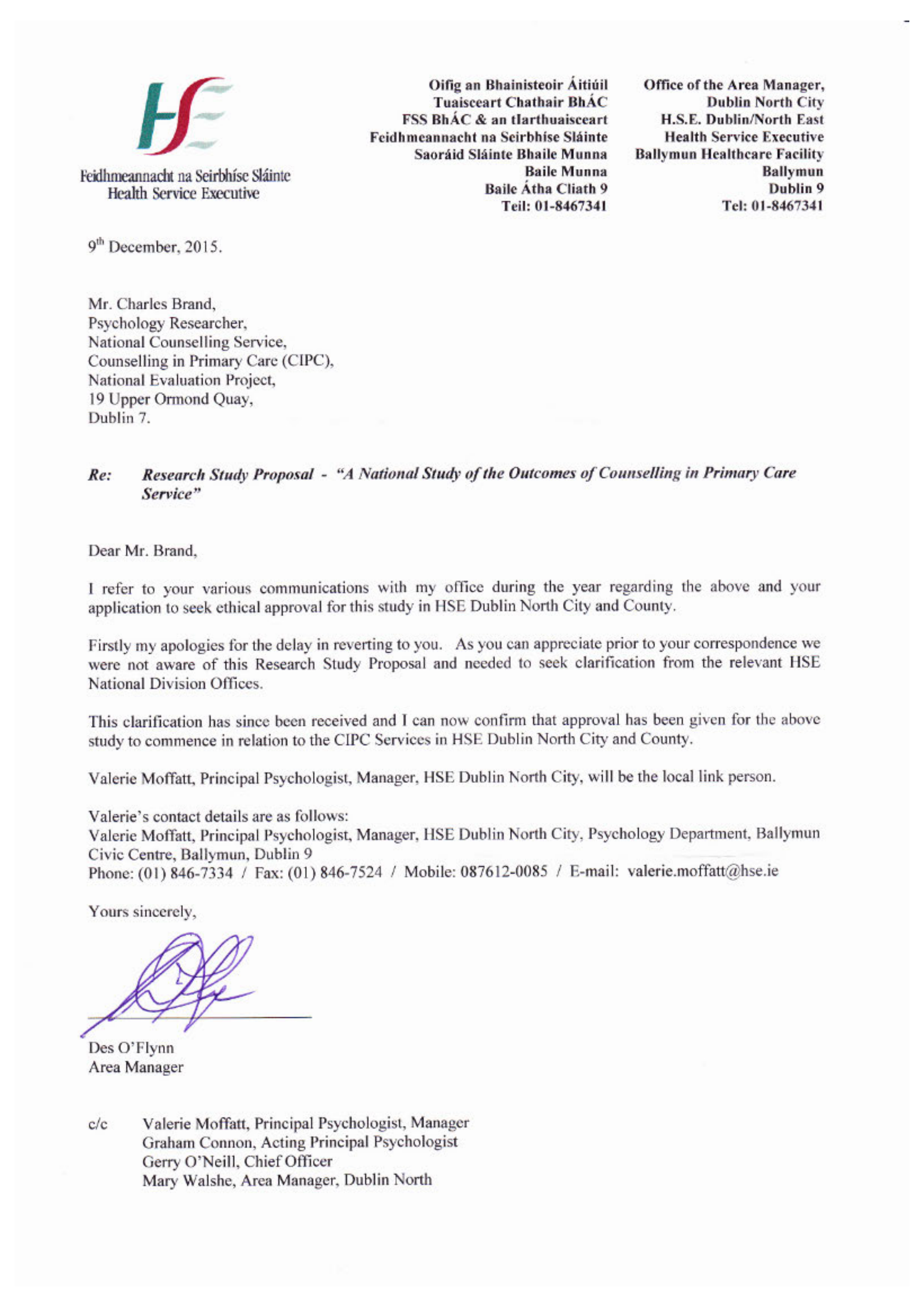
I am happy to endorse the position taken by the Directors of Counselling that as it was not possible to obtain ethical approval in CHO areas 6 and 7 due to the absence of a Regional Ethical Committee for these areas, that the approvals obtained indicate that the study proposed complies with HSE ethical standards.

I therefore recommend that it is in order to proceed with conducting the CIPC evaluation in Areas 6 and 7.

Yours sincerely,

Anne O'Connor
National Director
Mental Health

Appendix 1 Ethical approval documentation



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Oifig an Bhainisteoir Áitiúil
Tuaisceart Chathair BhÁC
FSS BhÁC & an tIarthuaisceart
Feidhmeannacht na Seirbhíse Sláinte
Saoráid Sláinte Bhaile Munna
Baile Munna
Baile Átha Cliath 9
Teil: 01-8467341

Office of the Area Manager,
Dublin North City
H.S.E. Dublin/North East
Health Service Executive
Ballymun Healthcare Facility
Ballymun
Dublin 9
Tel: 01-8467341

9th December, 2015.

Mr. Charles Brand,
Psychology Researcher,
National Counselling Service,
Counselling in Primary Care (CIPC),
National Evaluation Project,
19 Upper Ormond Quay,
Dublin 7.

Re: ***Research Study Proposal - "A National Study of the Outcomes of Counselling in Primary Care Service"***

Dear Mr. Brand,

I refer to your various communications with my office during the year regarding the above and your application to seek ethical approval for this study in HSE Dublin North City and County.

Firstly my apologies for the delay in reverting to you. As you can appreciate prior to your correspondence we were not aware of this Research Study Proposal and needed to seek clarification from the relevant HSE National Division Offices.

This clarification has since been received and I can now confirm that approval has been given for the above study to commence in relation to the CIPC Services in HSE Dublin North City and County.

Valerie Moffatt, Principal Psychologist, Manager, HSE Dublin North City, will be the local link person.

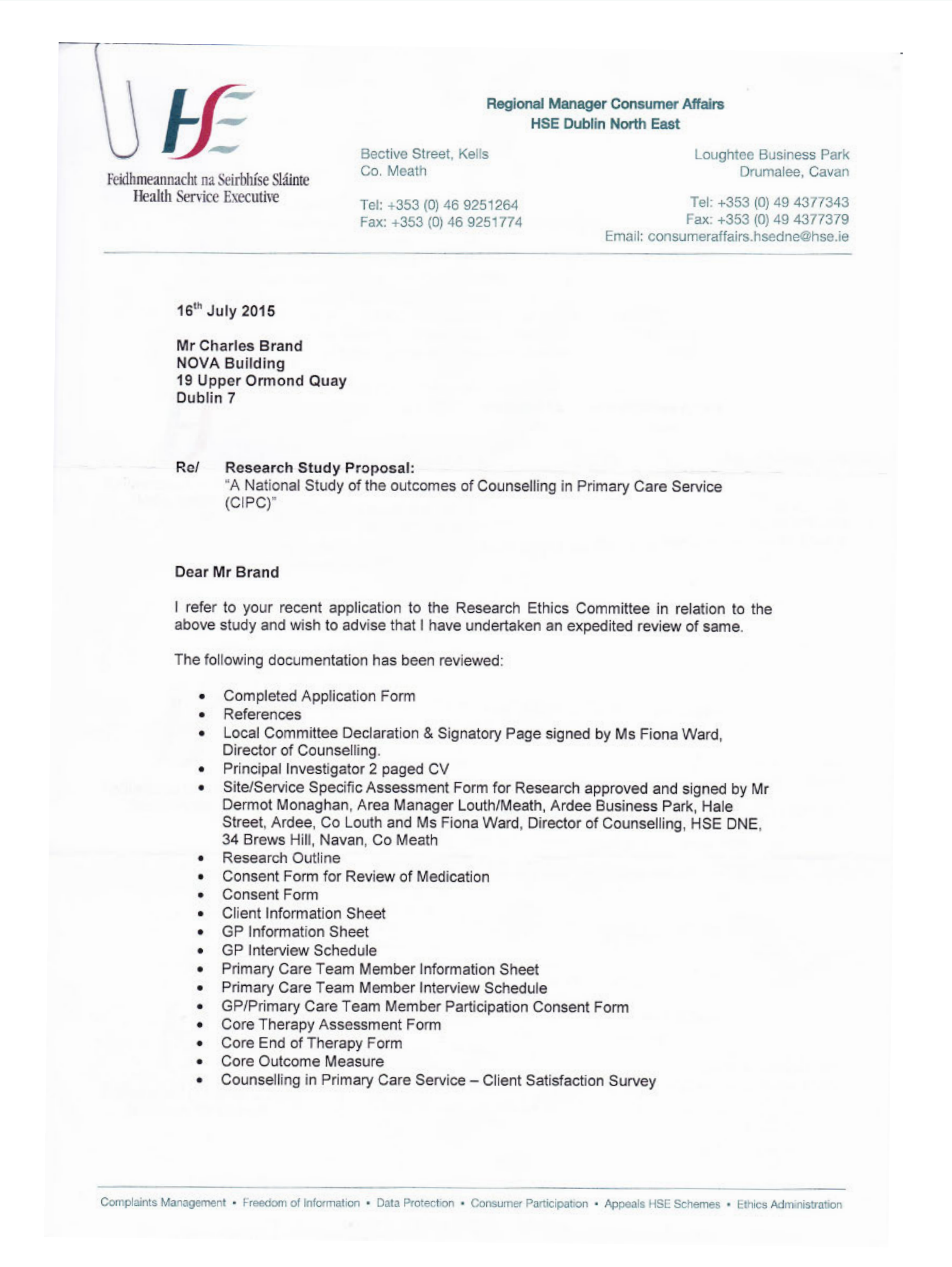
Valerie's contact details are as follows:
Valerie Moffatt, Principal Psychologist, Manager, HSE Dublin North City, Psychology Department, Ballymun Civic Centre, Ballymun, Dublin 9
Phone: (01) 846-7334 / Fax: (01) 846-7524 / Mobile: 087612-0085 / E-mail: valerie.moffatt@hse.ie

Yours sincerely,

Des O'Flynn
Area Manager

c/c Valerie Moffatt, Principal Psychologist, Manager
Graham Connon, Acting Principal Psychologist
Gerry O'Neill, Chief Officer
Mary Walshe, Area Manager, Dublin North

Appendix 1 Ethical approval documentation



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Regional Manager Consumer Affairs
HSE Dublin North East

Bective Street, Kells
Co. Meath

Tel: +353 (0) 46 9251264
Fax: +353 (0) 46 9251774

Loughtee Business Park
Drumalee, Cavan

Tel: +353 (0) 49 4377343
Fax: +353 (0) 49 4377379
Email: consumeraffairs.hsedne@hse.ie

16th July 2015

Mr Charles Brand
NOVA Building
19 Upper Ormond Quay
Dublin 7

Re/ **Research Study Proposal:**
"A National Study of the outcomes of Counselling in Primary Care Service (CIPC)"

Dear Mr Brand

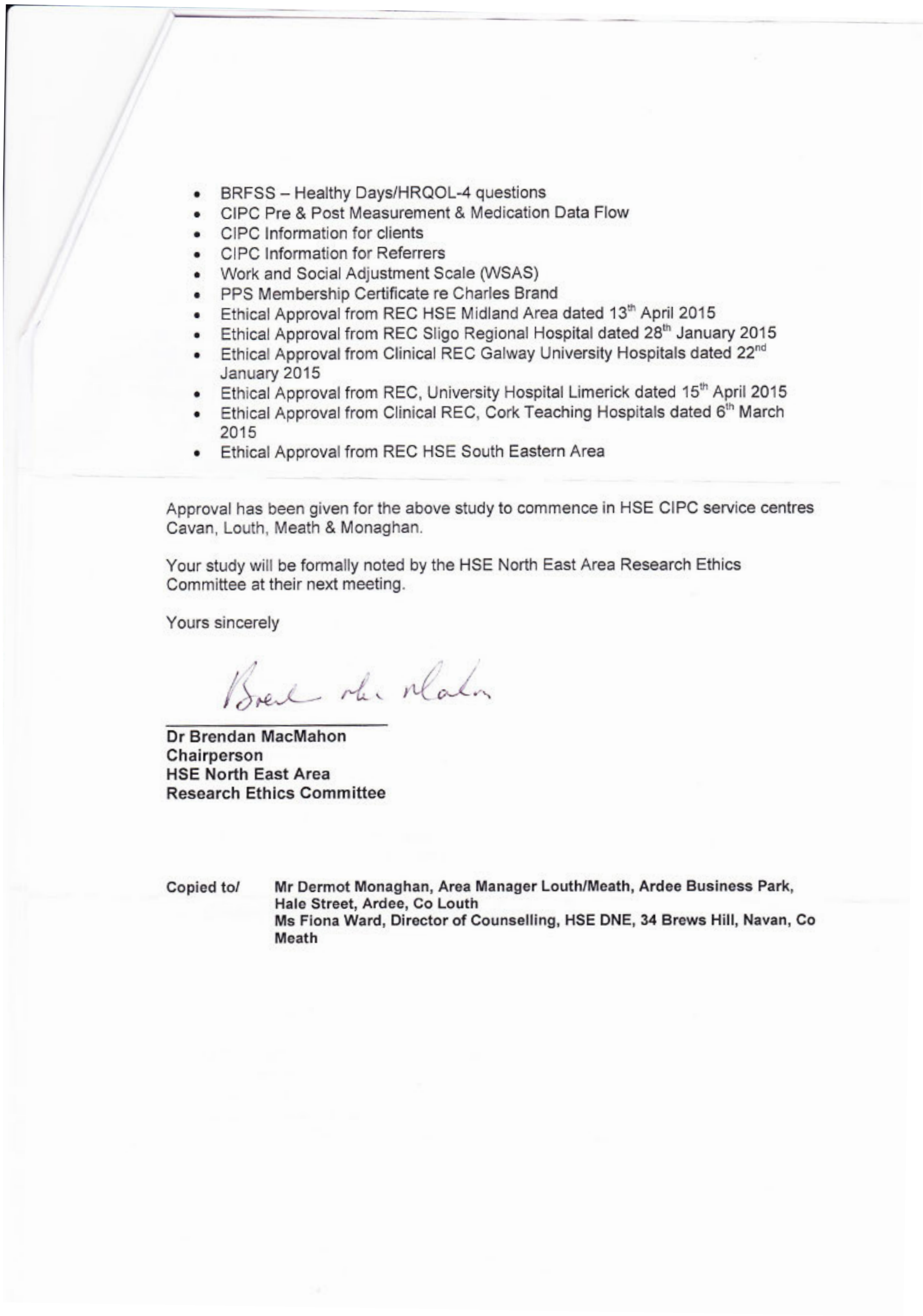
I refer to your recent application to the Research Ethics Committee in relation to the above study and wish to advise that I have undertaken an expedited review of same.

The following documentation has been reviewed:

- Completed Application Form
- References
- Local Committee Declaration & Signatory Page signed by Ms Fiona Ward, Director of Counselling.
- Principal Investigator 2 paged CV
- Site/Service Specific Assessment Form for Research approved and signed by Mr Dermot Monaghan, Area Manager Louth/Meath, Ardee Business Park, Hale Street, Ardee, Co Louth and Ms Fiona Ward, Director of Counselling, HSE DNE, 34 Brews Hill, Navan, Co Meath
- Research Outline
- Consent Form for Review of Medication
- Consent Form
- Client Information Sheet
- GP Information Sheet
- GP Interview Schedule
- Primary Care Team Member Information Sheet
- Primary Care Team Member Interview Schedule
- GP/Primary Care Team Member Participation Consent Form
- Core Therapy Assessment Form
- Core End of Therapy Form
- Core Outcome Measure
- Counselling in Primary Care Service – Client Satisfaction Survey

Complaints Management • Freedom of Information • Data Protection • Consumer Participation • Appeals HSE Schemes • Ethics Administration

Appendix 1 Ethical approval documentation



- BRFSS – Healthy Days/HRQOL-4 questions
- CIPC Pre & Post Measurement & Medication Data Flow
- CIPC Information for clients
- CIPC Information for Referrers
- Work and Social Adjustment Scale (WSAS)
- PPS Membership Certificate re Charles Brand
- Ethical Approval from REC HSE Midland Area dated 13th April 2015
- Ethical Approval from REC Sligo Regional Hospital dated 28th January 2015
- Ethical Approval from Clinical REC Galway University Hospitals dated 22nd January 2015
- Ethical Approval from REC, University Hospital Limerick dated 15th April 2015
- Ethical Approval from Clinical REC, Cork Teaching Hospitals dated 6th March 2015
- Ethical Approval from REC HSE South Eastern Area

Approval has been given for the above study to commence in HSE CIPC service centres Cavan, Louth, Meath & Monaghan.

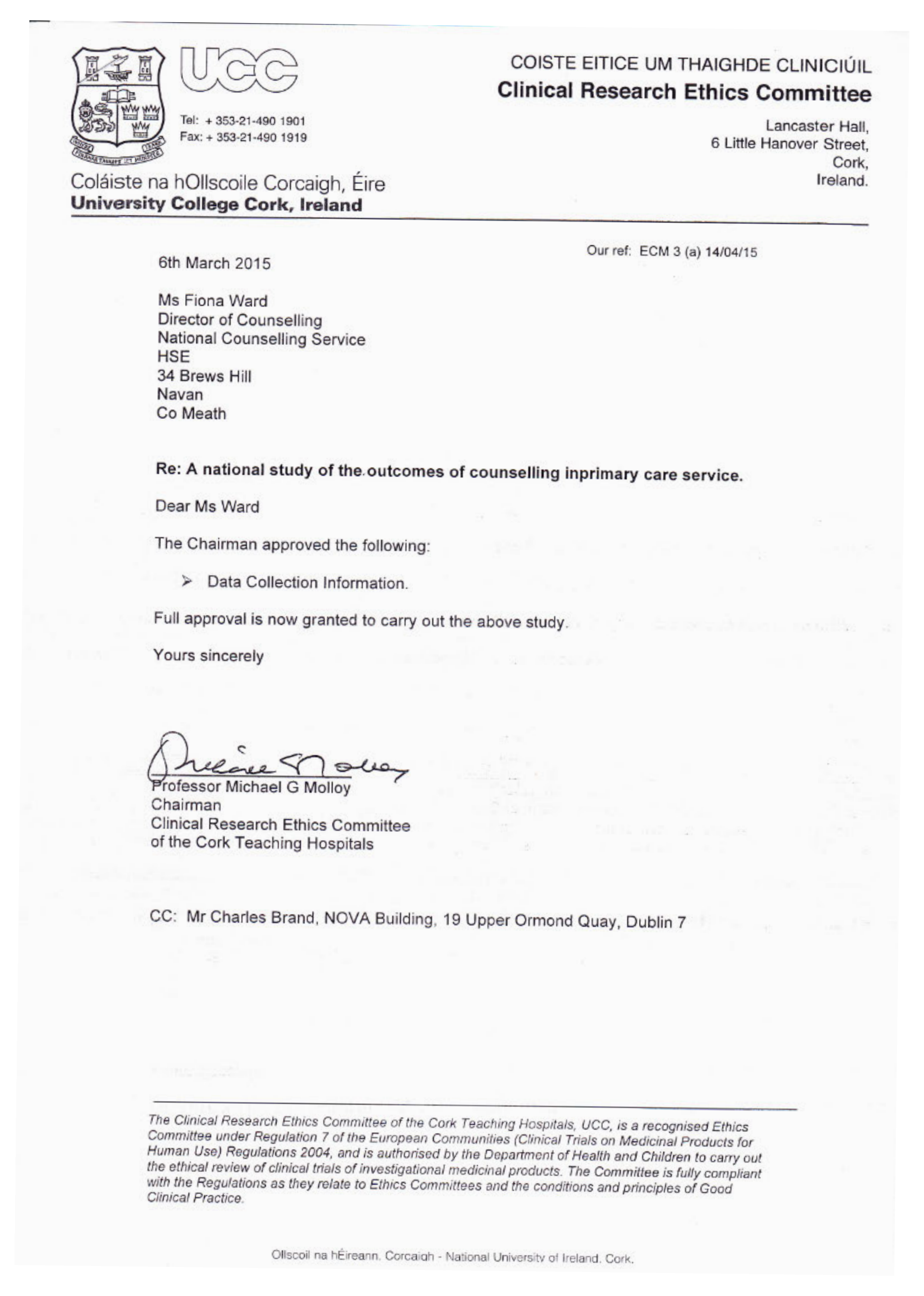
Your study will be formally noted by the HSE North East Area Research Ethics Committee at their next meeting.

Yours sincerely

Dr Brendan MacMahon
Chairperson
HSE North East Area
Research Ethics Committee

Copied to/ **Mr Dermot Monaghan, Area Manager Louth/Meath, Ardee Business Park, Hale Street, Ardee, Co Louth**
Ms Fiona Ward, Director of Counselling, HSE DNE, 34 Brews Hill, Navan, Co Meath

Appendix 1 Ethical approval documentation



UCC
Tel: + 353-21-490 1901
Fax: + 353-21-490 1919
Coláiste na hOllscoile Corcaigh, Éire
University College Cork, Ireland

COISTE EITICE UM THAIGHDE CLINICIÚIL
Clinical Research Ethics Committee
Lancaster Hall,
6 Little Hanover Street,
Cork,
Ireland.

Our ref: ECM 3 (a) 14/04/15

6th March 2015

Ms Fiona Ward
Director of Counselling
National Counselling Service
HSE
34 Brews Hill
Navan
Co Meath

Re: A national study of the outcomes of counselling inprimary care service.

Dear Ms Ward

The Chairman approved the following:

- Data Collection Information.

Full approval is now granted to carry out the above study.

Yours sincerely

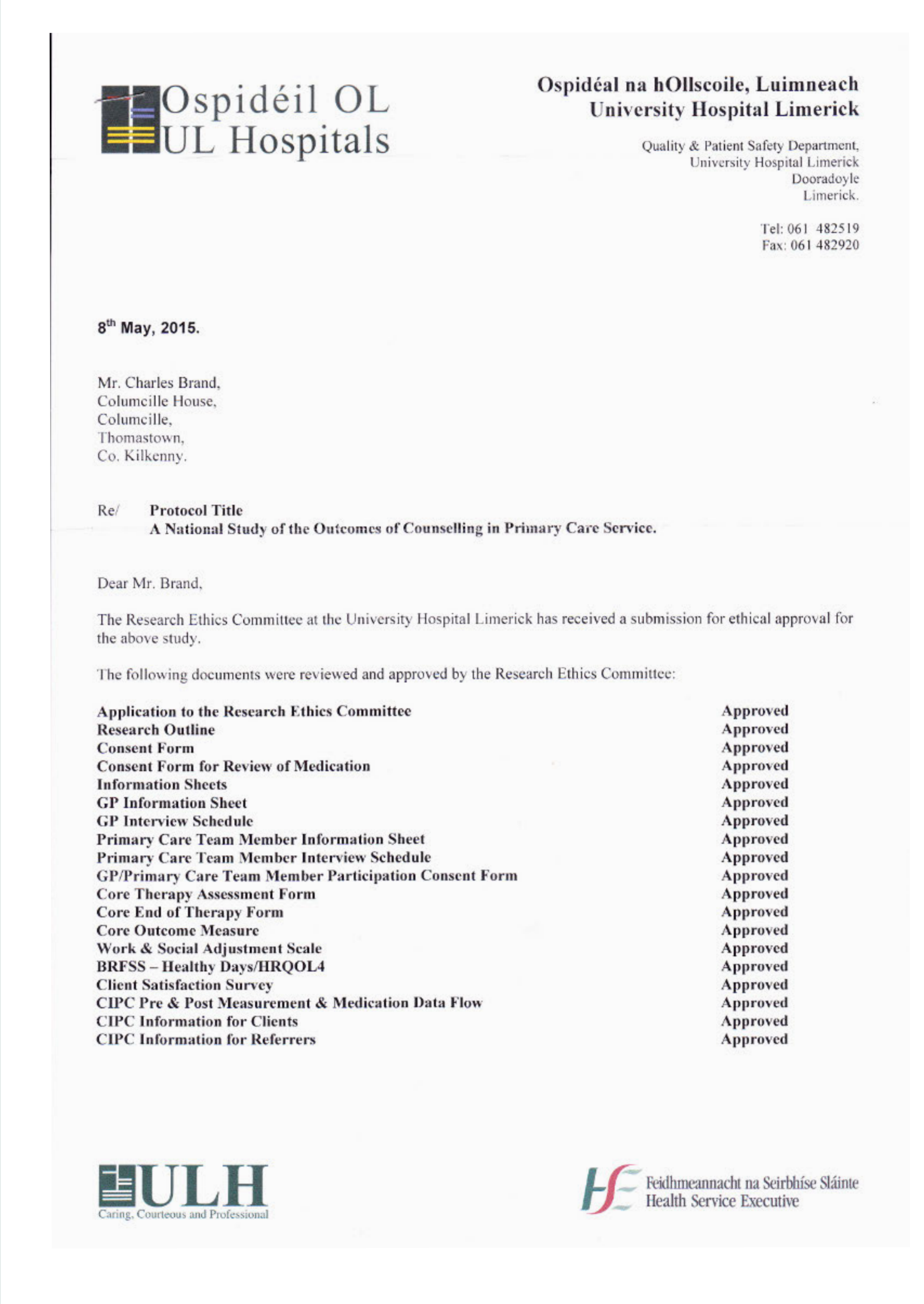
Professor Michael G Molloy
Chairman
Clinical Research Ethics Committee
of the Cork Teaching Hospitals

CC: Mr Charles Brand, NOVA Building, 19 Upper Ormond Quay, Dublin 7

The Clinical Research Ethics Committee of the Cork Teaching Hospitals, UCC, is a recognised Ethics Committee under Regulation 7 of the European Communities (Clinical Trials on Medicinal Products for Human Use) Regulations 2004, and is authorised by the Department of Health and Children to carry out the ethical review of clinical trials of investigational medicinal products. The Committee is fully compliant with the Regulations as they relate to Ethics Committees and the conditions and principles of Good Clinical Practice.

Ollscoil na hÉireann, Corcaigh - National University of Ireland, Cork.

Appendix 1 Ethical approval documentation



Ospidéil OL
UL Hospitals

Ospidéal na hOllscoile, Luimneach
University Hospital Limerick

Quality & Patient Safety Department,
University Hospital Limerick
Dooradoyle
Limerick.

Tel: 061 482519
Fax: 061 482920

8th May, 2015.

Mr. Charles Brand,
Columcille House,
Columcille,
Thomastown,
Co. Kilkenny.

Re/ **Protocol Title**
A National Study of the Outcomes of Counselling in Primary Care Service.

Dear Mr. Brand,

The Research Ethics Committee at the University Hospital Limerick has received a submission for ethical approval for the above study.

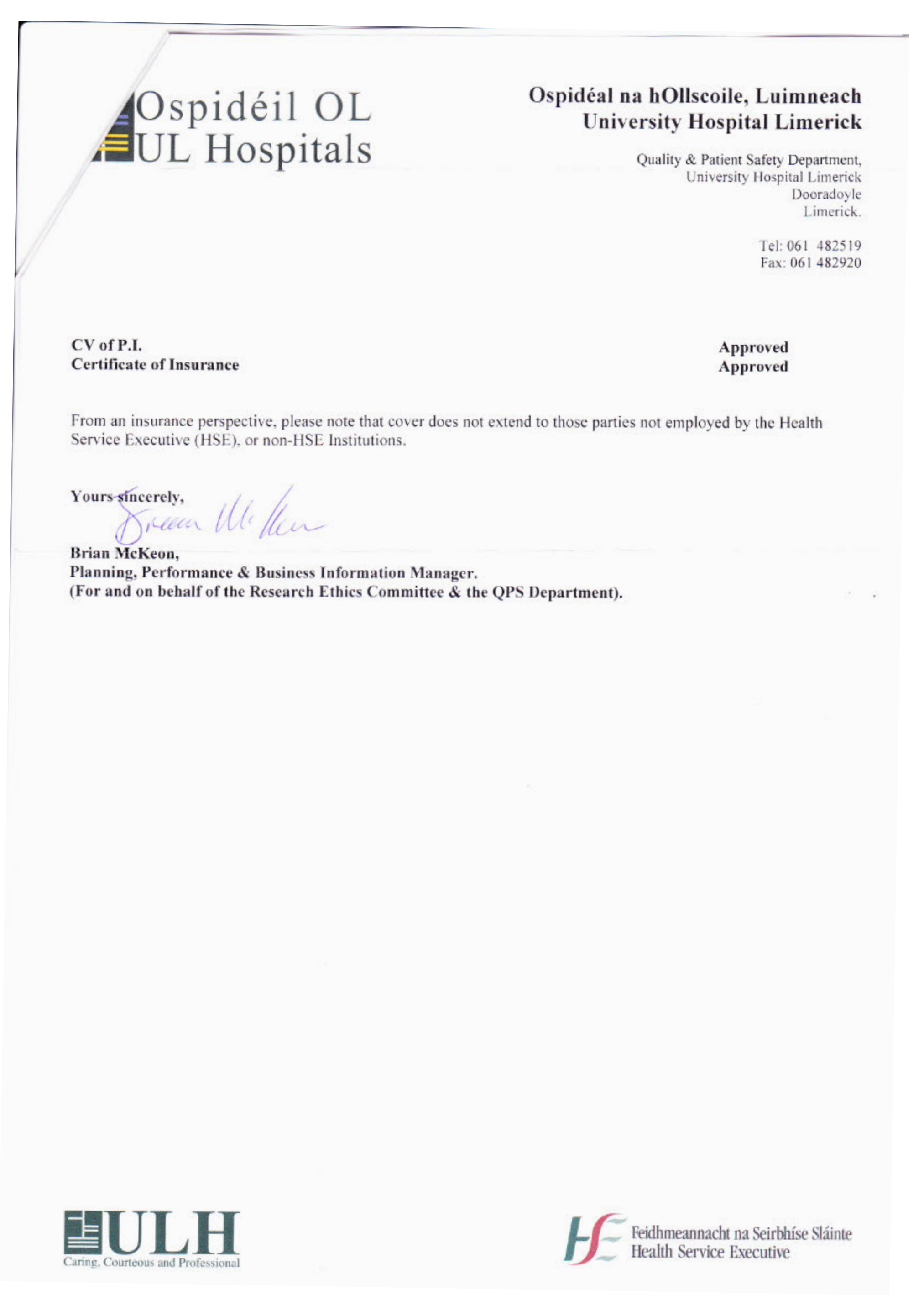
The following documents were reviewed and approved by the Research Ethics Committee:

Application to the Research Ethics Committee	**Approved**
Research Outline	**Approved**
Consent Form	**Approved**
Consent Form for Review of Medication	**Approved**
Information Sheets	**Approved**
GP Information Sheet	**Approved**
GP Interview Schedule	**Approved**
Primary Care Team Member Information Sheet	**Approved**
Primary Care Team Member Interview Schedule	**Approved**
GP/Primary Care Team Member Participation Consent Form	**Approved**
Core Therapy Assessment Form	**Approved**
Core End of Therapy Form	**Approved**
Core Outcome Measure	**Approved**
Work & Social Adjustment Scale	**Approved**
BRFSS – Healthy Days/HRQOL4	**Approved**
Client Satisfaction Survey	**Approved**
CIPC Pre & Post Measurement & Medication Data Flow	**Approved**
CIPC Information for Clients	**Approved**
CIPC Information for Referrers	**Approved**

ULH
Caring, Courteous and Professional

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Appendix 1 Ethical approval documentation



Ospidéil OL
UL Hospitals

Ospidéal na hOllscoile, Luimneach
University Hospital Limerick

Quality & Patient Safety Department,
University Hospital Limerick
Dooradoyle
Limerick.

Tel: 061 482519
Fax: 061 482920

CV of P.I.	**Approved**
Certificate of Insurance	**Approved**

From an insurance perspective, please note that cover does not extend to those parties not employed by the Health Service Executive (HSE), or non-HSE Institutions.

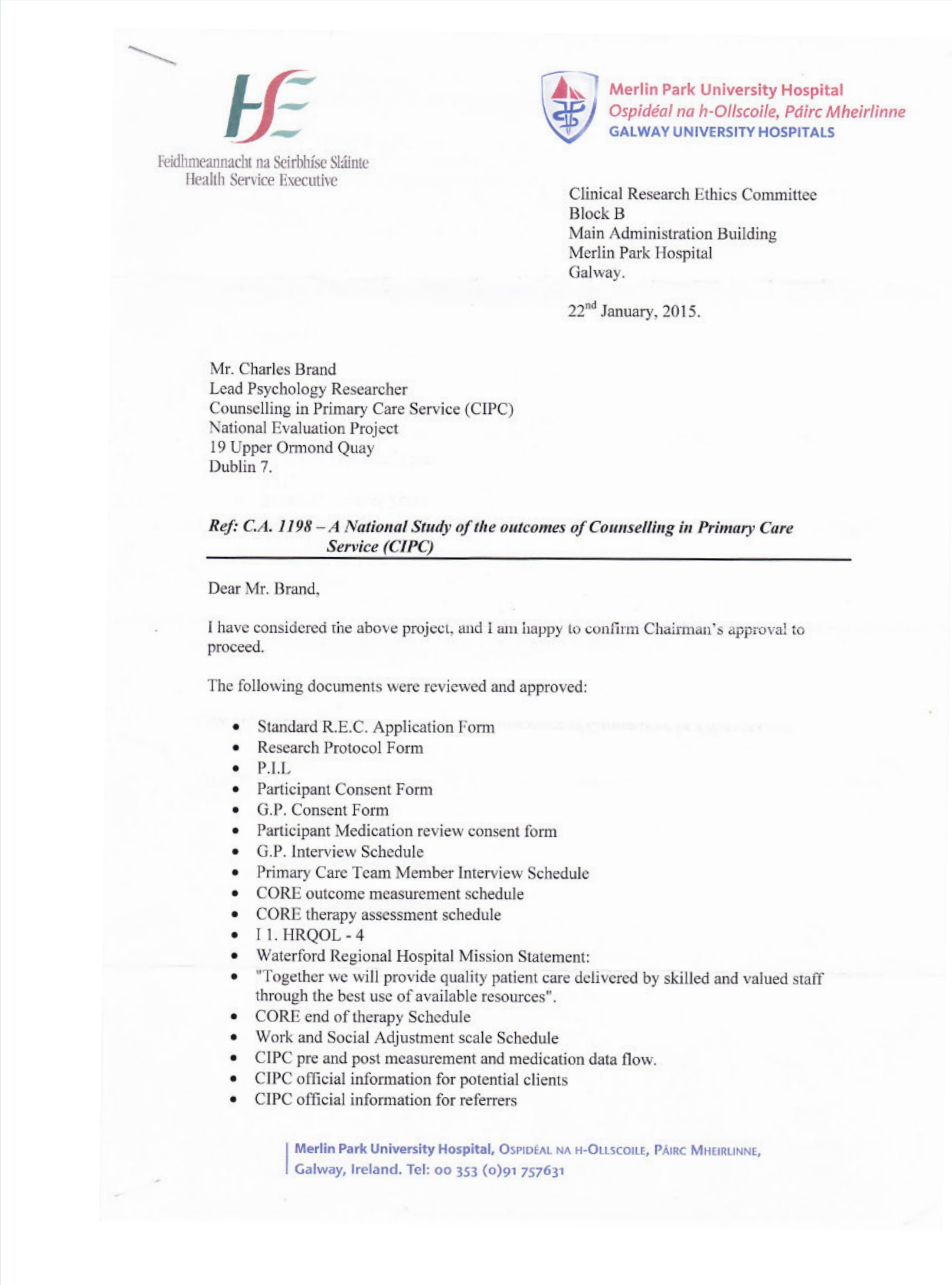
Yours sincerely,

Brian McKeon,
Planning, Performance & Business Information Manager.
(For and on behalf of the Research Ethics Committee & the QPS Department).

ULH
Caring, Courteous and Professional

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Appendix 1 Ethical approval documentation



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Merlin Park University Hospital
Ospidéal na h-Ollscoile, Páirc Mheirlinne
GALWAY UNIVERSITY HOSPITALS

Clinical Research Ethics Committee
Block B
Main Administration Building
Merlin Park Hospital
Galway.

22nd January, 2015.

Mr. Charles Brand
Lead Psychology Researcher
Counselling in Primary Care Service (CIPC)
National Evaluation Project
19 Upper Ormond Quay
Dublin 7.

Ref: C.A. 1198 – A National Study of the outcomes of Counselling in Primary Care Service (CIPC)

Dear Mr. Brand,

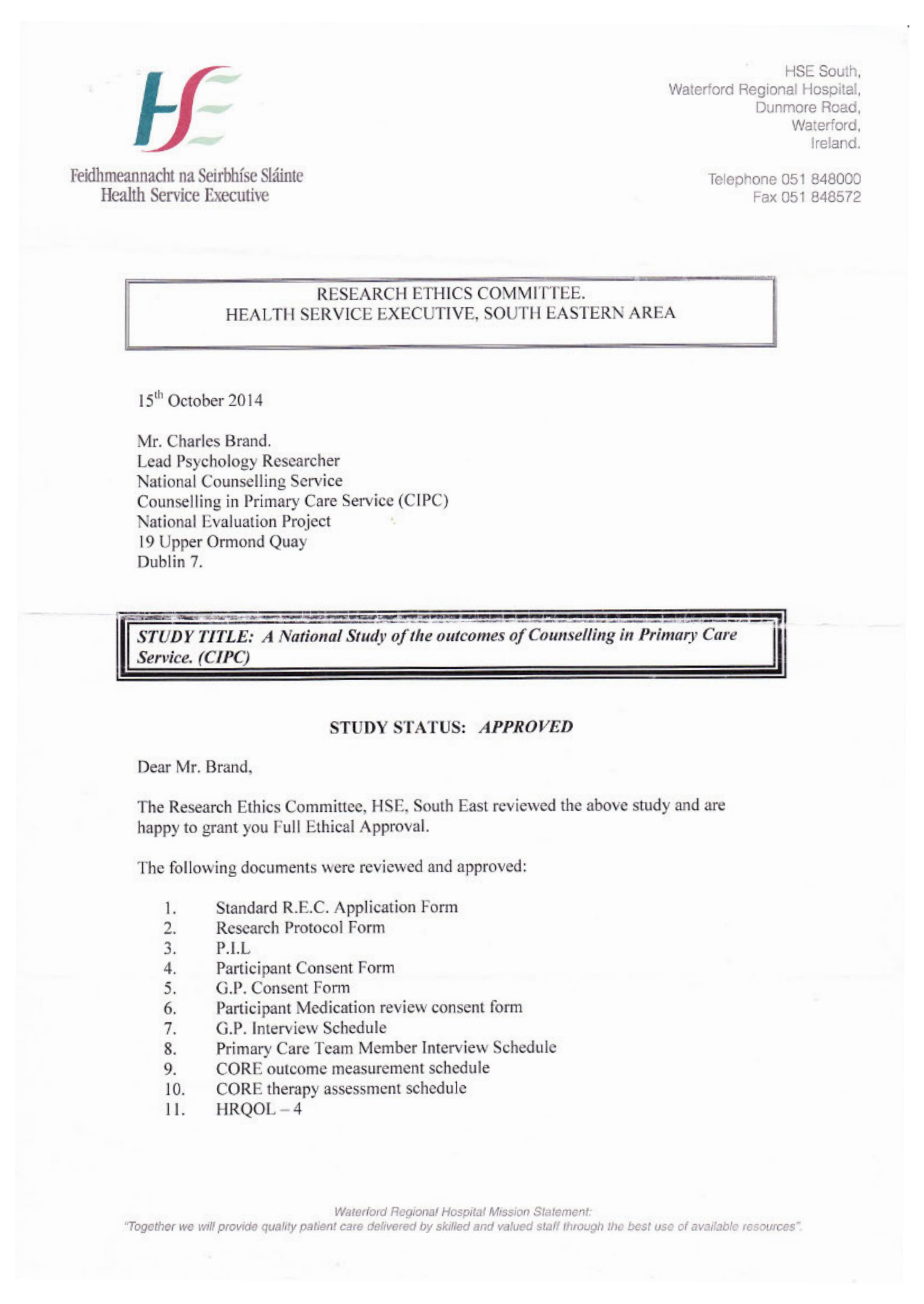
I have considered the above project, and I am happy to confirm Chairman's approval to proceed.

The following documents were reviewed and approved:

- Standard R.E.C. Application Form
- Research Protocol Form
- P.I.L
- Participant Consent Form
- G.P. Consent Form
- Participant Medication review consent form
- G.P. Interview Schedule
- Primary Care Team Member Interview Schedule
- CORE outcome measurement schedule
- CORE therapy assessment schedule
- I 1. HRQOL - 4
- Waterford Regional Hospital Mission Statement:
- "Together we will provide quality patient care delivered by skilled and valued staff through the best use of available resources".
- CORE end of therapy Schedule
- Work and Social Adjustment scale Schedule
- CIPC pre and post measurement and medication data flow.
- CIPC official information for potential clients
- CIPC official information for referrers

Merlin Park University Hospital, Ospidéal na h-Ollscoile, Páirc Mheirlinne,
Galway, Ireland. Tel: 00 353 (0)91 757631

Appendix 1 Ethical approval documentation



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

HSE South,
Waterford Regional Hospital,
Dunmore Road,
Waterford,
Ireland.

Telephone 051 848000
Fax 051 848572

RESEARCH ETHICS COMMITTEE.
HEALTH SERVICE EXECUTIVE, SOUTH EASTERN AREA

15th October 2014

Mr. Charles Brand.
Lead Psychology Researcher
National Counselling Service
Counselling in Primary Care Service (CIPC)
National Evaluation Project
19 Upper Ormond Quay
Dublin 7.

STUDY TITLE: A National Study of the outcomes of Counselling in Primary Care Service. (CIPC)

STUDY STATUS: ***APPROVED***

Dear Mr. Brand,

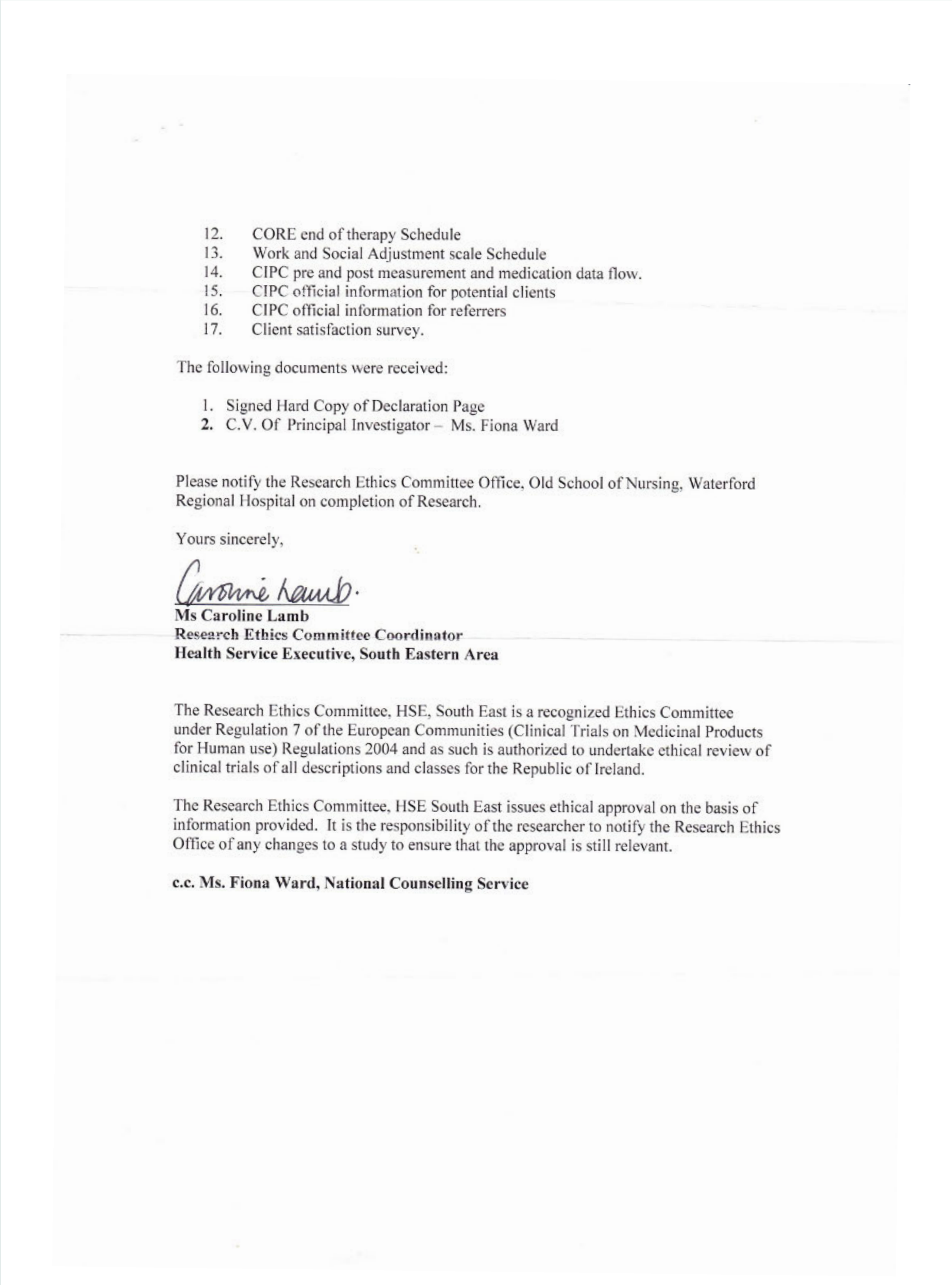
The Research Ethics Committee, HSE, South East reviewed the above study and are happy to grant you Full Ethical Approval.

The following documents were reviewed and approved:

1. Standard R.E.C. Application Form
2. Research Protocol Form
3. P.I.L
4. Participant Consent Form
5. G.P. Consent Form
6. Participant Medication review consent form
7. G.P. Interview Schedule
8. Primary Care Team Member Interview Schedule
9. CORE outcome measurement schedule
10. CORE therapy assessment schedule
11. HRQOL – 4

Waterford Regional Hospital Mission Statement:
"Together we will provide quality patient care delivered by skilled and valued staff through the best use of available resources".

Appendix 1 Ethical approval documentation



12. CORE end of therapy Schedule
13. Work and Social Adjustment scale Schedule
14. CIPC pre and post measurement and medication data flow.
15. CIPC official information for potential clients
16. CIPC official information for referrers
17. Client satisfaction survey.

The following documents were received:

1. Signed Hard Copy of Declaration Page
2. C.V. Of Principal Investigator – Ms. Fiona Ward

Please notify the Research Ethics Committee Office, Old School of Nursing, Waterford Regional Hospital on completion of Research.

Yours sincerely,

Caroline Lamb.

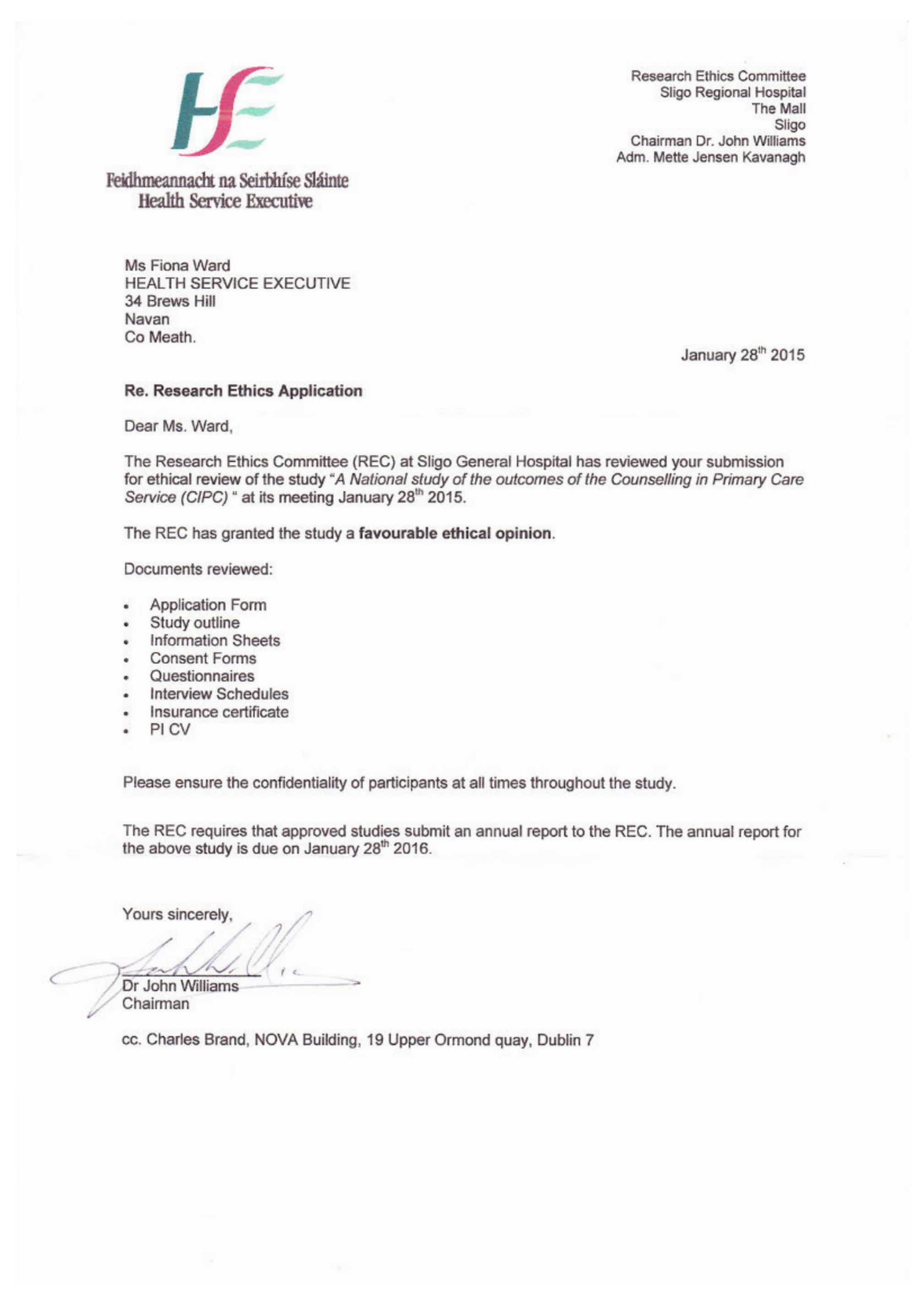
Ms Caroline Lamb
Research Ethics Committee Coordinator
Health Service Executive, South Eastern Area

The Research Ethics Committee, HSE, South East is a recognized Ethics Committee under Regulation 7 of the European Communities (Clinical Trials on Medicinal Products for Human use) Regulations 2004 and as such is authorized to undertake ethical review of clinical trials of all descriptions and classes for the Republic of Ireland.

The Research Ethics Committee, HSE South East issues ethical approval on the basis of information provided. It is the responsibility of the researcher to notify the Research Ethics Office of any changes to a study to ensure that the approval is still relevant.

c.c. Ms. Fiona Ward, National Counselling Service

Appendix 1 Ethical approval documentation



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Research Ethics Committee
Sligo Regional Hospital
The Mall
Sligo
Chairman Dr. John Williams
Adm. Mette Jensen Kavanagh

Ms Fiona Ward
HEALTH SERVICE EXECUTIVE
34 Brews Hill
Navan
Co Meath.

January 28th 2015

Re. Research Ethics Application

Dear Ms. Ward,

The Research Ethics Committee (REC) at Sligo General Hospital has reviewed your submission for ethical review of the study "*A National study of the outcomes of the Counselling in Primary Care Service (CIPC)* " at its meeting January 28th 2015.

The REC has granted the study a **favourable ethical opinion**.

Documents reviewed:

- Application Form
- Study outline
- Information Sheets
- Consent Forms
- Questionnaires
- Interview Schedules
- Insurance certificate
- PI CV

Please ensure the confidentiality of participants at all times throughout the study.

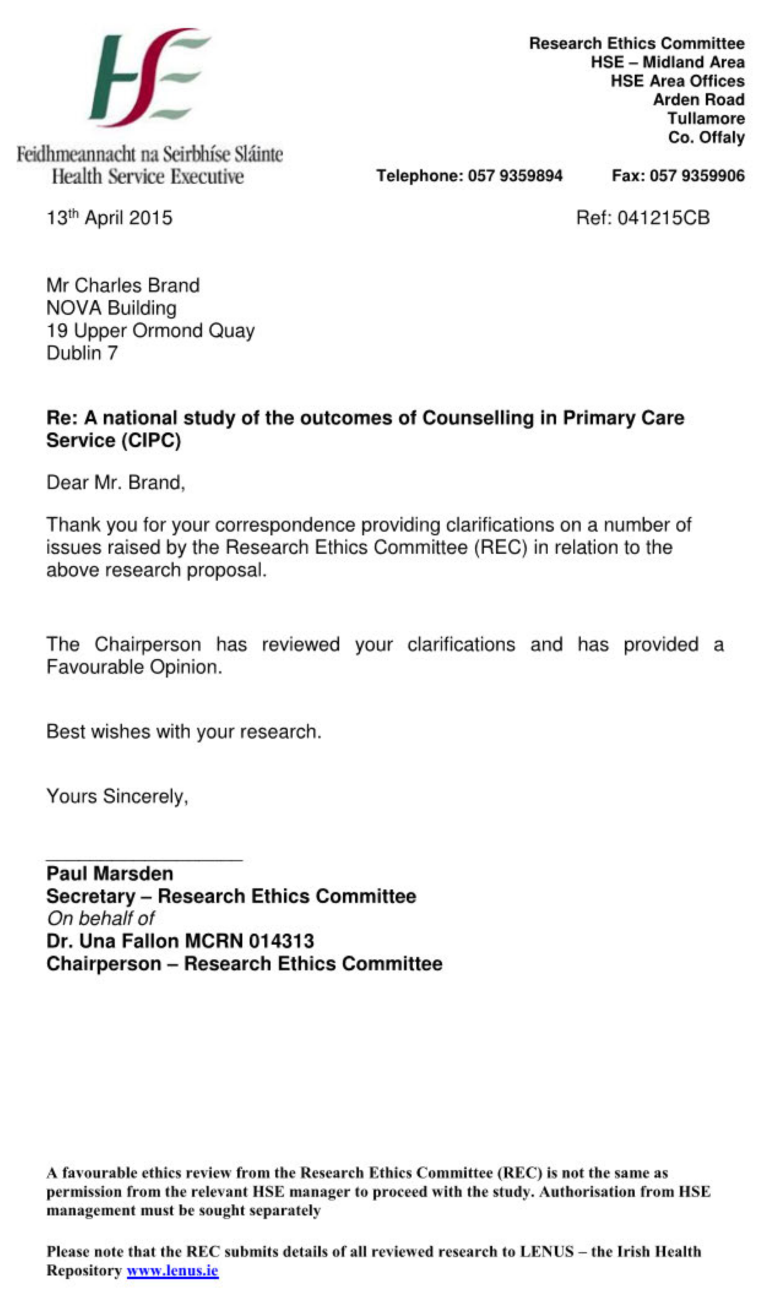
The REC requires that approved studies submit an annual report to the REC. The annual report for the above study is due on January 28th 2016.

Yours sincerely,

Dr John Williams
Chairman

cc. Charles Brand, NOVA Building, 19 Upper Ormond quay, Dublin 7

Appendix 1 Ethical approval documentation



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Research Ethics Committee
HSE – Midland Area
HSE Area Offices
Arden Road
Tullamore
Co. Offaly

Telephone: 057 9359894 **Fax: 057 9359906**

13th April 2015 Ref: 041215CB

Mr Charles Brand
NOVA Building
19 Upper Ormond Quay
Dublin 7

Re: A national study of the outcomes of Counselling in Primary Care Service (CIPC)

Dear Mr. Brand,

Thank you for your correspondence providing clarifications on a number of issues raised by the Research Ethics Committee (REC) in relation to the above research proposal.

The Chairperson has reviewed your clarifications and has provided a Favourable Opinion.

Best wishes with your research.

Yours Sincerely,

Paul Marsden
Secretary – Research Ethics Committee
On behalf of
Dr. Una Fallon MCRN 014313
Chairperson – Research Ethics Committee

A favourable ethics review from the Research Ethics Committee (REC) is not the same as permission from the relevant HSE manager to proceed with the study. Authorisation from HSE management must be sought separately

Please note that the REC submits details of all reviewed research to LENUS – the Irish Health Repository www.lenus.ie

Appendix 1 Ethical approval documentation

Coláiste na Tríonóide, Baile Átha Cliath
Trinity College Dublin
Ollscoil Átha Cliath | The University of Dublin

F.A.O. Charles Brand

School of Psychology Research Ethics Committee

14th March 2016

Dear Charles,

The School of Psychology Research Ethics Committee has reviewed your application entitled "Counselling in Primary Care National Evaluation" and I am pleased to inform you that it was approved.

Please note that you will be required to submit a completed **Project Annual Report Form** on each anniversary of this approval, until such time as the research is complete and the thesis is submitted. The form is available for download from the Ethics section of the School website.

Adverse events associated with the conduct of this research must be reported immediately to the Chair of the Ethics Committee.

Yours sincerely,

Richard Carson
Chair,
School of Psychology Research Ethics Committee

SCHOOL OF PSYCHOLOGY
Arás an Phiarsaigh
Trinity College
Dublin 2

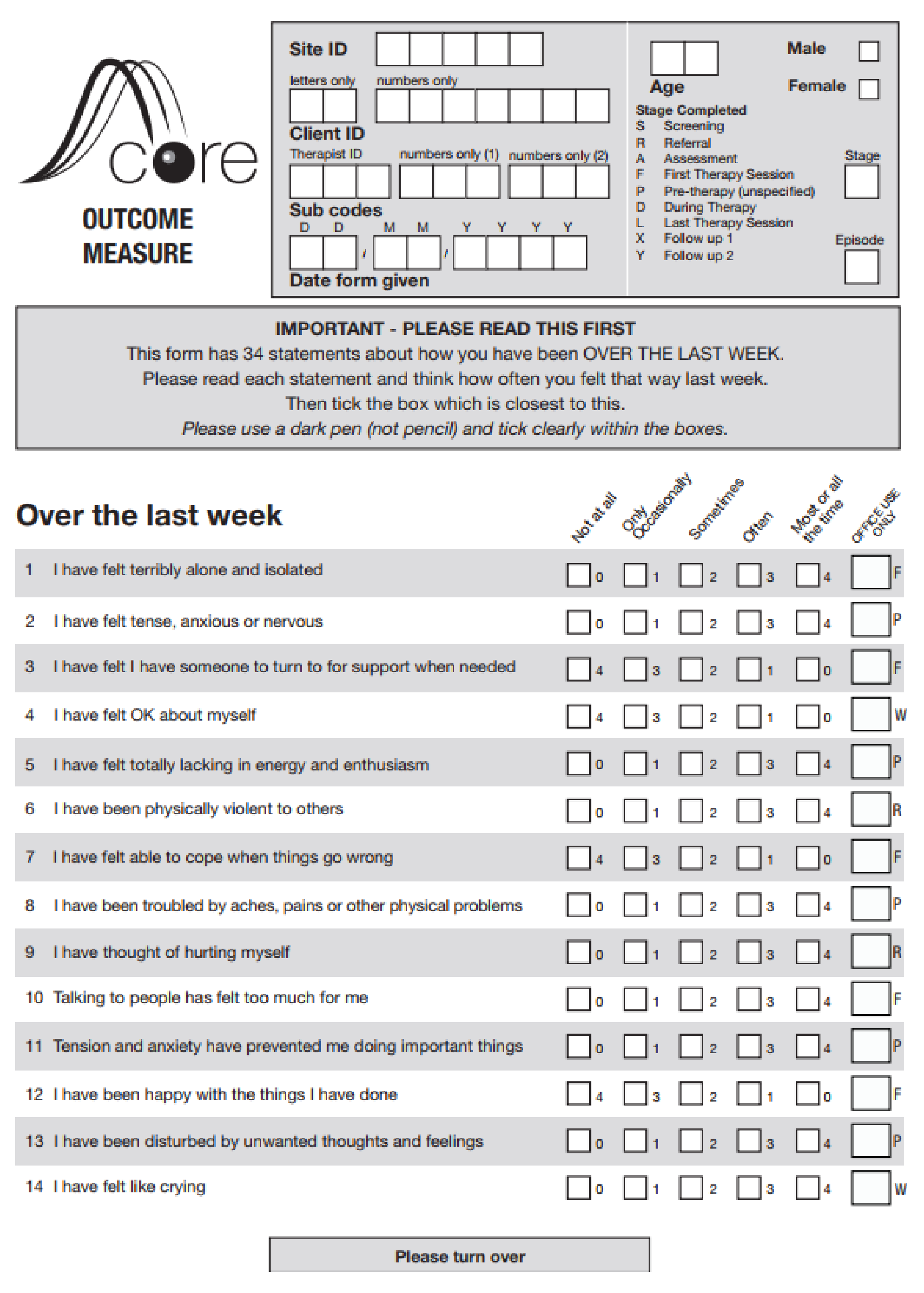
Scoil na Síceolaíochta
Dámh na nEolaíochtaí Sóisialta agus Daonna,
Áras an Phiarsaigh, Coláiste na Tríonóide,
Baile Átha Cliath 2, Éire.

School of Psychology
Faculty of Arts, Humanities and Social Sciences,
Áras an Phiarsaigh, Trinity College,
Dublin 2, Ireland.

T +353 1 896 1886
F +353 1 671 2006
psychology@tcd.ie
www.tcd.ie/psychology

Appendix 2 Study questionnaries

Appendix 2A Core outcome measure - 34



CORE
OUTCOME MEASURE

Site ID ☐☐☐☐☐
letters only ☐☐ numbers only ☐☐☐☐☐☐☐
Client ID
Therapist ID ☐☐☐ numbers only (1) ☐☐☐ numbers only (2) ☐☐☐
Sub codes
D D / M M / Y Y Y Y
☐☐ / ☐☐ / ☐☐☐☐
Date form given

☐☐ **Age**
Male ☐
Female ☐

Stage Completed
S Screening
R Referral
A Assessment
F First Therapy Session
P Pre-therapy (unspecified)
D During Therapy
L Last Therapy Session
X Follow up 1
Y Follow up 2

Stage ☐
Episode ☐

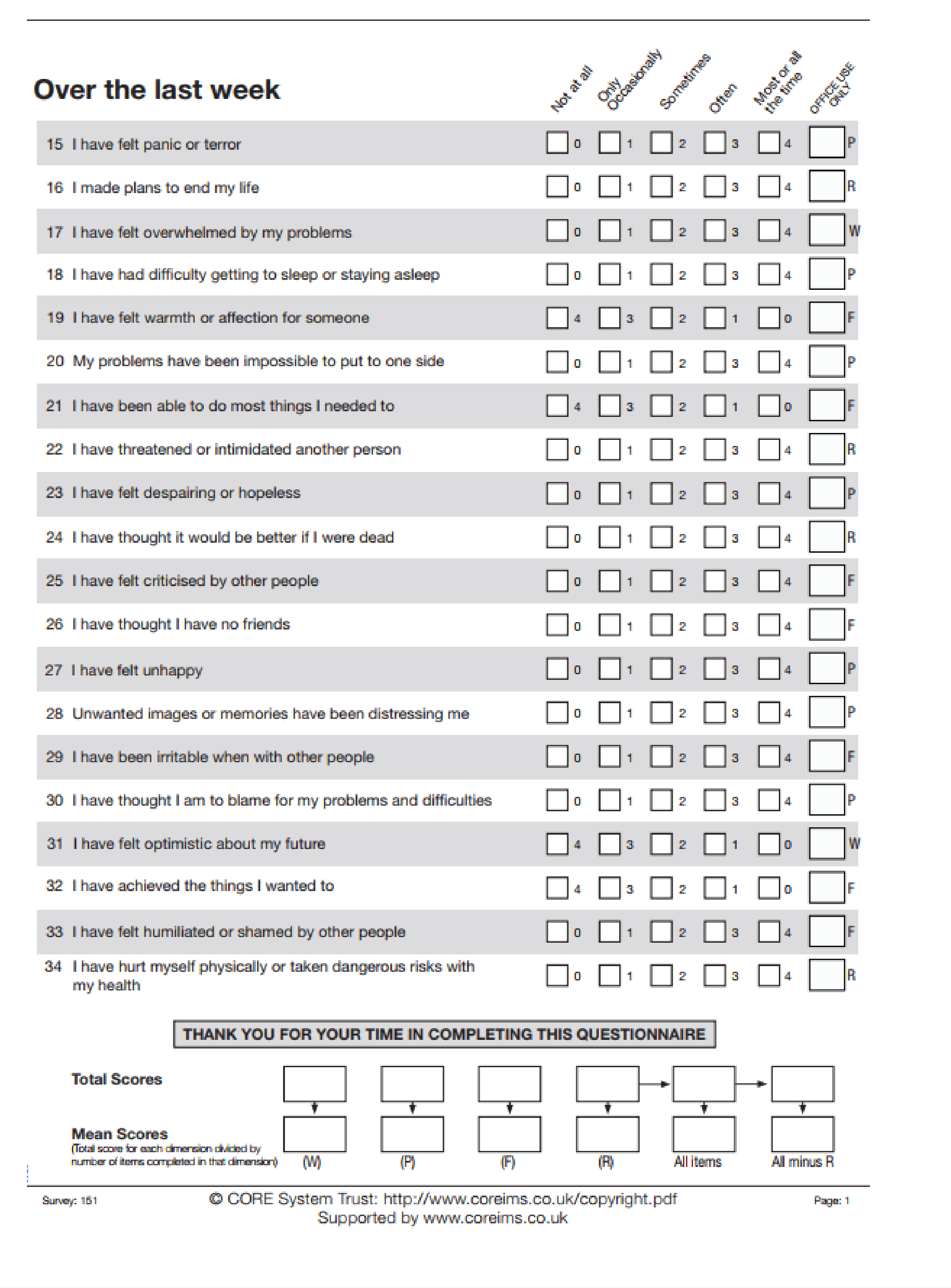
IMPORTANT - PLEASE READ THIS FIRST
This form has 34 statements about how you have been OVER THE LAST WEEK.
Please read each statement and think how often you felt that way last week.
Then tick the box which is closest to this.
Please use a dark pen (not pencil) and tick clearly within the boxes.

Over the last week	Not at all	Only Occasionally	Sometimes	Often	Most or all the time	OFFICE USE ONLY
1 I have felt terribly alone and isolated	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ F
2 I have felt tense, anxious or nervous	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ P
3 I have felt I have someone to turn to for support when needed	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0	☐ F
4 I have felt OK about myself	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0	☐ W
5 I have felt totally lacking in energy and enthusiasm	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ P
6 I have been physically violent to others	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ R
7 I have felt able to cope when things go wrong	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0	☐ F
8 I have been troubled by aches, pains or other physical problems	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ P
9 I have thought of hurting myself	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ R
10 Talking to people has felt too much for me	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ F
11 Tension and anxiety have prevented me doing important things	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ P
12 I have been happy with the things I have done	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0	☐ F
13 I have been disturbed by unwanted thoughts and feelings	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ P
14 I have felt like crying	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ W

Please turn over

Appendix 2 Study questionnaries

Appendix 2A Core outcome measure - 34



Over the last week

	Not at all	Only Occasionally	Sometimes	Often	Most or all the time	OFFICE USE ONLY
15 I have felt panic or terror	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ P
16 I made plans to end my life	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ R
17 I have felt overwhelmed by my problems	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ W
18 I have had difficulty getting to sleep or staying asleep	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ P
19 I have felt warmth or affection for someone	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0	☐ F
20 My problems have been impossible to put to one side	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ P
21 I have been able to do most things I needed to	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0	☐ F
22 I have threatened or intimidated another person	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ R
23 I have felt despairing or hopeless	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ P
24 I have thought it would be better if I were dead	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ R
25 I have felt criticised by other people	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ F
26 I have thought I have no friends	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ F
27 I have felt unhappy	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ P
28 Unwanted images or memories have been distressing me	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ P
29 I have been irritable when with other people	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ F
30 I have thought I am to blame for my problems and difficulties	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ P
31 I have felt optimistic about my future	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0	☐ W
32 I have achieved the things I wanted to	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0	☐ F
33 I have felt humiliated or shamed by other people	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ F
34 I have hurt myself physically or taken dangerous risks with my health	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ R

THANK YOU FOR YOUR TIME IN COMPLETING THIS QUESTIONNAIRE

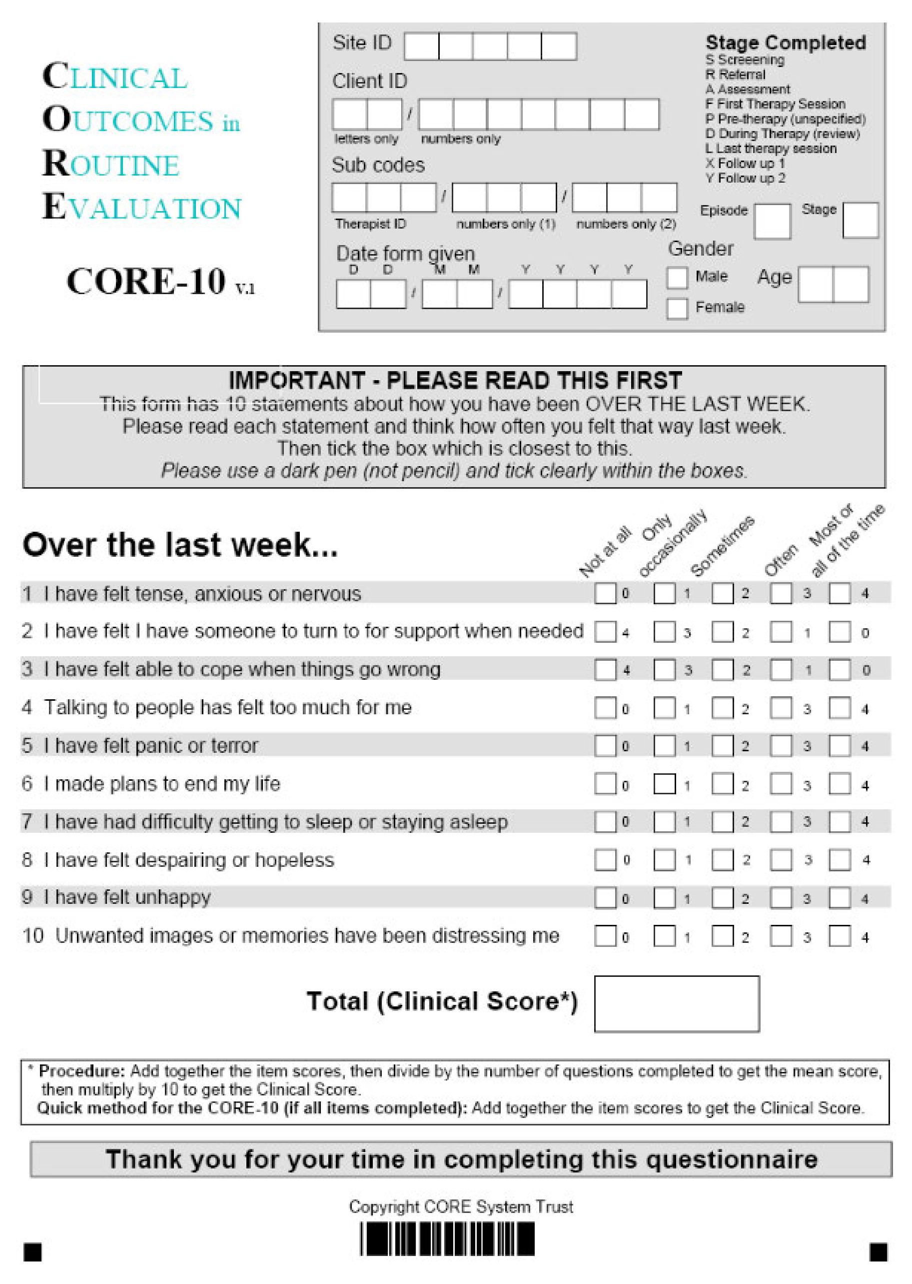
Total Scores	☐	☐	☐	☐ →	☐ →	☐
Mean Scores (Total score for each dimension divided by number of items completed in that dimension)	☐	☐	☐	☐	☐	☐
	(W)	(P)	(F)	(R)	All items	All minus R

Survey: 151

Page: 1

Appendix 2 Study questionnaries

Appendix 2B Core -10



CLINICAL
OUTCOMES in
ROUTINE
EVALUATION

CORE-10 v.1

Site ID ☐☐☐☐☐

Client ID ☐☐ / ☐☐☐☐☐☐☐
letters only numbers only

Sub codes ☐☐☐ / ☐☐☐ / ☐☐☐
Therapist ID numbers only (1) numbers only (2)

Date form given
D D / M M / Y Y Y Y
☐☐ / ☐☐ / ☐☐☐☐

Gender
☐ Male
☐ Female

Age ☐☐

Stage Completed
S Screeening
R Referral
A Assessment
F First Therapy Session
P Pre-therapy (unspecified)
D During Therapy (review)
L Last therapy session
X Follow up 1
Y Follow up 2

Episode ☐ Stage ☐

IMPORTANT - PLEASE READ THIS FIRST
This form has 10 statements about how you have been OVER THE LAST WEEK.
Please read each statement and think how often you felt that way last week.
Then tick the box which is closest to this.
Please use a dark pen (not pencil) and tick clearly within the boxes.

Over the last week...

	Not at all	Only occasionally	Sometimes	Often	Most or all of the time
1 I have felt tense, anxious or nervous	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
2 I have felt I have someone to turn to for support when needed	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
3 I have felt able to cope when things go wrong	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
4 Talking to people has felt too much for me	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
5 I have felt panic or terror	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
6 I made plans to end my life	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
7 I have had difficulty getting to sleep or staying asleep	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
8 I have felt despairing or hopeless	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
9 I have felt unhappy	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
10 Unwanted images or memories have been distressing me	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

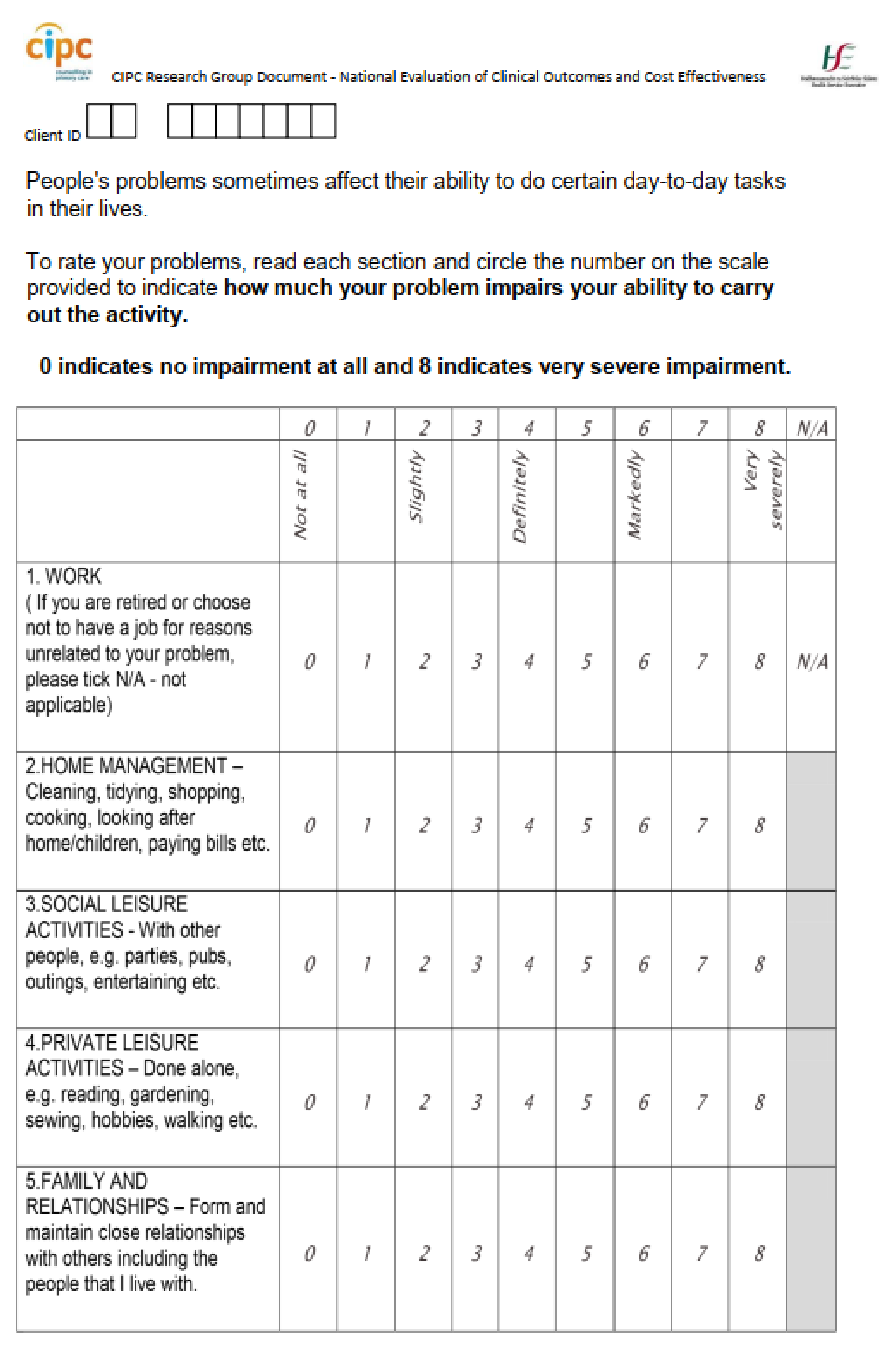
Total (Clinical Score*) ☐

* **Procedure:** Add together the item scores, then divide by the number of questions completed to get the mean score, then multiply by 10 to get the Clinical Score.
Quick method for the CORE-10 (if all items completed): Add together the item scores to get the Clinical Score.

Thank you for your time in completing this questionnaire

Appendix 2 Study questionnaries

Appendix 2C Work and Social Adjustment Questionnaire



CIPC Research Group Document - National Evaluation of Clinical Outcomes and Cost Effectiveness

Client ID

People's problems sometimes affect their ability to do certain day-to-day tasks in their lives.

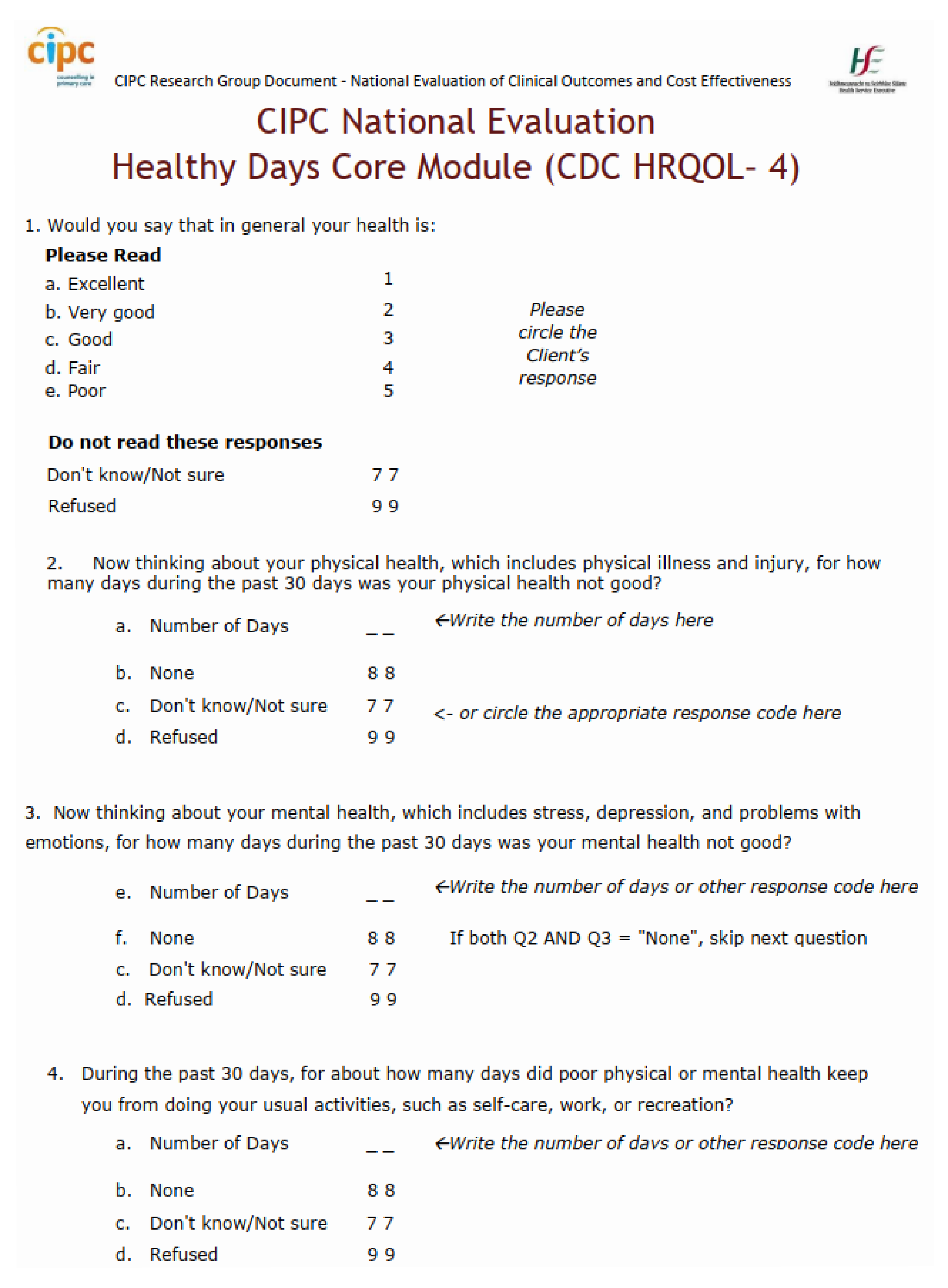
To rate your problems, read each section and circle the number on the scale provided to indicate **how much your problem impairs your ability to carry out the activity.**

0 indicates no impairment at all and 8 indicates very severe impairment.

	0	1	2	3	4	5	6	7	8	N/A
	Not at all		*Slightly*		*Definitely*		*Markedly*		*Very severely*	
1. WORK (If you are retired or choose not to have a job for reasons unrelated to your problem, please tick N/A - not applicable)	0	1	2	3	4	5	6	7	8	N/A
2.HOME MANAGEMENT – Cleaning, tidying, shopping, cooking, looking after home/children, paying bills etc.	0	1	2	3	4	5	6	7	8	
3.SOCIAL LEISURE ACTIVITIES - With other people, e.g. parties, pubs, outings, entertaining etc.	0	1	2	3	4	5	6	7	8	
4.PRIVATE LEISURE ACTIVITIES – Done alone, e.g. reading, gardening, sewing, hobbies, walking etc.	0	1	2	3	4	5	6	7	8	
5.FAMILY AND RELATIONSHIPS – Form and maintain close relationships with others including the people that I live with.	0	1	2	3	4	5	6	7	8	

Appendix 2 Study questionnaries

Appendix 2D Health Related Quality of Life Questionnaire



CIPC Research Group Document - National Evaluation of Clinical Outcomes and Cost Effectiveness

CIPC National Evaluation
Healthy Days Core Module (CDC HRQOL- 4)

1. Would you say that in general your health is:

Please Read

a. Excellent	1
b. Very good	2
c. Good	3
d. Fair	4
e. Poor	5

Please circle the Client's response

Do not read these responses

Don't know/Not sure	7 7
Refused	9 9

2. Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?

a. Number of Days	_ _	*←Write the number of days here*
b. None	8 8	
c. Don't know/Not sure	7 7	*<- or circle the appropriate response code here*
d. Refused	9 9	

3. Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?

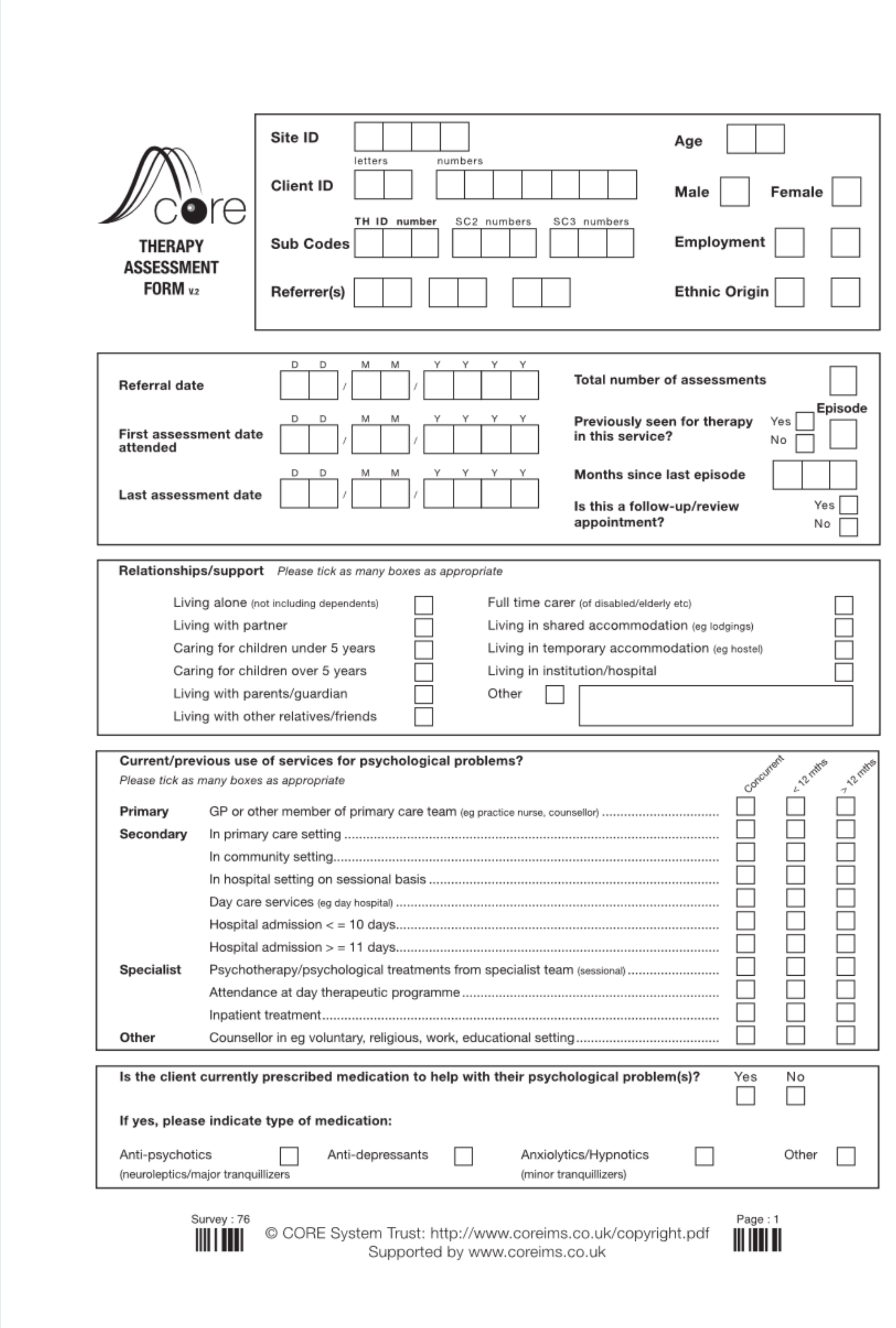
e. Number of Days	_ _	*←Write the number of days or other response code here*
f. None	8 8	If both Q2 AND Q3 = "None", skip next question
c. Don't know/Not sure	7 7	
d. Refused	9 9	

4. During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?

a. Number of Days	_ _	*←Write the number of days or other response code here*
b. None	8 8	
c. Don't know/Not sure	7 7	
d. Refused	9 9	

Appendix 2 Study questionnaries

Appendix 2E CORE Therapy Assessment Form



core
THERAPY
ASSESSMENT
FORM v.2

Site ID ☐☐☐☐

Client ID letters ☐☐ numbers ☐☐☐☐☐☐☐

Sub Codes TH ID number ☐☐☐ SC2 numbers ☐☐☐ SC3 numbers ☐☐☐

Referrer(s) ☐☐ ☐☐ ☐☐

Age ☐☐

Male ☐ **Female** ☐

Employment ☐ ☐

Ethnic Origin ☐ ☐

Referral date DD ☐☐ / MM ☐☐ / YYYY ☐☐☐☐

First assessment date attended DD ☐☐ / MM ☐☐ / YYYY ☐☐☐☐

Last assessment date DD ☐☐ / MM ☐☐ / YYYY ☐☐☐☐

Total number of assessments ☐

Previously seen for therapy in this service? Yes ☐ No ☐ **Episode** ☐

Months since last episode ☐☐☐

Is this a follow-up/review appointment? Yes ☐ No ☐

Relationships/support *Please tick as many boxes as appropriate*

Living alone (not including dependents)	☐	Full time carer (of disabled/elderly etc)	☐
Living with partner	☐	Living in shared accommodation (eg lodgings)	☐
Caring for children under 5 years	☐	Living in temporary accommodation (eg hostel)	☐
Caring for children over 5 years	☐	Living in institution/hospital	☐
Living with parents/guardian	☐	Other ☐	
Living with other relatives/friends	☐		

Current/previous use of services for psychological problems?
Please tick as many boxes as appropriate

		Concurrent	< 12 mths	> 12 mths
Primary	GP or other member of primary care team (eg practice nurse, counsellor)	☐	☐	☐
Secondary	In primary care setting	☐	☐	☐
	In community setting	☐	☐	☐
	In hospital setting on sessional basis	☐	☐	☐
	Day care services (eg day hospital)	☐	☐	☐
	Hospital admission < = 10 days	☐	☐	☐
	Hospital admission > = 11 days	☐	☐	☐
Specialist	Psychotherapy/psychological treatments from specialist team (sessional)	☐	☐	☐
	Attendance at day therapeutic programme	☐	☐	☐
	Inpatient treatment	☐	☐	☐
Other	Counsellor in eg voluntary, religious, work, educational setting	☐	☐	☐

Is the client currently prescribed medication to help with their psychological problem(s)? Yes ☐ No ☐

If yes, please indicate type of medication:

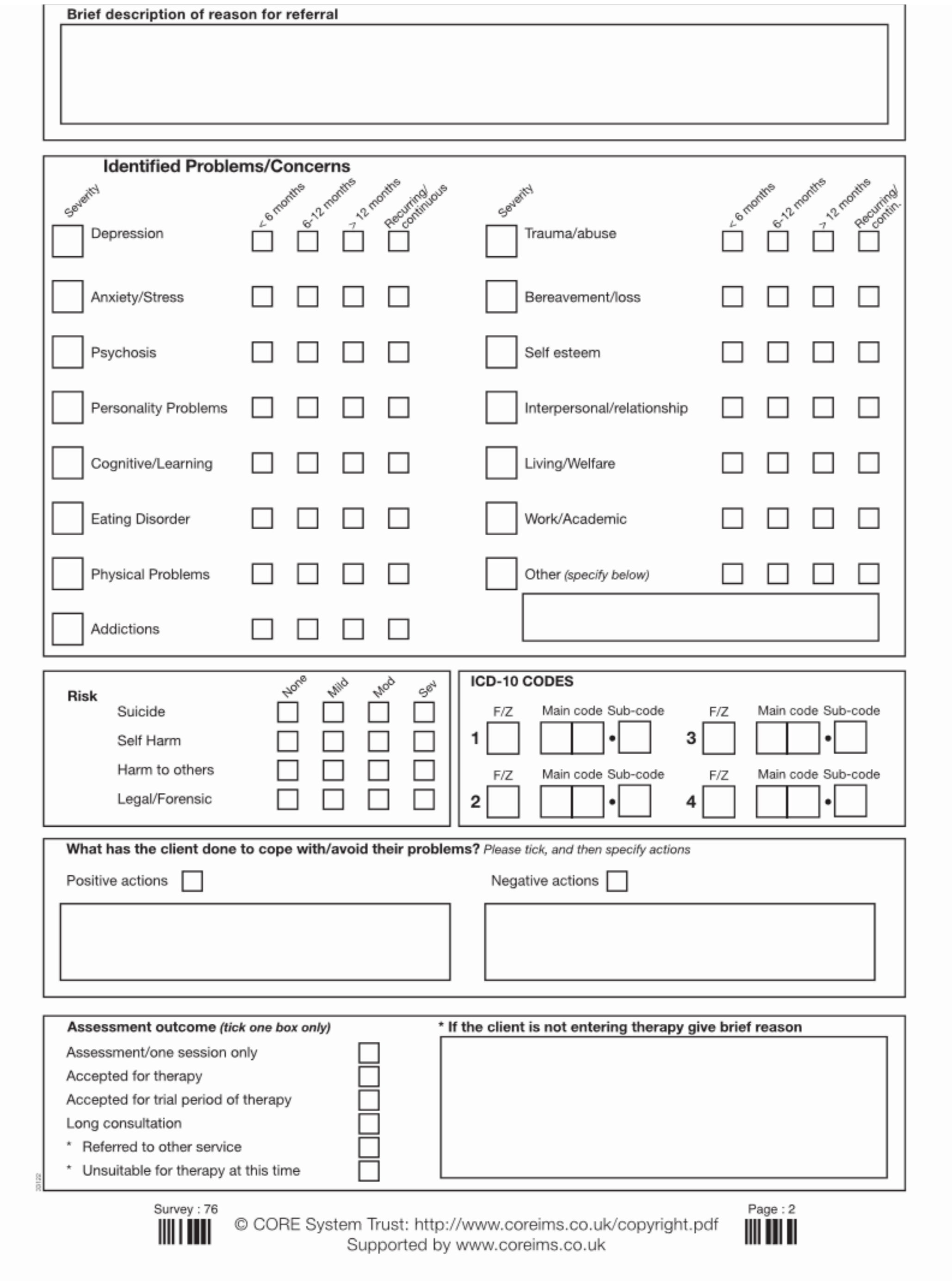
Anti-psychotics (neuroleptics/major tranquillizers) ☐ Anti-depressants ☐ Anxiolytics/Hypnotics (minor tranquillizers) ☐ Other ☐

Survey : 76

Page : 1

Appendix 2 Study questionnaries

Appendix 2E CORE Therapy Assessment Form



Brief description of reason for referral

☐

Identified Problems/Concerns

Severity		< 6 months	6-12 months	> 12 months	Recurring/ continuous	Severity		< 6 months	6-12 months	> 12 months	Recurring/ contin.
☐	Depression	☐	☐	☐	☐	☐	Trauma/abuse	☐	☐	☐	☐
☐	Anxiety/Stress	☐	☐	☐	☐	☐	Bereavement/loss	☐	☐	☐	☐
☐	Psychosis	☐	☐	☐	☐	☐	Self esteem	☐	☐	☐	☐
☐	Personality Problems	☐	☐	☐	☐	☐	Interpersonal/relationship	☐	☐	☐	☐
☐	Cognitive/Learning	☐	☐	☐	☐	☐	Living/Welfare	☐	☐	☐	☐
☐	Eating Disorder	☐	☐	☐	☐	☐	Work/Academic	☐	☐	☐	☐
☐	Physical Problems	☐	☐	☐	☐	☐	Other *(specify below)*	☐	☐	☐	☐
☐	Addictions	☐	☐	☐	☐		☐				

Risk

	None	Mild	Mod	Sev
Suicide	☐	☐	☐	☐
Self Harm	☐	☐	☐	☐
Harm to others	☐	☐	☐	☐
Legal/Forensic	☐	☐	☐	☐

ICD-10 CODES

	F/Z	Main code	Sub-code		F/Z	Main code	Sub-code
1	☐	☐☐ •	☐	3	☐	☐☐ •	☐
2	☐	☐☐ •	☐	4	☐	☐☐ •	☐

What has the client done to cope with/avoid their problems? *Please tick, and then specify actions*

Positive actions ☐

Negative actions ☐

Assessment outcome ***(tick one box only)***

- Assessment/one session only ☐
- Accepted for therapy ☐
- Accepted for trial period of therapy ☐
- Long consultation ☐
- * Referred to other service ☐
- * Unsuitable for therapy at this time ☐

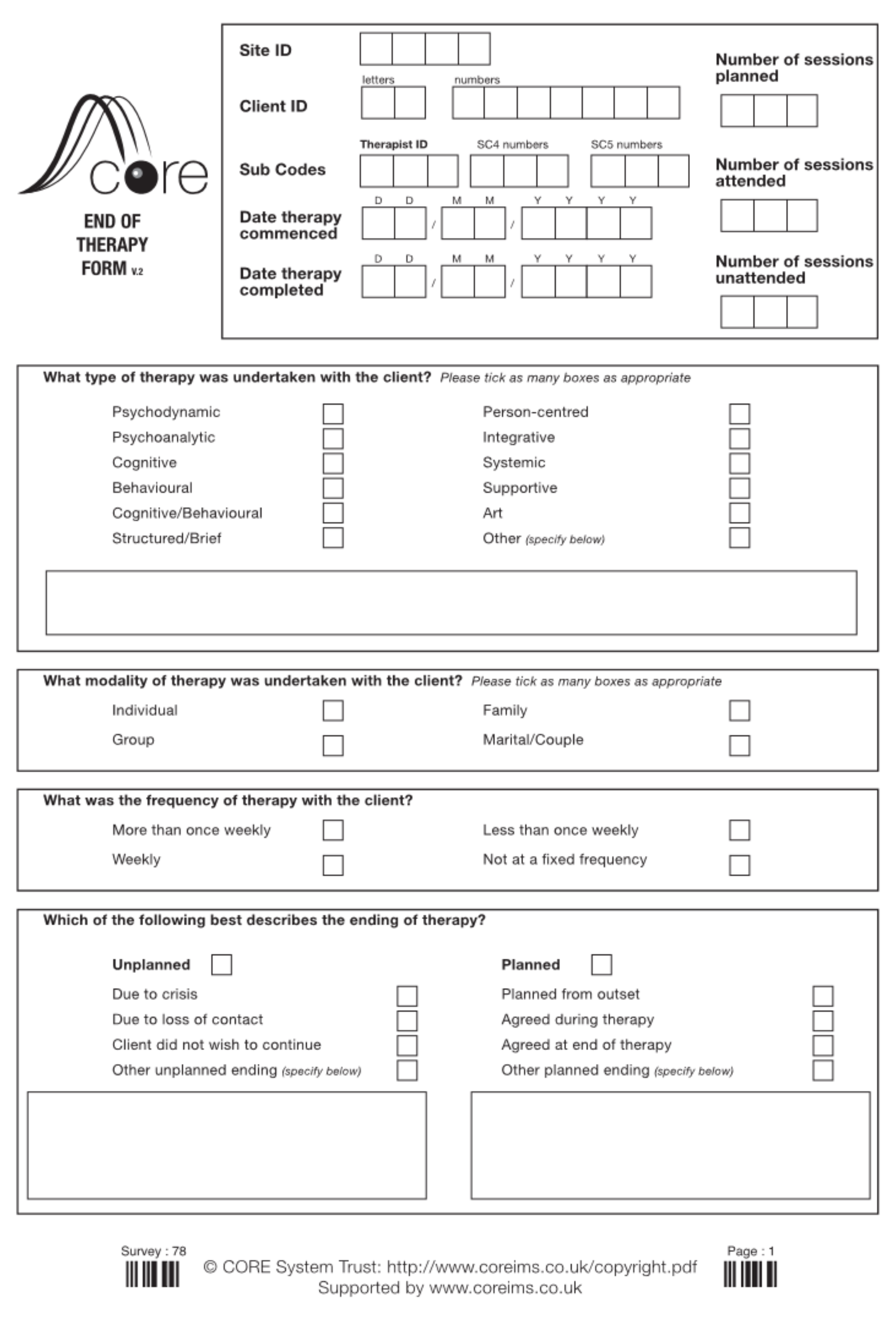
*** If the client is not entering therapy give brief reason**

Survey : 76

Page : 2

Appendix 2 Study questionnaries

Appendix 2F CORE End of Therapy Form



core

END OF THERAPY FORM v.2

Site ID ☐☐☐☐

Client ID letters ☐☐ numbers ☐☐☐☐☐☐☐

Sub Codes Therapist ID ☐☐☐ SC4 numbers ☐☐☐ SC5 numbers ☐☐☐

Date therapy commenced D D ☐☐ / M M ☐☐ / Y Y Y Y ☐☐☐☐

Date therapy completed D D ☐☐ / M M ☐☐ / Y Y Y Y ☐☐☐☐

Number of sessions planned ☐☐☐

Number of sessions attended ☐☐☐

Number of sessions unattended ☐☐☐

What type of therapy was undertaken with the client? *Please tick as many boxes as appropriate*

Psychodynamic	☐	Person-centred	☐
Psychoanalytic	☐	Integrative	☐
Cognitive	☐	Systemic	☐
Behavioural	☐	Supportive	☐
Cognitive/Behavioural	☐	Art	☐
Structured/Brief	☐	Other *(specify below)*	☐

What modality of therapy was undertaken with the client? *Please tick as many boxes as appropriate*

Individual	☐	Family	☐
Group	☐	Marital/Couple	☐

What was the frequency of therapy with the client?

More than once weekly	☐	Less than once weekly	☐
Weekly	☐	Not at a fixed frequency	☐

Which of the following best describes the ending of therapy?

Unplanned ☐		**Planned** ☐	
Due to crisis	☐	Planned from outset	☐
Due to loss of contact	☐	Agreed during therapy	☐
Client did not wish to continue	☐	Agreed at end of therapy	☐
Other unplanned ending *(specify below)*	☐	Other planned ending *(specify below)*	☐

Survey : 78

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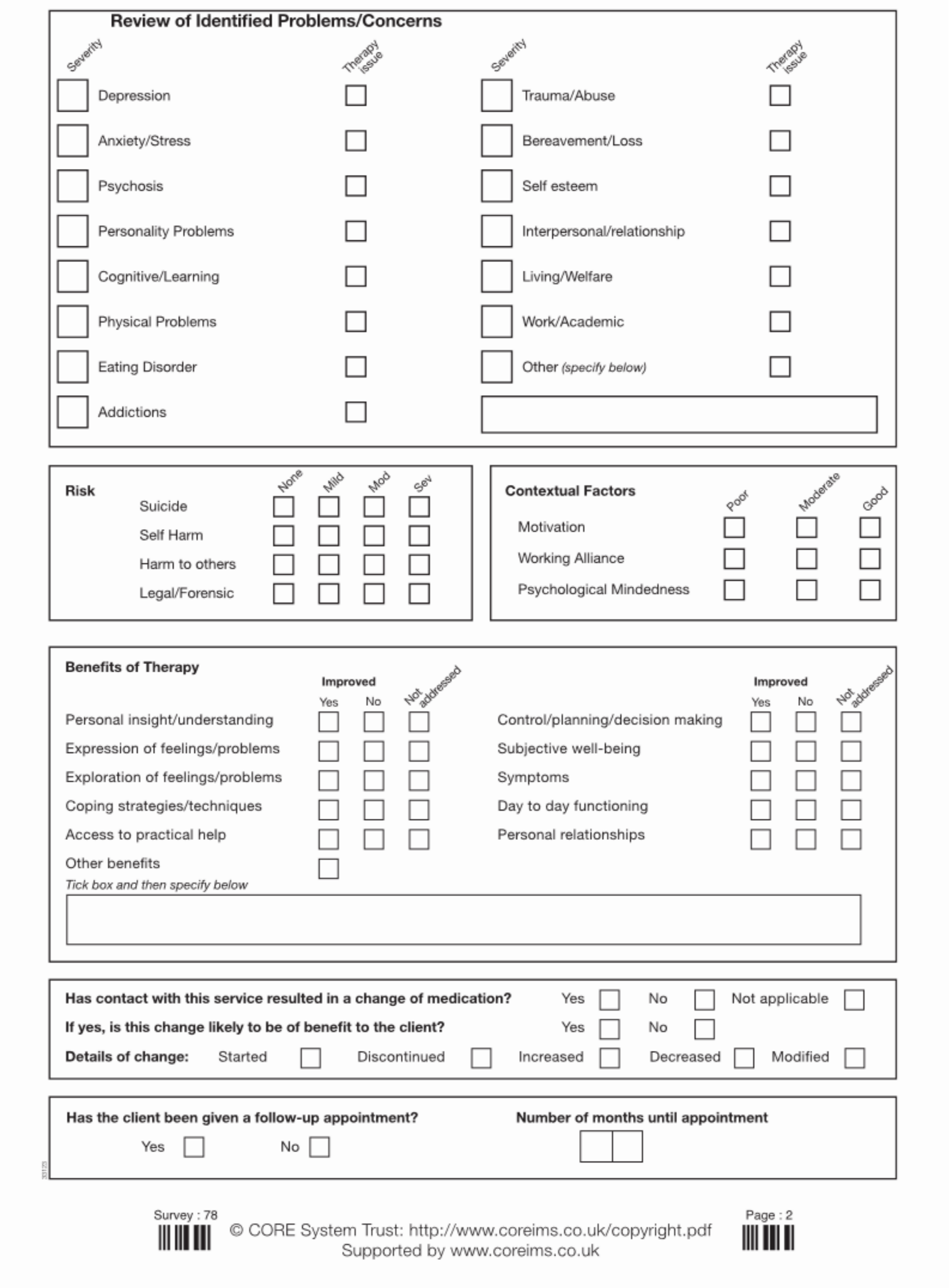
Appendix 2 Study questionnaries

Appendix 2F CORE End of Therapy Form



Review of Identified Problems/Concerns

Severity		Therapy issue	Severity		Therapy issue
☐	Depression	☐	☐	Trauma/Abuse	☐
☐	Anxiety/Stress	☐	☐	Bereavement/Loss	☐
☐	Psychosis	☐	☐	Self esteem	☐
☐	Personality Problems	☐	☐	Interpersonal/relationship	☐
☐	Cognitive/Learning	☐	☐	Living/Welfare	☐
☐	Physical Problems	☐	☐	Work/Academic	☐
☐	Eating Disorder	☐	☐	Other *(specify below)*	☐
☐	Addictions	☐			

Risk	None	Mild	Mod	Sev
Suicide	☐	☐	☐	☐
Self Harm	☐	☐	☐	☐
Harm to others	☐	☐	☐	☐
Legal/Forensic	☐	☐	☐	☐

Contextual Factors	Poor	Moderate	Good
Motivation	☐	☐	☐
Working Alliance	☐	☐	☐
Psychological Mindedness	☐	☐	☐

Benefits of Therapy

	Improved Yes	Improved No	Not addressed		Improved Yes	Improved No	Not addressed
Personal insight/understanding	☐	☐	☐	Control/planning/decision making	☐	☐	☐
Expression of feelings/problems	☐	☐	☐	Subjective well-being	☐	☐	☐
Exploration of feelings/problems	☐	☐	☐	Symptoms	☐	☐	☐
Coping strategies/techniques	☐	☐	☐	Day to day functioning	☐	☐	☐
Access to practical help	☐	☐	☐	Personal relationships	☐	☐	☐
Other benefits	☐						

Tick box and then specify below

Has contact with this service resulted in a change of medication? Yes ☐ No ☐ Not applicable ☐

If yes, is this change likely to be of benefit to the client? Yes ☐ No ☐

Details of change: Started ☐ Discontinued ☐ Increased ☐ Decreased ☐ Modified ☐

Has the client been given a follow-up appointment? Yes ☐ No ☐

Number of months until appointment ☐☐

Survey : 78

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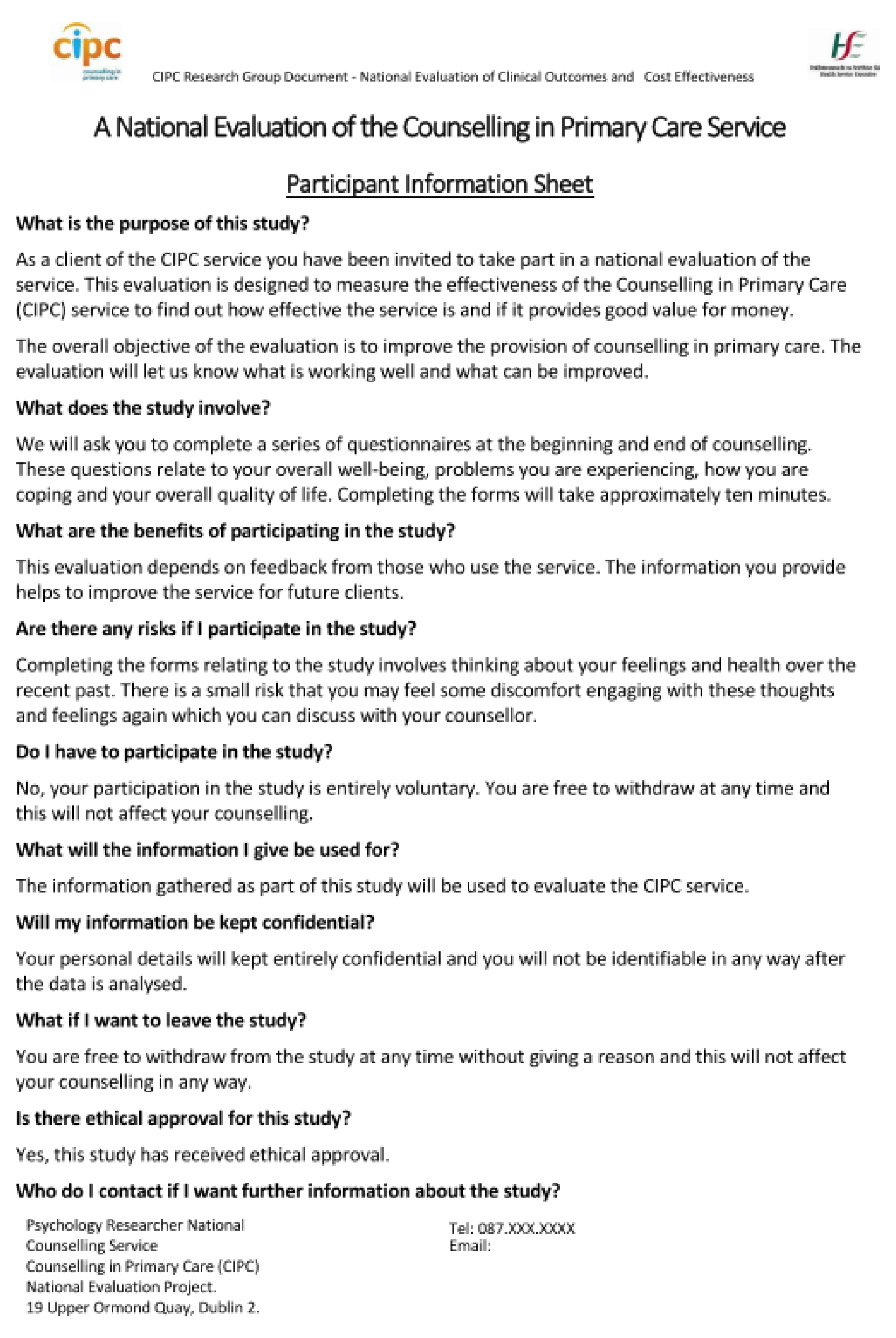
Appendix 3 Participant information and consent forms

Appendix 3A Participant Information Form



CIPC Research Group Document - National Evaluation of Clinical Outcomes and Cost Effectiveness

A National Evaluation of the Counselling in Primary Care Service

Participant Information Sheet

What is the purpose of this study?

As a client of the CIPC service you have been invited to take part in a national evaluation of the service. This evaluation is designed to measure the effectiveness of the Counselling in Primary Care (CIPC) service to find out how effective the service is and if it provides good value for money.

The overall objective of the evaluation is to improve the provision of counselling in primary care. The evaluation will let us know what is working well and what can be improved.

What does the study involve?

We will ask you to complete a series of questionnaires at the beginning and end of counselling. These questions relate to your overall well-being, problems you are experiencing, how you are coping and your overall quality of life. Completing the forms will take approximately ten minutes.

What are the benefits of participating in the study?

This evaluation depends on feedback from those who use the service. The information you provide helps to improve the service for future clients.

Are there any risks if I participate in the study?

Completing the forms relating to the study involves thinking about your feelings and health over the recent past. There is a small risk that you may feel some discomfort engaging with these thoughts and feelings again which you can discuss with your counsellor.

Do I have to participate in the study?

No, your participation in the study is entirely voluntary. You are free to withdraw at any time and this will not affect your counselling.

What will the information I give be used for?

The information gathered as part of this study will be used to evaluate the CIPC service.

Will my information be kept confidential?

Your personal details will kept entirely confidential and you will not be identifiable in any way after the data is analysed.

What if I want to leave the study?

You are free to withdraw from the study at any time without giving a reason and this will not affect your counselling in any way.

Is there ethical approval for this study?

Yes, this study has received ethical approval.

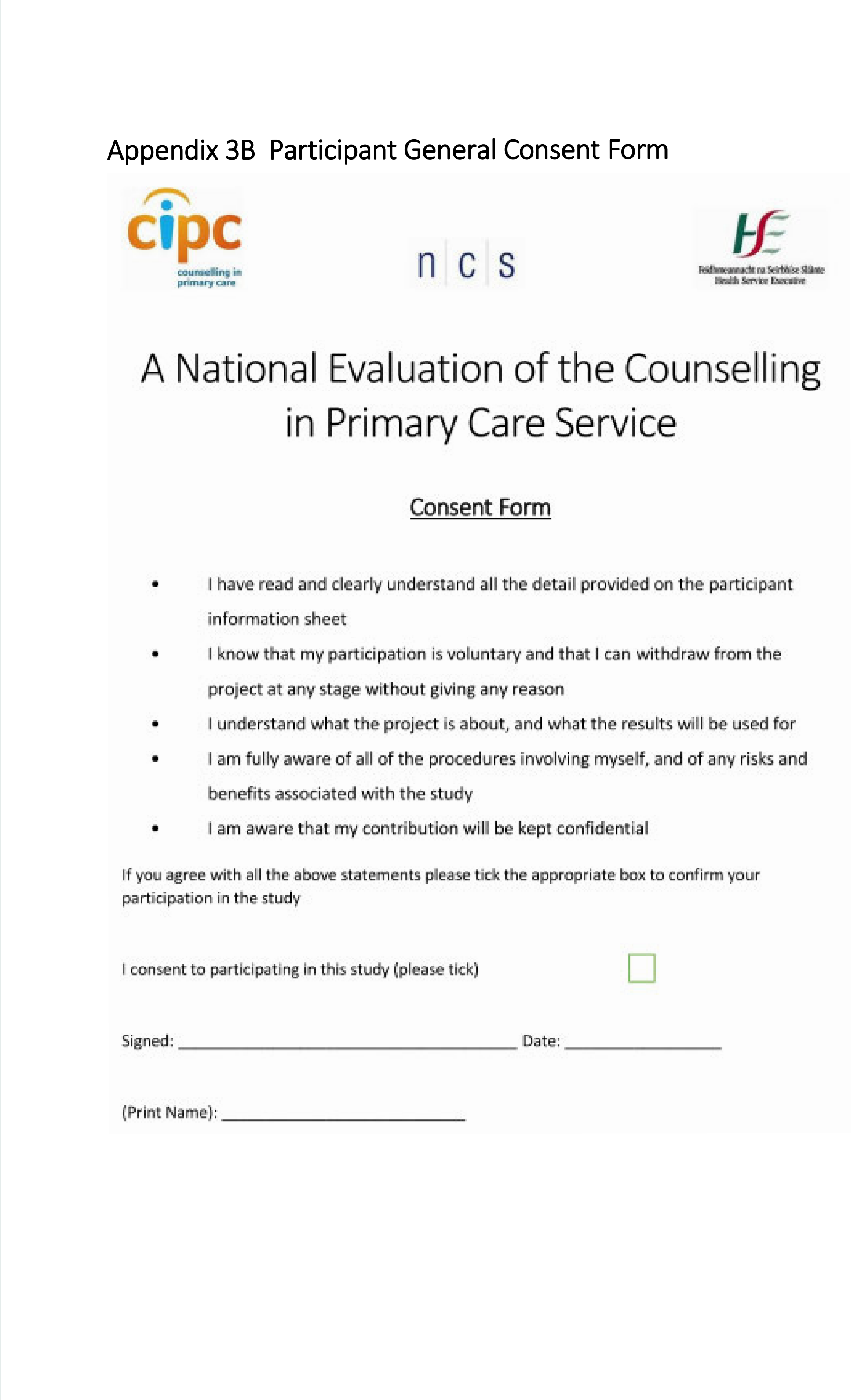
Who do I contact if I want further information about the study?

Psychology Researcher National
Counselling Service
Counselling in Primary Care (CIPC)
National Evaluation Project.
19 Upper Ormond Quay, Dublin 2.

Tel: 087.XXX.XXXX
Email:

Appendix 3 Participant information and consent forms

Appendix 3B Participant General Consent Form



Appendix 3B Participant General Consent Form

cipc counselling in primary care

ncs

HSE Feidhmeannacht na Seirbhíse Sláinte Health Service Executive

A National Evaluation of the Counselling in Primary Care Service

<u>Consent Form</u>

- I have read and clearly understand all the detail provided on the participant information sheet
- I know that my participation is voluntary and that I can withdraw from the project at any stage without giving any reason
- I understand what the project is about, and what the results will be used for
- I am fully aware of all of the procedures involving myself, and of any risks and benefits associated with the study
- I am aware that my contribution will be kept confidential

If you agree with all the above statements please tick the appropriate box to confirm your participation in the study

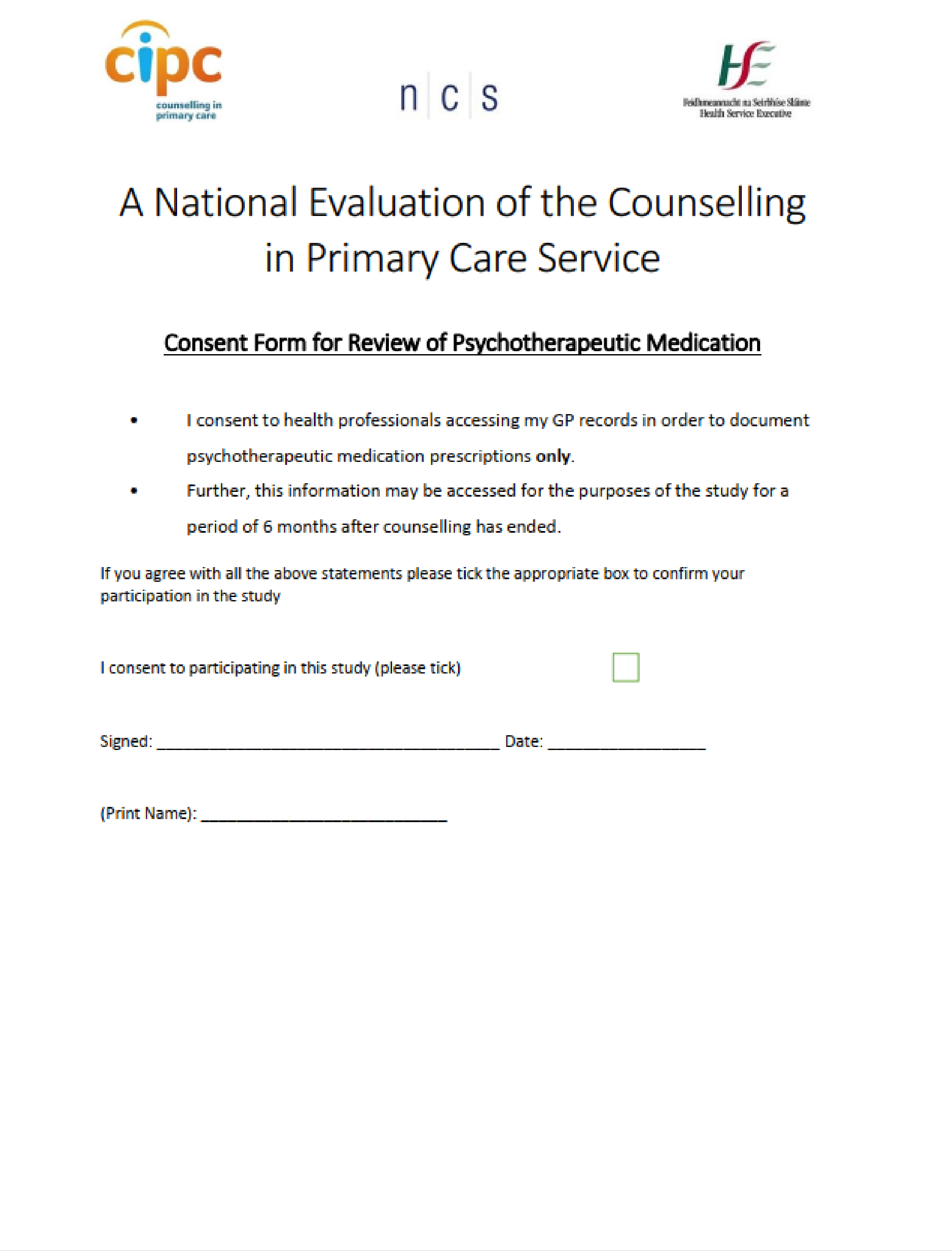
I consent to participating in this study (please tick) ☐

Signed: ______________________________ Date: ______________

(Print Name): ______________________

Appendix 3 Participant information and consent forms

Appendix 3C Participant Consent for Review of Psychotropic Medication Form



cipc counselling in primary care

n c s

HSE Feidhmeannacht na Seirbhíse Sláinte Health Service Executive

A National Evaluation of the Counselling in Primary Care Service

Consent Form for Review of Psychotherapeutic Medication

- I consent to health professionals accessing my GP records in order to document psychotherapeutic medication prescriptions **only**.
- Further, this information may be accessed for the purposes of the study for a period of 6 months after counselling has ended.

If you agree with all the above statements please tick the appropriate box to confirm your participation in the study

I consent to participating in this study (please tick) ☐

Signed: ______________________________________ Date: _________________

(Print Name): ___________________________

Appendix 4 Participant demographic information

Participant Demographic information (N = 2,928)

Demographic	Category	Mean age	Min-Max	*n*	%	Missing %
Age		42.5	18-89	2874	98.2	1.8
Age breakdown						
	18-25			369	12.6	
	26-35			635	21.7	
	36-45			750	25.6	
	46-55			553	18.9	
	56-65			337	11.5	
	66-75			177	6.0	
	76-85			48	1.6	
	85+			5	0.2	
Gender						
	Male	42.8	18-87	717	24.5	
	Female	42.4	18-89	2157	73.7	
Employment Status				2685		8.3
	Employed			934	31.9	
	Unemployed and seeking work			373	12.7	
	Student			167	5.7	
	Long Term Sick, Disabled or Benefits			489	16.7	
	Homemaker not working or actively seeking work			476	16.3	
	Not receiving benefits and not working or actively seeking work			13	0.4	
	Unpaid voluntary work, not working or actively seeking work			23	0.8	
	Retired			210	7.2	
Ethnic Origin				2636		9.0
	White Irish			2169	74.1	
	White Irish Traveller			21	0.7	
	Any other White Background			328	11.2	
	Black, or Black Irish - African			14	0.5	
	Black, or Black Irish - any other Black background			14	0.5	
	Asian or Asian Irish - Chinese			8	0.3	
	Asian or Asian Irish - any other Aisan background			9	0.3	
	Other including mixed background			27	0.9	
	N/A			46	1.6	

Appendix 4 Participant demographic information

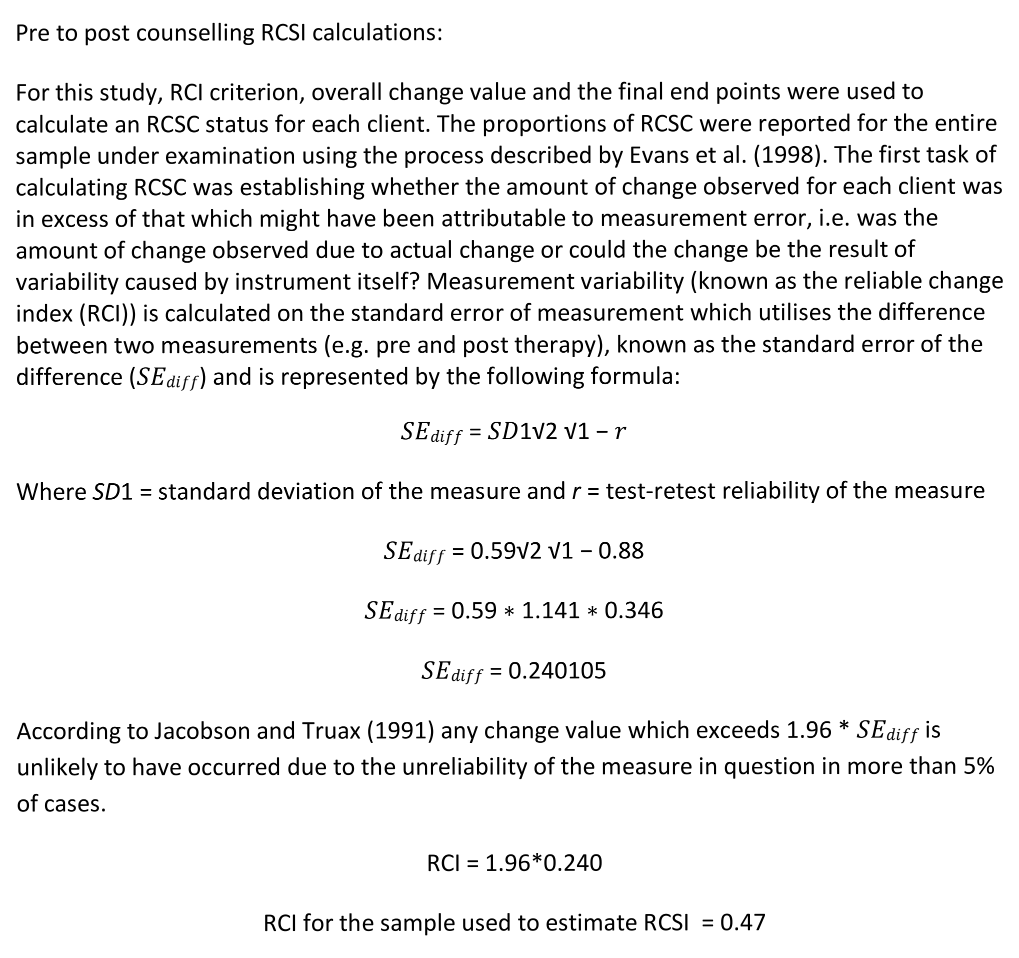
Appendix 4A Pre and post counselling questionnaire completion rates

CORE OM 34 and CORE - 10, HRQOL and WSAS questionnaire completion rates at pre and post counselling (N = 2,928)

	Pre counselling		Missing		Post counselling		Missing	
Measure	*n*	%	*n*	%	*n*	%	*n*	%
CORE OM 34*	2826	96.5	38	1.3	1751	59.8	515	17.6
CORE - 10	64	2.2			662	22.6		
HRQOL								
Question 1	2068	70.6	860	29.4	772	26.4	2156	73.63
Question 2	2065	70.5	863	29.5	765	26.1	2163	73.87
Question 3	2082	71.1	846	28.9	775	26.5	2153	73.53
Question 4	2012	68.7	916	31.3	729	24.9	2199	75.10
WSAS	2176	74.3	752	25.7	793	27.1	2135	72.92

* Valid CORE OM scores = questionnaires with < 32 completed items

Appendix 5 Reliable and clinically significant change index calculation



Pre to post counselling RCSI calculations:

For this study, RCI criterion, overall change value and the final end points were used to calculate an RCSC status for each client. The proportions of RCSC were reported for the entire sample under examination using the process described by Evans et al. (1998). The first task of calculating RCSC was establishing whether the amount of change observed for each client was in excess of that which might have been attributable to measurement error, i.e. was the amount of change observed due to actual change or could the change be the result of variability caused by instrument itself? Measurement variability (known as the reliable change index (RCI)) is calculated on the standard error of measurement which utilises the difference between two measurements (e.g. pre and post therapy), known as the standard error of the difference (SE_{diff}) and is represented by the following formula:

$$SE_{diff} = SD1\sqrt{2}\ \sqrt{1-r}$$

Where *SD*1 = standard deviation of the measure and *r* = test-retest reliability of the measure

$$SE_{diff} = 0.59\sqrt{2}\ \sqrt{1-0.88}$$

$$SE_{diff} = 0.59 * 1.141 * 0.346$$

$$SE_{diff} = 0.240105$$

According to Jacobson and Truax (1991) any change value which exceeds 1.96 * SE_{diff} is unlikely to have occurred due to the unreliability of the measure in question in more than 5% of cases.

$$\text{RCI} = 1.96*0.240$$

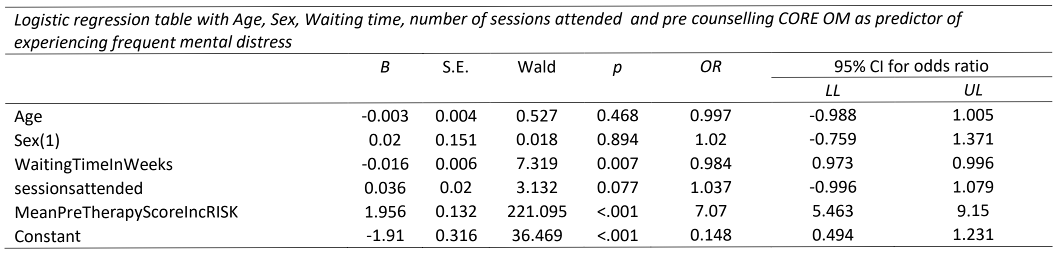
RCI for the sample used to estimate RCSI = 0.47

Appendix 6 Explanation of risk evaluation criteria

The CORE System Manual (CORE System Group, 1998) provides guidance in relation to the treatment of risk as assessed by the six risk items on the CORE OM 34 questionnaire. It suggests treating these items as flags that can indicate the possible presence of risk in each of the relevant areas of a client's life (i.e. risk of harm to self and risk of harm to others). Rather than considering these as items on a scale, the authors recommend that any score other than zero on any of the six risk items "should be flagged for further attention by the clinician" (CORE System Group, 1998, p. 13). Risk was considered in this manner for the purpose of analyses of risk in this evaluation (Bewick et al., 2006).

Clients were considered 'at risk' when they scored 1 on two or more of the six items or 2 on one or more of the risk items. Pre and post counselling comparisons were then made between the groups of participants indicated as being 'at risk' and those for whom risk was not present.

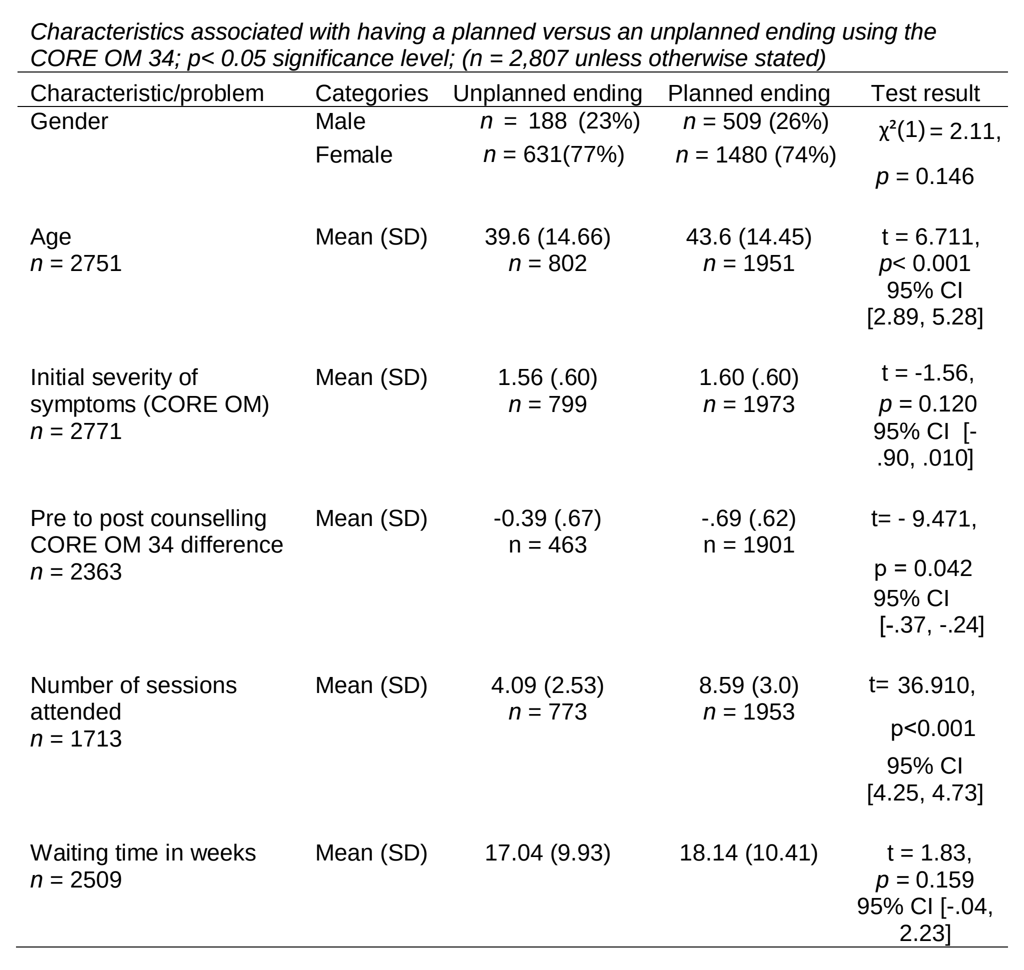
Appendix 7 Binary logistic regression table showing participant factors as predictors of frequent mental distress



Logistic regression table with Age, Sex, Waiting time, number of sessions attended and pre counselling CORE OM as predictor of experiencing frequent mental distress

	B	S.E.	Wald	*p*	*OR*	95% CI for odds ratio	
						LL	*UL*
Age	-0.003	0.004	0.527	0.468	0.997	-0.988	1.005
Sex(1)	0.02	0.151	0.018	0.894	1.02	-0.759	1.371
WaitingTimeInWeeks	-0.016	0.006	7.319	0.007	0.984	0.973	0.996
sessionsattended	0.036	0.02	3.132	0.077	1.037	-0.996	1.079
MeanPreTherapyScoreIncRISK	1.956	0.132	221.095	<.001	7.07	5.463	9.15
Constant	-1.91	0.316	36.469	<.001	0.148	0.494	1.231

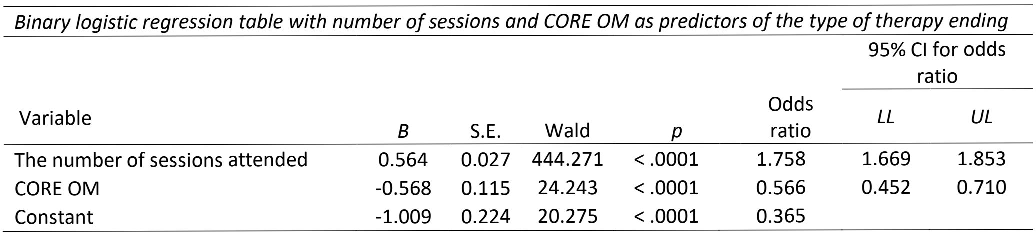
Appendix 8 Participant characteristics associated with planned versus unplanned endings



Characteristics associated with having a planned versus an unplanned ending using the CORE OM 34; p< 0.05 significance level; (n = 2,807 unless otherwise stated)

Characteristic/problem	Categories	Unplanned ending	Planned ending	Test result
Gender	Male Female	*n* = 188 (23%) *n* = 631(77%)	*n* = 509 (26%) *n* = 1480 (74%)	$\chi^2(1) = 2.11$, *p* = 0.146
Age *n* = 2751	Mean (SD)	39.6 (14.66) *n* = 802	43.6 (14.45) *n* = 1951	t = 6.711, *p*< 0.001 95% CI [2.89, 5.28]
Initial severity of symptoms (CORE OM) *n* = 2771	Mean (SD)	1.56 (.60) *n* = 799	1.60 (.60) *n* = 1973	t = -1.56, *p* = 0.120 95% CI [-.90, .010]
Pre to post counselling CORE OM 34 difference *n* = 2363	Mean (SD)	-0.39 (.67) n = 463	-.69 (.62) n = 1901	t= - 9.471, p = 0.042 95% CI [-.37, -.24]
Number of sessions attended *n* = 1713	Mean (SD)	4.09 (2.53) *n* = 773	8.59 (3.0) *n* = 1953	t= 36.910, p<0.001 95% CI [4.25, 4.73]
Waiting time in weeks *n* = 2509	Mean (SD)	17.04 (9.93)	18.14 (10.41)	t = 1.83, *p* = 0.159 95% CI [-.04, 2.23]

Appendix 9 Binary logistic regression table showing participant factors as predictors of type of therapy ending



Binary logistic regression table with number of sessions and CORE OM as predictors of the type of therapy ending

Variable	*B*	S.E.	Wald	*p*	Odds ratio	95% CI for odds ratio	
						LL	*UL*
The number of sessions attended	0.564	0.027	444.271	< .0001	1.758	1.669	1.853
CORE OM	-0.568	0.115	24.243	< .0001	0.566	0.452	0.710
Constant	-1.009	0.224	20.275	< .0001	0.365		

Appendix 10 Description of mixed ANOVA results for time and age category on CORE OM 34 scores

Effect for TIME on CORE OM 34 scores ($F(1,2365) = 215.924$, $p < .001$, $\eta_p^2 = .084$). The test of the main effect of the grouping variable (i.e. Age categories) on CORE OM 34 scores on the repeated measure averaged over time was also significant ($F(7,2365) = 6.893$, $p < .001$, $\eta_p^2 = .020$).

A significant TIME X Age Category interaction was observed for pre to post outcome scores across different age categories ($F(2,2365) = 3.094$, p $.003$, $\eta_p^2 = .009$). This showed that the change in CORE OM 34 scores between different age categories varied significantly between pre and post counselling.

Appendix 10 Description of mixed ANOVA results for time and age category on CORE OM 34 scores

Appendix 10A Differences in CORE OM 34 scores by age category

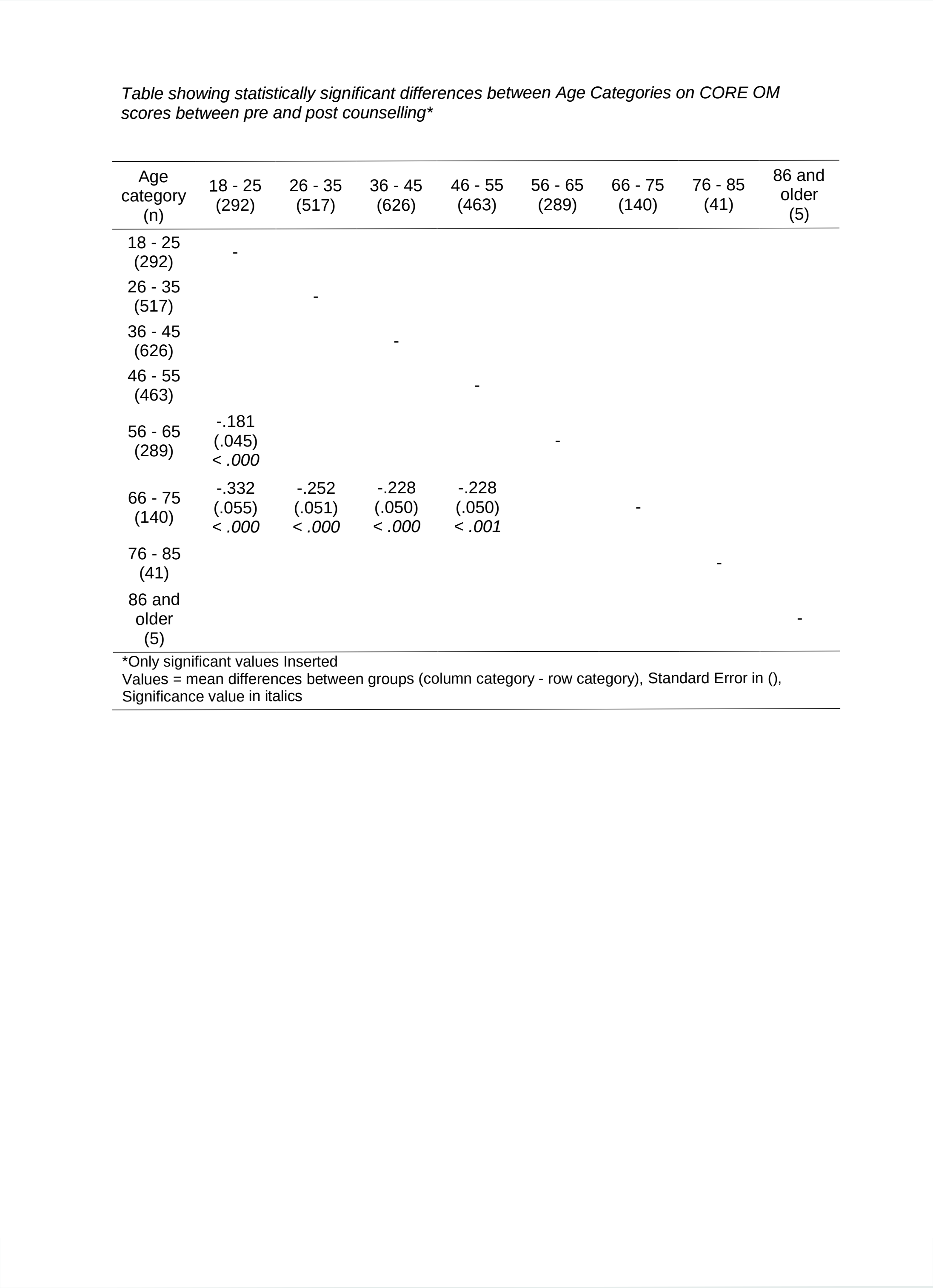
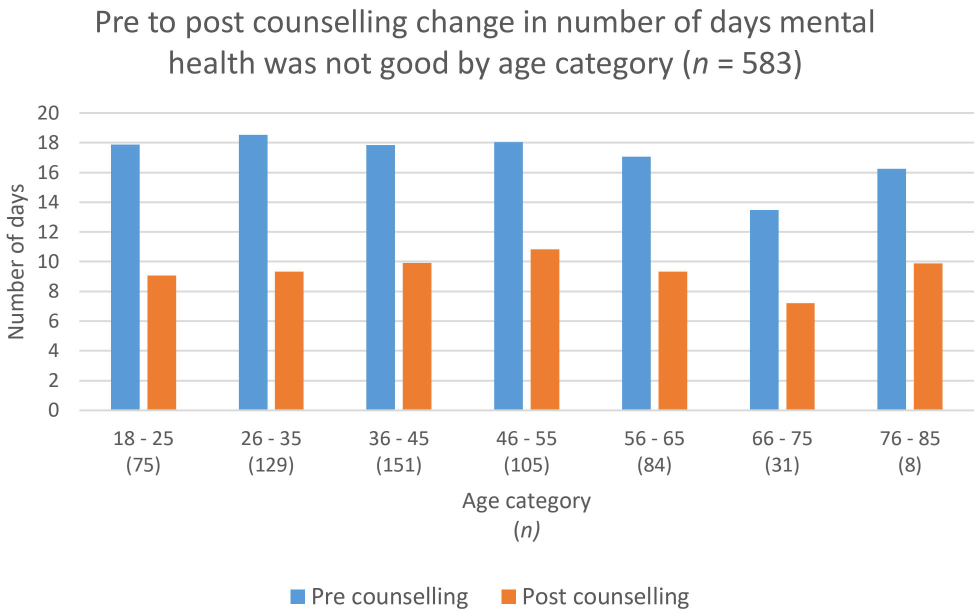


*Table showing statistically significant differences between Age Categories on CORE OM scores between pre and post counselling**

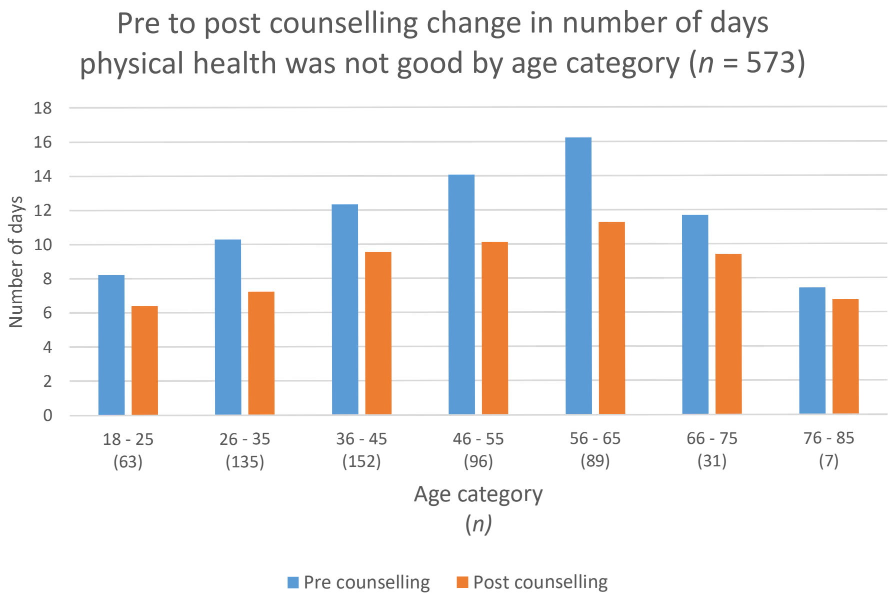
Age category (n)	18 - 25 (292)	26 - 35 (517)	36 - 45 (626)	46 - 55 (463)	56 - 65 (289)	66 - 75 (140)	76 - 85 (41)	86 and older (5)
18 - 25 (292)	-							
26 - 35 (517)		-						
36 - 45 (626)			-					
46 - 55 (463)				-				
56 - 65 (289)	-.181 (.045) < *.000*				-			
66 - 75 (140)	-.332 (.055) < *.000*	-.252 (.051) < *.000*	-.228 (.050) < *.000*	-.228 (.050) < *.001*		-		
76 - 85 (41)							-	
86 and older (5)								-

*Only significant values Inserted
Values = mean differences between groups (column category - row category), Standard Error in (), Significance value in italics

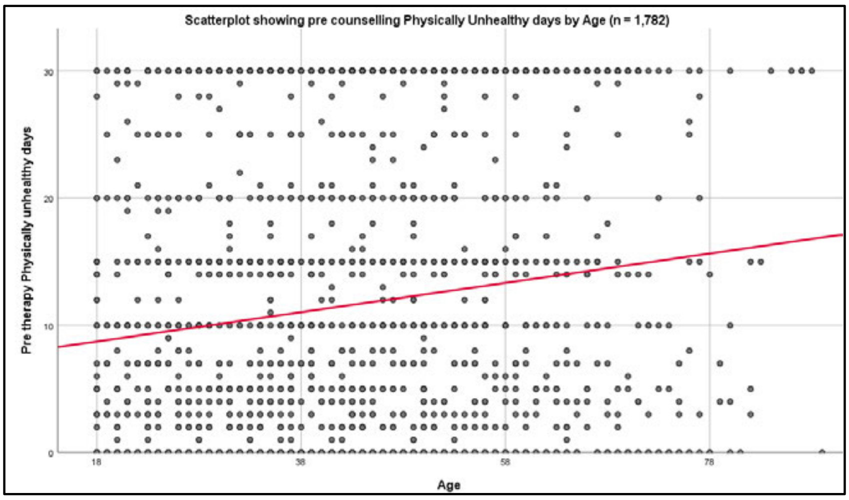
Appendix 11 HRQOL change in number of days participants' mental health was not good by age category



Appendix 11A HRQOL change in number of days participants' physical health was not good by age category



Appendix 11B Relationship between number of physically unhealthy days and age



Scatterplot showing relationship between number of Physically Unhealthy days and Age

Appendix 12 Results of long-term outcomes using multiple imputation generated data

Long term outcomes

Assessment of missing data

The data were examined and considered to be Missing Not At Random (MNAR) as outlined in Rubin (1976), as the progression of increasing "missingness" of the data were associated with each subsequent time point: 1.4% (*n* = 41) at pre counselling, 17.5% (*n* = 513) at post counselling, 74.1% (*n* = 2,170) at six month follow up and 80.6% (*n* = 2,360) and 12 months after counselling, i.e. for the majority of participants their drop out was time-related. As suggested in Knapstad et al. (2018) the bias introduced when estimating model parameters for MNAR datasets can be partly reduced by including other variables with missing data which correlate strongly with those being used in an MI model. In the current study, observed CORE OM scores at post counselling were relatively strongly correlated to WSAS scores at post and pre counselling, as were HRQOL scores.

CORE OM - Long term outcomes using Multiple Imputation generated data.

The imputation model used a linear regression for all variables over 10 iterations. Pre counselling data and pooled data results of the MI process are contained in the table below. The results of a repeated measure ANOVA using only those participants for whom data were available for all four data points are reported and graph produced as a visual aid.

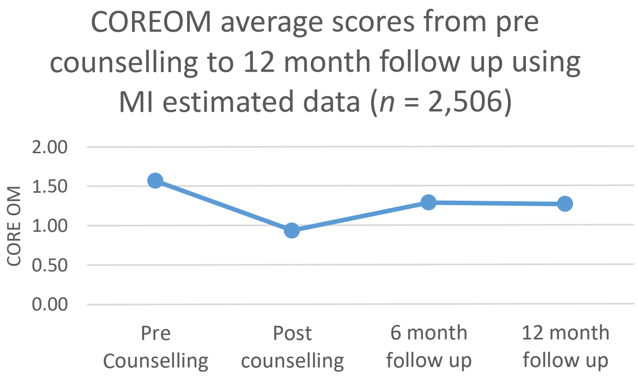


Figure 1 Line graph showing CORE OM pre, post, six and 12 month outcomes using multiple imputation estimated data

CORE OM scores in the model using imputed scores for missing data reduced by an average of .63 between pre and post counselling from 1.57 to 0.94 on the scale, then increased by an average of .35 between post counselling and six months later and (0.84 to 1.29) and finally decreased very slightly again between six months 12 months after counselling by an average of .02 (1.27 to 1.29)

Appendix 12 Results of long-term outcomes using multiple imputation generated data

WSAS - Long term outcomes using Multiple Imputation generated data.

Outcomes for participants in the dataset using MI to calculate values for missing WSAS data strongly reflected those in the dataset for which observed data points were available. Participants showed a significant average decrease in the severity of impairment in these areas from pre to post counselling – with a drop in scores from 17.2 to 10.8. This was followed by an increase between post counselling and 6 months later to 14.1 and a decrease to 13.5 12 months after counselling had ended.

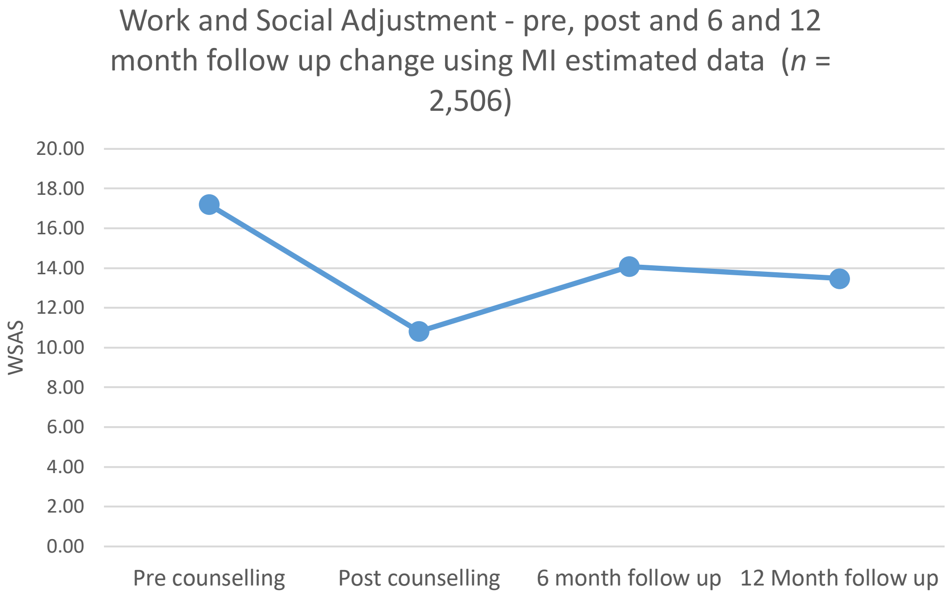


Figure 2 Line graph showing work and social adjustment at pre, post six and 12 months using multiple imputation estimated data

HRQOL outcomes using MI estimated data.

Using the MI process described earlier, data points were estimated for 270 participants for all four time points: pre and post counselling and six and 12 months after counselling ended. These data mirror the results produced by analyses using the observable data.

Appendix 12 Results of long-term outcomes using multiple imputation generated data

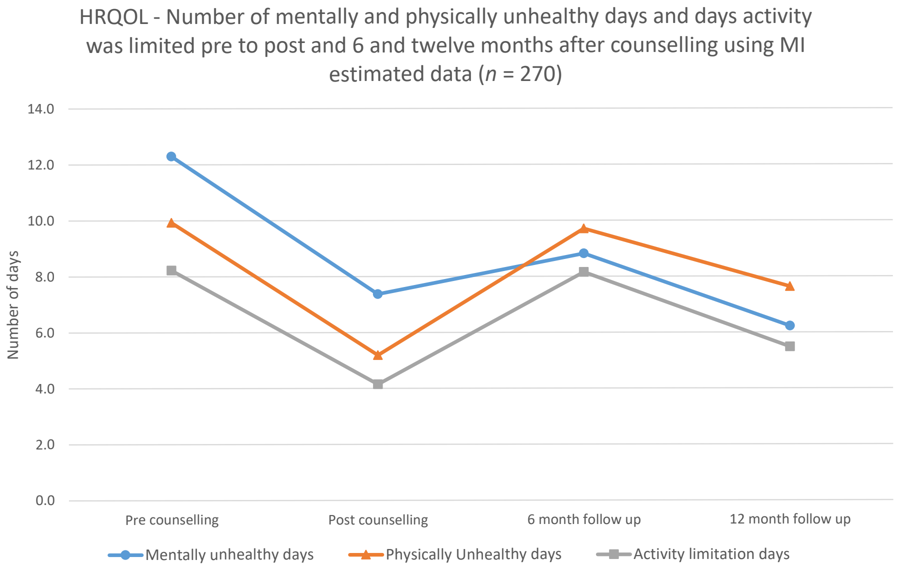


Figure 3 Line graph showing HRQOL mentally and physically unhealthy and activity limitation at pre, post six and 12 months using multiple imputation data

Six and 12 month reliable change calculations

To calculate if participants achieved RCSI at six and 12 month time-points, certain changes to the reliable change criterion used to calculate the Reliable Change Index (RCI) were required. Separate RCIs were calculated for six and 12 month time-points which were then used to produce reliable improvement and deterioration proportions for eligible participants. Using the aforementioned reliability coefficient of .88, a pre counselling standard deviation of .61 (six months) and .63 (12 months) produced RCIs of .59 and .60 for use in six month and 12 month reliable change calculations respectively. This meant that any change on the CORE OM scale between pre counselling six month follow up greater than .59 could be considered reliable.

Also, clinically significant change was not included in follow up results because the sensitivity of this measure as an indicator of change depends on the difference of each participants' level on some measure between the beginning and end of a therapy cycle. It is extensively documented that change for the vast majority of clients of counselling and psychotherapy services will generally occur between the beginning and end of therapy with the possibility of some further change, to a much lesser extent happening after the attending phase. Hence, from both a theoretical perspective and taking previous literature into account, the expectation of any significant proportion of clients who began their therapy above the clinical cut off dropping below cut off at follow up, having not already done so when measured immediately after their therapy ended, is considered very low.

Appendix 13 Prescription data collection instructions for GPs

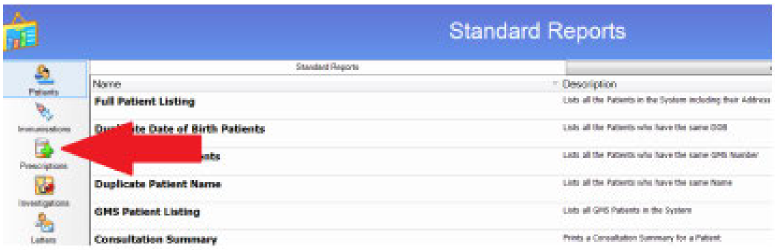
CIPC Medication data collection

GP instructions for **SOCRATES**

Start Date	End Date
XX/XX/XXXX	XX/XX/XXXX

1. Open Socrates patient record and practice management system
2. Select Reports.

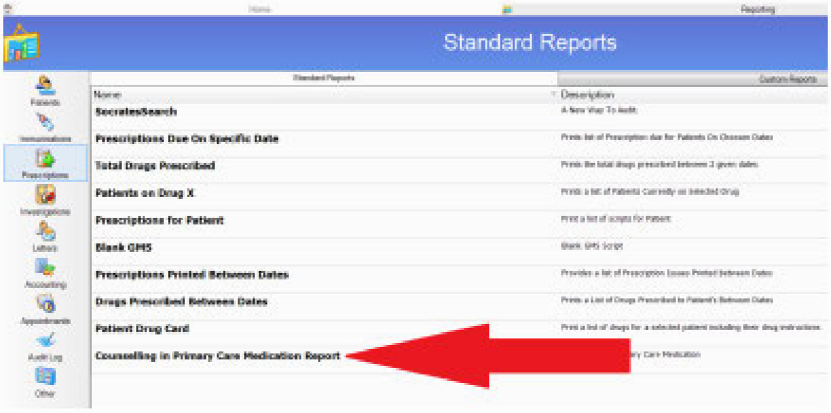
3. Select Prescriptions.



Name	Description
Full Patient Listing	Lists all the Patients in the System including their Addres
Dup te Date of Birth Patients	Lists all the Patients who have the same DOB
nts	Lists all the Patients who have the same GMS Number
Duplicate Patient Name	Lists all the Patients who have the same Name
GMS Patient Listing	Lists all GMS Patients in the System
Consultation Summary	Prints a Consultation Summary for a Patient

4. Select Counselling in Primary Care Medication Report.

Appendix 13 Prescription data collection instructions for GPs



Name	Description
SocratesSearch	A New Way To Audit
Prescriptions Due On Specific Date	Prints list of Prescription due for Patients On Chosen Dates
Total Drugs Prescribed	Prints the total drugs prescribed between 2 given dates
Patients on Drug X	Prints a list of Patients Currently on Selected Drug
Prescriptions for Patient	Print a list of scripts for Patient
Blank GMS	Blank GMS Script
Prescriptions Printed Between Dates	Provides a list of Prescription Issues Printed between Dates
Drugs Prescribed Between Dates	Prints a List of Drugs Prescribed to Patient's Between Dates
Patient Drug Card	Print a list of drugs for a selected patient including their drug instructions
Counselling in Primary Care Medication Report	ry Care Medication

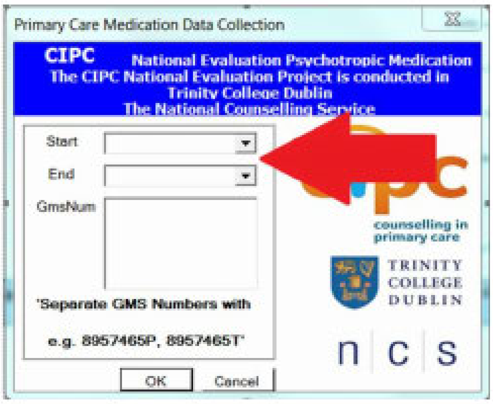
N.B. If the Counselling in Primary Care Medication Report is not showing in this list please complete the steps 4a and 4b. If the report is showing in this list proceed directly to step 5.

4a. Open the Reports section and click the 'Update Available' button in the bottom left corner. Tick the box beside 'Counselling in Primary Care Medical Data Collection' and click 'Install' (see below).

4b. Open the Prescriptions category of reports and double click 'Counselling in Primary Care Medical Data Collection' to run the report.

5. Next Insert the ***Start Date*** and ***End Date*** provided at the beginning of this letter in the boxes (as shown).

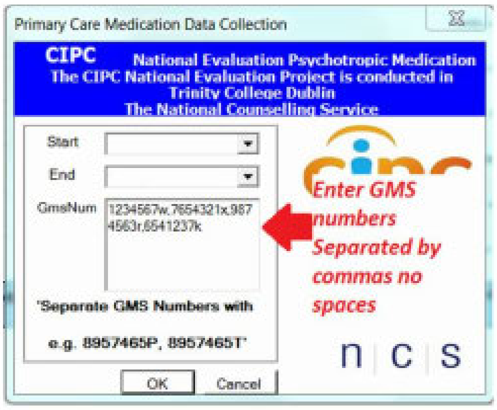
Appendix 13 Prescription data collection instructions for GPs



6. Next, in the box named **GmsNum** enter the GMS numbers listed on the page provided in this pack entitled "**GMS numbers for Entry in Report**". Multiple numbers must be separated by commas and no spaces as shown below.

Enter all GMS numbers separated by commas with no spaces

Separated by commas with no spaces

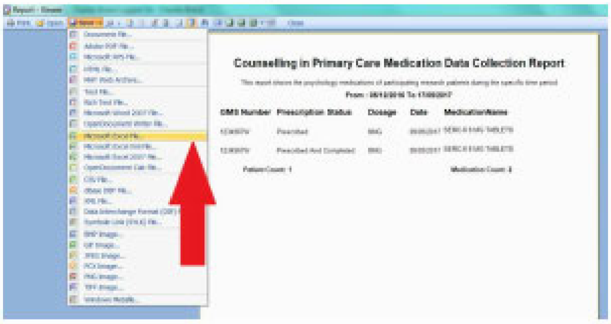


GmsNum: 1234567w,7654321x,9874563r,6541237k

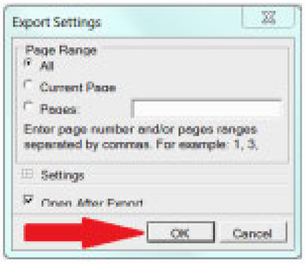
7. Click on **OK**

8. Once the report appears click on **Save** and select **to save as a Microsoft Excel File**

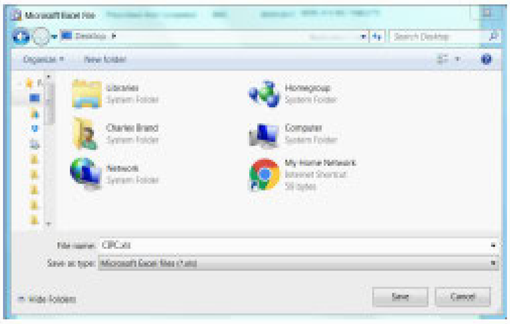
Appendix 13 Prescription data collection instructions for GPs



9. Click on **OK** on the **Export Settings** screen



10. Name the report CIPC



File name: CIPC.xls

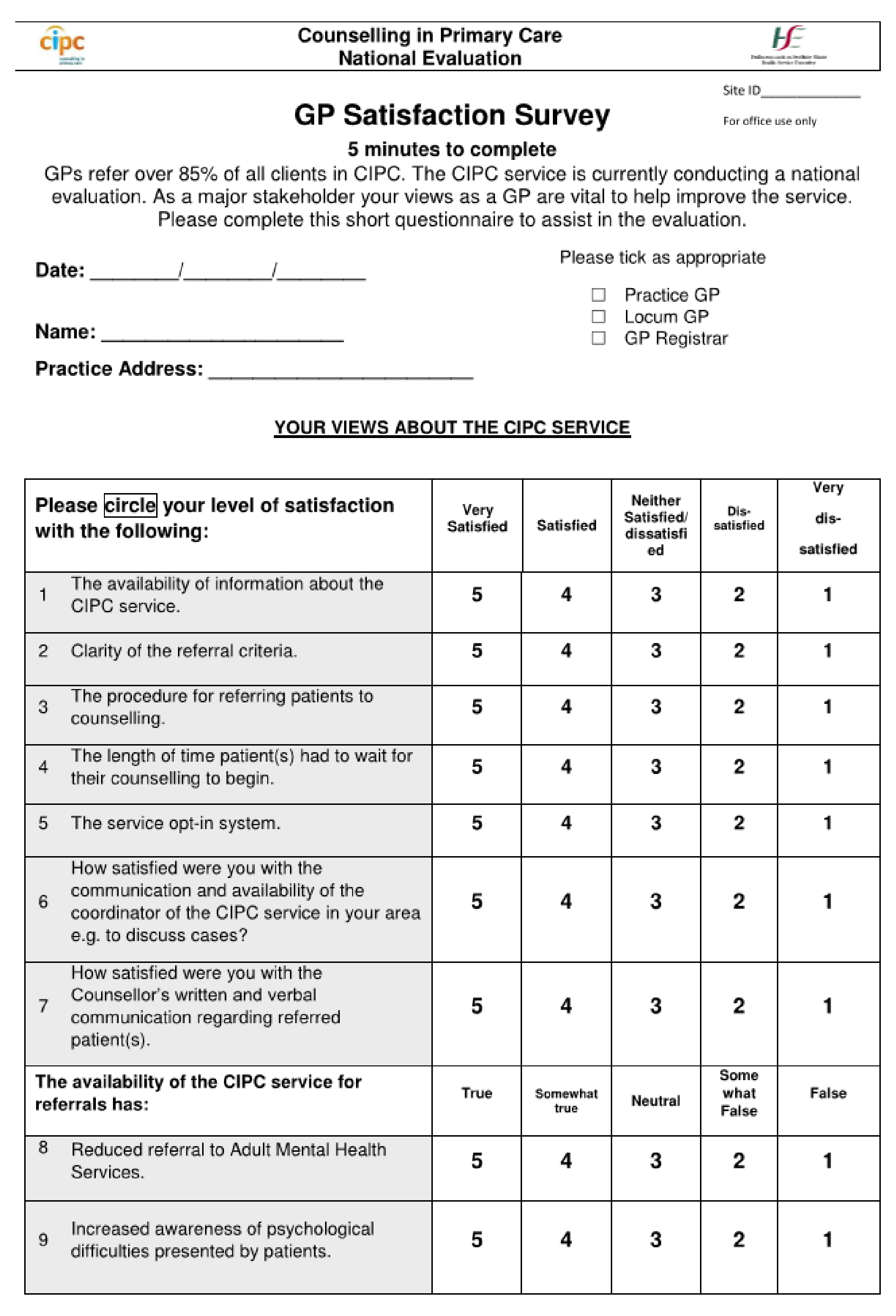
Save as type: Microsoft Excel files (*.xls)

11. Email the report to the CIPC Coordinator at the address provided in the accompanying letter via Healthmail or HSE email address only.

Thank you for taking the time to submit this data to the CIPC National Evaluation.

If you experience any difficulties running this report please contact XXXXXXXXXX - 087XXXXXXX

Appendix 14 GP satisfaction survey



Counselling in Primary Care
National Evaluation

Site ID_______________

For office use only

GP Satisfaction Survey

5 minutes to complete

GPs refer over 85% of all clients in CIPC. The CIPC service is currently conducting a national evaluation. As a major stakeholder your views as a GP are vital to help improve the service. Please complete this short questionnaire to assist in the evaluation.

Date: _________/_________/_________

Name: ________________________

Practice Address: __________________________

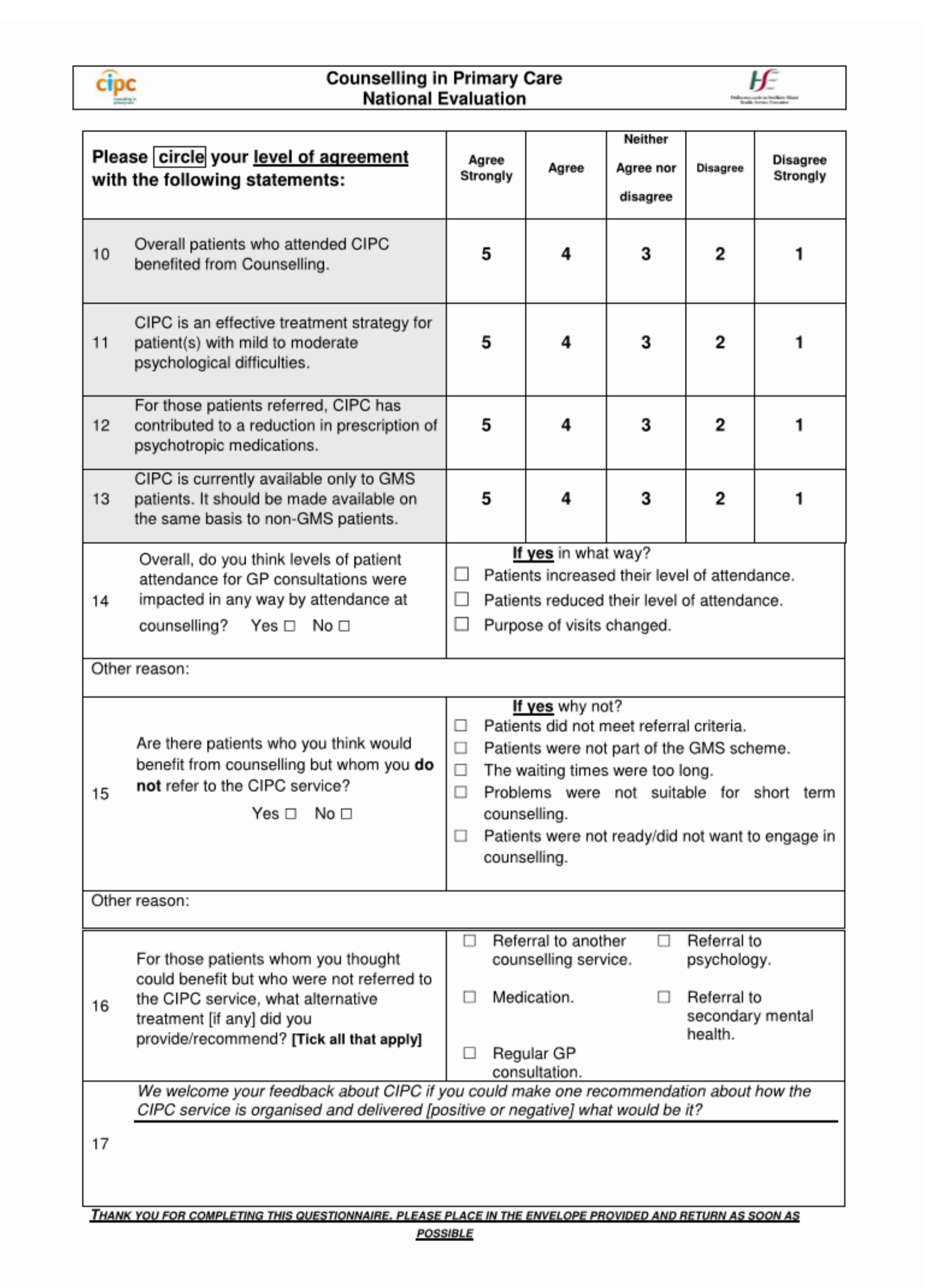
Please tick as appropriate

☐ Practice GP
☐ Locum GP
☐ GP Registrar

YOUR VIEWS ABOUT THE CIPC SERVICE

	Please circle your level of satisfaction with the following:	**Very Satisfied**	**Satisfied**	**Neither Satisfied/ dissatisfied**	**Dis-satisfied**	**Very dis-satisfied**
1	The availability of information about the CIPC service.	**5**	**4**	**3**	**2**	**1**
2	Clarity of the referral criteria.	**5**	**4**	**3**	**2**	**1**
3	The procedure for referring patients to counselling.	**5**	**4**	**3**	**2**	**1**
4	The length of time patient(s) had to wait for their counselling to begin.	**5**	**4**	**3**	**2**	**1**
5	The service opt-in system.	**5**	**4**	**3**	**2**	**1**
6	How satisfied were you with the communication and availability of the coordinator of the CIPC service in your area e.g. to discuss cases?	**5**	**4**	**3**	**2**	**1**
7	How satisfied were you with the Counsellor's written and verbal communication regarding referred patient(s).	**5**	**4**	**3**	**2**	**1**
	The availability of the CIPC service for referrals has:	**True**	**Somewhat true**	**Neutral**	**Some what False**	**False**
8	Reduced referral to Adult Mental Health Services.	**5**	**4**	**3**	**2**	**1**
9	Increased awareness of psychological difficulties presented by patients.	**5**	**4**	**3**	**2**	**1**

Appendix 14 GP satisfaction survey



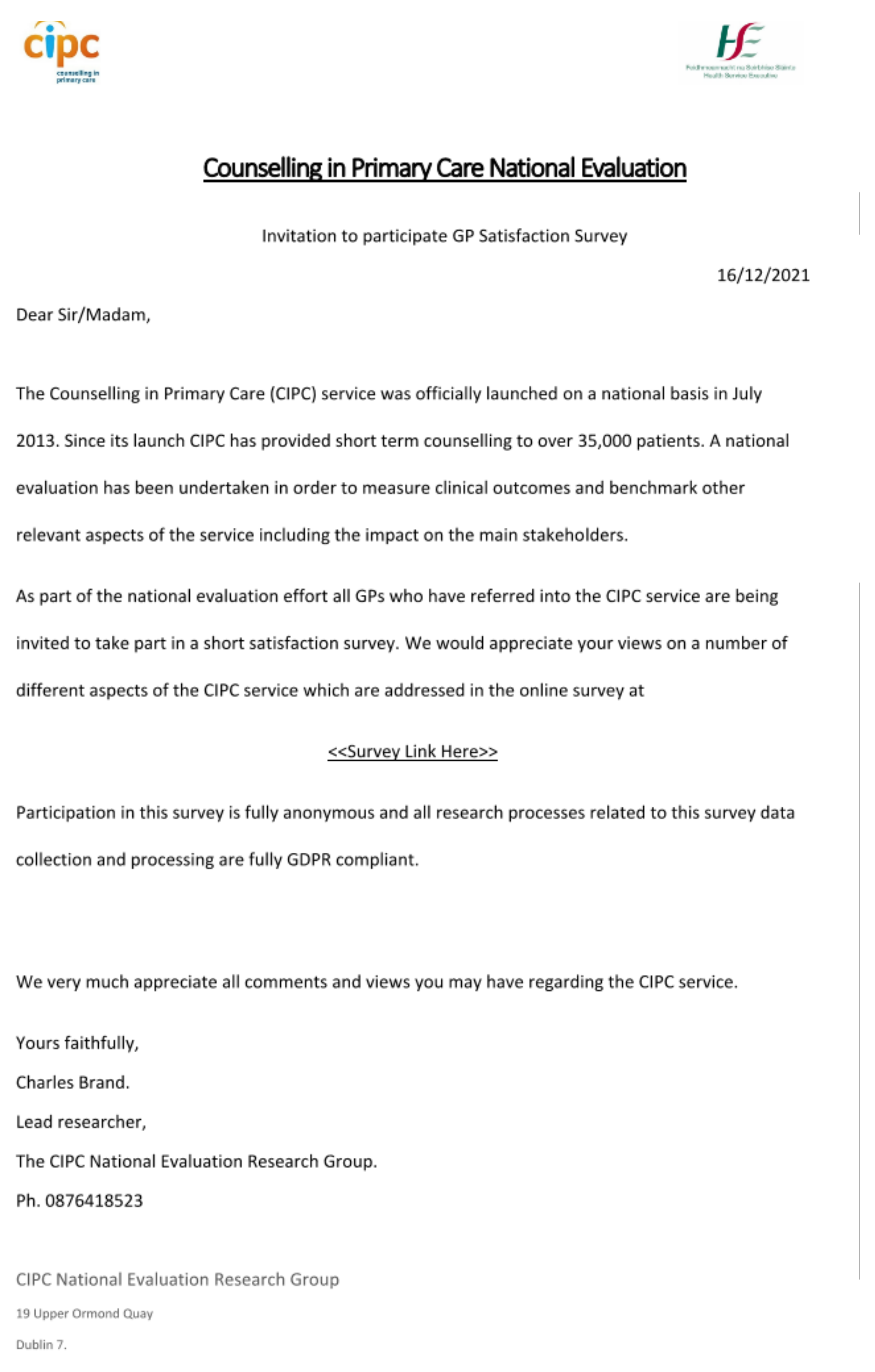
Counselling in Primary Care
National Evaluation

Please circle your level of agreement with the following statements:	**Agree Strongly**	**Agree**	**Neither Agree nor disagree**	**Disagree**	**Disagree Strongly**
10 Overall patients who attended CIPC benefited from Counselling.	**5**	**4**	**3**	**2**	**1**
11 CIPC is an effective treatment strategy for patient(s) with mild to moderate psychological difficulties.	**5**	**4**	**3**	**2**	**1**
12 For those patients referred, CIPC has contributed to a reduction in prescription of psychotropic medications.	**5**	**4**	**3**	**2**	**1**
13 CIPC is currently available only to GMS patients. It should be made available on the same basis to non-GMS patients.	**5**	**4**	**3**	**2**	**1**

14 Overall, do you think levels of patient attendance for GP consultations were impacted in any way by attendance at counselling? Yes ☐ No ☐	**If yes** in what way? ☐ Patients increased their level of attendance. ☐ Patients reduced their level of attendance. ☐ Purpose of visits changed.
Other reason:	
15 Are there patients who you think would benefit from counselling but whom you **do not** refer to the CIPC service? Yes ☐ No ☐	**If yes** why not? ☐ Patients did not meet referral criteria. ☐ Patients were not part of the GMS scheme. ☐ The waiting times were too long. ☐ Problems were not suitable for short term counselling. ☐ Patients were not ready/did not want to engage in counselling.
Other reason:	
16 For those patients whom you thought could benefit but who were not referred to the CIPC service, what alternative treatment [if any] did you provide/recommend? **[Tick all that apply]**	☐ Referral to another counselling service. ☐ Referral to psychology. ☐ Medication. ☐ Referral to secondary mental health. ☐ Regular GP consultation.
17 *We welcome your feedback about CIPC if you could make one recommendation about how the CIPC service is organised and delivered [positive or negative] what would be it?*	

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE. PLEASE PLACE IN THE ENVELOPE PROVIDED AND RETURN AS SOON AS POSSIBLE

Appendix 15 Invitation letter to GPs - Participation in satisfaction survey



Counselling in Primary Care National Evaluation

Invitation to participate GP Satisfaction Survey

16/12/2021

Dear Sir/Madam,

The Counselling in Primary Care (CIPC) service was officially launched on a national basis in July 2013. Since its launch CIPC has provided short term counselling to over 35,000 patients. A national evaluation has been undertaken in order to measure clinical outcomes and benchmark other relevant aspects of the service including the impact on the main stakeholders.

As part of the national evaluation effort all GPs who have referred into the CIPC service are being invited to take part in a short satisfaction survey. We would appreciate your views on a number of different aspects of the CIPC service which are addressed in the online survey at

<<Survey Link Here>>

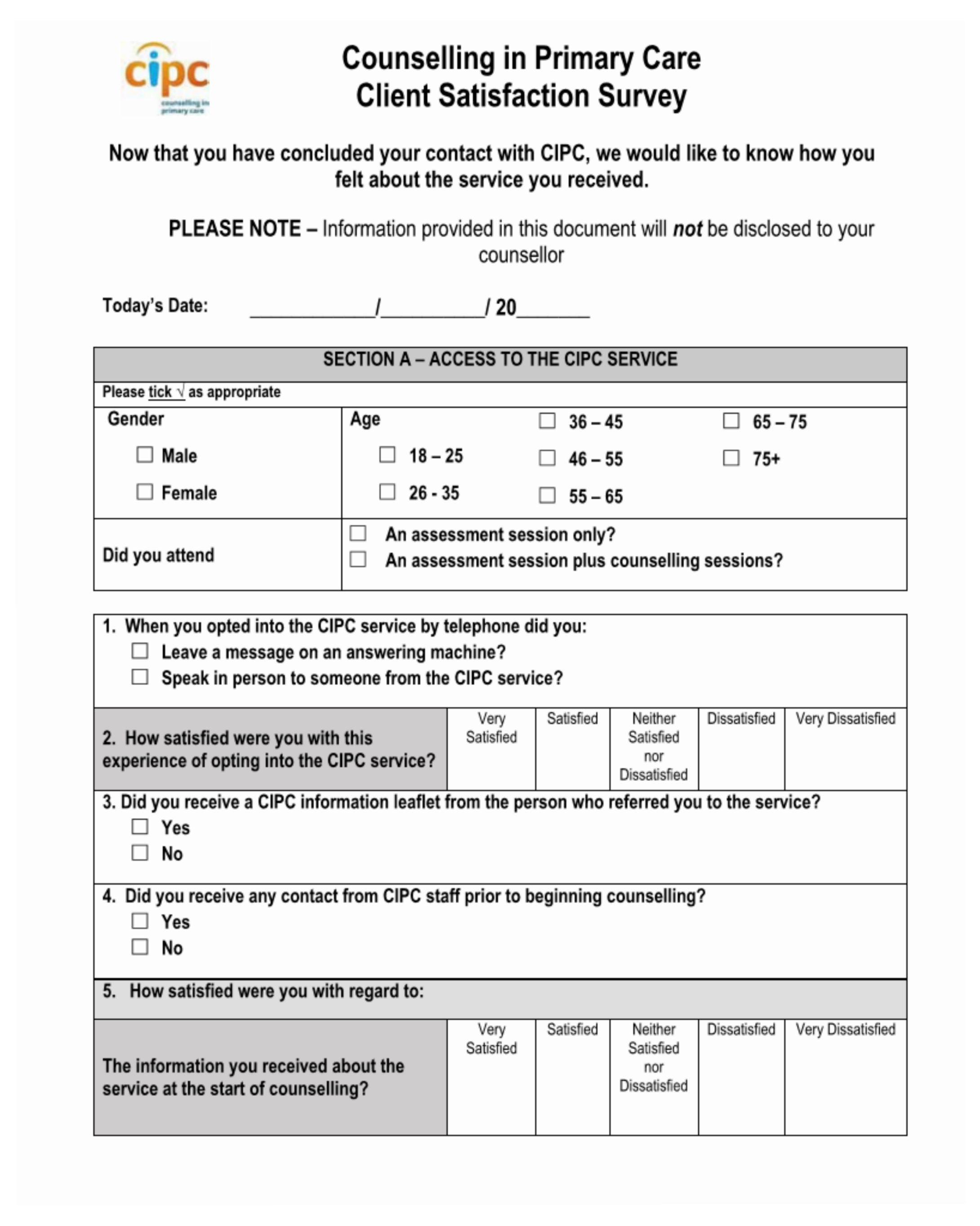
Participation in this survey is fully anonymous and all research processes related to this survey data collection and processing are fully GDPR compliant.

We very much appreciate all comments and views you may have regarding the CIPC service.

Yours faithfully,
Charles Brand.
Lead researcher,
The CIPC National Evaluation Research Group.
Ph. 0876418523

CIPC National Evaluation Research Group
19 Upper Ormond Quay
Dublin 7.

Appendix 16 Client satisfaction survey



Counselling in Primary Care
Client Satisfaction Survey

Now that you have concluded your contact with CIPC, we would like to know how you felt about the service you received.

PLEASE NOTE – Information provided in this document will ***not*** be disclosed to your counsellor

Today's Date: ____________/__________/ 20_______

SECTION A – ACCESS TO THE CIPC SERVICE			
Please tick √ as appropriate			
Gender ☐ **Male** ☐ **Female**	**Age** ☐ **18 – 25** ☐ **26 - 35**	☐ **36 – 45** ☐ **46 – 55** ☐ **55 – 65**	☐ **65 – 75** ☐ **75+**
Did you attend	☐ **An assessment session only?** ☐ **An assessment session plus counselling sessions?**		

1. When you opted into the CIPC service by telephone did you:
- ☐ **Leave a message on an answering machine?**
- ☐ **Speak in person to someone from the CIPC service?**

	Very Satisfied	Satisfied	Neither Satisfied nor Dissatisfied	Dissatisfied	Very Dissatisfied
2. How satisfied were you with this experience of opting into the CIPC service?					

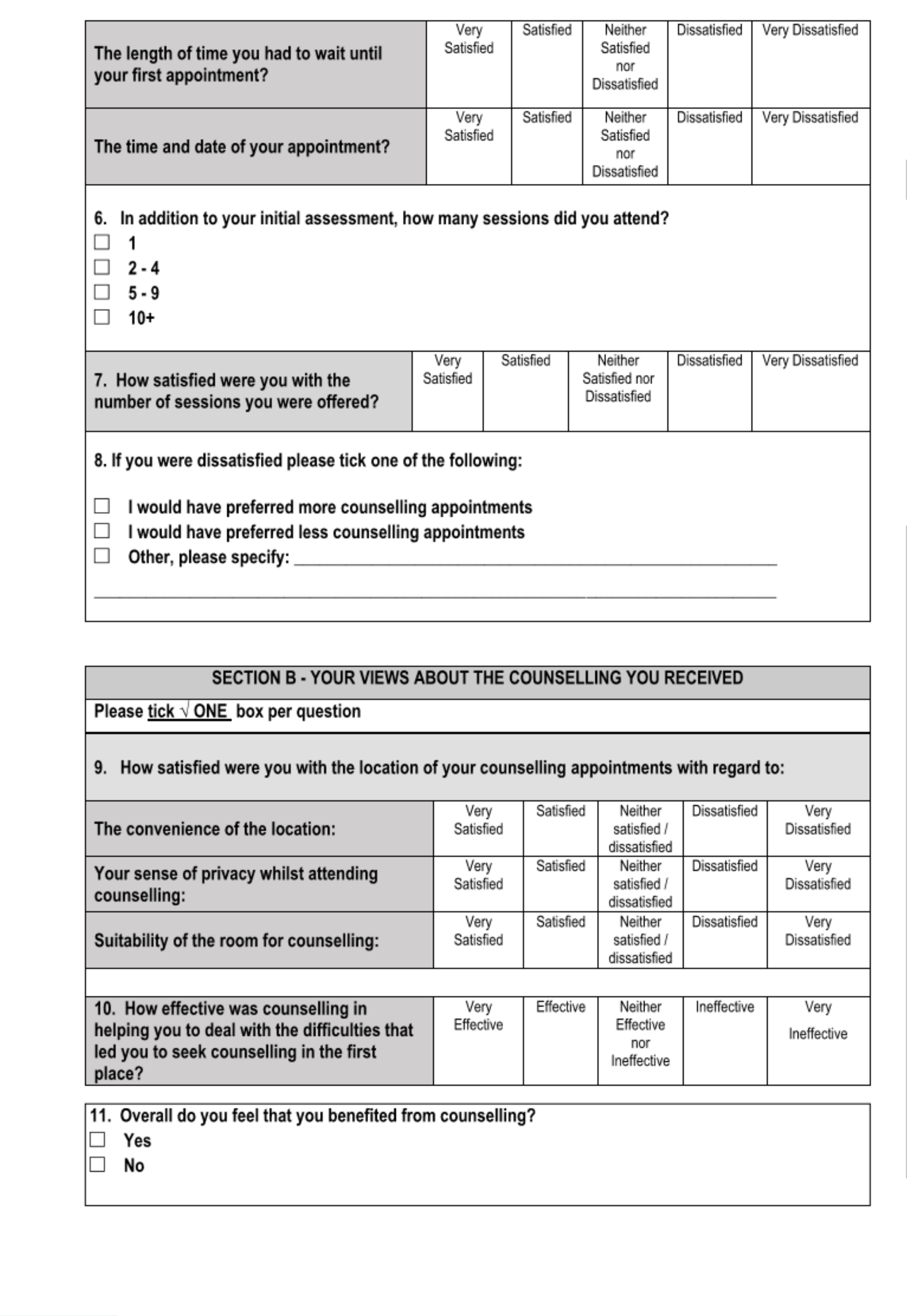
3. Did you receive a CIPC information leaflet from the person who referred you to the service?
- ☐ **Yes**
- ☐ **No**

4. Did you receive any contact from CIPC staff prior to beginning counselling?
- ☐ **Yes**
- ☐ **No**

5. How satisfied were you with regard to:

	Very Satisfied	Satisfied	Neither Satisfied nor Dissatisfied	Dissatisfied	Very Dissatisfied
The information you received about the service at the start of counselling?					

Appendix 16 Client satisfaction survey



The length of time you had to wait until your first appointment?	Very Satisfied	Satisfied	Neither Satisfied nor Dissatisfied	Dissatisfied	Very Dissatisfied
The time and date of your appointment?	Very Satisfied	Satisfied	Neither Satisfied nor Dissatisfied	Dissatisfied	Very Dissatisfied

6. In addition to your initial assessment, how many sessions did you attend?

☐ **1**
☐ **2 - 4**
☐ **5 - 9**
☐ **10+**

7. How satisfied were you with the number of sessions you were offered?	Very Satisfied	Satisfied	Neither Satisfied nor Dissatisfied	Dissatisfied	Very Dissatisfied

8. If you were dissatisfied please tick one of the following:

☐ **I would have preferred more counselling appointments**
☐ **I would have preferred less counselling appointments**
☐ **Other, please specify:** ____

____

SECTION B - YOUR VIEWS ABOUT THE COUNSELLING YOU RECEIVED

Please tick √ ONE box per question

9. How satisfied were you with the location of your counselling appointments with regard to:

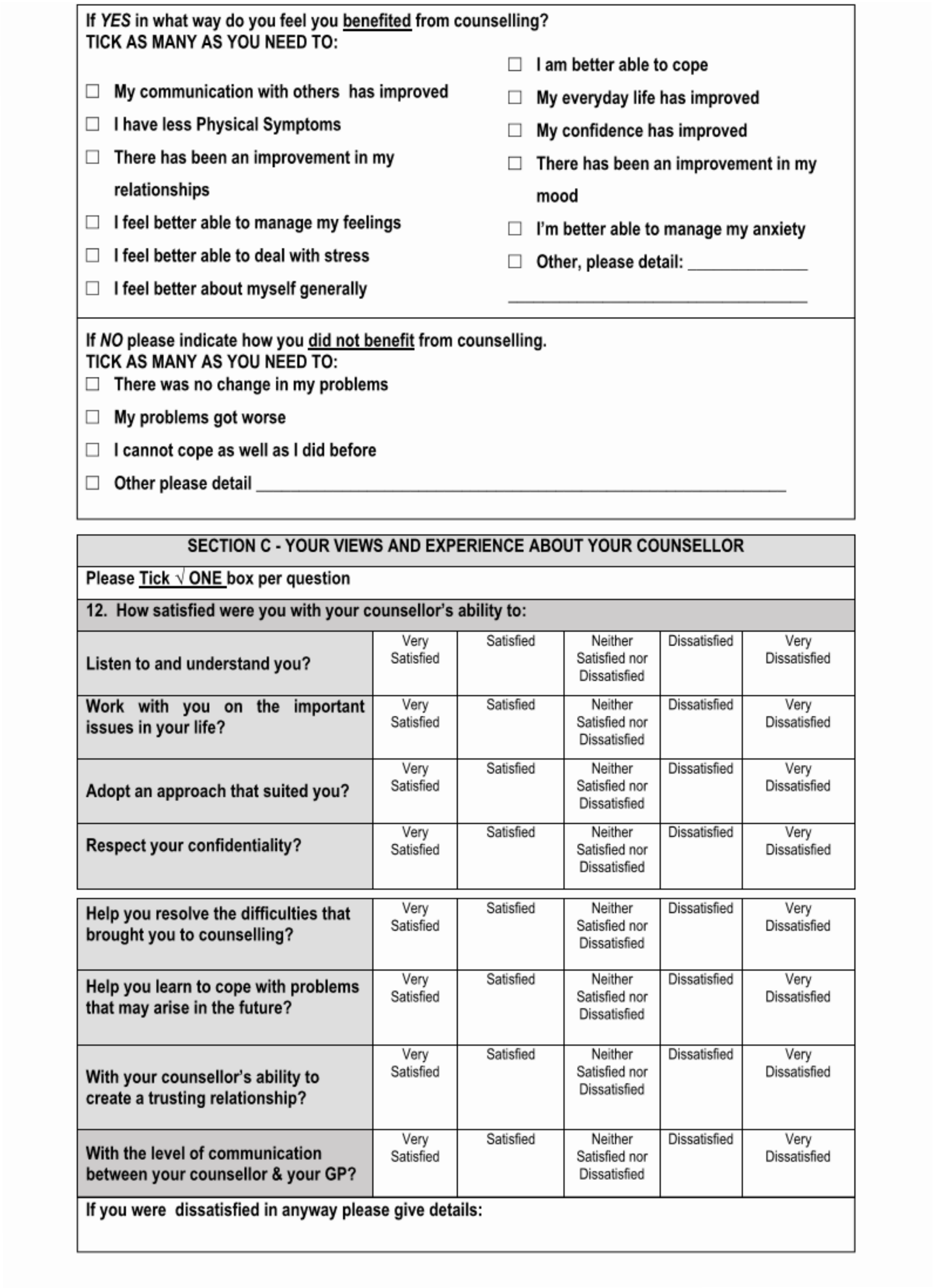
The convenience of the location:	Very Satisfied	Satisfied	Neither satisfied / dissatisfied	Dissatisfied	Very Dissatisfied
Your sense of privacy whilst attending counselling:	Very Satisfied	Satisfied	Neither satisfied / dissatisfied	Dissatisfied	Very Dissatisfied
Suitability of the room for counselling:	Very Satisfied	Satisfied	Neither satisfied / dissatisfied	Dissatisfied	Very Dissatisfied

10. How effective was counselling in helping you to deal with the difficulties that led you to seek counselling in the first place?	Very Effective	Effective	Neither Effective nor Ineffective	Ineffective	Very Ineffective

11. Overall do you feel that you benefited from counselling?

☐ **Yes**
☐ **No**

Appendix 16 Client satisfaction survey



If *YES* in what way do you feel you benefited from counselling?
TICK AS MANY AS YOU NEED TO:

☐ My communication with others has improved
☐ I have less Physical Symptoms
☐ There has been an improvement in my relationships
☐ I feel better able to manage my feelings
☐ I feel better able to deal with stress
☐ I feel better about myself generally
☐ I am better able to cope
☐ My everyday life has improved
☐ My confidence has improved
☐ There has been an improvement in my mood
☐ I'm better able to manage my anxiety
☐ Other, please detail: ______________
____

If *NO* please indicate how you did not benefit from counselling.
TICK AS MANY AS YOU NEED TO:

☐ There was no change in my problems
☐ My problems got worse
☐ I cannot cope as well as I did before
☐ Other please detail ____

SECTION C - YOUR VIEWS AND EXPERIENCE ABOUT YOUR COUNSELLOR

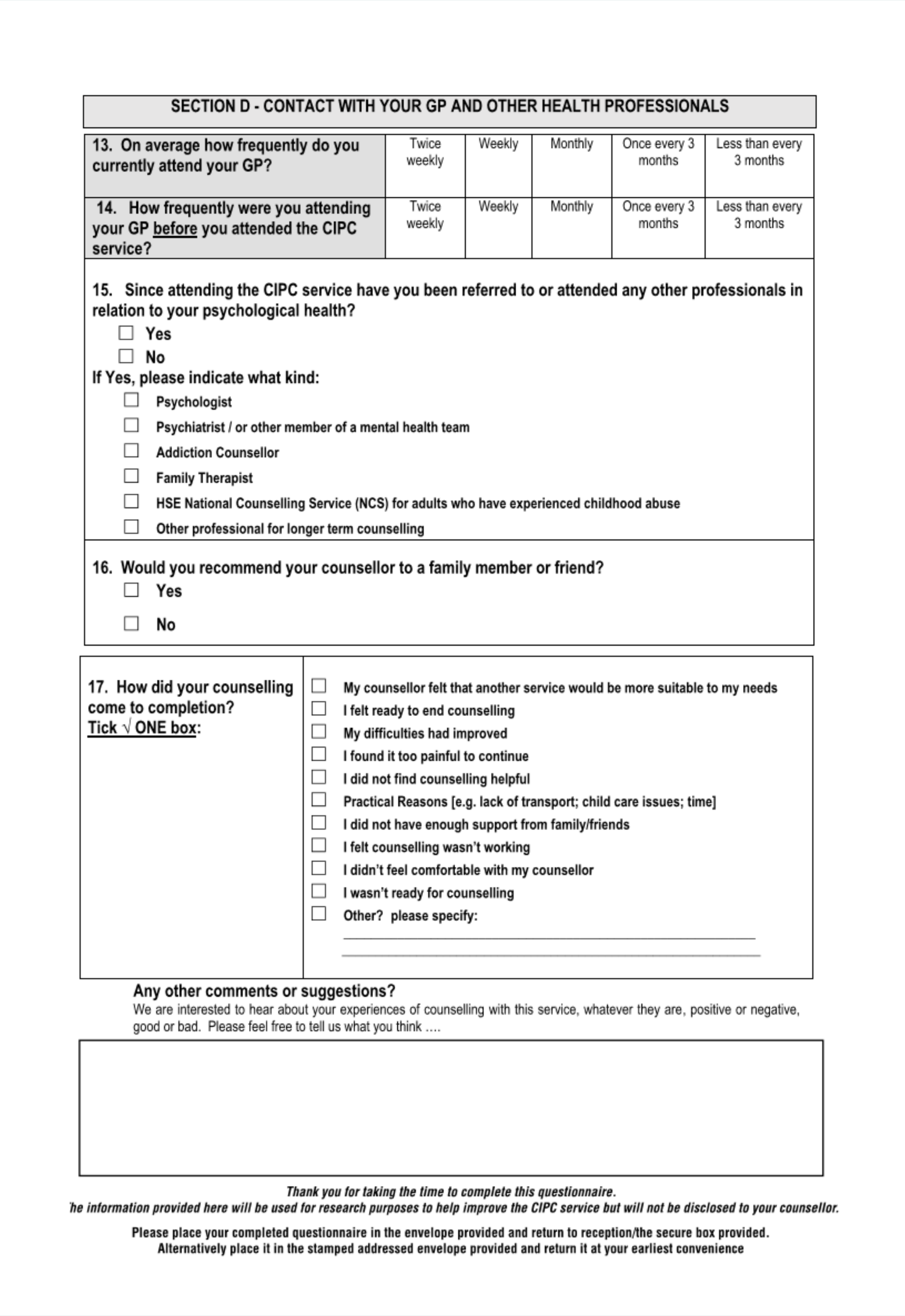
Please Tick √ ONE box per question

12. How satisfied were you with your counsellor's ability to:

Listen to and understand you?	Very Satisfied	Satisfied	Neither Satisfied nor Dissatisfied	Dissatisfied	Very Dissatisfied
Work with you on the important issues in your life?	Very Satisfied	Satisfied	Neither Satisfied nor Dissatisfied	Dissatisfied	Very Dissatisfied
Adopt an approach that suited you?	Very Satisfied	Satisfied	Neither Satisfied nor Dissatisfied	Dissatisfied	Very Dissatisfied
Respect your confidentiality?	Very Satisfied	Satisfied	Neither Satisfied nor Dissatisfied	Dissatisfied	Very Dissatisfied
Help you resolve the difficulties that brought you to counselling?	Very Satisfied	Satisfied	Neither Satisfied nor Dissatisfied	Dissatisfied	Very Dissatisfied
Help you learn to cope with problems that may arise in the future?	Very Satisfied	Satisfied	Neither Satisfied nor Dissatisfied	Dissatisfied	Very Dissatisfied
With your counsellor's ability to create a trusting relationship?	Very Satisfied	Satisfied	Neither Satisfied nor Dissatisfied	Dissatisfied	Very Dissatisfied
With the level of communication between your counsellor & your GP?	Very Satisfied	Satisfied	Neither Satisfied nor Dissatisfied	Dissatisfied	Very Dissatisfied

If you were dissatisfied in anyway please give details:

Appendix 16 Client satisfaction survey



SECTION D - CONTACT WITH YOUR GP AND OTHER HEALTH PROFESSIONALS					
13. On average how frequently do you currently attend your GP?	Twice weekly	Weekly	Monthly	Once every 3 months	Less than every 3 months
14. How frequently were you attending your GP before you attended the CIPC service?	Twice weekly	Weekly	Monthly	Once every 3 months	Less than every 3 months

15. Since attending the CIPC service have you been referred to or attended any other professionals in relation to your psychological health?

☐ **Yes**
☐ **No**

If Yes, please indicate what kind:

☐ **Psychologist**
☐ **Psychiatrist / or other member of a mental health team**
☐ **Addiction Counsellor**
☐ **Family Therapist**
☐ **HSE National Counselling Service (NCS) for adults who have experienced childhood abuse**
☐ **Other professional for longer term counselling**

16. Would you recommend your counsellor to a family member or friend?

☐ **Yes**

☐ **No**

17. How did your counselling come to completion? **Tick √ ONE box:**	☐ **My counsellor felt that another service would be more suitable to my needs** ☐ **I felt ready to end counselling** ☐ **My difficulties had improved** ☐ **I found it too painful to continue** ☐ **I did not find counselling helpful** ☐ **Practical Reasons [e.g. lack of transport; child care issues; time]** ☐ **I did not have enough support from family/friends** ☐ **I felt counselling wasn't working** ☐ **I didn't feel comfortable with my counsellor** ☐ **I wasn't ready for counselling** ☐ **Other? please specify:** ______________________________________ ______________________________________

Any other comments or suggestions?

We are interested to hear about your experiences of counselling with this service, whatever they are, positive or negative, good or bad. Please feel free to tell us what you think ….

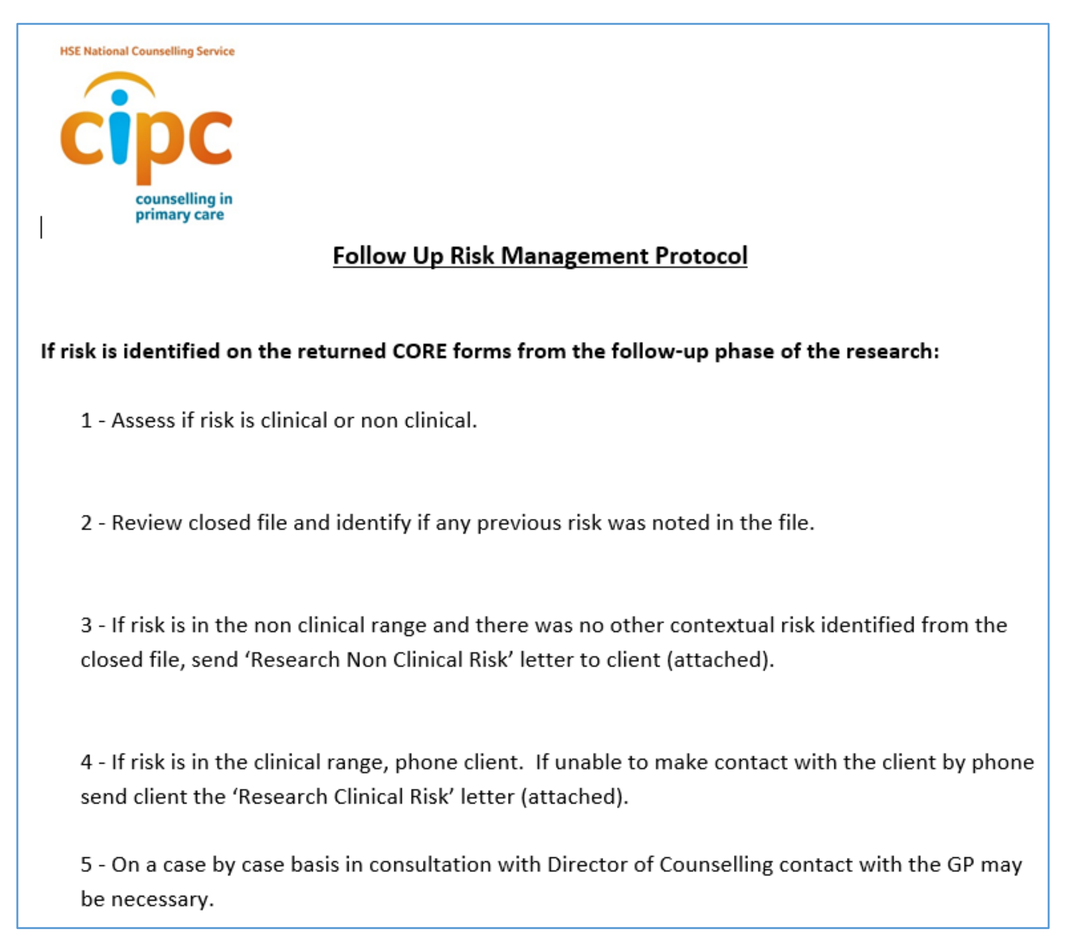
Thank you for taking the time to complete this questionnaire.

he information provided here will be used for research purposes to help improve the CIPC service but will not be disclosed to your counsellor.

Please place your completed questionnaire in the envelope provided and return to reception/the secure box provided.
Alternatively place it in the stamped addressed envelope provided and return it at your earliest convenience

Appendix 17 Follow-up risk management protocol and letters for clients

Appendix 17A Follow-up risk management protocol



HSE National Counselling Service

cipc counselling in primary care

Follow Up Risk Management Protocol

If risk is identified on the returned CORE forms from the follow-up phase of the research:

1 - Assess if risk is clinical or non clinical.

2 - Review closed file and identify if any previous risk was noted in the file.

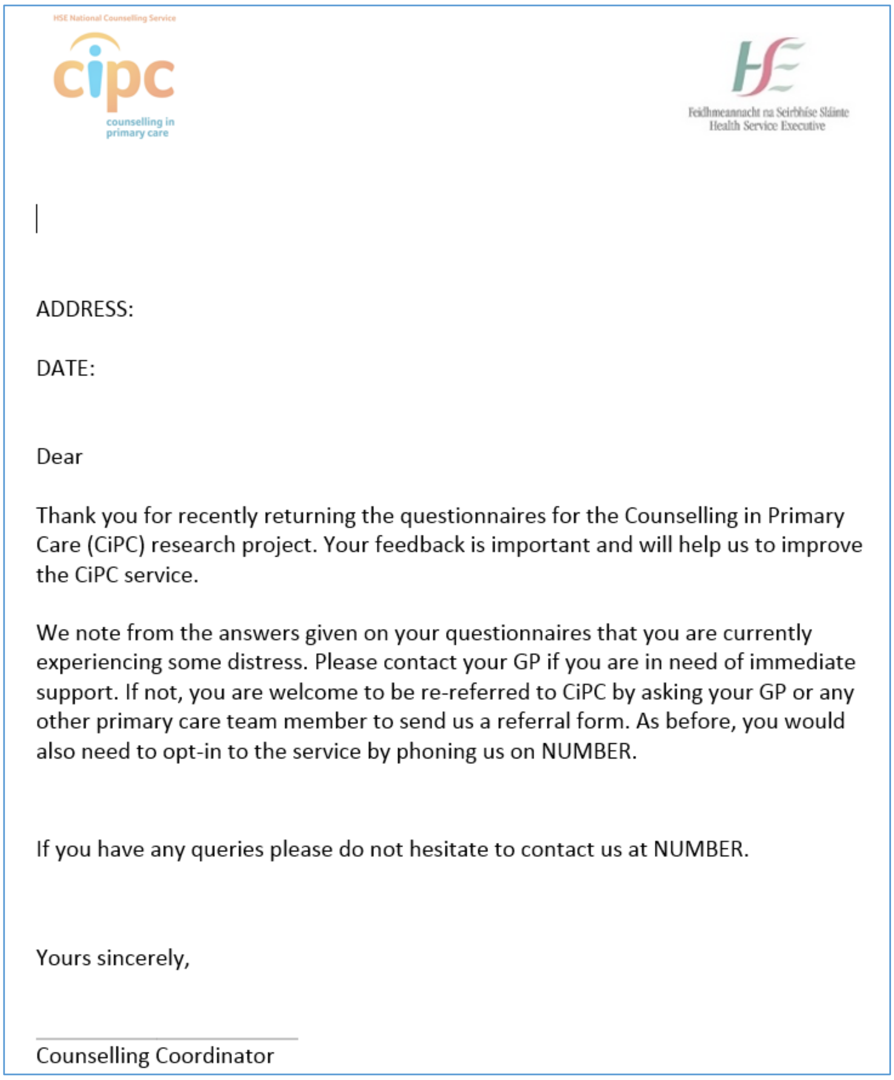
3 - If risk is in the non clinical range and there was no other contextual risk identified from the closed file, send 'Research Non Clinical Risk' letter to client (attached).

4 - If risk is in the clinical range, phone client. If unable to make contact with the client by phone send client the 'Research Clinical Risk' letter (attached).

5 - On a case by case basis in consultation with Director of Counselling contact with the GP may be necessary.

Appendix 17 Follow-up risk management protocol and letters for clients

Appendix 17B Clinical risk - letter to client



HSE National Counselling Service
cipc
counselling in primary care

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

ADDRESS:

DATE:

Dear

Thank you for recently returning the questionnaires for the Counselling in Primary Care (CiPC) research project. Your feedback is important and will help us to improve the CiPC service.

We note from the answers given on your questionnaires that you are currently experiencing some distress. Please contact your GP if you are in need of immediate support. If not, you are welcome to be re-referred to CiPC by asking your GP or any other primary care team member to send us a referral form. As before, you would also need to opt-in to the service by phoning us on NUMBER.

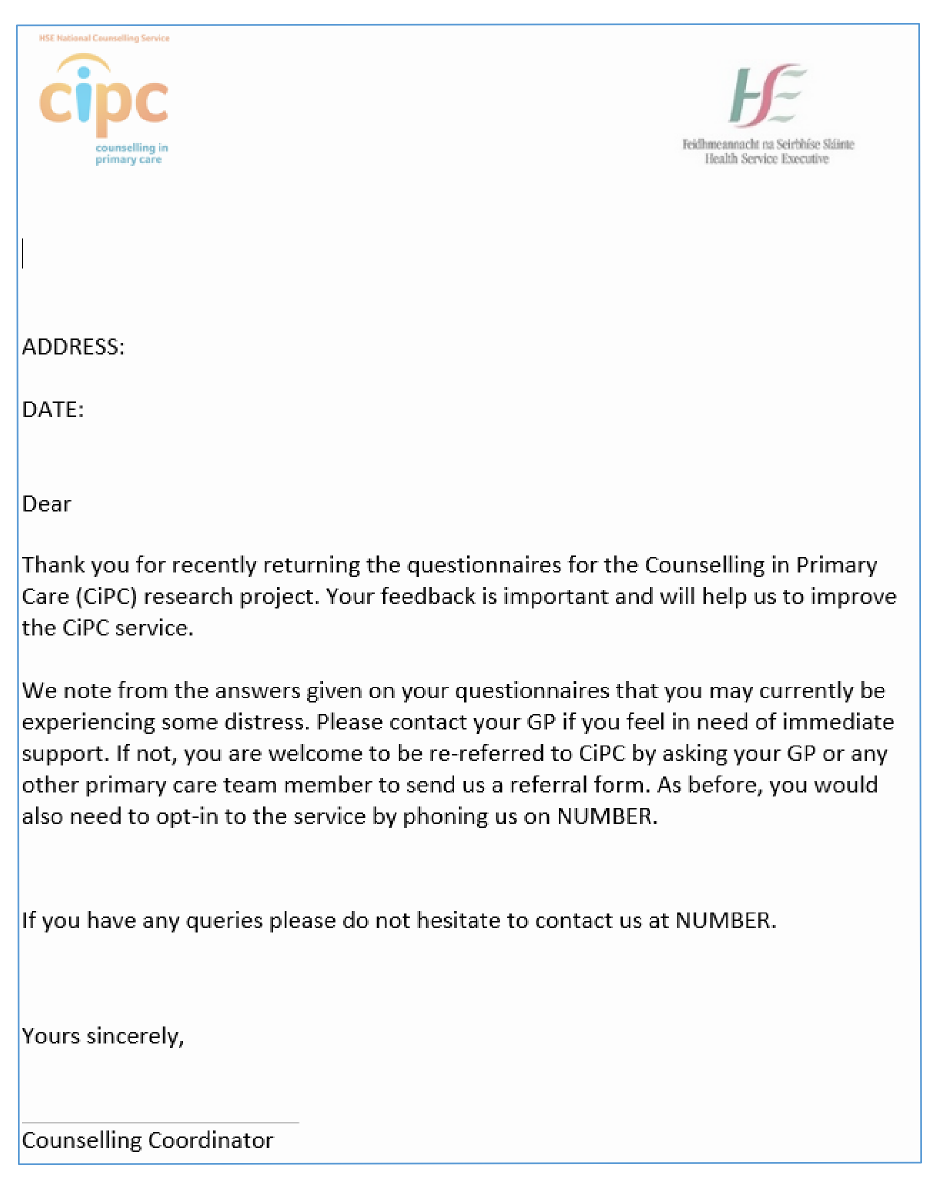
If you have any queries please do not hesitate to contact us at NUMBER.

Yours sincerely,

Counselling Coordinator

Appendix 17 Follow-up risk management protocol and letters for clients

Appendix 17C Research non-clinical letter to client



HSE National Counselling Service
cipc
counselling in primary care

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

ADDRESS:

DATE:

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We note from the answers given on your questionnaires that you may currently be experiencing some distress. Please contact your GP if you feel in need of immediate support. If not, you are welcome to be re-referred to CiPC by asking your GP or any other primary care team member to send us a referral form. As before, you would also need to opt-in to the service by phoning us on NUMBER.

If you have any queries please do not hesitate to contact us at NUMBER.

Yours sincerely,

Counselling Coordinator