



# Counselling in Primary Care Service

## National Evaluation Study Report of Phase 1

HSE NCS

CIPC National Research Group

April 2018



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# Purpose of this report

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This report describes Phase 1 of the HSE National Evaluation of the Counselling in Primary Care Service (CIPC) which was conducted in the HSE South East region during 2015.

The purpose of this phase of the evaluation was to assess the research approach, methodology, data collection methods and report the clinical outcomes. Key learning outcomes and recommendations have been identified from this phase of the evaluation which will inform the procedures for the rest of the national evaluation.



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# Acknowledgements

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The CIPC national research group would like to thank all those who have contributed to Phase 1 of the CIPC National Evaluation Study. We wish to acknowledge in particular the clients who participated in the research and gave so generously of their time.

A special thanks to the director of counselling, CIPC clinical coordinator, administration staff and all of the Counsellor/Therapists in the South East CIPC service who engaged so enthusiastically with the first phase of this research.

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We wish to acknowledge the valuable support of the general practitioners and primary care teams.

Finally, the research group would like to thank all those who have joined the CIPC National Evaluation since Phase 1 was completed. The ongoing participation of coordinators, Counsellor/Therapists, administration support staff and clients is making a significant contribution to what is the first national evaluation of counselling in primary care in Ireland.

## Counselling in Primary Care National Evaluation Research Group Membership

**Fiona Ward** – *Director of Counselling, CHO8 LM/CHO9, Chair, CIPC National Research Group*

**Miriam Barrow** – *CIPC Clinical Coordinator, CHO5*

**Charles Brand** – *CIPC Psychology Researcher*

**Sharon Cunningham** – *CIPC Clinical Coordinator CHO8*

**Niamh Mac Donagh** – *Director of Counselling CHO7*

**Dr Philip Moore** – *Director of Counselling CHO4*

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# Foreword

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The development of mental health services within primary care settings was one of the key recommendations of *A Vision for Change: Report of the Expert Group on Mental Health Policy* (2006). In line with this strategy and following a Government commitment to increase access to counselling, the Counselling in Primary Care Service (CIPC) was established nationally in 2013. Evidence indicates that positive outcomes in terms of physical and mental health are associated with increased access to psychological therapies for people particularly in the primary care setting. CIPC addresses some of this need providing as it does primary care counselling for adult GMS cardholders with mild to moderate psychological difficulties.

The critical role of CIPC in providing nationwide access to counselling is highlighted by the rapid growth in referrals since its launch, as awareness of the service has grown demand has increased with more than 19,000 referrals in 2017, an increase of 4% on the previous year.

A National Evaluation of the CIPC service is currently underway to examine the impact and outcomes of CIPC across Ireland. This exciting research is the first assessment of the effectiveness of primary care counselling on a national scale in Ireland's Health Service. This report describes the findings from Phase 1 of the study which was conducted in the South East region (CHO 5) during 2015.

This report is welcomed; demonstrating as it does the positive impact that counselling can have in the lives of so many people who are experiencing common mental health difficulties such as anxiety and depression. For 97% of clients who took part in the research, counselling was effective in reducing their distress. Counselling was also effective for those clients identified as being at risk, with significant reductions in the level of risk at the conclusion of counselling. Evaluations of the type described in this report and the subsequent phases of research are essential to help ensure service-wide quality improvement.

In addition to evaluating clinical outcomes and overall service model effectiveness, the next phase of the CIPC National Evaluation is seeking to ascertain if short-term counselling impacts on GPs' prescribing behaviour in relation to psychotropic medication. This is an issue of real importance to GPs, their patients and the broader discussion about mental health in Ireland. The ambitious CIPC National Evaluation will inform the future planning of counselling in primary care settings and pave the way for the health service to make counselling accessible to all Irish people.

The CIPC service continues to impact positively on the lives of thousands of people across Ireland and I wish to acknowledge this important work. I would like to express my appreciation to the Primary Care Teams and GPs, who have shown great support for CIPC during its roll out and development. I would also like to extend my thanks to the CIPC Clinical Coordinators and the Counsellor/Therapists who work with CIPC for the critical role they play in making psychological help more accessible to the Irish people.

**Ms Anne O'Connor**  
*National Director Community Operations*

# Executive Summary

## Counselling in Primary Care National Evaluation Phase 1

### Introduction

#### Development of CIPC

Increasing access to counselling in primary care was set out as an objective in the 2011 Programme for Government. The HSE subsequently provided for the roll out of a national Counselling in Primary Care service (CIPC) in its 2012 service plan. CIPC was launched in July 2013. CIPC was established to provide counselling for patients experiencing mild to moderate psychological difficulties who present in the primary care setting. All adults in receipt of a medical card are eligible for the service. Since its establishment the service has grown rapidly with more than 19,000 referrals during 2017 and counselling provided from more than 180 locations nationwide.

#### Benefits of Primary Care Counselling

Positive outcomes in terms of physical and mental health are associated with increased access to psychological therapies for service users (WHO 2008). The National Institute for Health and Care Excellence (NICE) guidelines recommend psychological therapies for clients suffering from mild to moderate depression and Generalised Anxiety Disorder and as the first line treatment of choice over medication (NICE 2011). Counselling is considered a preferred option to medication by service users (Brettell et al., 2008) with public demand for psychological approaches to emotional difficulties and dissatisfaction with a medication only approach growing (Batt et al., 2002). Vision for Change (2006) highlighted the need for a comprehensive range of psychological therapies to be provided in the Irish Health Service.

Extensive support for the benefits of primary care counselling services has been documented in psychotherapy research literature. In the UK, primary care counselling services are shown to be effective in studies involving large number of clients e.g. 11,953 clients (see Mullin, Barkham, Mothersole, Bewick, & Kinder, 2006). However, the effectiveness of primary care counselling in Ireland has never been assessed at a national level.

#### CIPC National Evaluation – Phase 1

The CIPC National Evaluation Study is a four year project which seeks to address the following key questions:

- Is counselling effective in reducing client psychological distress?
- What is the impact of the service on other stakeholders?
- What are the benefits of the CIPC service model and is it effective?

This report describes Phase 1 of the CIPC National Evaluation conducted in the South East region (CHO 5) undertaken during 2015. This study involved assessing the feasibility of proposed research methods, data collection and evaluation of clinical outcomes for participating clients attending counselling in the South East. It also captured information about the stakeholder experience of the CIPC service and the research process. Evaluations of the type described in this report are essential to help ensure service-wide quality improvement. This study enabled the suitability and practicality of the proposed research plan and methodology to be tested under the environmental conditions of a real world counselling and psychotherapy service, CIPC. Additionally, stakeholder feedback served to identify key learning outcomes which shaped the research approach in the

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remaining HSE areas where the research is currently being rolled out. A careful approach to ethical and data compliance was employed throughout the study. Ethical approval was granted by the HSE South East Regional Ethics Committee and Trinity College Dublin. All research activities are overseen by the CIPC National Evaluation Research Group.

## Phase 1 – Participants

During Phase 1 of the study, 122 clients participated over a 4 month period. 90% of those who participated were referred by their GP. 81% of participants were female which is reflective of the service profile in the South East. Clients presented for assessment with a range of multiple problems with anxiety and depression being the two most common reasons for referral (88.5% and 64.8% of clients were referred for anxiety and depression respectively). 64% of participating clients were taking medication prescribed by their GP to help with psychological symptoms at the time of assessment for counselling.

Clients completed the CORE Outcome Measure (CORE-OM 34) which is a global measure of psychological distress used extensively in clinical settings across primary and secondary care services in Ireland, the UK and Europe (CORE, 2014). This measure addresses subjective well-being, symptoms, functioning and risk and is a valid measure of clinical effectiveness (Barkham, 2007). The remaining questionnaires in the CORE system (i.e. CORE Assessment form and CORE End of Therapy form) capture a range of audit, client related and therapeutic process data. Counsellors completed the CORE Therapy Assessment and End of Therapy forms for all participating clients when possible. In addition, the Work and Social Adjustment Scale (Mundt, 2002) and Health Related Quality of Life scale (Horner et al., 2009) which assess quality of life and functioning were also completed by participants.

## Phase 1 – Key Findings

- Clients attended for an average of 6 sessions most commonly on a weekly basis
- 80% of clients scored in the clinical range for psychological distress at assessment
- 89% of participants in the study presented with distress caused by depression and anxiety which had been problematic for 12 months or more
- The longer clients experienced their psychological difficulties prior to engaging in counselling, the more severe their symptoms were as they began therapy
- Counselling reduced symptoms for 97% of clients
- 77% of clients were deemed to have recovered at the end of counselling i.e. they showed a significant reduction in their CORE scores and were no longer in the clinical range for psychological distress
- 49% of clients identified risk as an issue at the outset of counselling, this figure reduced to just 7.7% by the end of counselling
- 57% of participants reported an improvement in their general health
- Participants reported a 78% increase in the number of mentally healthy days between the beginning and end of counselling
- 46% of clients showed a clinically significant reduction on the impact of their psychological problems on their work and social functioning
- Counsellor/Therapists employed a range of therapeutic approaches with clients, primarily Person Centred Therapy (89.9% of clients), Cognitive Behavioural (74.7% of clients) and Integrative Therapy (65.8% of clients) depending on the nature of each client's presenting problems
- There was a high level of engagement by Counsellor/Therapists with the research process and minimal impact on clients in counselling. 80% of counsellors reported that they felt the research process had not impacted clients' decision to engage in counselling



## CIPC National Evaluation – Next Phase

Following completion of Phase 1 the CIPC National Evaluation Study was initiated in two additional CIPC services across the HSE. Data collection commenced in CHO areas 3 & 7, followed by CHO 6. All remaining CHO Areas began data collection by February 2018.

Subsequent phases of the CIPC National Evaluation will include:

- Qualitative data collection and analysis from key service stakeholders including GPs
- Follow up evaluation of clinical outcomes at 6 and 12 months
- An evaluation of psychotropic medication prescription patterns for clients attending counselling
- Evaluation of Client and GP satisfaction with CIPC

Results from all remaining CHOs of the evaluation are expected by mid 2019.

# Literature Review

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## 1.1. Counselling in Primary Care – origins and international research context

The need for effective counselling and psychology services at a primary health care level was recognised during the 1960's (see McFarlane & O'Connell, 1969). Historically in the UK many GPs adopted a counselling role within their own practices in order to meet the needs of patients presenting with mental health difficulties (Eatock, 1996). However, during the 1960's and 1970's there was growing recognition by GPs that psychological therapies could be further utilised as part of an overall approach to helping patients. This, coupled with increased financial opportunities for GPs in the UK to hire ancillary staff contributed to the movement of counsellors into larger GP practices. Further, hospital and community-based mental health teams endeavoured to forge links with GP practices as a way of becoming more integrated in their local communities (Eatock, 2000). Thus, by 1992 51% of all GP practices in the UK employed dedicated counsellors (Sibbald, Addington-Hall, Brenneman, & Freeling, 1993).

As a consequence of the evolution of primary health care services globally, the World Health Organisation has reported that the integration of mental health services into primary care is a viable way of increasing access to psychological services. They also assert that the utilisation of this model can lead to other important benefits such as increasing the likelihood of positive outcomes for both mental and physical problems for service users (World Health Organization & World Health Organisation, 2008). Additionally, the National Institute for Health and Care Excellence (NICE) guidelines recommend psychotherapy for clients suffering from mild to moderate depression (Clark, 2011) and Generalised Anxiety Disorder (GAD) (NICE, 2011) over medication as a first line treatment.

The first UK based clinical trial of the effectiveness of counselling in a primary care setting is considered to be that by Ashurst in 1979 (Ashurst, 1979; Ashurst & Ward, 1983; Corney & Jenkins, 2005). This study was conducted across a number of general practices in the UK, but did not identify any differences in outcomes between patients assigned to counselling or routine GP practice. However, client motivation has been highlighted as a possible factor contributing to reducing the effects of counselling treatment in this study (Corney & Jenkins, 2005), as many participants had not indicated that they wanted help in the form of counselling. Early research also tried to ascertain the impact of short term counselling on the rates of psychotherapeutic medication prescribed by GPs (see Earll & Kincey, 1982; Teasdale, Fennell, Hibbert, & Amies, 1984). Teasdale et al. (1984) assessed the use of cognitive therapy for treating depression in primary care as opposed to the more common practice of prescribing patients psychotherapeutic medication (i.e. treatment as usual). They concluded that while the group receiving cognitive therapy were significantly less depressed after completing treatment, three months later differences in the severity of depressive symptoms were equivalent between both groups. They believed this to be attributable more to the continuing improvement of the treatment as usual group rather than a deterioration in the cognitive therapy group.

The international research focus during the 1990s and 2000s became concentrated in three main areas: first, identifying which therapies were most effective at reducing symptoms (e.g. Bower et al., 2000; Chilvers et al., 2001; King et al., 2000); second, identifying cohorts of patients for whom counselling was most effective (e.g. Salmon, Sharma, Valori, & Bellenger, 1994) and third, assessing the research methodologies used to determine the effectiveness of counselling (e.g. Brette, Hill, & Jenkins, 2008; Margison et al., 2000; Papadopoulos & Bor, 1995). These converging research strands were directed by a consensus in the UK and United States for establishing the primacy of Empirically Supported Treatments (ESTs) as the foundation for psychological services delivered in primary care settings (Barkham, Mellor-Clark, Connell, & Cahill, 2006; Lambert, 2013), as well as demonstrating the influence of a growing service user movement in the mental health area (Szmukler, Staley, & Kabir, 2011).

Reflecting the trend internationally to situate ESTs (a term later updated to Evidence Based Treatments) at the centre of large scale commissioning of psychological services at a primary level, the Improving Access to Psychological Treatment (IAPT) initiative was officially launched in the UK by the NHS in 2007. This model of service provision is largely based on NICE guidelines which recommended some psychological therapies, in particular Cognitive Behavioural Therapy (CBT) as effective in helping people to deal with a range of different problems including anxiety and depression, two of the most prevalent disorders at the time (Singleton, Bumpstead, O'Brien, Lee, & Howard, 2000).

There was also an increase in research that considered a service user perspective on mental health services. Research in this area found that counselling was considered a preferred option to medication (Bower & Rowland, 2006; Brettle et al., 2008; King et al., 2000) and that there was a reduced stigma associated with attending counselling in a primary care setting than attendance at psychiatric services (Gask, Sibbald, & Creed, 1997; Hemmings, 2000).

## 1.2. Establishing Counselling in Primary Care – the Irish context and existing services

By 2001 in Ireland, there was a widely recognised need to develop primary care services “so that they become the cornerstone of care and preventive services for communities across the country” as this was recognised to be “...consistent with best international practice.” (Department of Health & Children, 2006, p. 17). Allied to this was a growing body of international evidence for the benefits of an integrated approach to the provision of psychological and counselling services within the context of primary care (see Bor & McCann, 1999; Davidson, 2000; Evans, Mellor-Clark, Barkham, & Mothersole, 2006).

Vision for Change (2006), the document which set out a mental health policy framework and produced by an expert group on mental health in Ireland stated that “The popularity of these [talk therapies] approaches and the evidence for their effectiveness has been growing in recent years. The emerging consensus is that they should be regarded as fundamental to basic mental health services” (Department of Health & Children, 2006, p. 246) and concluded that:

**Counselling is often the preferred term for a brief intervention with an individual who presents with a circumscribed difficulty, precipitated by some specific challenging event in their life, such as a career crisis, a sudden bereavement or a medical illness.**

(Department of Health & Children, 2006, p. 246)

Further, within Ireland the public demand for psychological approaches to address emotional and psychological difficulties coupled with a growing dissatisfaction with a medication-only approach to such problems became increasingly apparent (Batt, Nic Gabhainn, & Falvey, 2002). Service users generally perceived psychological therapy services positively, however they also reported high levels of dissatisfaction with the lack of availability, access and choice of services available (Batt et al., 2002; HSRC, 2003). Vision for Change recognised the “... pivotal role of primary care services in addressing the mental health needs of the population.” (2006, p. 60) and highlighted the need for “...a comprehensive range of psychological therapies to be provided at primary, secondary and tertiary levels” (2006, p. 60).

Prior to the publication of Vision for Change in 2006, some HSE services around Ireland were already providing psychological and counselling care within the primary care system. In 2003 the National Counselling Service (NCS) in the Dublin North East (DNE) region conducted a survey of GPs to investigate their views on the level of need for counselling, referral practices and their opinions regarding current models of counselling service provision. 45% of GPs in the DNE region responded and analysis revealed that many had limited referral options because of particular barriers to accessing counselling. These included a lack of available public services, long waiting lists and prohibitive cost. GPs voiced a significant need for counselling services at a primary care level to address their patients' psychological difficulties. It was evident there was limited counselling available in the DNE region, and what was available was not accessible for many patients due to cost and location. Limited available treatment options often resulted in referral to mental health services and reliance on medication even where provision of psychological therapy would be preferable and more acceptable to the client (Ward, 2012). Provided with this evidence, the NCS in the DNE region set about developing a counselling service in primary care called Primary Care Counselling Provision (PCCP), initially on a pilot basis. The service provided time limited counselling for clients presenting with non-complex psychological difficulties. Between 2007 and 2011 this service received in excess of 5,000 referrals from more than 50 GP practices and several primary care units across the DNE region (Ward, 2012).

Martin, Hawkins, Hicks, & O'Flynn (2008) also reported on psychology and Counsellor/Therapists services for adults in three services across Dublin in operation between 2005 and 2008 in the North Inner City of Dublin, South Inner City of Dublin and Ballymun, North Wicklow and in the aforementioned Dublin North East region.

Bourke and Byrne (2012) assessed the clinical effectiveness of the first year of a stepped care model of service delivered in Co. Roscommon which incorporated counselling and psychotherapy. The stepped service model is described as "...a framework of organisation of pathways of care designed to reduce burden to patients while maximising health gain" (NICE, 2011, p. 79). Adopted by the Improving Access to Psychological Therapies (IAPT) initiative in the UK, this model of care provides a particular "step", (i.e. a type of intervention which can include counselling) based on the assessed level of intensity required by the service user at that time and depending on their response to treatment during the previous step.

### 1.3. The effectiveness of counselling/psychotherapy – international research

Before examining the area of counselling and psychotherapy effectiveness, it is worth unpacking the different types of approaches taken in order to understand the various aims of the researchers involved. Research studies in the area of counselling and psychotherapy tend to be distinguished by approaches positioned on a continuum between the *efficacy* and the *effectiveness* of therapy. Efficacy studies refer to those designed to minimise threats to internal validity and are characterised by an adherence to the rules governing Randomised Controlled Trials (RCTs), i.e. control, comparison and randomisation (Barkham & Margison, 2007). Other types of effectiveness studies (also referred to as pragmatic or practical trials) focus on gathering therapeutic outcome and other relevant data in a manner which is more representative of a typical clinical setting, but may still employ a comparative element i.e. a wait-list condition in order to create a control group or follow treatment procedures that are protocol-driven. Finally, there are effectiveness studies which gather data from samples of clients which is wholly representative of how treatments are delivered in routine practice in a real world service – providing pre/post data for all research participants for comparison regardless of factors such as type of therapy undertaken, presenting problem type etc. The objective of these practice-based studies is to gather *practice-based* evidence with a view to "... enhancing treatment quality" (Barkham & Mellor-Clark, 2003, p. 319).

The overall effectiveness of counselling and psychotherapy within a primary care context has been well established through both individual studies and the use of meta-analysis (see Bower, Knowles, Coventry, & Rowland, 2011; Brette et al., 2008; Hemmings, 1997, 2000; Mufson, Yanes-Lukin, & Anderson, 2015; Smith & Glass, 1977). Gibbard and Hanley (2008) compared the effectiveness of person-centred counselling over no treatment (i.e. those clients on a wait-list for treatment) and found an average pre-post effect size of 1.2<sup>1</sup> over a five year period compared with a waitlist effect size of 0.24 (between referral and pre therapy) over a three year period. Shapiro and Shapiro (1982) analysed 143 outcome studies and found a mean effect size of .93 from 414 different treatment groups. A three year naturalistic study conducted in Sweden by Werbart, Levin, Andersson, & Sandell (2013) found the psychotherapy and counselling service was beneficial for the majority of those who received it in the public system. A large scale study of more than 11,900 clients from 32 primary care NHS services in the UK found that 72.2% of clients who scored above the clinical cut-off distress rate at intake were either improved (moved from clinical to sub-clinical) or recovered at the end of their therapy (Mullin et al., 2006). Notably, the large scale study by Mullin et al. (2006) among others in this review also utilised the same battery of questionnaires used in this study (i.e. CORE OM and the CORE Assessment and End of Therapy questionnaires).

Psychotherapy research has also focused on particular elements of therapy, i.e. specific or common, and how these might influence outcomes for clients. Common factors that are general or common to all therapy recipients regardless of their therapy environment could be the number of sessions attended (see Barkham et al., 2006), the amount of time spent waiting for therapy to commence (see Beck, Burdett, & Lewis, 2015; Trusler, Doherty, Mullin, Grant, & McBride, 2006), the working alliance between the therapists and the client (see Horvath, Del Re, Flückiger, & Symonds, 2011) or the consensus about the goals of therapy (see Tryon & Winograd, 2011). Both common and specific factors are investigated by researchers with regard to the degree to which they contribute to the overall variance found in psychotherapy outcomes. According to Lambert (2013) up to 30% of the overall variance can be attributed to common factors. One specific factor which can be attributed to the therapeutic context is the type of therapy employed by the therapist. A very broad range of psychotherapeutic approaches are employed by psychotherapists and counsellors in the primary care sector. Notably, the most common finding in studies examining the efficaciousness of different therapy approaches is that there are negligible differences in outcomes for most clients, regardless of the type of approach employed by the therapists (see Luborsky et al., 2002; Wampold et al., 1997).

## 1.4. Effectiveness of counselling/psychotherapy – Irish research

For 79% of clients in the PCCP service in DNE there was reliable improvement in their symptomatology and 65% showed an improvement to the extent that their difficulties were no longer within the clinical range (see Ward, 2007). Also, based on client satisfaction questionnaires returned by 884 respondents between 2007 and 2011 97% of respondents identified high levels of satisfaction in terms of their counsellor's ability to listen to and understand their problems, their experience of trust in their counsellor (95%) and 90% of clients believed that counselling had been effective in addressing their difficulties. The main reason cited for attending counselling was depression (31.1%) (Reddan, 2011).

Martin, Hawkins, Hicks & O Flynn (2008) provided a cross-sectional snapshot of adult primary care psychology provision across five services that operated across parts of Dublin, Wicklow and DNE. They reported on a variety of service related, clinical and service user characteristics and found that 89% of clients in the Dublin North Inner

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<sup>1</sup> Effect size is a method of measuring the magnitude of treatment effects. They are calculated as a way of aggregating changes in psychotherapy outcomes across different studies and reported for the purposes of comparison. The most commonly used effect size measure used is that developed by Cohen (1988) which is summarised as small effect sizes having values up to 0.2, moderate effect sizes up to 0.5 and large effect sizes are those greater than 0.8.

City study "...showed a decrease in surgery attendances since completion of therapy..." (Martin et al., 2008, p. 12). These findings echoed those found in the pilot study conducted in 2006 by Ward (2007) whereby 60% of clients who attended for counselling were identified as having moved from the clinical to the non-clinical range at the end of counselling. Bourke and Byrne (2012) indicated clinically significant change or reliable improvement for the majority of those who attended their counselling service based on the stepped care model in 2012. During an additional second year evaluation, the service received 112 referrals with 38.4% (n = 43) progressing to initial assessment. Of these, six (75%), of eight service users who provided follow-up data three months after receiving brief cognitive behavioural counselling continued to demonstrate clinical and reliable improvement (McHugh, Brennan, Galligan, McGonagle, & Byrne, 2013).

Another use for practice-based research data are benchmarking against outcome data from samples in other jurisdictions. One of the ways this is accomplished is by the collection of pre and post therapy outcome data using standardised outcome measures. Several such standards for the measurement of outcomes in the primary care sector have been developed and assessed such as the COMPASS System (Sperry, Brill, Howard, & Grissom, 1996), predominantly used in U.S. mental health care systems. The Clinical Outcome in Routine Evaluation Outcome Measure (CORE-OM: Barkham, 2005) is widely utilised in the UK and has been adopted by a wide variety of institutions, colleges and health services in Ireland, Portugal, Norway, Holland and Denmark (CORE, 2014). The CORE-OM 34 is one of three components of the CORE System, a suite of data collection questionnaires and administrative documents designed to act as an audit, quality evaluation and clinical outcome benchmarking system for services delivering counselling and psychotherapy.

## 1.5. Development of HSE Counselling in Primary Care Service (CIPC)

Vision for Change (2006) highlighted the absence of Irish national data on the prevalence of mental health problems in primary care. However, as previously mentioned, certain areas in Ireland had undertaken outcome and evaluation studies, and they did so within a practice-based research paradigm, i.e. to capture research data within naturalistic, everyday clinical settings. The HSE National Service Plan 2012 provided for the national roll-out of a Counselling in Primary Care Service (CIPC) based on the PCCP model developed in the DNE region, under the governance of the National Counselling Service. This would go towards meeting the requirement to improve access to counselling in Primary Care which had been set out in the *Programme for Government* (2011).

# CIPC Service and Research Aims

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## 2.1. The CIPC Model of Service

The HSE Counselling in Primary Care (CIPC) service was developed to provide counselling for patients experiencing mild to moderate psychological difficulties who present in the primary care setting. The service is based on a short-term counselling model for medical card holders aged over 18 years. Referrals can be made by GPs and members of Primary Care Teams (with the knowledge of patients' GPs).

The national CIPC service operates from over 180 locations situated throughout the HSE. Counselling is delivered from a variety of different sites including Primary Care Centres which are sometimes co-located with other HSE services but also from GP surgeries, National Counselling Service locations and Community / Voluntary Sector Centres. NCS Directors of Counselling oversee the service which is coordinated by local CIPC coordinators. Counselling is delivered by 148 Counsellor/Therapists employed on a contract and sessional basis delivering 434 counselling days per week<sup>2</sup>. All Counsellor/Therapists meet certain minimum qualification criteria including an accredited qualification in counselling or psychotherapy recognised by the Irish Association for Counselling and Psychotherapy or the Irish Association of Humanistic and Integrative Psychotherapy and a recognised qualification at Level 7 or higher qualification on the NQAI framework in Medicine, relevant Health & Social Care Professionals plus a minimum of two years' experience or a post-graduate qualification in counselling or clinical psychology recognised by the Psychological Society of Ireland.

The CIPC model of service incorporates:

- On site provision of counselling in primary care settings
- Pre-counselling information to GPs and Clients 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 outcomes.

The CIPC model of service is anchored in a client centred therapeutic approach with Counsellor/Therapists employing a range of therapy types including Person Centred, Cognitive Behavioural, Psychoanalytical, Psychodynamic, Integrative and Supportive. As previously discussed, it is common factors, as opposed to a specific therapeutic approach which can contribute to a large proportion (up to 30%) of psychotherapy outcome variance, and the relationship between the therapist and the client is critical to a positive outcome (Norcross & Wampold, 2011b). Moreover, upon examination of the evidence from more than two dozen reviews an expert group from the American Psychological Association's Divisions of Clinical Psychology and Psychotherapy concluded that "The therapy relationship makes substantial and consistent contributions to psychotherapy outcome independent of the specific type of treatment." (Norcross & Wampold, 2011a, pp. 423–424).

### 2.1.1. Referral Eligibility Criteria

Eligibility criteria currently limit referrals to CIPC to patients holding valid General Medical Services (GMS) cards. However, these criteria are constantly reviewed in light of any changes in national policy on primary care eligibility. Eligible clients can be referred for counselling by their GP or by a designated member of the primary care/practice team for time-limited counselling for mild to moderate psychological problems, e.g. mild depression or anxiety or difficulties adjusting to life events. Short term counselling in Primary Care is not recommended as the main intervention for severe and complex mental health problems or personality disorder, those with a history of severe trauma, severe depression or anxiety.

<sup>2</sup> Approximate number as of April 2017.

### 2.1.2. Objectives of the CIPC National Evaluation

A core feature of HSE CIPC Service model is routine evaluation of clinical outcomes. A national evaluation of the CIPC service was commissioned in 2014 in order to evaluate the clinical effectiveness and appropriateness of the service model in the Irish health system. Once completed, this will provide evidence on the outcomes of counselling on a national scale for the first time in Ireland.

Without accurate measurement of the outcomes and an examination of the processes within the CIPC service there is no foundation on which to improve the quality of the service for those who avail of it. Quality assurance is a continuous objective according to Cummings, O'Donohue and Cummings, (2009) who comment on the importance of appropriate evaluation of behavioural healthcare programs; "Quality improvement should be continuous – the bar is always moving higher. Quality always requires consistent measurement to determine the extent to which these [sic] objectives are being achieved." (p. 31).

The CIPC national evaluation will seek to answer questions of effectiveness (i.e. achieving intended results under real-world conditions) and efficiency (i.e. optimizing the use of limited resources) as well as client satisfaction (i.e. acceptability of the programme). This evaluation will also provide alternatives to consider: better processes or better ways of implementing the overall model. It will provide the information needed for identifying best service practices and determining lessons learned thus far. In addition, on completion of the study the NCS will possess the first set of national benchmarks for outcomes associated with counselling and psychotherapy in an Irish primary care context. International research (with an emphasis on routine practice) on the effectiveness of psychological therapies has been conducted (Barkham et al., 2001; Gilbert, Barkham, Richards, & Cameron, 2005; Margison et al., 2000) and benchmarks from this research are a standard to which the Irish experience of providing counselling in the primary care setting can be compared.

Specifically, the CIPC national evaluation seeks to address the following questions:

- Is counselling effective in reducing client's levels of psychological distress?
- What is the impact of CIPC on key stakeholders, health care resources etc.?
- What are the benefits of the CIPC service model and is it effective?
- If so, what are the processes and procedures within the model that work well and what areas of the model could be improved?

### 2.1.3. What information is required to answer these research questions?

The main outcome measure for measuring clinical effectiveness will be captured by the Clinical Outcomes in Routine Evaluation Outcome Measure (CORE-OM 34: CORE, 2014). The CORE-OM 34 is one of four forms in the CORE System suite which captures a range of relevant audit, client related, therapist and therapeutic process data. The CORE-OM 34 is a commonly used measure in clinical effectiveness studies internationally (Barkham, 2005; Gilbody, Richards, & Barkham, 2007).

Additional clinical outcome measures will also be administered to clients for the purposes of assessing more global changes, e.g. Work and Social Adjustment Scale (WSAS) and the Health-Related Quality of Life Measure (CDC HRQOL- 4). The Work and Social Adjustment measure (WSAS; Mundt, 2002) and the Health Related Quality of Life scale (HR-QOL; (Horner-Johnson, Krahn, Andresen, & Hall, 2009) measure occupational and social functioning and quality of life from a mental and physical health perspective respectively. The WSAS has been demonstrated as being a good measure of change in the social and occupational spheres (Zahra et al., 2014). The HR-QOL has also performed well when tested for its ability to accurately target the constructs which are thought to represent self-reported expressions of mental and physical health (see Horner et al. 2009). More detailed information regarding these measures follows in the report.

Depression is implicated in the majority of problems for patients presenting to GPs in Ireland (Ni Shiothcháin & Byrne, 2009). Further, the use of multiple outcome measures is particularly relevant for the assessment of psychotherapy for clients suffering depression as the use of a single measure "... may not sufficiently characterize the effect of a treatment on a broad set of domains". (Tyler, Normand, & Horton, 2011, p. 1). This method enables the capture not only the statistical, but also other clinically relevant changes in the lives of clients and provides a more contextualised representation of the impact of psychotherapy delivered by counsellors for the CIPC service.

In addition, CORE-OM 34 the CORE Assessment (CORE-A) and CORE End of Therapy (CORE-EOT) forms will also be administered to participants in the evaluation. These forms collect data on routine audit items (e.g. waiting times, appropriateness of referral, non-attendance rates) which contribute towards a comprehensive profiling of service throughput. Items on these forms such as the type of therapy undertaken and the duration of session episodes and frequency of individual sessions also help profile services and contextualise client self-report and practitioner-rated outcomes.

Another important consideration in the context of primary care is the issue of psychoactive medication. Suggestions of over-reliance on medication therapy within the Irish general practice have been put forward (see Ni Shiothcháin & Byrne, 2009). In the UK while there has been some evidence found that counselling services can contribute to a perception by GPs of reduced psychoactive medication prescribing (Schafer, Amoateng, & Wrycraft, 2009), other studies have found evidence contradicting this perception (Sibbald, Addington-Hall, Brenneman, & Freeling, 1996). In order to gain a more definitive description of this phenomenon from an Irish perspective the next phase of the CIPC National Evaluation will compare psychoactive medication prescription rates for research participants before therapy with a six and 12 month follow-up period to assess any longer term effects.

Further data will come in the form of evaluation of satisfaction with the CIPC service from GPs and Clients of the service. All GPs who have referred clients to the CIPC service will be invited to complete a satisfaction survey. All clients who receive counselling are invited to complete a paper satisfaction survey which is supplied with a return envelope upon the completion of counselling. Questionnaires returned by clients who have consented to take part in the national evaluation will be included in the final data analysis. In addition to the quantitative data collection and analysis, interviews with stakeholders such as GPs and other referral sources will provide qualitative data on the nature of any perceived changes since the introduction of the CIPC service. Participants will be asked to retrospectively discuss how much impact the service has had on their normal operations and also probe their perceptions of its overall delivery and performance.

All research activities are overseen by the CIPC National Evaluation Research Group (see Appendix 12).

## To conclude

This section of the report described the past and recent research literature pertaining to psychotherapy outcomes in counselling in primary care, both internationally and in Ireland. The delineation between efficacy and effectiveness research was discussed in order to correctly situate this study and the overall CIPC National Evaluation within a practice based research paradigm. The development of CIPC from its original incarnation located in a small number of HSE regions to a fully national service was described and the main objectives of Phase 1 of the National Evaluation conducted in the HSE South East region were described. Finally, the feasibility elements of Phase 1 particularly important to conducting the remainder of the National Evaluation were detailed. The following section will report the outcomes of Phase 1 of the National Evaluation along with the measures and methodology used to collect the data. The resulting outcome data will be discussed in relation to other studies of outcomes in similar services in the UK. Finally the remaining tasks of Phase 1 and the additional tasks for the National Evaluation will be outlined.

# CIPC National Evaluation Phase 1 Results

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### 3. CIPC National Evaluation Phase 1 Results

The CIPC service in the HSE South East region has been in operation since the commencement of the national service and has delivered in excess of 21,800 counselling sessions to over 4,600 clients. The region is serviced by one CIPC Counselling Coordinator and 23 Counsellor/Therapists who provide therapy sessions in 15 sites including, Primary Care Centres, community care buildings and local day hospitals.

The first phase of the national evaluation was the completion of a feasibility study in the South East HSE area. The key objectives of Phase 1 were:

- To provide initial results of clinical outcomes for clients CIPC attending in the South East
- To test and finalise the national evaluation research processes
- To evaluate and modify the data collection processes as required
- To capture the research experiences of the Counsellor/Therapists in the SE area
- To streamline research training and materials
- To capture Counsellor/Therapist feedback on research data collection processes
- To document and disseminate all learning outcomes to inform the next phase of the National Evaluation.

#### 3.1. Overview

The following describes the data analysis and results of the first phase of a national evaluation carried out with CIPC South East Region. A description of the study sample is provided along with the results of descriptive and inferential data analysis. The measures used are described and changes in scores for all questionnaires are outlined as well as relevant relationships and differences between important variables highlighted.

#### 3.2. Method

##### 3.2.1. Data Collection

Clinical outcome data were gathered at three time points during clients' therapy period, i.e. at Time 1 (initial assessment), at Time 2 (roughly halfway through the agreed number of sessions with the client) and at Time 3 (during the final or penultimate therapy session). The rationale for collecting data at three time points was to minimise the impact of client drop-out before the end of the therapy cycle. The CORE Assessment, CORE End of Therapy and Health Related Quality of Life (HRQOL) questionnaires were administered on paper by the Counsellor/Therapist, and the Work and Social Adjustment Survey (WSAS) was completed by the client. In cases where the client was unable to complete a questionnaire, e.g. poor eyesight then its contents were relayed to them by the Counsellor/Therapist and the responses given by the client to be inserted by the Counsellor/Therapist. Data was submitted for analysis by 15 Counsellor/Therapists.

##### 3.2.2. Ethical Approval Process

A wide-reaching, rigorous ethical approval process was undertaken before any data collection began for the current study as well as for the National Evaluation. Ethical approval was sought and granted in all HSE areas where Research Ethics Committees (RECs) were in operation (see Appendix 10 for full list). For 2 HSE areas where ethical approval was not available due to the absence of an REC, concomitant approval was granted by the HSE National Director of Mental Health. Approval was also granted by the TCD ethics committee.

### 3.2.3. Consent

Full and informed consent was provided by all participants in the current study. Clients who had chosen to opt-in to the CIPC service were contacted by their allocated Counsellor/Therapist. During this contact they were informed about the evaluation. All clients who presented for initial assessment during the 4 month data collection period were fully briefed about the evaluation and data collection and consent processes before being invited to take part in the research. During the initial assessment session aspects of the study were discussed with all potential participants before consent was sought by their counsellor including:

- The purpose of the research
- Their right to refuse participation
- The implications of their participation
- The voluntary nature of participation and their right to withdraw at any point
- Confidentiality of the data provided
- Reassurance regarding implications of non-participation.

### 3.2.4. Confidentiality and Data Protection

All data storage, transfer and usage methods were and data collection processes were in accordance with the WMA Declaration of Helsinki - Ethical Principles for Medical Research 2008 and submitted for review by the Office of the Data Protection Commissioner who reviewed and approved the processes as outlined to them.

### 3.2.5. Psychological measures and other service related data

The Counselling in Primary Care (CIPC) evaluation used three clinical measures to investigate the effects of therapy on clients' level of distress, the perceived level of functional impairment caused by clients' given problems, the perception of their physical and mental health as well as assessment data and end of therapy data.

#### 3.2.5.1. The CORE Assessment and End of Therapy forms

These are practitioner-completed forms used to capture treatment evaluation and service related data which can be used for audit purposes. Included in these data are:

- Routine audit items (e.g. waiting times, appropriateness of referral, non-attendance rates)
- Presenting and emerging problems
- Planned and unplanned endings
- Therapy descriptors (e.g. therapy type, duration and frequency)
- Client data (problem type, client rated severity of the problem).

*List adapted from (CORE, 2014)*

### 3.2.5.2. The CORE-OM 34

The CORE-OM 34 (Clinical Outcome in Routine Evaluation) is a 34 item global measure of distress and is used extensively in clinical settings across primary and secondary services in Ireland, the UK and Europe (CORE, 2014; Mellor-Clark, 2006). High completion rates of the CORE-OM 34 in primary care counselling service settings (Barkham, 2005) attest to its usefulness as a brief measure in primary care settings and Evans et al. (2002) reported 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). The CORE-OM 34 comprises 34 items addressing domains of subjective well-being (4 items), symptoms (12 items), functioning (12 items) and risk (6 items: 4 'risk to self' items and 2 'risk to others' 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 of the 34 items focus on low-intensity problems (e.g. 'I feel anxious/nervous') and 17 focus on high-intensity problems (e.g. 'I feel panic/terror'). Eight items are scored positively.

### 3.2.5.3. The Work and Social Adjustment Scale

The Work and Social Adjustment Scale (WSAS: Mundt, 2002) has been demonstrated as a reliable and valid measure of impairment in functioning due to specific problems (Zahra et al., 2014). The WSAS has been shown to be concurrently valid (i.e. that it corresponds with other established scales measuring the same construct) and its brevity is positively regarded by patients (Zahra et al., 2014).

The WSAS comprises five items scored on a nine -point scale ranging from 0 = *Not at all* to 8 = *Very severely*. Participants are asked to indicate the level of severity their particular psychological problem impacts on their ability to carry out activities in each item with each one corresponding to one area of their lives i.e. 1 = work; 2 = home management; 3 = social leisure activities; 4 = private leisure activities and 5 = family and relationships.

### 3.2.5.4. The Health Related Quality of Life Measure (HRQOL-4)

The Health Related Quality of Life (HRQOL: Moriarty, Zack, & Kobau, 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, Fayers, Bjordal, & Kaasa, 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, Krueger, Vermeulen, & Chambers, 2000) and Puerto Rico (National Center for Chronic Disease Prevention and Health Promotion, 2002).

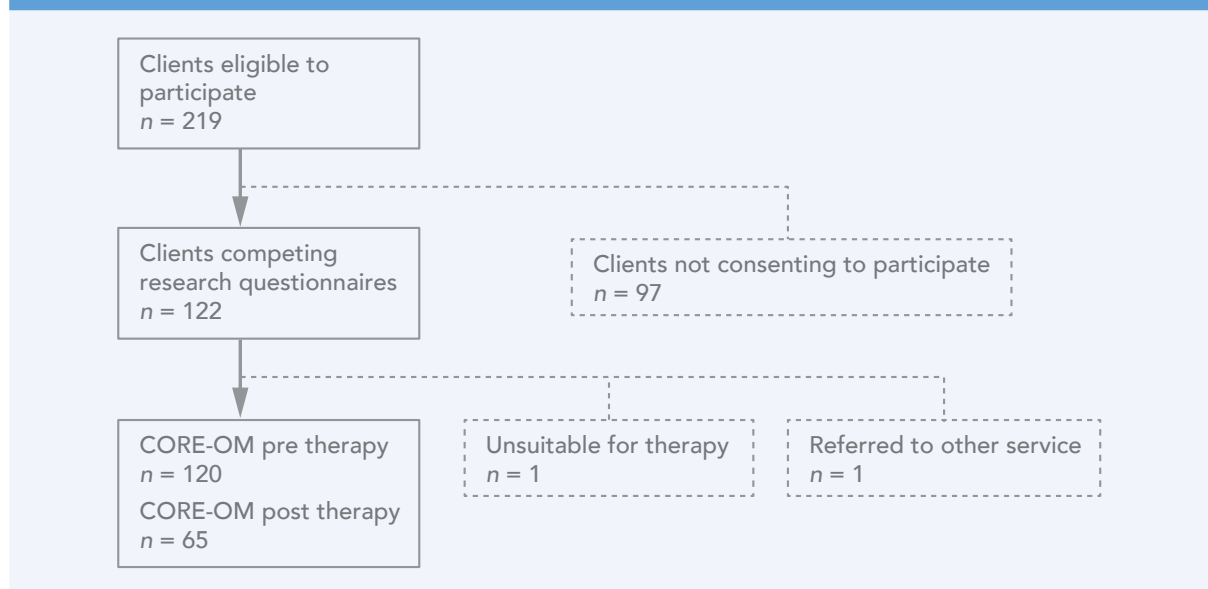
The HRQOL-4 measure consists of four questions relating to 1) self-rated general health (physical and mental), 2) client rated number of days when their physical health and 3) mental health were not good, and 4) the number of days when activity was limited as a result of poor physical or mental health. These responses were 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.

### 3.3. Descriptive and Service Related Statistics

#### 3.3.1. Participation and completion rates

The diagram below illustrates the flow of clients who were eligible to take part in the research. A participation rate of 55.5% ( $n = 122$ ) was achieved.

Figure 1. Participation rate



#### 3.3.2. Questionnaire completion rates

Therapists completed CORE Assessment forms for all participants ( $n = 122$ ). 120 (pre therapy) CORE OM 34 questionnaires and 65 (54.1%) valid pre and post-therapy CORE-OM 34. Pre therapy CORE-OM 34 data for non-participants were not available. 117 (96%) clients completed pre therapy Work and social Adjustment questionnaires and 69 (69%) completed pre and post questionnaires. 116 (95%) completed Health Related Quality of Life questionnaires were returned pre therapy with all 4 of the items on the questionnaire completed. At the post therapy stage the HRQOL items were returned to varying degrees of completion. See Table 1 for post therapy return rate breakdown for each of the questionnaires.

Table 1. Pre and post therapy questionnaire return rates

Measure	Pre Therapy		Pre and Post Therapy	
	<i>n</i>	%	<i>n</i>	%
CORE-OM 34	120	98	65	54
Work & Social Adjustment Measure	117	96	69	59
Health Related Quality of Life	116	95	63	52

Referral and opt-in numbers did not differ significantly from figures for the period prior to and after the research data collection period indicating that the sample is representative of the service in general.

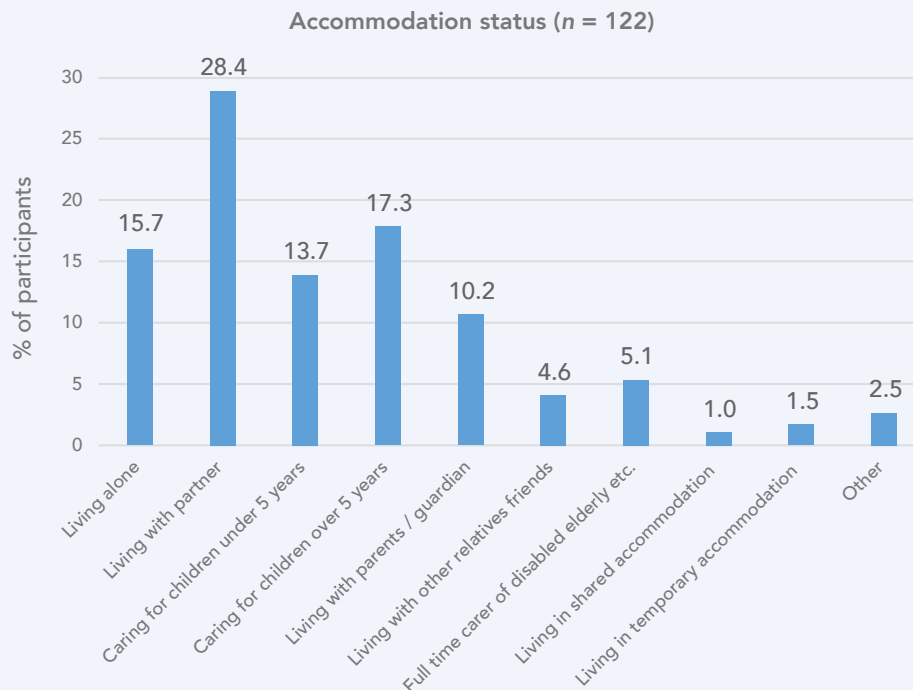


### 3.3.3. Gender, age, employment and ethnicity

99 clients who chose to participate were female (81%) and 23 were male (19%). The mean age of participants was 41.1 years (range 17-83) and the overall rate of unemployment amongst participants was 51.3%. 90.2% of the sample reported being White Irish (see Appendix 1 for all demographic data). These data are broadly in line with normal service data reported for the South East region during the previous 12 month period.

### 3.3.4. Accommodation status

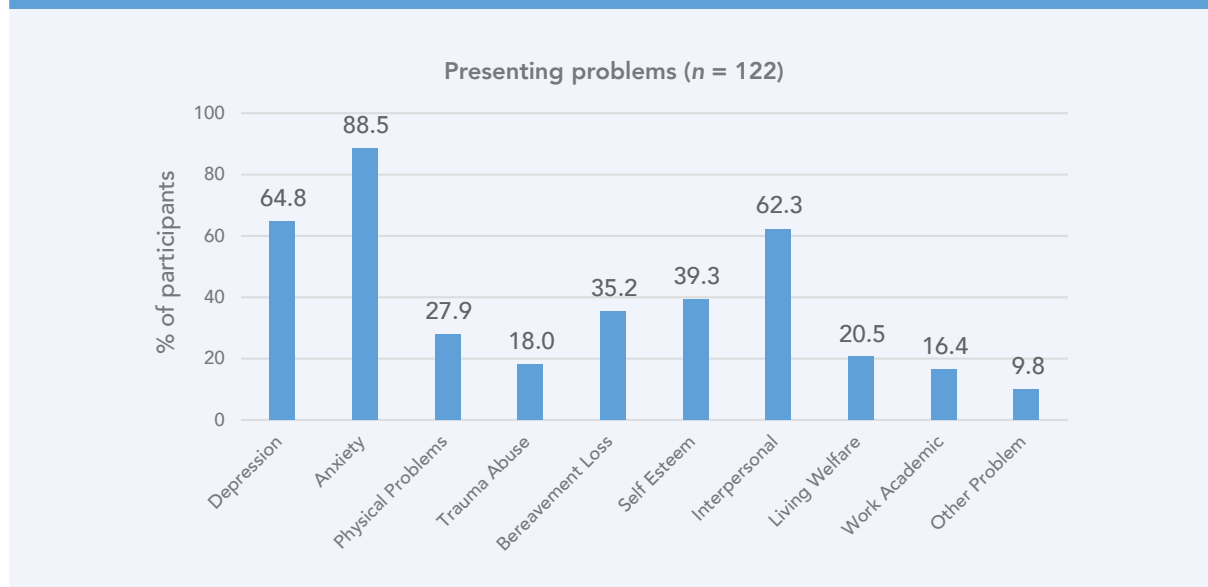
Figure 2. Breakdown of participant accommodation status



Almost half of participants reported they were either living alone (15.7%) or living with their partner (28.4%). 31% of clients reported that they were caring for children either over or under the age of five and just over 10% reported living with their parents or guardian.

### 3.3.5. Types of presenting problems

Figure 3. Percentage of main presenting problems recorded by therapists at initial assessment



Clients of the CIPC service, as with the majority of primary care counselling services presented with more than a single problem with which they required help (see Figure 3). The majority or 88.5% of clients reported difficulty with anxiety and stress related issues ( $n = 108$ ) and 64.8% reported depression as a major reason for seeking help from the service ( $n = 79$ ). 76 (62.3%) of the 122 participants cited interpersonal issues as being a cause of their distress and 39.3% reported self-esteem issues ( $n = 48$ ). Bereavement and physical problems accounted for 35.2% and 27.9% of presenting problems respectively ( $n = 43$ ,  $n = 34$ ). (See Appendix 3 for a complete breakdown of problems identified at time of referral).

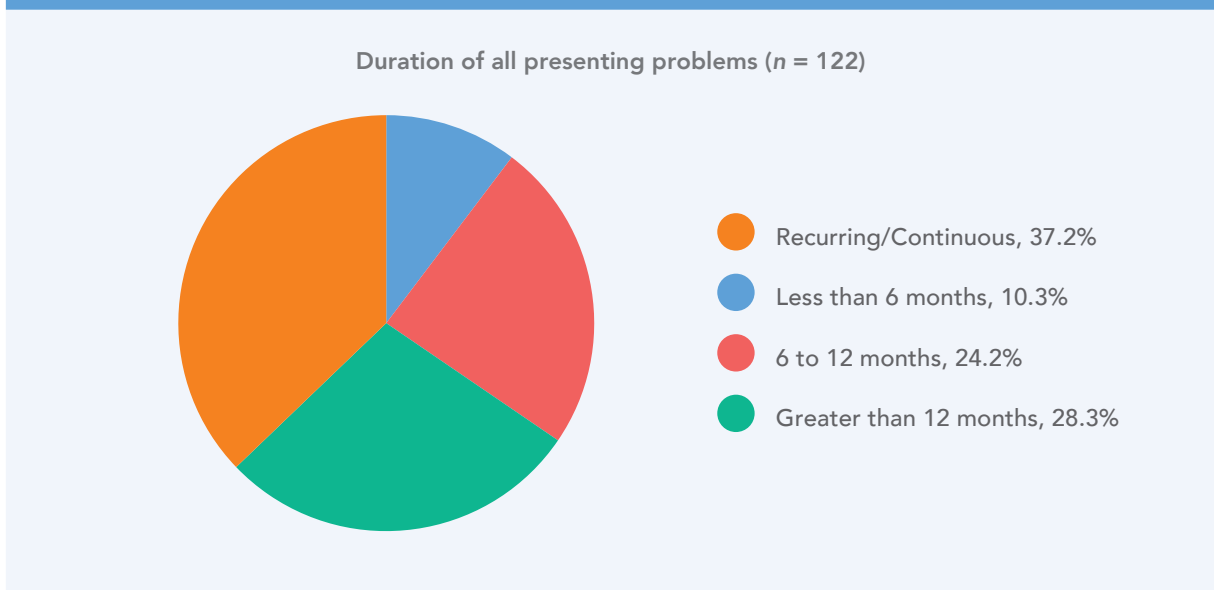
### 3.3.6. Severity and duration of problems

In addition to the type of problems causing distress, the level of severity and duration of each problem was also discussed with clients and recorded on the CORE Assessment form by the Counsellor/Therapist. During the initial assessment session Counsellor/Therapists indicated the level of severity by inserting a number ranging from 1 to 4, with 1 = "causing minimal difficulty", 2 = "causing mild difficulty", 3 = "causing moderate difficulty" and 4 = "causing severe difficulty". Duration was indicated by ticking one of four boxes alongside the corresponding problem types consisting of the following selection: < 6 months, 6 to 12 months, > than 12 months and Recurring/Continuous.

### 3.3.7. Duration of all presenting problems

Combining all problem types together, the majority of clients in the study (37.2%) reported that their main problems were recurring or continuous and over a quarter (28.3%) had experienced problems for more than 12 months.

Figure 4. Duration of all presenting problems

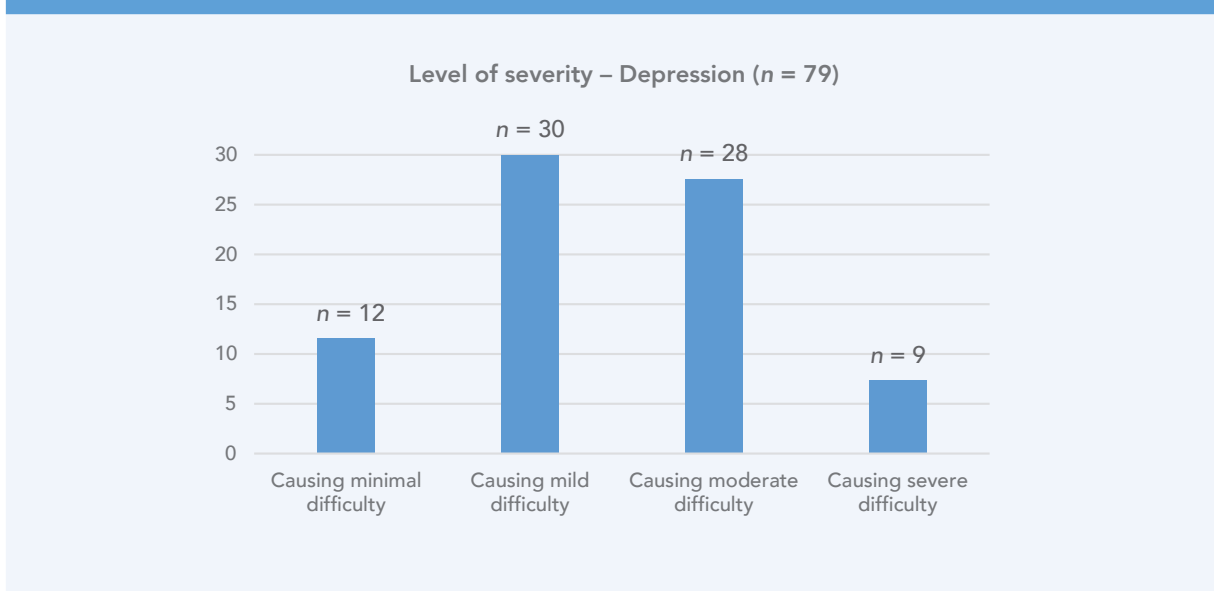


### 3.3.8. Severity of presenting problems – depression and anxiety

Due to the large majority of clients' problems being reported as depression and/or anxiety/stress, these problems types are further broken down as follows:

### 3.3.9. Depression – therapist rated severity of the problem at assessment

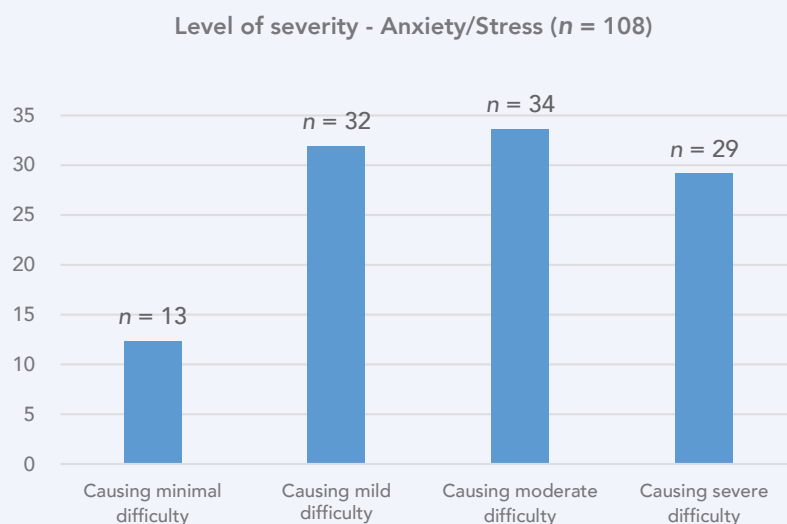
Figure 5. Severity of participants' depressive symptoms



64.8% (n = 79) of participants reported some level of suffering due to the effect of their depressive symptoms.

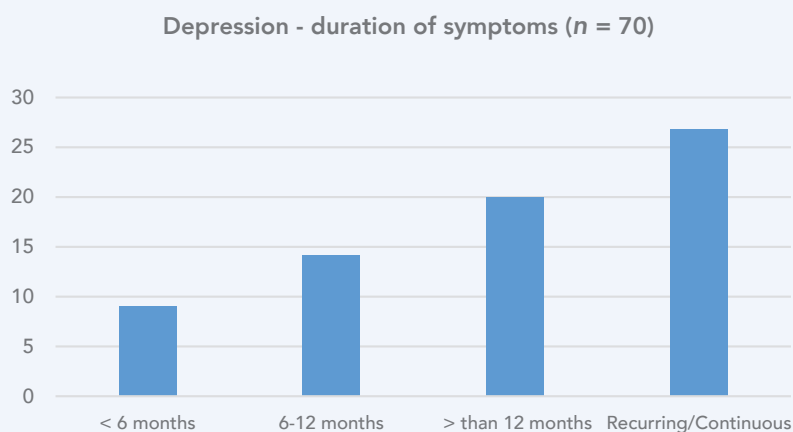
### 3.3.10. Anxiety – therapist rated severity of the problem at assessment

Figure 6. Severity of participants' anxious symptoms

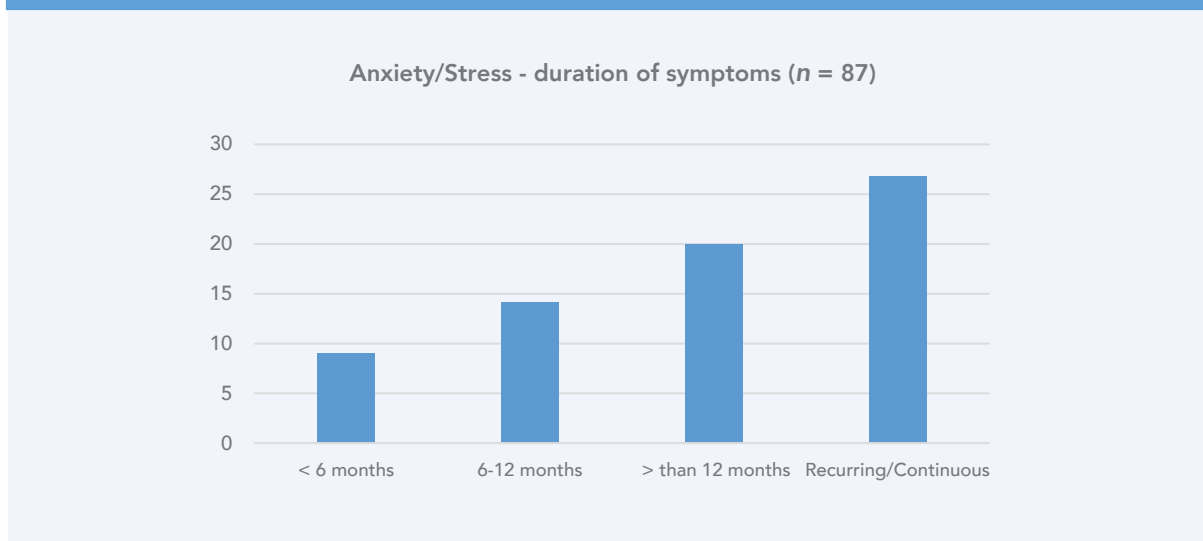


### 3.3.11. Duration of reported problems

Figure 7. Duration of reported problems



12.9% (n = 9) of all clients who reported the duration of their depressive symptoms reported suffering from them for less than 6 months, 20% (n = 14) for 6 to 12 months, 28.6% (n = 20) for more than 12 months and 38.5% (n = 27) on a recurring or continuous basis.

**Figure 8. Duration of participants' anxious symptoms**

11.5% ( $n = 10$ ) of all clients who reported the duration of their anxious symptoms reported suffering from them for less than 6 months, with 10.3% ( $n = 9$ ) reporting that their symptoms had effected them for 6 to 12 months, 32.2% ( $n = 28$ ) for more than 12 months and 46% ( $n = 40$ ) on a recurring or continual basis.

### 3.3.12. Referrers to the CIPC service

The majority of clients (90%,  $n = 110$ ) in the study were referred to the service by their GP. The remaining 4% ( $n = 5$ ) of participants were referred by a member of the Primary Care Team and referral information was not recorded by therapists for 7 of the 122 participants (6%).

### 3.3.13. Previous contact with CIPC service

5.7% of clients in the study had been previously seen or previously referred by the CIPC service. This represents the number of clients who have attended at least one previous assessment session.

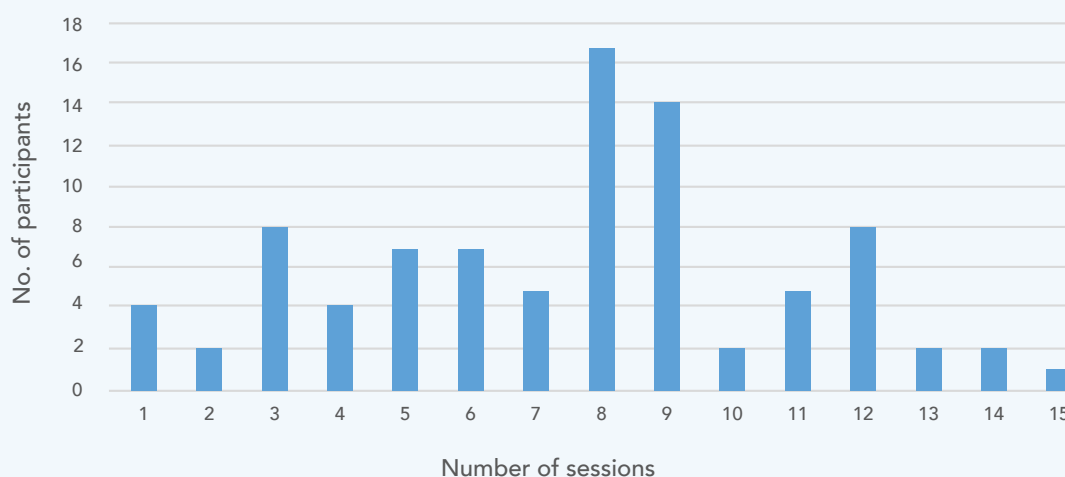
### 3.3.14. Waiting times

During the period of the study the spread of waiting times was, in the main, under six months and, at one point no clients were waiting over six months. The majority of client wait times were grouped in the 0-4 months at between 76-80% of clients, with the remaining 20-24% waiting between 4-6 months.

### 3.3.15. Number of sessions

Data were available for 89 clients was normally distributed in terms of the number of sessions attended. The median number of sessions attended by participants in the study was 5 while the range from the least to the most amount of sessions attended by clients was 2 ( $n = 4$ ) to 18 ( $n = 1$ ). The majority of clients, 13.9% attended 8 sessions ( $n = 17$ ) while 11.5% attended 9 sessions ( $n = 14$ ). The average number of sessions attended was 6.

Figure 9. Number of sessions attended



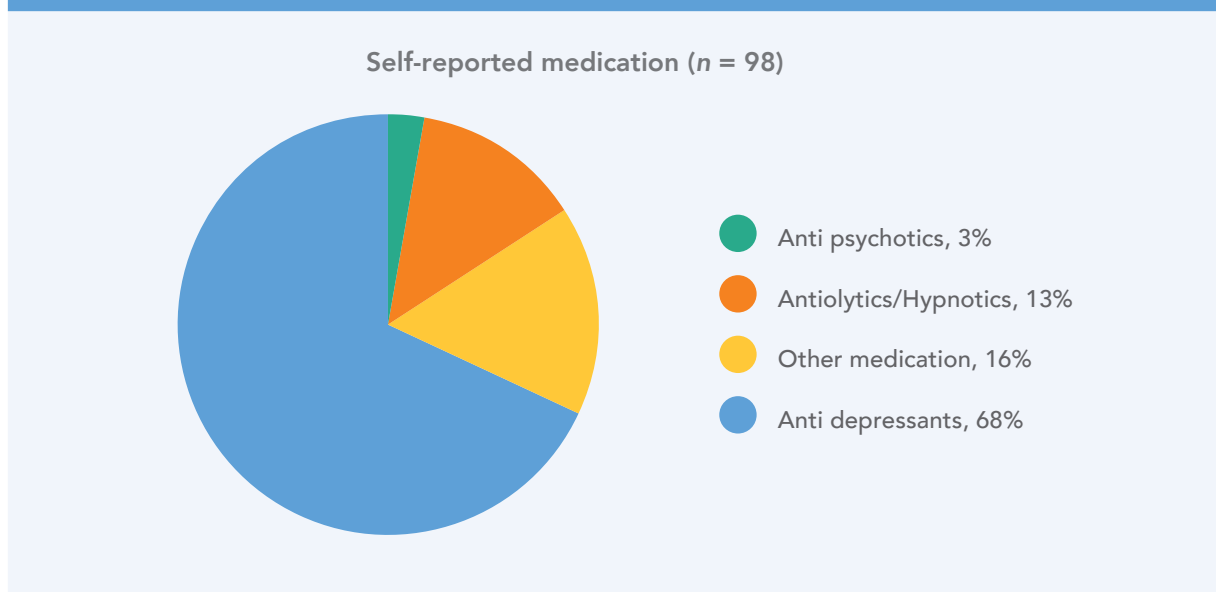
### 3.3.16. Pre therapy outcomes

Therapists taking part in the study reported the assessment outcomes for 122 participants. The vast majority or 98% ( $n = 120$ ) were accepted for therapy, 1 participant was identified as being unsuitable for therapy, 1 participant was referred to another service.

### 3.3.17. Pre therapy self-reported medication

At the initial assessment the majority 98 clients (63.9%) reported that they were taking medication prescribed by their GP to help with psychological problems. Of the 98 clients 68% ( $n = 66$ ) reported receiving prescriptions for anti-depressant medication, 16% ( $n = 16$ ) reported being prescribed some other kind of medication not specified. 13% ( $n = 13$ ) reported being prescribed minor tranquilisers in the form of anxiolytics or hypnotics, 3% ( $n = 3$ ) of participants reported that they were prescribed anti-psychotic medication. Self-reported medication data were not reported for 24 participants.

Figure 10. Self-reported medication

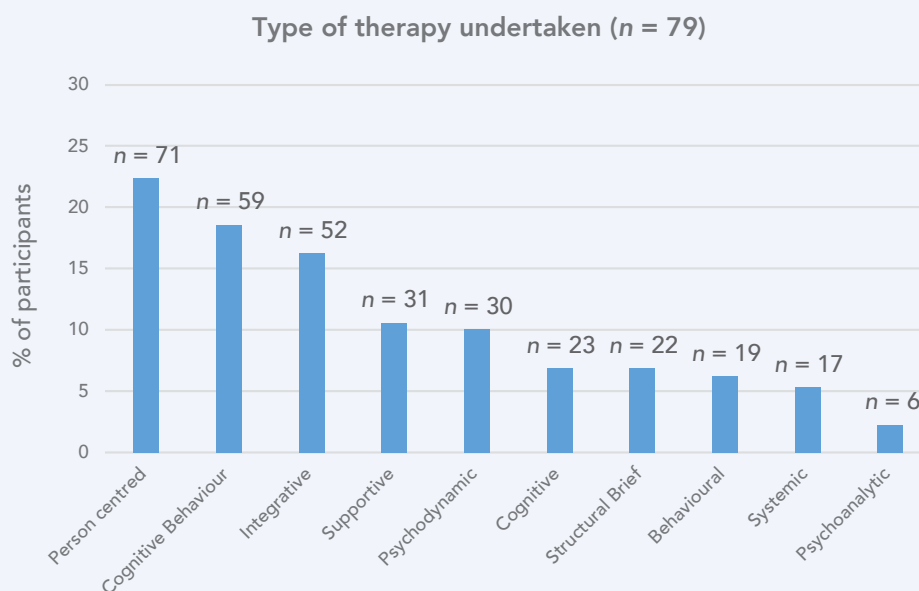


### 3.3.18. Type and frequency of therapy

The CORE End of Therapy form allows Counsellor/Therapists to enter a single or multiple instances of the type of therapy undertaken during the course of therapy for any one client. All 13 Counsellor/Therapists whom reported therapy type, recorded more than one type of therapy approach was employed with their clients. Therapy type was reported by Counsellor/Therapists for 65% of clients (n = 79).

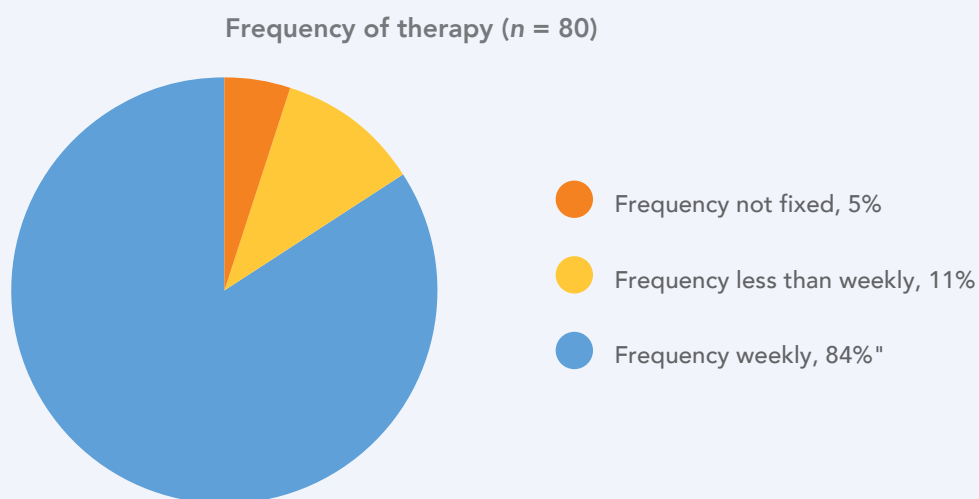
Three therapeutic approaches accounted for the main forms of therapy utilised by participating Counsellor/Therapists (Person Centred, Cognitive Behavioural Therapy and Integrative Therapy). All Counsellor/Therapists indicated that they utilised person centred therapy which was recorded for 89.9% (n = 71) clients. 74.7% (n = 59) of clients were indicated as receiving cognitive behavioural therapy and 65.8% (n = 52) of clients received integrative therapy (see figure below for full list of Counsellor/Therapist recorded therapies).

Figure 11. Types of therapy undertaken with participants



The majority of clients 84% (n = 67) attended therapy sessions weekly while 11% (n = 9) attended less frequently. The attendance of 5% (n = 4) of participants were recorded as not fixed.

Figure 12. Frequency of therapy

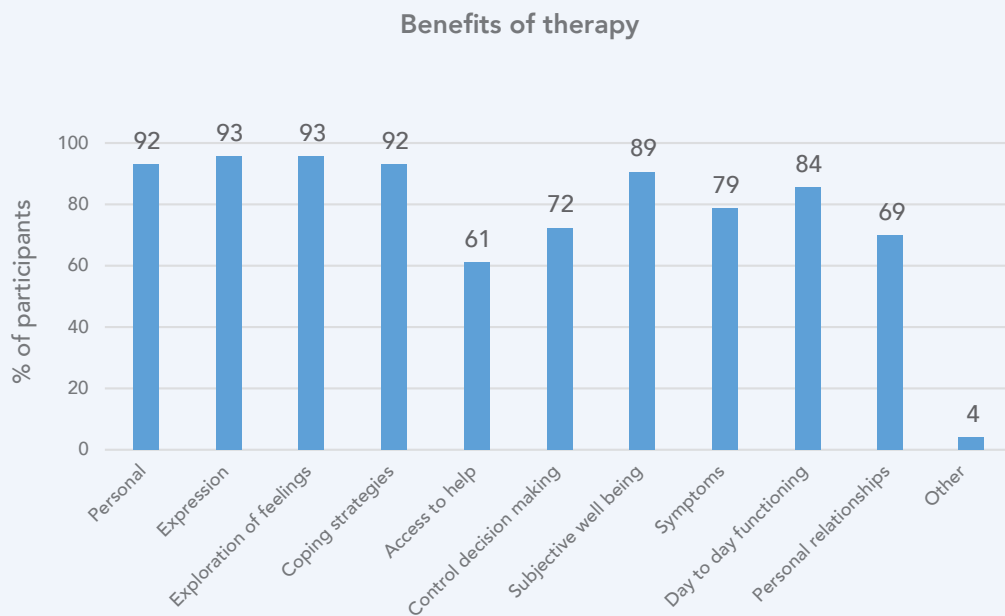




### 3.3.19. Contextual factors and benefits of therapy (Therapist reported)

Counsellor/Therapists are presented with the opportunity to indicate what they consider to be important benefits of therapy for each client they treat. This list is not exhaustive but provides some of the most common benefit responses as observed by Counsellor/Therapists. Expression, exploration of feelings, personal and coping strategies were the most commonly observed benefits selected 92%, 93%, 93% and 92% respectively. For a full breakdown of all categories see Appendix 4.

Figure 13. Counsellor/Therapist reported benefits of therapy



# Analysis of Risk

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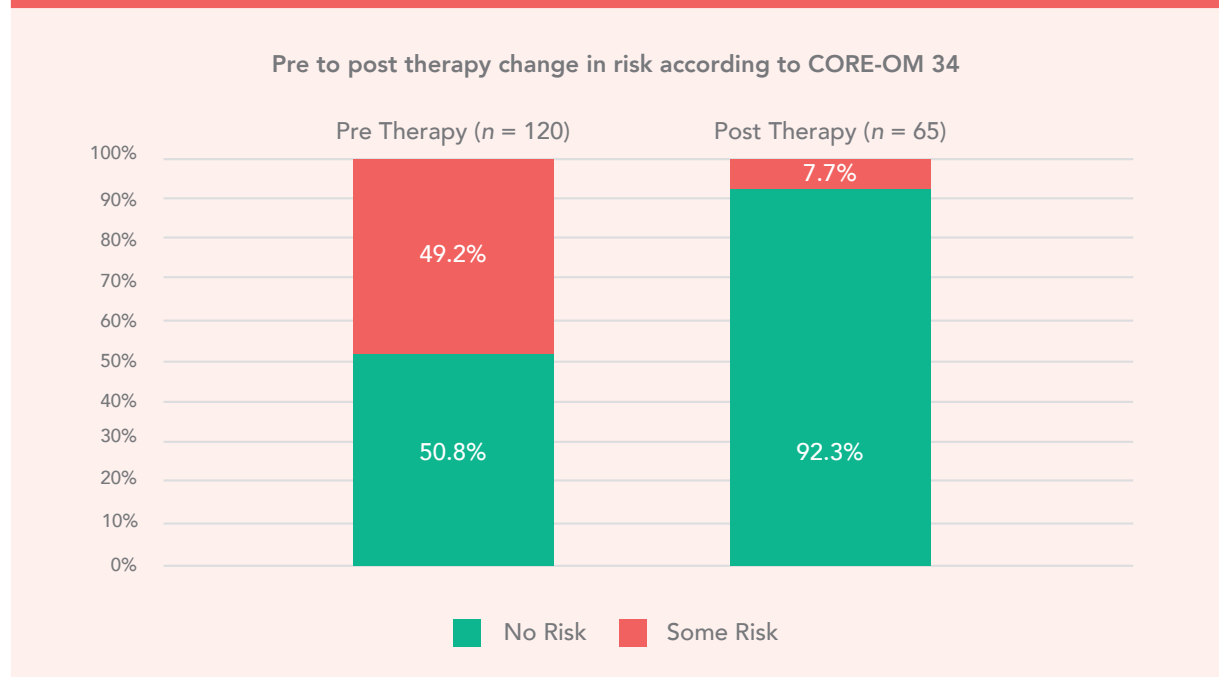
## 4.1. Risk according to CORE-OM 34 risk items

Clients answered six items related to the risk dimension on the CORE-OM 34 during the assessment and end of therapy sessions, four pertaining to risk to self and two related to the level of risk to others. Scoring of these risk items followed the same format as the rest of the CORE-OM 34 items; a five-point Likert scale from 0 to 4 ('Not at all', 'Only occasionally', 'Sometimes', 'Often', and 'All or most of the time') with all scores summed to result in a possible total of 24 (range 0-24).

A comparison of pre and post levels of risk as indicated by total scores of CORE-OM 34 risk items was conducted. Participants were classified as either being at no risk if they scored zero for all of the risk items, i.e. zero out of a possible 24, and the remaining participants with scores of greater than zero were classified as at some risk. Pre and post therapy risk scores of the resulting proportions of participants with complete and valid CORE-OM questionnaire scores were then compared.

Before therapy, 49.2% ( $n = 60$ ) of the sample scored higher than zero on one or more items from the Risk items (range 1 – 7). At post therapy this proportion had reduced to 7.7% ( $n = 5$ ) (range 1-3).

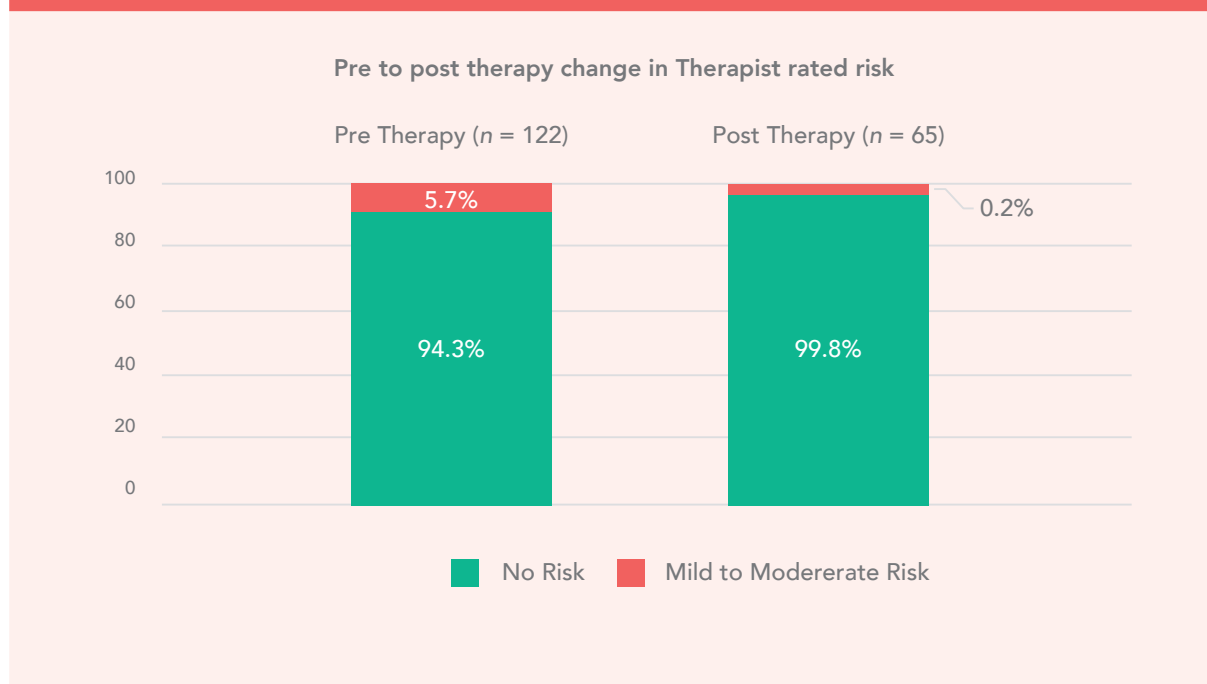
Figure 14. Proportions of pre to post therapy change CORE-OM 34 Risk



#### 4.1.1. Therapist rated risk

During the assessment sessions a risk rating is also assessed by the therapist. This rating is selected from one or more 4 risk domains; *Suicide, Self-harm, Harm to others* and *Legal/Forensic*. The level of risk is selected from each risk domain on a scale containing *None, Mild, Moderate*, and *Severe*.

Figure 15. Proportions of counsellor rated change in RISK scores.



For the purposes of assessing a change in therapist rated risk levels at assessment participants were categorised into two groups based on indicated risk categories on the CORE Assessment and End of Therapy forms: a *No Risk* group (i.e. indications of *None*) and a *Mild to Severe* risk group (i.e. all risk selections of *Mild, Moderate* or *Severe*). Analysis showed that before therapy 7 participants (5.7%) were deemed as presenting with some level of mild, moderate or severe risk by Counsellor/Therapists. At post therapy this proportion had reduced to one participant (0.2%) rated as mild and no clients rated as severe or moderate in the post therapy *Mild to Severe* group.

#### 4.1.2. Counsellor/Therapist rated versus participant rated risk at assessment

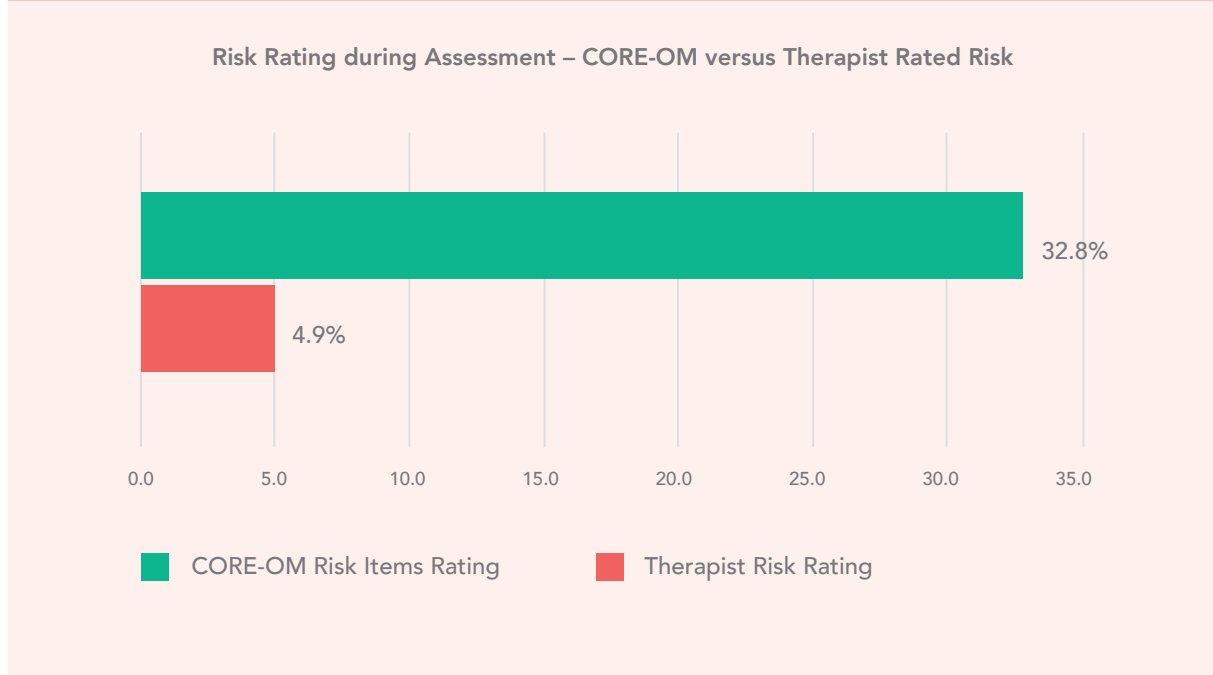
For the purposes of comparative analyses, attention is focussed on three of the four available risk categories as per the classification method used by Bewick et al. (2006), participants were classified as 'at risk' by Counsellor/Therapists if they scored 'moderate' or 'severe' on any of the Counsellor/Therapist-rated risk items during assessment.

Client rated risk was calculated by adding together the response item scores for all six risk items on the CORE OM. Clients who scored a total of 2 or more (i.e. 'Only occasionally' on two or more items or 'Sometimes' on 1 or more items) from the total CORE-OM 34 risk score (range 0-24) were classified as 'at risk'.

The level of agreement at assessment between counsellor/therapist and participant self-report ratings of risk as per the risk items on the CORE Assessment form and CORE OM-34 respectively were measured and compared. Using Counsellor/Therapist rating from the CORE Assessment form of 'moderate' or 'severe' risk on any of the risk items Counsellor/Therapists identified 6 participants (4.9%) participants. By contrast, using the clients'

responses to the CORE-OM 34 risk items 40 participants (32.8%) were identified as 'at risk'. This resulted in a discrepancy rate of 27.9%.

Figure 16. CORE-OM versus Therapist rated pre therapy Risk



## 4.2. Therapy endings

How therapy ended with clients was reported for 78% ( $n = 95$ ) of clients from the total sample of 122 participants. 53% ( $n = 65$ ) were reported as planned endings and 25% ( $n = 30$ ) were reported as unplanned endings. Therapy end data was missing for 22% ( $n = 27$ ) of participants. Of the planned endings 52% ( $n = 37$ ) were agreed during therapy, 9% ( $n = 8$ ) at the end of therapy and 29% ( $n = 20$ ) of the endings were agreed from the outset of therapy. Of the 27% ( $n = 30$ ) of unplanned endings, the type of ending was only recorded for 27 participants resulting in missing data for 3 clients. Of the unplanned endings reported 15% ( $n = 4$ ) were unplanned due to a crisis, 33% ( $n = 9$ ) were due to loss of contact, 30% ( $n = 8$ ) were unplanned ended by the client and 22% ( $n = 6$ ) were unplanned endings due to other reasons.

# Clinical Outcomes Data Analysis

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## 5.1. Missing data analysis and exclusion criteria

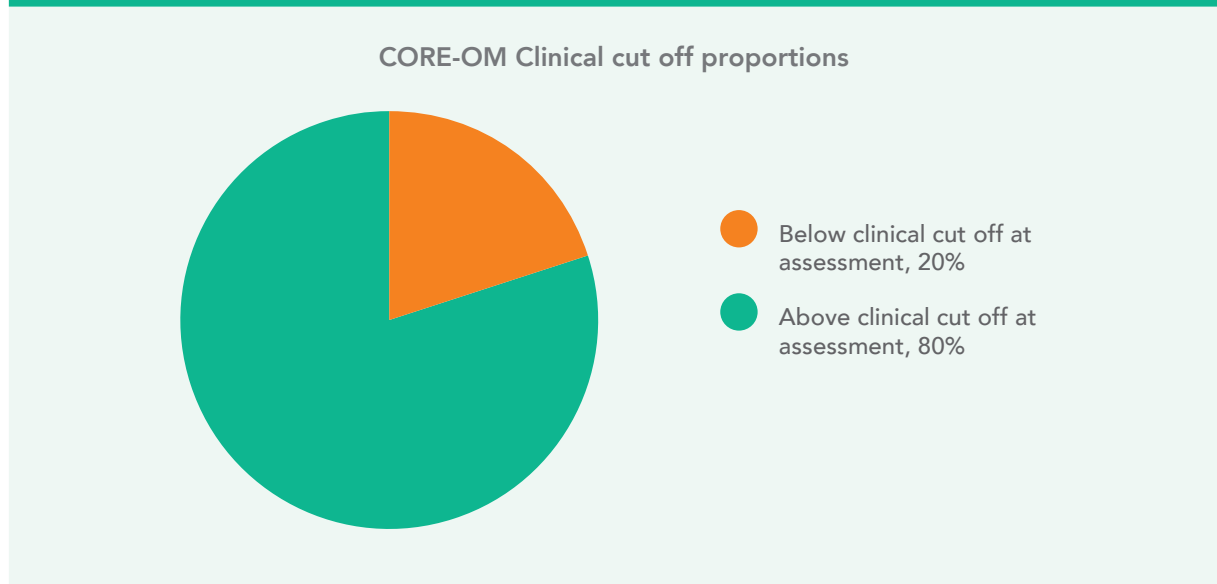
Analysis of the CORE-OM 34, WSAS scores and individual HRQOL-4 items was conducted based on pairwise deletion (available-case analysis) thus maximising all data available on an analysis by analysis basis. Further, participants with post therapy CORE-OM 34 and WSAS scores of 0 were excluded from pre/post analysis as well as those participants attending only one session in total (i.e. the assessment session). Time 2 data were used for pre/post analysis when appropriate i.e. in cases of missing end of therapy data and when more than 2 therapy sessions had been attended.

## 5.2. Analysis of CORE-OM 34 outcome data

### 5.2.1. Cut-off points for CIPC participants

At assessment 80% ( $n = 97$ ) of clients' CORE OM scores exceeded the clinical cut-off point. In other words at assessment 8 out of every 10 clients assessed scored in the clinical range.

Figure 17. Pre therapy percentage of CIPC client above and below clinical cut-off rates

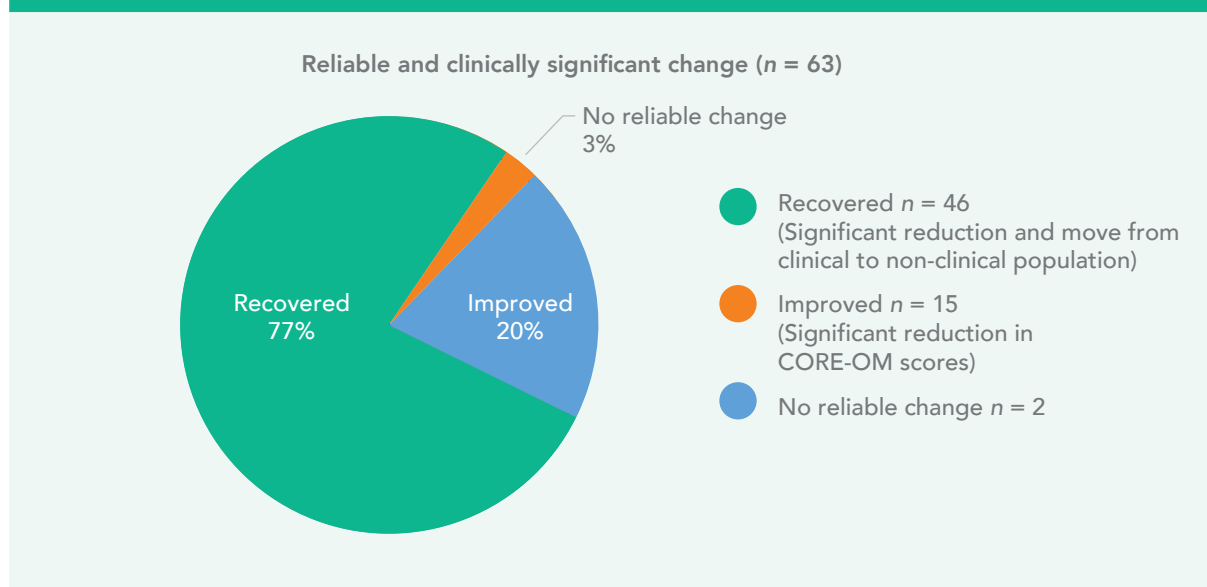


### 5.2.2. CORE-OM 34 Reliable and clinically significant change data

There are two main components used to calculate Reliable and Clinically Significant Change (RCSC). First is the amount of change observed, commonly referred to as the Reliable Change Index (RCI) for the measure and speaks to its reliability. The change between pre and post therapy scores must be sufficiently large as to be able to infer that it was the result of therapy as opposed to chance or error in the measurement instrument, i.e. is the measure reliable? For the CORE OM the RCI for samples from counselling populations comparative to those in this study is currently proposed as a .50 difference between pre and post scores (see Barkham et al., 2006; C. Evans, Connell, Barkham, Marshall, & Mellor-Clark, 2003; Mullin et al., 2006). Second, the amount of change in scores must be of a magnitude whereby it shifts a client's CORE-OM 34 score from within the range of the clinical population to that of the general population. The cut-off point between the clinical and general population has been established as 1.00 (see Connell et al., 2007; Evans et al., 2003; Mullin et al., 2006 for further information). Hence, both reliability and significance (improvement) criteria must be sufficiently met in order for a client to be considered reliably and significantly improved.

'Recovery' indicates reliable improvement in addition to a significant reduction in scores to move the client out of the clinical population into the non-clinical population, i.e. reliable and clinically significant change. 'Reliable Improvement Only', (i.e. improvement) denotes when a client's score meets the criteria for reliable improvement, but the change in scores is not sufficient to move them from the clinical to the non-clinical range. This can be the case when a client remains in the clinical population, while still showing a large reduction in the intensity of their symptoms. Also some clients enter counselling with a score below the clinical cut off but still report a considerable diminishment of problems. 'No Reliable Change' comprises of clients who did not meet the criteria for reliable change and the 'Reliable Deterioration' category indicates clients whose post- therapy scores were at least 0.5 higher than their pre-therapy scores.

**Figure 18. Reliable and clinically significant change \***



\* 5 clients scored below the clinical cut-off of 1.00 at assessment but still attained Reliable Change (i.e. < 0.5 change). While these clients did not meet the Significant Change criterion they were still included in the improved group in order to accurately represent the client profile.

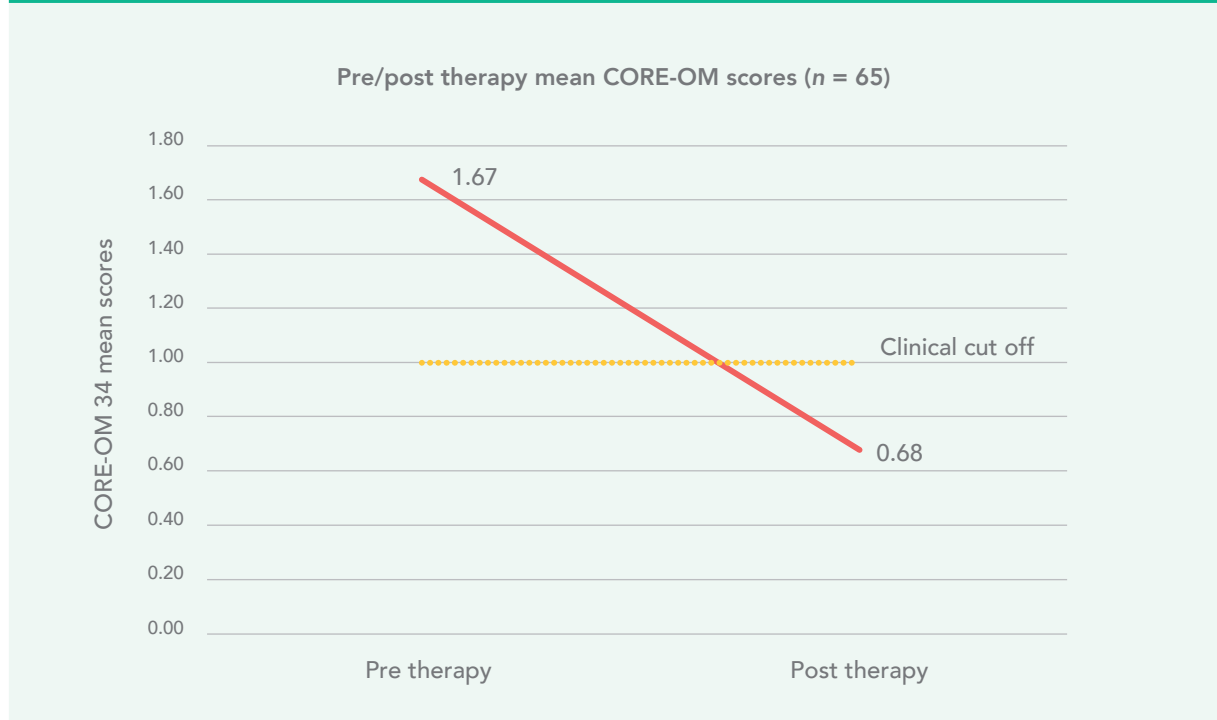
Overall 97% (n = 61) of clients in the study demonstrated either 'improvement' or 'recovery'. 77% of CIPC clients showed 'recovery' (n = 46) and 20% demonstrated 'significant improvement' (n = 15) in CORE-OM 34 scores after attending CIPC. Those clients showing 'no reliable change' showed a change in their scores less than the required level to move them from the clinical to the non-clinical range (n = 2). No clients who completed pre and post CORE OM demonstrated significant deterioration in their outcomes.



### 5.2.3. Pre and post CORE-OM 34 scores

The mean CORE OM score for participants ( $n = 120$ ) at assessment was 1.60 ( $SD = .60$ ). Initial CORE-OM 34 scores for those participants for whom pre and post therapy data was available ( $M = 1.72$ ,  $SD = .52$ ) did not differ significantly from those participants for whom only pre therapy data was available ( $M = 1.50$ ,  $SD = .65$ );  $t(115) = 1.87$ ,  $p = .064$ .

Figure 19. Pre to post change in CORE-OM 34 scores



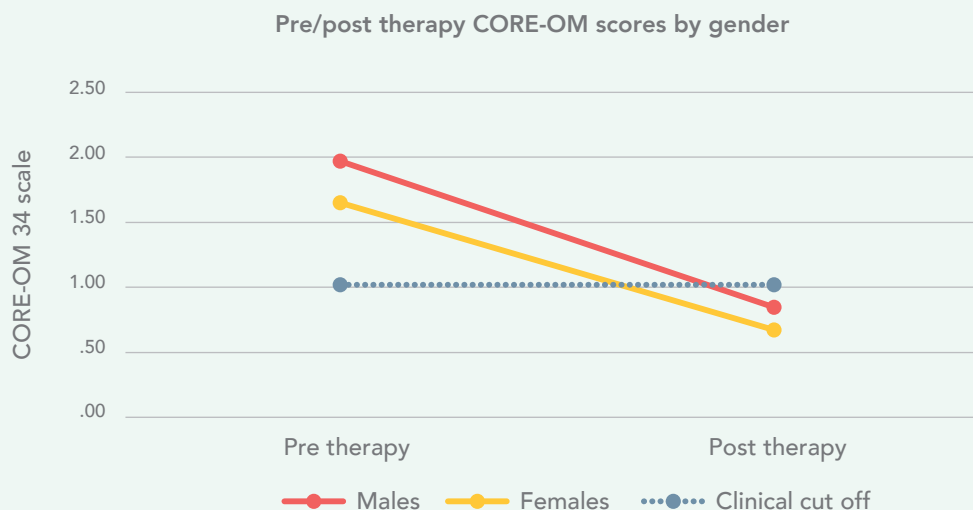
A paired samples t-test was conducted to evaluate the impact of counselling on participants scores for the CORE-34 Outcome Measure. There was a statistically significant decrease in CORE-OM scores from a pre therapy mean average of 1.67 to a post therapy mean average of 0.68 ( $n = 65$ ,  $p < .0005$ ). This resulted in an overall mean reduction of 0.99. Effect size was calculated in accordance with the method described by Cohen (1988) (ETA squared calculation). A moderate to large effect size <sup>3</sup> (.67) associated with the impact of counselling.

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

### 5.2.4. Gender differences in pre/post CORE-OM 34 therapy scores

Minor (non-significant) gender differences have been reported for clients who present for psychotherapy assessment using the CORE-OM 34 (Connell et al., 2007). No significant gender differences were found in the CIPC SE sample.

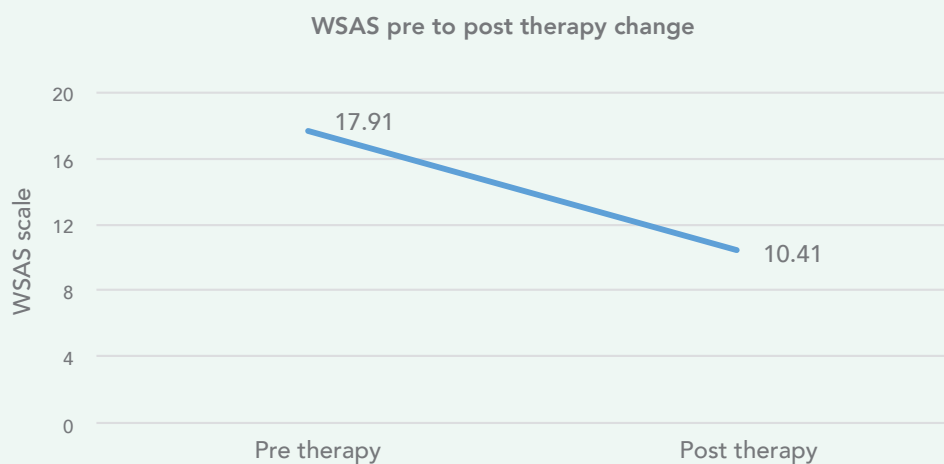
Figure 20. Change in CORE-OM scores by gender



## 5.3. Analysis of Work and Social Adjustment outcome data

Overall, there was an average reduction of 7.5 points in WSAS scores ( $n = 69$ ,  $SD = 8.60$ ) from 17.91 to 10.41. According to Löwe et al. (2004) a reduction rate of 2 standard errors of measurement is the minimum that should be considered clinically significant.

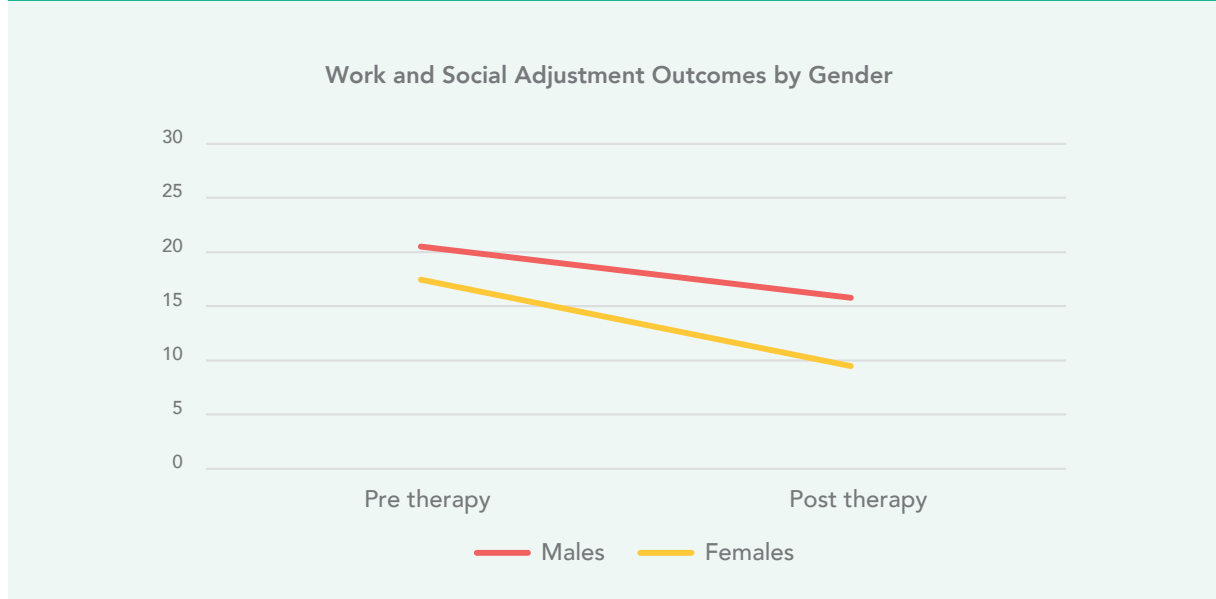
Figure 21. Work and Social Adjustment Outcomes



Applying this standard, a reduction of 8 points on the 40 point WSAS scale is considered clinically significant. The proportion of study participants who reached this level of reduction was 46.37% ( $n = 32$ )

There were moderate and large reduction in scores for men (20.5 to 16.6) and women (17.6 to 9.1) respectively. As also observed in the study by Zahra (2014) there were differences in baseline (pre therapy) and post therapy scores between males and females.

**Figure 22. Work and Social Adjustment Outcomes by Gender**



## 5.4. Analysis of Health Related Quality of Life outcome data

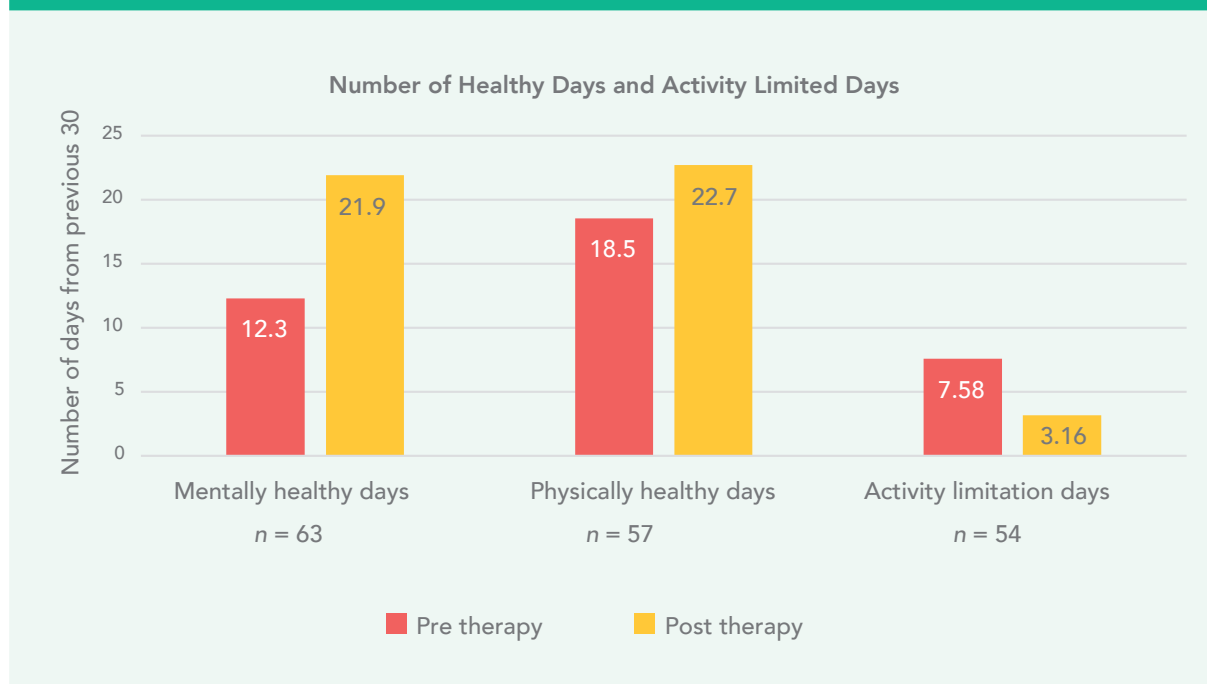
### General health at baseline and post therapy

52% ( $n = 64$ ) of participants provided pre and post therapy answers to the first question on the Health Related Quality of Life questionnaire pertaining to their general health. Before commencing therapy 6.3% ( $n = 4$ ) of participants reported feeling that their general health (i.e. combined physical and mental health) was Excellent. This number rose to 14.1% ( $n = 9$ ) by the end of therapy, an increase of 12%. 15.6% ( $n = 10$ ) of participants reported before therapy that they felt their general health was Very Good and this rose to 25% ( $n = 16$ ) by the end of therapy. There was a 10% increase to 37.5% ( $n = 24$ ) in the number of participants who reported that their general health was Good after therapy, up from 31.3% ( $n = 20$ ) before therapy began. 26.6% ( $n = 17$ ) felt their pre therapy general health was Fair and 18.8% ( $n = 12$ ) reported that they felt their general health was Poor. Both of these categories dropped by 17% to 15.6% ( $n = 12$ ) and 7.8% ( $n = 5$ ) respectively once therapy had ended.

Table 2. Pre/post HRQOL Question 1 response breakdown

HRQOL Question 1	Pre Therapy (n = 64)		Post Therapy (n = 64)	
	%	n	%	n
Would you say that in general your health is:				
Excellent	6.3	4	14.1	9
Very good	15.6	10	25	16
Good	31.3	20	37.5	24
Fair	26.6	17	15.6	10
Poor	18.8	12	7.8	5

Figure 23. Changes in mentally and physically healthy and activity limitation days



#### 5.4.1. Mentally healthy days at pre and post therapy

The number of healthy days is calculated by subtracting the number of unhealthy days from 30 days. Participants in the study (n = 27) reported an increase of 20.1% in the average number of healthy days in the 30 days prior to beginning therapy and the 30 days before therapy ended.

In terms of mentally and physically healthy days – there was a 78.05% increase in mentally healthy days from 12.3 to 21.9 from pre to post therapy (n = 63) and a 22.7% increase in the number of physically healthy days from 18.5

to 22.7. The number of days when clients' activity was limited because of their presenting psychological problem dropped by 58.31% from 7.58 to 3.16 days.

Paired sample t-tests indicated statistically significant differences between the mean number of mentally unhealthy days before therapy ( $M = 17.72$ ,  $SD = 9.68$ ) and after therapy ( $M = 8.09$ ,  $SD = 7.55$ )  $t(56)$ ,  $p < 0.001$ , the mean number of physically unhealthy days before therapy ( $M = 11.46$ ,  $SD = 12.26$ ) and after therapy ( $M = 7.30$ ,  $SD = 8.96$ )  $t(53)$ ,  $p = 0.006$  and mean number of activity limitation days before therapy ( $M = 7.58$ ,  $SD = 9.50$ ) and after therapy ( $M = 3.16$ ,  $SD = 5.00$ )  $t(56)$ ,  $p < 0.001$ .

### Associations between pre therapy WSAS, HRQOL and CORE-OM 34 scores

Correlational analysis (using Pearson product-moment correlation coefficient) were performed in order to determine if any significant relationships were present between the number of pre therapy HRQOL mentally unhealthy days, physically unhealthy days and activity limitation, WSAS and CORE-OM 34 scores. Positive relationships or associations indicate that as the mean value of one variable (e.g. WSAS) increased in value so did the mean value of the corresponding variable (e.g. HRQOL number of mentally unhealthy days). A negative relationship would indicate that as one variable increased, its corresponding variable under inspection decreased.

There were positive relationships between WSAS scores and the number of mentally unhealthy days [ $r = .302$ ,  $n = 106$ ,  $p = .002$ ] and the number of activity limitation days [ $r = .266$ ,  $n = 101$ ,  $p = .007$ ]. Also, the relationship between CORE-OM 34 scores and the number of mentally unhealthy days was in a positive direction [ $r = .539$ ,  $n = 108$ ,  $p < .001$ ], as was the association between CORE OM scores and the number of activity limitation days [ $r = .422$ ,  $n = 104$ ,  $p < .001$ ]. There were no statistically significant relationships found between the number of physically unhealthy days and WSAS scores [ $r = .038$ ,  $n = 103$ ,  $p = .0705$ ] of CORE OM scores [ $r = .156$ ,  $n = 105$ ,  $p = .113$ ]. Additionally, the severity of clients' symptoms as measured by the CORE-OM 34 was associated with increased levels of work and social adjustment impairment [ $r = .408$ ,  $n = 107$ ,  $p < .001$ ]. For full table see Appendix 11.

# Counsellor/Therapist Research Experience

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## Counsellor/Therapist Research Experience

A survey was undertaken to assess Counsellor/Therapist experiences of engaging in Phase 1 of the study with a particular focus on Counsellor/Therapist views of the potential impact of the research on clients. This was conducted on-line via Survey Monkey™ between 15/02/2017 and 06/03/2017. Fifteen Counsellor/Therapists, all of whom participated in data collection, completed the survey. 74% of Counsellor/Therapists found the task of inviting clients to take part in the evaluation easy. 80% of Counsellor/Therapists felt that the invitation to participate in the research had no influence on clients' decisions to engage in/continue in therapy. Participating Counsellor/Therapists expressed a sense of involvement with the study and research process. These results indicated a high level of engagement by Counsellor/Therapists with the research process and minimal impact on clients in counselling.

# Discussion

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## Discussion

In terms of questionnaire completion rates; Bewick et al. (2006) reported a 39% mean completion rate at assessment for pre and post therapy CORE-OM 34 across 35 NHS primary care centres in the UK ( $n = 64,610$ ) compared with a higher rate of 54.1% ( $n = 65$ ) in this study. This is slightly above the 75th percentile rate reported in the Bewick et al (2006) study of 53%. This is a very favourable outcome when considered in light of the changes to coordinator and counsellors' administrative and clinical practices due to the introduction of additional questionnaires and data submission tasks.

Questionnaire response rates for the HRQOL-4 have also been reported as high as 98.6% to 99.3% in continuous telephone based data collection across 50 states in the U.S. (CDC, 2001). In the current study a 95% pre therapy completion rate is comparable and a 52% post therapy completion rate is considered above average for practice based studies such as this. Also, the method of data collection used by the Centre for Disease Control in the U.S., i.e. telephone allows for multiple attempts to gather the data from the same participants, a method that was not available to the Counsellor/Therapists who gathered data for this study.

44% of clients did not consent to participate in the research. This appears high compared to studies in similar services (see Werbart, Levin, Andersson, & Sandell, 2013) and could be due to factors attributable to normal aspects of feasibility research. For example, Counsellor/Therapists were required to incorporate new aspects into their routine clinical process such as inviting clients to participate in the study and introducing them to extra questionnaires. It is reasonable to assume not all Counsellor/Therapists acquired the same level of comfort and capability integrating these new processes or in the same amount of time.

Participants in the study generally presented for assessment with multiple problems. Counsellor/Therapists used a range treatment approaches with person-centred, cognitive-behavioural and integrative being the most commonly utilised. This suggests a level of flexibility and competence during the client assessment process and ability to apply a central principle of the CIPC service i.e. providing a therapeutic approach that focuses on the individual needs of clients as they present for treatment.

There was a significant difference between CIPC Counsellor rated risk and levels reported by clients. The proportion of difference found between Counsellor/Therapists' and client's rating of risk - 27.9% is broadly congruent with that reported in the literature (see Bewick, McBride, et al., 2006; Brown, Jones, Betts, & Wu, 2003). While this may initially appear to be a cause of concern, Bewick et al. (2006) point to 2 important factors that contribute to this level of discrepancy; first the CORE-OM 34 completed by the client and Therapy Assessment Form completed by the counsellor frame the assessment of risk in slightly different ways. In addition a strict operational definition of 'mild', 'moderate' or 'severe' risk has not yet been developed. Further work is needed in order to underpin judgements used to apply these criteria to clinical work. From a learning perspective, Bewick et al. (2006) point to the fact that such discrepancies, when viewed from a conversational model of therapy (i.e. Hobson, 2013) can act as a starting point for communication between the client and practitioner and, as such become part of the interactional process between them.

Significantly lower levels of distress, both statistically and clinically were observed in a substantial proportion of participants post therapy for both the CORE-OM 34 and WSAS. Also, significantly less impairment was reported by a majority of participants in the area of functional ability. According to the HRQOL, significantly lower numbers of mentally and physically unhealthy days were reported along with better perceptions of overall health and higher levels of activity for clients after therapy. A significant gender difference in the WSAS scores was identified with less change noted amongst males.

The Work and Social Adjustment Scale (WSAS) and Health Related Quality of Life (HR-QOL) measures have been used in combination in previous studies. Trivedi et al. (2006) utilised both measures to evaluate health related quality of life dysfunction across psychological, physical, and social domains for people with Major Depressive Disorder (MDD) ( $n = 2307$ ) before they entered a course of psychotherapy. Findings by Trivedi et al. support the findings in the current study i.e. greater severity of depressive symptoms was associated with greater impairment of work and social adjustment and poorer quality of life.

### Comparison of severity of problems between CIPC CORE-OM data and UK Primary Care Studies

How data in the current study compare with data from similar sample types in other primary care counselling/psychotherapy services in the UK can be informative from a service perspective. Large scale benchmarking of services with the aim of profiling the severity of client problems at intake (i.e. assessment) in the UK has been conducted by Barkham et al. (2005), who compared CORE-OM 34 scores of client samples from 32 primary care settings with those from 17 secondary care setting ( $n = 5733$  and  $n = 1918$  respectively). Mullin et al. (2006) also drew on data from a sample of over 11,953 clients from 32 NHS counselling services and compared outcomes across these services. These data are presented in the table below.

**Table 3.** Comparison of data from CIPC SE Feasibility, Mullin et al. (2006) and Barkham et al. (2005)

	CIPC Feasibility Study			UK Primary Care Mullin et al. (2006)			Barkham et al. (2005)					
	SE						Primary Care			Secondary Care		
	<i>n</i>	Mean	SD	<i>n</i>	Mean	SD	<i>n</i>	Mean	SD	<i>n</i>	Mean	SD
All	120	P r e 1.67	0.61	11953	P r e 1.75	0.63	5733	1.81	0.67	1918	1.81	0.74
	63	P o s t 0.68	0.50	11953	P o s t 0.85	0.63						

Of interest is the comparison of intake and outcome data between all 3 sites. An initial examination of mean pre therapy scores shows a decrease from both the Primary Care and Secondary care samples in Barkham et al. (2005) of 1.81, to 1.75 in the Mullin et al. sample and finally to 1.67 for the CIPC SE Feasibility study. These minor differences may be as a consequence of slight variation between the CIPC model of service and those employed in NHS sites in the UK. Primary care counselling in the UK include as criteria for service entry particular eligibility disorders and problem types which are regarded as exclusion criteria in the CIPC service model; i.e. Post-Traumatic Stress Disorder and Obsessive Compulsive Disorder. Hence, the CIPC service appears to screen out these types of clients who may require referral to secondary services at the assessment stage. Thus, it could be argued that such screening occurs as a concomitant function of the CIPC assessment process and should provide a basis for feedback to a GP who can then refer these clients on to secondary services if required.

Statistically significant differences between pre and post therapy CORE-OM 34 scores in the South East region convey a certain amount of and particular type of change. A recovered rate of 74% of those clients with pre and post therapy data ( $n = 63$ ) is very encouraging. This compares to an average recovered rate of 51% in the study by Mullin et al. (2006) ( $n = 11953$ ). However, this comparative difference must be viewed in the context of the different sample sizes whereby a smaller sample size will generally lead to less accurate estimation precision. This precision will increase as more study participants complete their therapy in the remaining HSE regions completing the National Evaluation.

Using reliable and significant change categorisation allows for more practical interpretation of statistical output by providing a more meaningful measure of change for clients for review by both practitioners and others involved at all levels of the CIPC service. Additionally, the contribution of these data to the overall national sample along with the production of clinical outcome benchmarks for each study area acts to build an overall national service profile. This regional profile can be compared against other HSE areas and eventually the national CIPC service profile with similar primary care services in the UK and other jurisdictions using the CORE-OM 34.

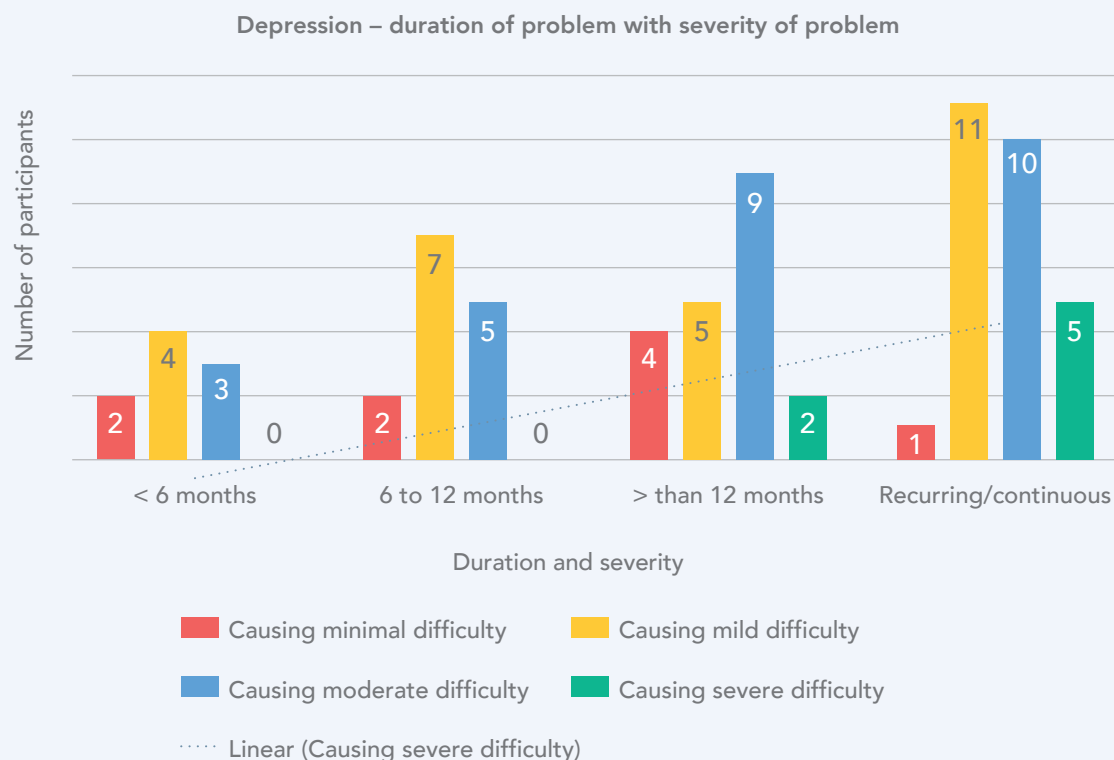
Some analyses were conducted in order to investigate the relationship between the initial severity of participants' symptoms and CORE-OM 34 outcomes. Participants were categorised into 3 levels of severity depending on their CORE OM score. The cut-off points for these categories are defined by Mullin et al. (2006) as Low severity < 1 (i.e. below clinical cut-off), Mild/Moderate severity 1 to 2.49 and High severity  $\geq 2.5$ . The initial severity of Participants' symptoms, as measured by their pre therapy CORE-OM 34 scores, was shown to have a significant effect on the level of their improvement at post therapy. However, while all categories of participants showed marked improvement (with the greatest improvement being shown by the patients who started treatment in the severe severity group) the number of participants in the sample was too low to be included in the formal analyses. In other words, at this stage this analysis can only be said to indicate a trend towards greater improvement for those experiencing more severe levels of distress, but is one that will be examined more formally as participant numbers increase during the remainder of the National Evaluation.

Finally, no analyses were conducted to examine the effect of using participant's Time 2 (as opposed to Time 3) data as post therapy measures. Hence, the potential effect of any positive or negative bias on final outcomes for these particular participants was not examined.

#### **Relationship between pre therapy CORE OM scores and problem severity and duration for depression and anxiety**

As described earlier, the severity of clients' main presenting difficulties were assessed and indicated by Counsellor/Therapists on the CORE Assessment Form usually during the first session. More than one type of problem was reported as causing distress for most clients and different presenting problems were reported as causing varying levels of distress or difficulty. Additionally, different durations of presenting problems were reported and these in turn related to the severity of particular problems. Cross tabulation of problem severity and duration was examined for the two main problems with which clients presented, i.e. anxiety and depression. See figures 24 and 25 below.

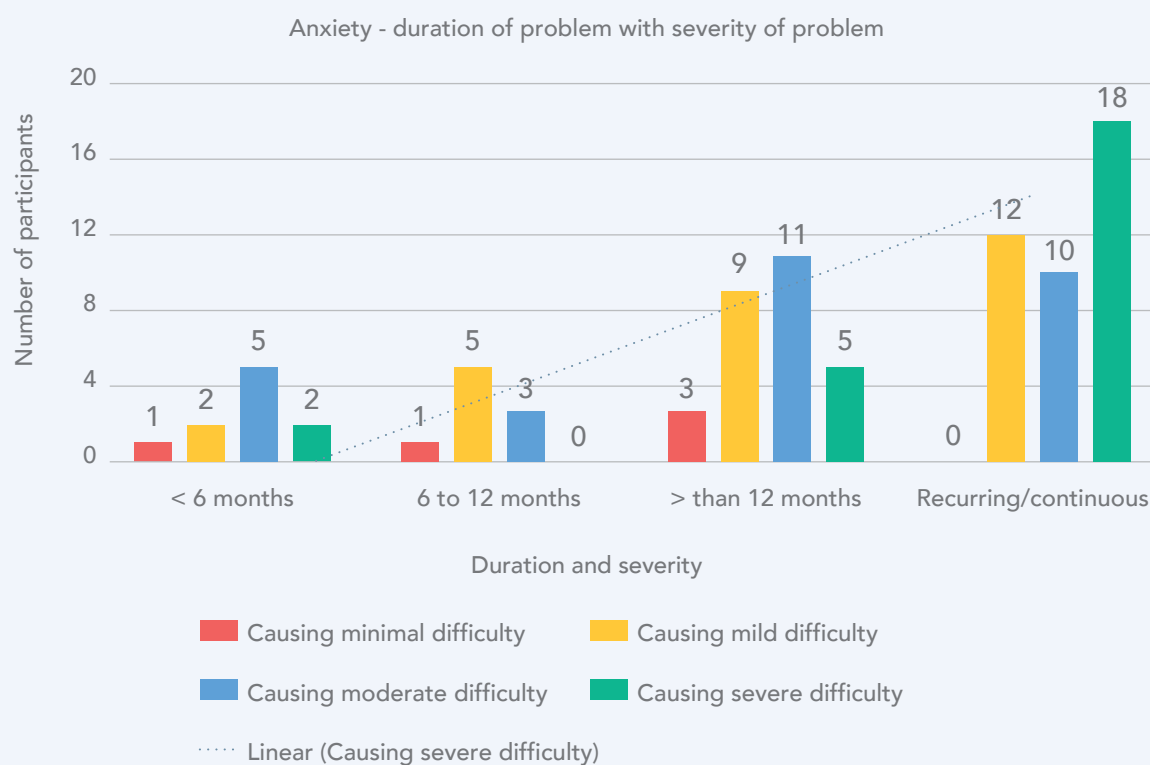
Figure 24. Depression – severity of distress as a function of duration of depressive symptoms



Statistically significant relationships were found between initial problem severity and duration of depressive symptoms ( $r = .265$ ,  $N = 70$ ,  $p < .05$ ) and between the initial severity and duration of anxiety/stress related symptoms ( $r = .236$ ,  $N = 87$ ,  $p < .05$ ). What is visually observable is an almost linear increase in the number of clients from low to high symptom severity as the duration of depressive and anxious/stress related symptoms extends from less than 6 months to being a problem that is continuous/recurring for clients.

A combined rate of 89.3% of participants in the study presented with a level of distress caused by symptoms related to depression and anxiety which had been problematic for more than 12 months. The results suggest that the longer potential clients have been experiencing their mental health problems, the higher the likelihood they will present with more severe symptoms. Bebbington et al. (2000) found that the main determinant of contacting a GP for help with mental health problems was the severity of those symptoms, i.e. the more severe the symptoms the less likely they were to seek help. Hence, as the data in the current study show, as the severity of symptoms increased for participants in the current study, the longer the period before they were referred to the CIPC service. One possible reason is that the clients in the sample for the current study also did not seek help until their symptoms were increasingly severe, reflecting the behaviour of those in the study by Bebbington. Further, gender differences in help seeking behaviour for mental health problems is well documented (see Oliver, Pearson, Coe, & Gunnell, 2005) with young men being particularly unlikely to seek help. Additional information to address this question, and how these data relate to therapy outcomes requires a larger sample would be aided by more complex and powerful analysis. This can be accomplished once additional data has been gathered as the study progresses.

Figure 25. Anxiety – severity of distress as a function of duration of anxious symptoms



The remaining phases of the CIPC National Evaluation Study will incorporate outcome follow up data at six and twelve months providing a picture of impact of counselling over time. Davis, Corrin-Pendry, & Savill (2008) found that 30 months after brief, time-limited integrative counselling their CORE-OM 34 scores were continuing to improve on their post therapy scores ( $n = 58$ ). A randomised controlled trial conducted by Corney and Simpson (2005) did find an overall significant improvement in the actual scores over time but no differences between the experimental group receiving short term counselling ( $n = 92$ ) (i.e. psychodynamic and cognitive behavioural) and the group receiving usual GP care only ( $n = 89$ ). Differences between the results of RCTs and practice-based studies in the effectiveness of counselling and psychotherapy are not unusual (see Hemmings (2000). Reasons for this have included the fact that participation in an RCT may not be desirable by certain clients of a counselling service who then refuse to be randomised leading to a skewed representation in the control arm of participants who do accept placebo or wait-list conditions. This type of client self-selection, among other factors has been said to diminish the generalisability of findings in RCTs (Seligman, 1995).

Once data collection is complete, the current study will comprise data for a large dataset (>1000 participants) and this volume of data will mitigate some of the limitations associated with RCT studies, e.g. impact of drop out of clients from the trial, non-representation of real world client sample (i.e. heterogeneous) in favour of an homogenous sample or use of single outcome measures. Further, analysis of the predictors and relationships between client experiences in counselling can be linked with outcomes, with the large number of participants providing significant power to those subsequent analyses. Hence, the final results of the overall national evaluation will provide a robust and valid practice-based profile of the CIPC service in terms of clinical outcomes.

# Conclusion

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## 8. Conclusion

The above reports on Phase 1 of the Counselling in Primary Care National Evaluation. The purpose of this phase of the evaluation was twofold; first, to test the planned research methods in order to inform these processes in the remaining HSE areas. Second, to report the outcomes for all relevant variables of interest to the service managers, directors, coordinators, Counsellor/Therapists and other main stakeholders. Relevant documentation on the main learning outcomes has been produced and disseminated to those CIPC staff members undertaking the research in the remaining HSE areas (see CIPC Coordinators report 2016). This includes those data from the survey of Counsellor/Therapists which captured their experience of taking part in the data collection process and a comprehensive updating of research processes for both Counsellor/Therapists and area coordinators.

### 8.1. Evaluation tasks outstanding

Data collection has continued since Phase 1 was completed. To date client outcome data has been gathered from two additional CHO areas, with data collection commenced in CHO areas 3 & 7, followed by CHO 6. All remaining CHO Areas began data collection by February 2018. Data collection will continue in all remaining HSE areas contributing to the overall national sample available for analysis. A number of planned evaluation tasks remain outstanding and will be addressed during the completion of the national evaluation in the remaining areas:

- Qualitative data collection and analysis from key service stakeholders including GPs.
- Follow up evaluation of clinical outcomes at 6 and 12 months
- An evaluation of psychotropic medication prescription patterns for clients attending counselling
- Evaluation of Client and GP satisfaction with CIPC

Preliminary results of the next phase of the CIPC evaluation are expected in 2018.

The addition of these research elements to the overall national evaluation report for all 10 HSE areas will provide a comprehensive and textured account of one of the first National Evaluations of Counselling in Primary Care service performed anywhere in the world.

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# Appendices

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## Appendix 1

### Participant Demographic Information

SE CIPC Evaluation Study – Participant Demographics							
		Mean	Min-Max	n	%	Total	Missing %
Age		40.11	17-83			122	
Gender							
	Male	41.61	19-63	23	18.9		
	Female	39.76	17-83	99	81.1		
Employment Status						117	4.1
	Full time paid employment (>30 hrs per week)			15	12.3		
	Part time paid employment (<30 hrs per week)			19	15.6		
	Receiving sickness/incapacity/invalidity benefit			11	9.4		
	Unemployed			60	51.3		
	Full time student			5	4.3		
	Part time student			2	1.7		
	retired			4	3.4		
Ethnic Origin						122	
	White Irish			110	90.2		
	White Irish Traveller			2	1.6		
	Any other White Background			10	8.2		

## Appendix 2

### Use of other services

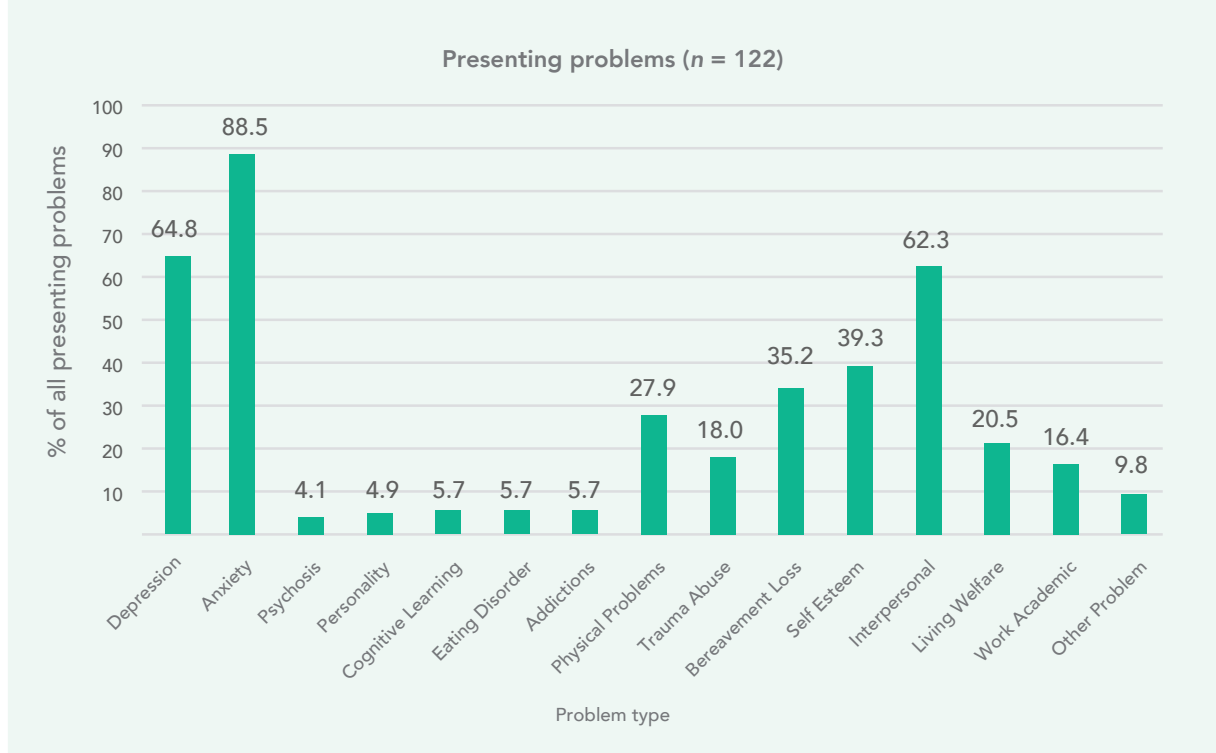
Other Service	Concurrent use		Used in the last 12 months		Used more than 12 months ago	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
GP or Primary Care Team	66	39.5	17	10.2	29	17.4
Services In Primary Care	5	3.0	2	1.2	0	0
Services In the Community	1	0.8	0	0	1	0.8
Sessional Services in Hospital	3	2.5	0	0	0	0
Day Care Services	2	1.6	1	0.8	1	0.8
Use of Hospital Services for Ten Days or Less	0	0	1	0.8	1	0.8
Hospital Services for More than Eleven Days	0	0	0	0	1	0.8
Psychological Services From a Special Team	3	2.5	4	3.3	4	3.3
Day Program Services	1	0.8	0	0	0	0
In Patient Services - Treatment	0	0	1	0.8	1	0.8
Other Counselling Services	1	0.8	8	6.6	13	10.7



## Appendix 3

### Presenting problems

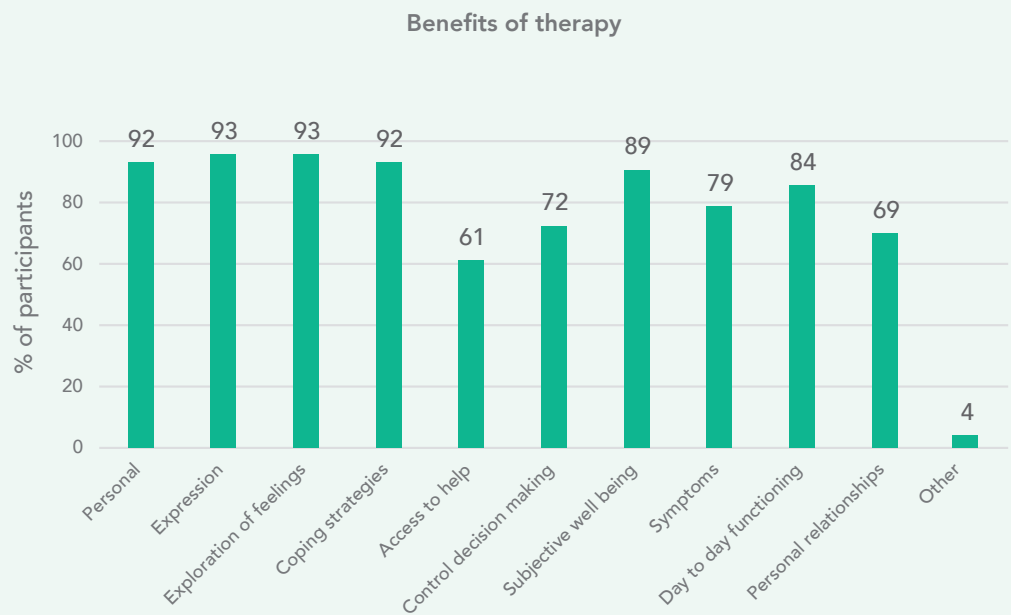
#### Appendix 3. Presenting problems



# Appendix 4


## Counsellor/Therapist indicated benefits of therapy

Appendix 4. Counsellor/Therapist benefits of therapy



## Appendix 5

### Core Assessment Questionnaire



**Site ID**

letters      numbers

**Client ID**

**Sub Codes** **TH ID number**    **SC2 numbers**    **SC3 numbers**

**Referrer(s)**

**Age**

**Male** ☐ **Female** ☐

**Employment** ☐ ☐

**Ethnic Origin** ☐ ☐

**Referral date**   /   /

**First assessment date attended**   /   /

**Last assessment date**   /   /

**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) <input type="checkbox"/>	Full time carer (of disabled/elderly etc) <input type="checkbox"/>
Living with partner <input type="checkbox"/>	Living in shared accommodation (eg lodgings) <input type="checkbox"/>
Caring for children under 5 years <input type="checkbox"/>	Living in temporary accommodation (eg hostel) <input type="checkbox"/>
Caring for children over 5 years <input type="checkbox"/>	Living in institution/hospital <input type="checkbox"/>
Living with parents/guardian <input type="checkbox"/>	Other <input type="checkbox"/> <input style="width: 150px; border: 1px solid black;" type="text"/>
Living with other relatives/friends <input type="checkbox"/>	

**Current/previous use of services for psychological problems?**  
*Please tick as many boxes as appropriate*

	Concurrent	< 12 mths	> 12 mths
<b>Primary</b> GP or other member of primary care team (eg practice nurse, counsellor) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Secondary</b> In primary care setting .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In community setting.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In hospital setting on sessional basis .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Day care services (eg day hospital) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hospital admission <= 10 days.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hospital admission >= 11 days.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Specialist</b> Psychotherapy/psychological treatments from specialist team (sessional) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attendance at day therapeutic programme .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inpatient treatment.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Other</b> Counsellor in eg voluntary, religious, work, educational setting.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>


  

**Is the client currently prescribed medication to help with their psychological problem(s)?** Yes ☐ No ☐

**If yes, please indicate type of medication:**


Anti-psychotics <input type="checkbox"/> (neuroleptics/major tranquillizers)	Anti-depressants <input type="checkbox"/>	Anxiolytics/Hypnotics <input type="checkbox"/> (minor tranquillizers)	Other <input type="checkbox"/>
---	---	--	--------------------------------

Survey : 76



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Supported by [www.coreims.co.uk](http://www.coreims.co.uk)

Page : 1



## Appendix 5

### Core Assessment Questionnaire (Contd.)

<b>Brief description of reason for referral</b> <div style="border: 1px solid black; height: 50px; margin-top: 5px;"></div>																																																																																																																					
<b>Identified Problems/Concerns</b> <table style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 15%; text-align: left;">Severity</th> <th style="width: 20%;"></th> <th style="width: 10%; text-align: center;">&lt; 6 months</th> <th style="width: 10%; text-align: center;">6-12 months</th> <th style="width: 10%; text-align: center;">&gt; 12 months</th> <th style="width: 10%; text-align: center;">Recurring/continuous</th> <th style="width: 15%; text-align: left;">Severity</th> <th style="width: 20%;"></th> <th style="width: 10%; text-align: center;">&lt; 6 months</th> <th style="width: 10%; text-align: center;">6-12 months</th> <th style="width: 10%; text-align: center;">&gt; 12 months</th> <th style="width: 10%; text-align: center;">Recurring/continuous</th> </tr> <tr> <td><input type="checkbox"/> Depression</td> <td></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Trauma/abuse</td> <td></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Anxiety/Stress</td> <td></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Bereavement/loss</td> <td></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Psychosis</td> <td></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Self esteem</td> <td></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Personality Problems</td> <td></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Interpersonal/relationship</td> <td></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Cognitive/Learning</td> <td></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Living/Welfare</td> <td></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Eating Disorder</td> <td></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Work/Academic</td> <td></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Physical Problems</td> <td></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Other (specify below)</td> <td></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Addictions</td> <td></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td colspan="6" style="border: 1px solid black; height: 20px; margin-top: 5px;"></td> </tr> </table>										Severity		< 6 months	6-12 months	> 12 months	Recurring/continuous	Severity		< 6 months	6-12 months	> 12 months	Recurring/continuous	<input type="checkbox"/> Depression		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Trauma/abuse		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Anxiety/Stress		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Bereavement/loss		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Psychosis		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Self esteem		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Personality Problems		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Interpersonal/relationship		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Cognitive/Learning		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Living/Welfare		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Eating Disorder		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Work/Academic		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Physical Problems		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Other (specify below)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Addictions		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
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<table style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 25%;">Risk</th> <th style="width: 10%; text-align: center;">None</th> <th style="width: 10%; text-align: center;">Mild</th> <th style="width: 10%; text-align: center;">Mod</th> <th style="width: 10%; text-align: center;">Sev</th> </tr> <tr> <td>Suicide</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Self Harm</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Harm to others</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Legal/Forensic</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>										Risk	None	Mild	Mod	Sev	Suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Self Harm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Harm to others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Legal/Forensic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>ICD-10 CODES</b> <table style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 5%;">F/Z</th> <th style="width: 15%;">Main code</th> <th style="width: 10%;">Sub-code</th> <th style="width: 5%;">F/Z</th> <th style="width: 15%;">Main code</th> <th style="width: 10%;">Sub-code</th> </tr> <tr> <td>1</td> <td><input type="text"/></td> <td><input type="text"/> • <input type="text"/></td> <td>3</td> <td><input type="text"/></td> <td><input type="text"/> • <input type="text"/></td> </tr> <tr> <td>2</td> <td><input type="text"/></td> <td><input type="text"/> • <input type="text"/></td> <td>4</td> <td><input type="text"/></td> <td><input type="text"/> • <input type="text"/></td> </tr> </table>					F/Z	Main code	Sub-code	F/Z	Main code	Sub-code	1	<input type="text"/>	<input type="text"/> • <input type="text"/>	3	<input type="text"/>	<input type="text"/> • <input type="text"/>	2	<input type="text"/>	<input type="text"/> • <input type="text"/>	4	<input type="text"/>	<input type="text"/> • <input type="text"/>																																																												
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<b>What has the client done to cope with/avoid their problems? Please tick, and then specify actions</b> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;">           Positive actions <input type="checkbox"/>  <div style="border: 1px solid black; height: 40px; margin-top: 5px;"></div> </div> <div style="width: 45%;">           Negative actions <input type="checkbox"/>  <div style="border: 1px solid black; height: 40px; margin-top: 5px;"></div> </div> </div>																																																																																																																					
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 45%; vertical-align: top;"> <b>Assessment outcome (tick one box only)</b>            Assessment/one session only <input type="checkbox"/>            Accepted for therapy <input type="checkbox"/>            Accepted for trial period of therapy <input type="checkbox"/>            Long consultation <input type="checkbox"/>            * Referred to other service <input type="checkbox"/>            * Unsuitable for therapy at this time <input type="checkbox"/> </td> <td style="width: 55%; vertical-align: top;"> <b>* If the client is not entering therapy give brief reason</b>  <div style="border: 1px solid black; height: 70px; margin-top: 5px;"></div> </td> </tr> </table>										<b>Assessment outcome (tick one box only)</b> Assessment/one session only <input type="checkbox"/> Accepted for therapy <input type="checkbox"/> Accepted for trial period of therapy <input type="checkbox"/> Long consultation <input type="checkbox"/> * Referred to other service <input type="checkbox"/> * Unsuitable for therapy at this time <input type="checkbox"/>	<b>* If the client is not entering therapy give brief reason</b> <div style="border: 1px solid black; height: 70px; margin-top: 5px;"></div>																																																																																																										
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## Appendix 6

### CORE OM 34 Questionnaire



<b>Site ID</b> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <small>letters only</small> <input type="text"/> <input type="text"/> <b>Client ID</b> <small>numbers only</small> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <b>Therapist ID</b> <small>numbers only (1)</small> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <small>numbers only (2)</small> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <b>Sub codes</b> <small>D D M M Y Y Y Y</small> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <b>Date form given</b>	<input type="text"/> <input type="text"/> <b>Age</b> <b>Male</b> <input type="checkbox"/> <b>Female</b> <input type="checkbox"/> <b>Stage Completed</b> 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 <b>Stage</b> <input type="text"/> <b>Episode</b> <input type="text"/>
--	---

#### 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	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> F
2 I have felt tense, anxious or nervous	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
3 I have felt I have someone to turn to for support when needed	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> F
4 I have felt OK about myself	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> W
5 I have felt totally lacking in energy and enthusiasm	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
6 I have been physically violent to others	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> R
7 I have felt able to cope when things go wrong	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> F
8 I have been troubled by aches, pains or other physical problems	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
9 I have thought of hurting myself	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> R
10 Talking to people has felt too much for me	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> F
11 Tension and anxiety have prevented me doing important things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
12 I have been happy with the things I have done	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> F
13 I have been disturbed by unwanted thoughts and feelings	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
14 I have felt like crying	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> W

Please turn over



## Appendix 6

### CORE OM 34 Questionnaire (Contd.)

#### 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	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
16 I made plans to end my life	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> R
17 I have felt overwhelmed by my problems	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> W
18 I have had difficulty getting to sleep or staying asleep	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
19 I have felt warmth or affection for someone	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> F
20 My problems have been impossible to put to one side	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
21 I have been able to do most things I needed to	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> F
22 I have threatened or intimidated another person	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> R
23 I have felt despairing or hopeless	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
24 I have thought it would be better if I were dead	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> R
25 I have felt criticised by other people	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> F
26 I have thought I have no friends	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> F
27 I have felt unhappy	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
28 Unwanted images or memories have been distressing me	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
29 I have been irritable when with other people	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> F
30 I have thought I am to blame for my problems and difficulties	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
31 I have felt optimistic about my future	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> W
32 I have achieved the things I wanted to	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> F
33 I have felt humiliated or shamed by other people	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> F
34 I have hurt myself physically or taken dangerous risks with my health	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> R

THANK YOU FOR YOUR TIME IN COMPLETING THIS QUESTIONNAIRE

Total Scores

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Mean Scores

(Total score for each dimension divided by number of items completed in that dimension)

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
(W)	(P)	(F)	(R)	All items	All minus R

## Appendix 7

### CORE End of Therapy Questionnaire



**END OF  
THERAPY  
FORM v2**

<b>Site ID</b>	<div style="border: 1px solid black; width: 40px; height: 20px; display: flex; justify-content: space-around;"><div style="width: 10px; height: 10px;"></div><div style="width: 10px; height: 10px;"></div><div style="width: 10px; height: 10px;"></div><div style="width: 10px; height: 10px;"></div></div>		
	<small>letters</small>	<small>numbers</small>	
<b>Client ID</b>	<div style="border: 1px solid black; width: 40px; height: 20px; display: flex; justify-content: space-around;"><div style="width: 10px; height: 10px;"></div><div style="width: 10px; height: 10px;"></div></div>	<div style="border: 1px solid black; width: 100px; height: 20px; display: flex; justify-content: space-around;"><div style="width: 15px; height: 10px;"></div><div style="width: 15px; height: 10px;"></div><div style="width: 15px; height: 10px;"></div><div style="width: 15px; height: 10px;"></div><div style="width: 15px; height: 10px;"></div><div style="width: 15px; height: 10px;"></div></div>	<b>Number of sessions planned</b> <div style="border: 1px solid black; width: 40px; height: 20px; display: flex; justify-content: space-around;"><div style="width: 10px; height: 10px;"></div><div style="width: 10px; height: 10px;"></div><div style="width: 10px; height: 10px;"></div></div>
	<b>Therapist ID</b>	<b>SC4 numbers</b>	<b>SC5 numbers</b>
<b>Sub Codes</b>	<div style="border: 1px solid black; width: 40px; height: 20px; display: flex; justify-content: space-around;"><div style="width: 10px; height: 10px;"></div><div style="width: 10px; height: 10px;"></div><div style="width: 10px; height: 10px;"></div></div>	<div style="border: 1px solid black; width: 40px; height: 20px; display: flex; justify-content: space-around;"><div style="width: 10px; height: 10px;"></div><div style="width: 10px; height: 10px;"></div><div style="width: 10px; height: 10px;"></div></div>	<div style="border: 1px solid black; width: 40px; height: 20px; display: flex; justify-content: space-around;"><div style="width: 10px; height: 10px;"></div><div style="width: 10px; height: 10px;"></div><div style="width: 10px; height: 10px;"></div></div>
<b>Date therapy commenced</b>	<div style="display: flex; justify-content: space-around;"><div style="text-align: center;"><small>D</small> <div style="border: 1px solid black; width: 20px; height: 20px;"></div></div><div style="text-align: center;"><small>D</small> <div style="border: 1px solid black; width: 20px; height: 20px;"></div></div><div style="text-align: center;">/</div><div style="text-align: center;"><small>M</small> <div style="border: 1px solid black; width: 20px; height: 20px;"></div></div><div style="text-align: center;"><small>M</small> <div style="border: 1px solid black; width: 20px; height: 20px;"></div></div><div style="text-align: center;">/</div><div style="text-align: center;"><small>Y</small> <div style="border: 1px solid black; width: 20px; height: 20px;"></div></div><div style="text-align: center;"><small>Y</small> <div style="border: 1px solid black; width: 20px; height: 20px;"></div></div><div style="text-align: center;"><small>Y</small> <div style="border: 1px solid black; width: 20px; height: 20px;"></div></div><div style="text-align: center;"><small>Y</small> <div style="border: 1px solid black; width: 20px; height: 20px;"></div></div></div>		<b>Number of sessions attended</b> <div style="border: 1px solid black; width: 40px; height: 20px; display: flex; justify-content: space-around;"><div style="width: 10px; height: 10px;"></div><div style="width: 10px; height: 10px;"></div><div style="width: 10px; height: 10px;"></div></div>
<b>Date therapy completed</b>	<div style="display: flex; justify-content: space-around;"><div style="text-align: center;"><small>D</small> <div style="border: 1px solid black; width: 20px; height: 20px;"></div></div><div style="text-align: center;"><small>D</small> <div style="border: 1px solid black; width: 20px; height: 20px;"></div></div><div style="text-align: center;">/</div><div style="text-align: center;"><small>M</small> <div style="border: 1px solid black; width: 20px; height: 20px;"></div></div><div style="text-align: center;"><small>M</small> <div style="border: 1px solid black; width: 20px; height: 20px;"></div></div><div style="text-align: center;">/</div><div style="text-align: center;"><small>Y</small> <div style="border: 1px solid black; width: 20px; height: 20px;"></div></div><div style="text-align: center;"><small>Y</small> <div style="border: 1px solid black; width: 20px; height: 20px;"></div></div><div style="text-align: center;"><small>Y</small> <div style="border: 1px solid black; width: 20px; height: 20px;"></div></div><div style="text-align: center;"><small>Y</small> <div style="border: 1px solid black; width: 20px; height: 20px;"></div></div></div>		<b>Number of sessions unattended</b> <div style="border: 1px solid black; width: 40px; height: 20px; display: flex; justify-content: space-around;"><div style="width: 10px; height: 10px;"></div><div style="width: 10px; height: 10px;"></div><div style="width: 10px; height: 10px;"></div></div>

**What type of therapy was undertaken with the client? Please tick as many boxes as appropriate**

Psychodynamic <input type="checkbox"/>	Person-centred <input type="checkbox"/>
Psychoanalytic <input type="checkbox"/>	Integrative <input type="checkbox"/>
Cognitive <input type="checkbox"/>	Systemic <input type="checkbox"/>
Behavioural <input type="checkbox"/>	Supportive <input type="checkbox"/>
Cognitive/Behavioural <input type="checkbox"/>	Art <input type="checkbox"/>
Structured/Brief <input type="checkbox"/>	Other (specify below) <input type="checkbox"/>

**What modality of therapy was undertaken with the client? Please tick as many boxes as appropriate**

Individual <input type="checkbox"/>	Family <input type="checkbox"/>
Group <input type="checkbox"/>	Marital/Couple <input type="checkbox"/>


**What was the frequency of therapy with the client?**

More than once weekly <input type="checkbox"/>	Less than once weekly <input type="checkbox"/>
Weekly <input type="checkbox"/>	Not at a fixed frequency <input type="checkbox"/>

**Which of the following best describes the ending of therapy?**


<b>Unplanned</b> <input type="checkbox"/> Due to crisis <input type="checkbox"/> Due to loss of contact <input type="checkbox"/> Client did not wish to continue <input type="checkbox"/> Other unplanned ending (specify below) <input type="checkbox"/>	<b>Planned</b> <input type="checkbox"/> Planned from outset <input type="checkbox"/> Agreed during therapy <input type="checkbox"/> Agreed at end of therapy <input type="checkbox"/> Other planned ending (specify below) <input type="checkbox"/>
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## Appendix 7

### CORE End of Therapy Questionnaire (Contd.)

Review of Identified Problems/Concerns				
Severity		Therapy issue		
<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Trauma/Abuse
<input type="checkbox"/>	Anxiety/Stress	<input type="checkbox"/>	<input type="checkbox"/>	Bereavement/Loss
<input type="checkbox"/>	Psychosis	<input type="checkbox"/>	<input type="checkbox"/>	Self esteem
<input type="checkbox"/>	Personality Problems	<input type="checkbox"/>	<input type="checkbox"/>	Interpersonal/relationship
<input type="checkbox"/>	Cognitive/Learning	<input type="checkbox"/>	<input type="checkbox"/>	Living/Welfare
<input type="checkbox"/>	Physical Problems	<input type="checkbox"/>	<input type="checkbox"/>	Work/Academic
<input type="checkbox"/>	Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Other (specify below)
<input type="checkbox"/>	Addictions	<input type="checkbox"/>		

Risk		None	Mid	Mod	Sev
	Suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Self Harm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Harm to others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Legal/Forensic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Contextual Factors		Poor	Moderate	Good
	Motivation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Working Alliance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Psychological Mindedness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Benefits of Therapy			
	Improved	Yes	No
Personal insight/understanding		<input type="checkbox"/>	<input type="checkbox"/>
Expression of feelings/problems		<input type="checkbox"/>	<input type="checkbox"/>
Exploration of feelings/problems		<input type="checkbox"/>	<input type="checkbox"/>
Coping strategies/techniques		<input type="checkbox"/>	<input type="checkbox"/>
Access to practical help		<input type="checkbox"/>	<input type="checkbox"/>
Other benefits		<input type="checkbox"/>	<input type="checkbox"/>
Tick box and then specify below			

Has contact with this service resulted in a change of medication?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Not applicable <input type="checkbox"/>
If yes, is this change likely to be of benefit to the client?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Details of change:	Started <input type="checkbox"/>	Discontinued <input type="checkbox"/>	Increased <input type="checkbox"/> Decreased <input type="checkbox"/> Modified <input type="checkbox"/>

Has the client been given a follow-up appointment?	Number of months until appointment
Yes <input type="checkbox"/> No <input type="checkbox"/>	<div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 30px; height: 20px; display: inline-block;"></div>

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## Appendix 8

### Work and Social Adjustment Questionnaire (WSAS)

#### Work & Social Adjustment Scale

People's problems sometimes affect their ability to do certain day-to-day tasks in their lives. To rate your problems, look at each section and determine on the scale provided 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	

Scoring of WSAS – SUM THE TOTAL NUMBER OF SCORES FROM ALL QUESTIONS

1-10 – mild functional impairment

11-20 – moderately severe functional impairment

21+ – severe functional impairment

## Appendix 9

### Health Related Quality of Life Scale

Please rate the following:

1. Would you say that in general your health is:

a. Excellent

b. Very Good

c. Good

d. Fair

e. Poor

or

f. Don't Know/Not Sure

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?

Insert number of days here

or

a. None

b. Don't Know/Not Sure

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?

Insert number of days here

or

a. None

b. Don't Know/Not Sure

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?

Insert number of days here

or

a. None

b. Don't Know/Not Sure

## Appendix 10

### Ethical approvals – full list of RECs

HSE Area	Approving Research Ethics Committee	Date of receipt of approval
South-East	Research Ethics Committee, Waterford Regional Hospital	15/10/2015
South	Clinical Research Ethics Committee, University College Cork Teaching Hospital	06/03/2015
Cavan, Monaghan, Meath & Louth	HSE North East Area Research Ethics Committee	16/07/2015
Dublin North	HSE Dublin North City/Dublin North	19/12/2015
Dublin City North	HSE Dublin North City/Dublin North	20/12/2015
Dublin South, East Wicklow	Formal approval received in writing from Director of Mental Health Anne O'Connor	17/05/2016
Dublin South Central, West Wicklow, West Kildare	Formal approval received in writing from Director of Mental Health Anne O'Connor	17/05/2016
Mid-lands	Research Ethics Committee, HSE - Midland Area	13/04/2015
North West (Donegal North)	Research Ethics Committee, Letterkenny Hospital	29/07/2015
North West	Research Ethics Committee, Sligo Regional Hospital	28/01/2015
Mid-West	Research Ethics Committee, University Hospital Limerick	08/05/2015
West	Clinical Research Ethics Committee, Merlin Park University Hospital	22/01/2015

## Appendix 11

### Correlations between Pre therapy HRQOL, WSAS and CORE-OM 34

Associations between Pre therapy HRQOL, WSAS and CORE-OM						
HRQOL Characteristic	WSAS			CORE-OM 34		
	<i>n</i>	<i>P</i>	<i>n</i>	<i>r</i>	<i>P</i>	<i>n</i>
Mentally unhealthy days	.302**	.002	106	.539**	.000	108
Activity limitation days	.266**	.007	101	.422**	.000	104
Physically unhealthy days	.038	.705	103	.156	.113	105
CORE-OM 34	.408**	.000	107			

\*\* Correlation is significant at the 0.01 level (2-tailed)

## Appendix 12

### Counselling in Primary Care National Evaluation Research Group Membership

**Fiona Ward** – *Director of Counselling, CHO8 LM/CHO9, Chair, CIPC National Research Group*

**Miriam Barrow** – *CIPC Clinical Coordinator, CHO5*

**Charles Brand** – *CIPC Psychology Researcher*

**Sharon Cunningham** – *CIPC Clinical Coordinator CHO8*

**Niamh Mac Donagh** – *Director of Counselling CHO7*

**Dr Philip Moore** – *Director of Counselling CHO4*







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