CHANGING LIVES FOR THE BETTER:

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

Executive Summary

Acknowledgements

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.

We would like to say a sincere thank you to:

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Most importantly, we wish to thank every CIPC client who participated in the clinical outcome and follow-up study, those who consented to their medication prescription data being accessed and those who provided their personal feedback on their experience of attending CIPC. We are conscious of what a big step it can be for anyone to attend a counselling service, and even more so to participate in research about it. The voices and experiences of you, our clients, are invaluable in helping us to improve the provision of counselling in Ireland. Current and future clients of CIPC will benefit from these contributions, and we thank you most sincerely.

The CIPC National Research Group
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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) schemecard 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

The Counselling in Primary Care (CIPC) service: Origins

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 service (CIPC) as one of its mental health initiatives in the 2012 service plan. The HSE National Counselling Service, in place since 2000, extended its remit when tasked with implementing this Development. CIPC was subsequently launched CIPC in July 2013 with the objective of increasing access to psychological therapies. CIPC is currently 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 is currently limited to patients holding a valid General Medical Services (GMS) card on referral from their GP or primary care practitioner. While CIPC is considered a "welcome development" by GPs and other mental health stakeholders (Houghton, 2014, p. 69; Mental Health Reform, 2017), it has also 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. After its launch in 2013, 5,153 clients were referred to CIPC. Demand for the service grew year on year with more than 20,000 people being referred in 2019. By the end of 2021, almost 150,000 people have been referred to CIPC.

The CIPC National Evaluation Study

The purpose of the CIPC National Evaluation Study 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. Data for the CIPC National Evaluation Study was collected by the HSE National Counselling Service between 2015 and 2020.

This report summarises the aims and objectives of this research and outlines the main research findings. Conclusions from the research as well as key learning outcomes and recommendations for the further development of the service are identified.

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 and to provide feedback from key stakeholders (i.e., clients and GPs) about their experiences of the service.

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

- 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.

Approach to the research

CIPC was established as a service for mild to moderate psychological difficulties but clients with a range of difficulties in terms of complexity, severity and duration are regularly referred to it. A practice-based approach to evaluating the impact of the service was used as it is important to reflect the client population who avail of CIPC counselling.

Practice-based studies focus on routine data collection from clients in usual health settings (Castonguay et al., 2013) and typically include all service users. This allows for a more flexible approach and the inclusion of participants from under-represented groups in the population who are not typically accessible in randomised controlled trial research (Barkham et al., 2010). Additionally, psychological treatments are delivered in usual service locations and are not manualised. Practice-based studies, such as this study conducted by CIPC, are therefore more reflective of counselling in the 'real world'.

Clinical outcomes measures are a standard 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 were 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 to continue to improve service quality for clients.

Impact of COVID-19 on mental health in Ireland: The role of CIPC

COVID-19 has had a major impact on the mental health of the Irish population with more than a quarter 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 reporting 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 these needs.

Sláintecare, the Committee on the Future of Mental Health and Sharing the Vision recognised the importance of ensuring access to psychological therapies for mild to moderate psychological difficulties at primary care level. CIPC is central to this provision. 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. 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." (Mental Health Reform, 2021, p. 12).

During the COVID-19 pandemic the CIPC service expanded its service provision to include telehealth through provision of structured telephone counselling and online video counselling. This meant that throughout the pandemic, CIPC continued to work with clients by maintaining consistent access to counselling.

The integration of telehealth provision into the CIPC service model will help to ensure that CIPC continues to be an accessible service into the future. This is essential given the current and future need for psychological therapies to address the impact of the pandemic.

Summary of main research findings

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, i.e. most were female (75% of all participants) with an average age of 42, indicating that the sample was representative of CIPC clients. A total of 85% of participants were from white or white Irish backgrounds, which is 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 (ES) 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, 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."
(GP survey respondent)

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, 2017), 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 GMS scheme 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 dropout and develop additional supports to optimise client engagement in counselling.

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 significantly, 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 + doc surgeries. All my physical symptoms went when my mind felt better."*

What clients think: Service users' experience of CIPC

To gather a holistic picture of how CIPC counselling impacted service users, a client satisfaction survey was conducted as part of the research study. A total of 1,322 clients responded. Results show clearly that clients who attended had a positive experience. The majority (96%) 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.

"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."

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. Most (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 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. The 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 the services they require (Ward, 2010).

Qualitative feedback provided by clients that CIPC highlighted the need for CIPC to improve its waiting times and its communication with clients while they were 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 for a first appointment. 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 (Department of Health, 2020, p. 95), future resource allocation decisions should take account of CIPC's essential role in implementing these key objectives.

“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 it is worth noting that 88% of counsellors/therapists employed multiple therapy approaches in their work with clients, a concrete indicator of a counsellors/therapist’s capacity to adapt to a client’s presenting needs.

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.

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) although findings are not consistent (Altmann et al., 2018). The quality of the therapeutic alliance (Roos & Werbart, 2013) is also linked to 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 8 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 although 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 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 dropout 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. The longer a client waits, the more severe their psychological difficulties are likely to become. 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.

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 anti-depressants reflect a lack of psychological therapies and a lack of social therapies and resources in society' (Murphy et al., 2018, 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 was a requirement.

A total of 86% of GPs who responded to the CIPC GP survey reported 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" [original emphasis]

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. Just 16% of clients had 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 very clear (Mental Health Reform, 2017; OCFH, 2017; Sharing the Vision, 2020). There is a need now 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 healthcare costs arising from medication usage (Davies & Read, 2019; 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 can have 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 and includes a worsening of client symptoms, the potential for poorer engagement in counselling as well as 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.

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 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, 2012; 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 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-term 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 and 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 are identified at the outset of counselling for additional support to reduce the risk of dropout.
- CORE-10 should be implemented on a session-by-session basis in CIPC to enable feedback to counsellors/therapists regarding counselling progress. This will help to identify clients at risk of dropout 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 dropout and improve clinical outcomes.

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."* 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. A total of 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, over 92% (n = 1218) of whom were satisfied or very satisfied with the process of opting into the CIPC service.

The opt-in system measures 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.

It is recommended that CIPC review its current opt-in procedures and consider standardising these processes with a view to minimising any potential barriers to client access. In addition, consideration should be given to communicating with GPs regarding 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 is whether better communication between GPs, patients and CIPC counsellors 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 demonstrated that 8.9% of client's psychotropic prescriptions ceased in the months following counselling with the CIPC service. This suggests 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 of psychotropic medication use and cessation. Grace et al'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 regarding further mental health interventions including the prescribing of psychotropic medication, i.e., continuation, change in dosage, or cessation. This would help to facilitate more integrated, co-ordinated care planning with the patient.

Conclusion

"I truly believe counselling has changed my life for the better."(CIPC client)

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 of the main report, show that counselling as provided by the CIPC service in Ireland is clinically and cost effective. The 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 it was 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 GP 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 (OCFH, 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" (Department of Health, 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 a 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 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 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 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 is essential to** ensure ease of access to CIPC for 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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