

**PCA South West**

**Counselling and  
Psychotherapy:**

**Research Outcomes  
Conference**

**Friday 17<sup>th</sup> October 2003**

**Research Outcomes:  
A Parochial View**

**By**

**Steve Vincent**

PCA South West

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A Parochial View  
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## Introduction

In preparing for today, I thought and hoped that it might have relevance if I were to attempt to respond to questions relevant to *you, now* – hence our effort to log and collate your responses from the start of the day.

I also thought that it might be helpful and relevant to try and find out what questions might have been around in Southampton prior to the emergence of a well established counselling service – through doing so I hoped to at least have some evidence available to draw upon, albeit some of it based on memories, or anecdotal in nature.

I am responsible for inputting CORE and other data for Southampton, and produce the PCCS (Primary Care Counselling Services) annual statistical report, from which I have drawn data – although it has to be said that at the moment we only apply CORE to a five per cent sample of clients, so that this element of the data is inevitably somewhat skewed – though hopefully not too much.

I draw upon my own experience, thoughts and feelings, too.

The following outcomes, then, hardly represent thorough, scientific research: On the one hand I simply asked a few GPs (six, if I'm honest), a few (three) Practice managers, a PCT Commissioning Manager, a Finance Manager and several counsellors (a dozen or so) to think back to what had relevance for them a few years ago. On the other hand our group data is based on a small sample of the whole.

I feel that I have just 'come clean'! Yet I nevertheless hope that what I have to say will be of interest.

I also feel that our *process* was really important to us – and still is. There are many relationships involved: among the counsellors, between counsellors and GPs, with practice managers, with reception staff, with a raft of people within the PCT centrally and, last but by no means least, with our clients.

I hope that for you a balance can be struck between not having to needlessly reinvent a wheel, yet nevertheless engaging in self-directed and shared personal and professional development.

**FAQ's:**  
Some  
Frequently Asked Questions

GPs, Practice and PCT Managers and Counsellors were asked:

*Imagine there is no counselling provision in general practices  
and you are approached with the possibility....  
What questions might you ask?*

**Practice Managers**

- How much will it cost?
- How soon can it start?
- From which budget will it be funded?
- What will the lines of accountability be?
- How much counselling can we get?
- Who pays for the overheads?
- How many sessions can each patient have?
- Does it work?

**General Practitioners**

- How soon can you start?
- How quick can access be?
- Can it be tailored to patient need?
- What will it cost me as a GP?
- How will patients be referred?
- How many patients can I refer? (Grateful for whatever we can get)
- What range of patients can you see?
- What waiting times can patients expect?
- Can it be in-house? (Involvement, ownership, prioritizing etc)
- Do we really need counselling?
- Could I do more? (I wish I could do more...)

**Counsellors**

- How much will I be paid?
- Can I still have flexible working hours?
- Will I be able to maintain client confidentiality?
- Will I be bombarded with bureaucracy and administration?
- Will I be able to keep my existing supervisor?
- Will privacy with patients be guaranteed (e.g. appropriate accommodation)?
- Will we be able to offer placements for trainee counsellors?

## PCT

- Managed service within PCT?
- How much will it cost?
- Is it cost effective?
- Can we afford it?
- Is there a need?
- What qualifications will the counsellors have?
- What is our best option (e.g. buying in services or managing our own)?

## Questions, Answers and Outcomes in Southampton

### Q1. Why?

**There is a need** for counselling. Evidence of a national trend towards recognition of this need might be that, as of 2001: -

PCTs providing or intending to provide primary care counselling	<b>74%</b>
Primary care counselling under discussion	<b>12%</b>
No provision	<b>7%</b>
No data	<b>4%</b>
No policy/not under discussion	<b>3%</b>

(National Primary Care Research and Development Centre tracker survey)

### Q2. Where?

Prior to Primary Care Commissioning, counselling in Southampton was all over the place. Some practices had no provision. Some had trainee counsellors on placement. Some had private practitioners attached to the practice, others had volunteer counsellors, while some relied on voluntary agencies, and some surgeries used counsellors from a Community Health trust.

Look: No Equity!

In early 1999, many of the private practitioner counsellors formed a co-ordinated group: Primary Care Counselling Services. Supported by the national Counsellors in Primary Care organisation, a bid was prepared and submitted to the Chief Executive to cover nineteen practices, and PCCS has existed (and grown) as a coherent counselling provider since that time, having a presence in the majority of surgeries within the PCT (with the minority being served by a Mental Health trust service). In January this year all interested parties (including the PCT Development Manager, Commissioning Manager, Mental Health lead and Human Resources Manager) met for a whole day conference with a view to determining the shape of counselling provision over the coming years.

Options identified for the location of a counselling service were: -

- (a) PCT managed service
- (b) Mental Health Trust
- (c) Private Providers

It was agreed that in Southampton there would be a **managed counselling service within the PCT**. Although the case for a PCT managed service was not unanimously agreed, on balance this model was deemed by far the most appropriate when considering issues of: -

- A location within primary, not secondary, care,
- Integration,
- Equity,
- Clinical governance, and
- Self-regulation.

The main opposition to becoming a PCT managed service came from the counsellors themselves, several of whom had “left lives of administrative and bureaucratic control” and become self-employed. These counsellors felt that they would no longer feel so free...

Frankly, they might not earn so much, either! However, although without doubt income will fall for many of our therapists, there will be many plus factors that will serve to balance this out – such as paid holiday, sickness pay, job security (and to be equally frank, freelance counselling is a really soft target if cuts are to be made), pensions, paid supervision and indemnity cover, paid administration time and administrative support, free access to clinical consultation - and so on. We were all impressed, too, by the contracts offered by Human Resources – flexibility and part-time working need not be lost, it seems.

**Q3. When?**

By **April 2004**. Hmm...

**Q4. What?**

**General primary care counselling will be available through every GP surgery.**

It is also possible that longer-term therapy and specialist services will be offered.

There are still many issues to be resolved, not least of which cost, which in turn affects quantity. Although we have moved towards equity, there is still a way to go. For instance, comparing fourteen practices monitored in 2002 with minimum recommended provision, three were above and eleven below (and we still have several practices with no counselling provision and hence no monitoring).

Spending per patient per practice varied from zero (one extreme) to £6.29 (another extreme).

Our total counselling hours were 4,830 compared with a CPC recommended minimum of 10,367. In other words, counselling provision would have to more than double to meet minimum standards – and that means an increased budget.

**It is possible to work out costs.** The usual way of costing is by patient population. The recommended minimum counselling provision is two hours per week per one thousand patients. Counselling in Primary Care suggest a *total* cost (including management, administration, accommodation, counselling, supervision et cetera) of £42.60 per clinical hour. Off you go!

I wonder if it will ever be possible to work out the cost of *not* having a counselling service for patients? I am mindful of the one practice in Southampton that considerably exceeds the minimum counselling recommendations. Ask the GP there, and you will hear that referrals to secondary care from that practice are way below average, as is their prescription rate. At this time, we simply do not know whether the savings in secondary referrals and drugs outweigh the cost of counselling – though many believe that they might. There is another issue around waiting times for secondary referrals (up to nine months locally), and costs in terms of health and medication in the meantime.

Our current agreement with the PCT is to provide a service that averages eight sessions per patient (beyond twelve in agreement with the referring GP) – and we are well within that target. The average for the complete data for last year was that sessions per patient averaged 7.5 (we did not have the facility to break this down by counselling approach). Limited data (just over twenty five per cent of the projected total) for this year thus far by therapy type on average sessions shows:-

<b>THERAPY TYPE</b>	<b>SESSIONS</b>
Client-Centred	10
Other (TA/Gestalt)	6
Cognitive-Behavioural	7
Integrative	6

**Q5. Who?**

Current provision in terms of type of therapy offered is: -

Client-Centred	24%
Other (TA/Gestalt)	24%
Cognitive Behavioural	22%
Integrative	16%
Structured/Brief	9%
Psychodynamic	3%
Supportive	1%

Therapy is offered by BACP (or equivalent) **accredited practitioners**, and it is also hoped to offer **trainee placements**.

**Q6. Is It Effective?**

Yes. Certainly our CORE data for last year supports this. Filtering effectiveness by therapy modality (which we are now able to do) gives us the following data for this year thus far: -

**Average scores by domain**

**Functioning**

<b>THERAPY TYPE</b>	<b>PRE</b>	<b>POST</b>	<b>CHANGE</b>
Client-Centred	2.48	0.83	1.65
Other (TA/Gestalt)	1.84	0.61	1.23
Cognitive-Behavioural	2.08	1.11	0.97
Integrative	1.87	1.35	0.52

**Problems**

<b>THERAPY TYPE</b>	<b>PRE</b>	<b>POST</b>	<b>CHANGE</b>
Client-Centred	2.82	0.76	2.06
Other (TA/Gestalt)	2.30	0.86	1.44
Cognitive-Behavioural	2.50	1.23	1.27
Integrative	2.43	1.47	0.96

**Risk**

<b>THERAPY TYPE</b>	<b>PRE</b>	<b>POST</b>	<b>CHANGE</b>
Client-Centred	1.23	0.09	1.14
Other (TA/Gestalt)	0.36	0.01	0.35
Cognitive-Behavioural	0.63	0.13	0.50
Integrative	0.50	0.11	0.39

**Well-Being**

<b>THERAPY TYPE</b>	<b>PRE</b>	<b>POST</b>	<b>CHANGE</b>
Client-Centred	3.19	0.92	2.27
Other (TA/Gestalt)	2.48	0.69	1.79
Cognitive-Behavioural	2.87	1.30	1.57
Integrative	2.54	1.47	1.07

The first thing that hit me when I produced these figures was how smug those of us aligned to client-centred therapy could feel, coming out top in all categories. Hey!

However, my training in research triggered scepticism, and my next reaction was that these figures were, I knew, skewed. I know personally the people from whom forms have been received and in what quantity and so on – there is a considerable degree to which I felt like Peter Snow on an ‘election special’ (“this is hardly scientific or real – but just for fun”).

I also became puzzled: why were the initial scores so much higher for client-centred therapy than for other approaches? The only significant factor to emerge from the CORE data was that the patients completing forms for client-centred therapists filled them out alone (as the client-centred therapists tended not to undertake assessments), whereas all others tended to complete their forms in the counsellor’s presence. There might be factors to do with how GPs view the therapists working with them and the nature of referrals... The ‘bottom line’ fact is that I simply don’t know why this should be. Could I somehow make allowances for these high initial scores with the client-centred counsellors by changing the data to percentages? I did so: -

### **CHANGE BY PERCENTAGE**

<b>THERAPY TYPE</b>	<b>FUNCTIONING</b>	<b>PROBLEMS</b>	<b>RISK</b>	<b>WELL-BEING</b>
Client-Centred	66.53	73.01	92.68	77.16
Other (TA/Gestalt)	66.84	62.61	97.22	72.18
Cognitive-Behavioural	46.63	50.80	79.36	54.70
Integrative	27.81	39.51	78.00	42.13

### **AVERAGE PERCENTAGE CHANGE ACROSS DOMAINS**

<b>THERAPY TYPE</b>	<b>AVERAGE</b>
Client-Centred	77.35
Other (TA/Gestalt)	74.71
Cognitive-Behavioural	57.87
Integrative	46.86

We client-centred folk could still feel pretty smug! Maybe slightly less so as we only managed second place for RISK and, albeit marginally, Functioning – but we still managed first place overall. Pretty good, eh? Another facility CORE offers is data on health outcomes. What might this show us? Might there be any corroboration of any of the above? Here is the data: -

<b>Reliable Change</b>	<b>Clinical Change</b>	<b>CCT</b>	<b>Other</b>	<b>CBT</b>	<b>Integrative</b>
<b>Deterioration</b>	Below Cut Off		6%		11%
<b>Improvement</b>	Below Cut Off		12%	10%	
	Improvement	83%	75%	50%	45%
	No Change	11%		20%	
<b>No Change</b>	Improvement		6%		11%
	No Change			20%	33%
	Below Cut Off	6%			

Yet again, it seemed, client-centred therapy fared very well.

Still I had a nagging doubt: still I was sceptical. I hit on the idea (and felt that my methods were becoming more and more ridiculous) of dividing the data input thus far this year for percentage change across all domains by the average number of sessions. This resulted in: -

<b>THERAPY TYPE</b>	<b>AVERAGE CHANGE</b>	<b>AVERAGE SESSIONS</b>	<b>CHANGE PER SESSION</b>
Client-Centred	77.35	10	7.7
Other (TA/Gestalt)	74.71	6	12.4
Cognitive-Behavioural	57.87	7	8.3
Integrative	46.86	6	7.8

I wish I hadn't done that! From first to last with one quick flick of the calculator!

I didn't feel too despondent. I know, for instance, that my own average number of sessions per client is currently under six, and my data forms part of the whole. I know that one particular data input for one specific client-centred therapist included a client seen 55 times, and that this skewed the average sessions data for client-centred therapy upwards. I've tried my best to even things out for other approaches, so why not for my own, too!

I would, albeit in acknowledgement of incomplete data and some somewhat dubious figure-fiddling, like to speculate on some of these findings: -

**Some Issues,**  
**Some Red Herrings,**  
**Some Controversy!**

First, some FAQs I asked of me! If I had free rein to set up a counselling service, how would it be? It would be a managed service within the PCT, being accountable and in line with clinical governance requirements. There would be equity of provision, free at the point of delivery. It would *not* be time limited but *would* be monitored. Assessment would *not* be undertaken, evaluation *would*. It *would* be multi-disciplinary but *not* individually 'eclectic' or 'integrative' and efforts would be made to minimize missed appointments.

My guess is that most if not all people present can see the wisdom of a PCT managed, accountable, equitable, freely delivered service in line with clinical governance requirements. You might not agree, but can understand the thinking: yes?

Why, though, would I court controversy by not managing a time-limited service?

## Time Limited?

To me, time-limited therapy is one of the most ridiculous red herrings to have ever flopped around in the counselling pool! Evidence from a variety of research sources (including national CORE data 2002, Budman and Gurman 1990, Jossey Bass, 1989) indicates that where open-ended therapy is offered, sessions average around the six per patient mark. Our own service averaged between seven and eight sessions in our sample survey, yet just under six sessions in total. Since April 2001, I have personally conducted 1,367 therapy sessions with 235 patients, so my own average is currently (as of October 3<sup>rd</sup>) 5.82 sessions per client.

There is no need to time limit therapy. Interestingly, when I conducted my 'off-the-cuff research' questions for this meeting, it was the practice, commissioning and finance managers who had time limits in mind – based on purely *financial* thinking. GPs and counsellors were very much against time limiting counselling – for *therapeutic* reasons. (Imagine a GP or consultant limiting the treatment of a heart or cancer patient irrespective of need. Why should psychotherapy be any different?)

Perhaps finance and practice managers have fantasies too! Perhaps they imagine that without limits therapy would be never-ending... Not so! Perhaps those of us with therapeutic interests at heart can supply evidence.

I am, as will become clear, a big fan of monitoring and evaluation. If I were manager of a counselling practice and monitoring indicated one of more counsellors were exceeding an average of between six and, say, ten sessions per patient, I'd be asking why...

However, this big fan of monitoring and evaluation is not so keen on assessment: -

## Assessment

### ***GPs ain't stoopid!***

As a client-centred practitioner assessment, diagnosis and treatment is in fundamental opposition to my philosophy and practice. I reject it. My rejection is not out of hand – however my reasoning is perhaps for another time and place. For the moment I can state that there are existential, humanist and person-centred approaches to therapy – proven to be effective - within which assessment is anathema. If I imagine I were manager of a counselling service and held beliefs in equality of opportunity, the celebration and embracing of diversity, and the employment on behalf of patients of practitioners from therapeutic approaches proven to be effective, I would feel deeply uncomfortable at eliminating from employment a broad range of resources on the grounds that they were uncomfortable with the whole notion of formal assessing. (I am reminded of something Carl Rogers said about this issue: he spoke of the many people he had met who, often after many years, had left organisations to practise privately. Overwhelmingly, they also tended to leave the “folderol” of systems behind them – often stating that this was because they cared *more* about their patients or clients, not less...)

Now let me fantasise again, this time that I am a PCT Finance Manager: -

In Southampton last year, the PCCS group worked with approximately one thousand patients. Following assessment, 97 per cent were accepted for therapy, two per cent accepted for a trial period of therapy, and just one per cent only attended assessment. So an assessment session costs £42.60 per patient – that's £42,600.00 spent last year on assessment alone... The counselling service averages 7.5 sessions per patient... If one per cent of patients received seven and a half sessions of therapy each, that would come to... £3,195.00. So we are spending £39,405.00 a year to make a saving of £3,195.00. Hmm.

Now I fantasise that I am a GP or therapist, and get rather passionate about quality and clinical governance issues, stressing that it is not all about money. Okay – yet in Southampton all of the one per cent who were not 'accepted' for therapy was due to there being insufficient need, not because their problems were too severe. I ask: Which is preferable: spending around three thousand pounds on patients who don't really need therapy, or spending around forty three thousand pounds on needless assessments?

In Southampton, nearly ninety seven per cent of referrals to counsellors were made by GPs (the remainder were from a practice that operates a self-referral system for patients) – although there were some referrals from more than one source (including the GP). My own experience has been that GPs can be trusted to make appropriate referrals. It also occurs to me that as actual supply of counselling falls way short of ideal demand, GPs are very discriminating in deciding whom to refer or not refer to counsellors. In effect, the GP has *already* assessed a patient as potentially benefiting from counselling. Why spend thousands of pounds and waste valuable resources repeating the exercise?

## **Equity**

In our CORE sample, just one per cent of patients seen were from ethnic categories other than White British (compared with a catchment profile of around eight per cent ethnic minority population in Southampton). Also, nearly three quarters of all clients were female, one quarter male.

Again, it has been my experience that a good many counsellors tend not to want to monitor their practice. Why? How can I know whether I am offering equality of opportunity, for instance, unless I engage with monitoring, evaluation and review?

One suggested approach to widening participation for males was to work more flexible hours, offering evening and weekend appointments. Not many of our therapists are that keen on doing so...

I personally have thought of ways of trying to broaden ethnic minority take-up. I end up confused. For instance, although I can have my leaflets and CORE forms translated into Punjabi, for instance (the second most prevalent language in Southampton), I am advised that it could be received as patronising, insincere and misleading if the therapy is conducted in English...

For me, we counsellors must discover and address issues of equity. And yes, we might have to be prepared to 'put ourselves out' as a reaction to our findings...

## Eclectic Practitioners?

### *Quack of all trades, master of none!*

So-called 'eclecticism' or 'integrative' counselling is very much the vogue, it seems. Personally, if I were manager of a counselling service I would be wary indeed of employing such practitioners. Why?

First, training. As a counsellor trainer of many years (and moderator and validator and external consultant and so on), I can tell you that minimum counsellor training tends to be around 450 hours – and for *financial* reasons most courses are close to this minimum. Regrettably in my view, marketing of counsellor training seems to have moved into a kind of 'Buy One – Get One Free!' mode – or even 'Buy One – Get Two Or Three Free!' Yet can trainers maintain with integrity that several approaches to counselling can be thoroughly learned and integrated in just 450 hours? Further, very often these different approaches are not integrated at all – courses are modular, not exactly coherent.

In the 2001 Hampshire Association for Counselling Resources Directory (paper version), only seventeen per cent of therapists stated that they worked within a single, core approach. (Incidentally, eighty three per cent stated that they incorporated person-centred with other approaches!) The remainder offered an average of just over three approaches each - yet I would stake my entire earnings that few if any are thoroughly versed in all approaches or that all of these approaches are (or even can be) integrated with integrity.

I have written and spoken on such issues many times and will not go on at length here. I would like to stress one point most strongly though. If we set aside philosophical and academic considerations for the moment (such as client-centred therapy having fundamental conditions that are deemed both necessary and sufficient, yet integrative counsellors claiming that a person-centred approach underpins their other practices), can we, perhaps, listen to our clients? Within the British Association for Counselling and Psychotherapy, counsellors identifying as person-centred are the largest single group. Counsellors who implement a number of approaches tend to adopt the term 'person-centred' as they believe that it seems to best fit their practice. According to as yet unpublished research by Professor Dave Mearns, they also attract a disproportionate number of complaints. I can't repeat what a senior official responsible for accreditation at BACP said of so-called integrative practitioners. Suffice to say that just one of the words was 'nightmare' – and another began with 'F'!

Here is another speculation: cognitive behavioural work does not appear to be the most effective approach in Southampton. This is true. Yet to my mind, this has nothing to do with cognitive behavioural *therapy*, it has to do with cognitive behavioural *therapists*. There is no formal training offered in cognitive behavioural therapy anywhere nearer Southampton than London. Very few of our counsellors who identify themselves as cognitive behavioural undertook their main substantial training in cognitive behavioural therapy: rather, the majority undertook local training in either client-centred, gestalt, transactional analysis, psychodynamic or integrative therapy, and later attended workshops or other professional development activities.

On a personal note, if asked by a good friend to refer them to a therapist, my first thought would be to try and think of a 'good' client-centred one, because client-centred is the approach I most have faith and trust in. However, I'd rather refer a good friend to a good cognitive-behavioural therapist than a bad client-centred one – and regrettably, just as there are many local therapists who describe themselves as cognitive-behavioural when in fact they are more akin to 'quacks of all trades' so there are as many (if not more) who describe themselves as 'person-centred' when to my way of thinking they are nothing of the sort.

*In my experience, a good therapist beats a good approach any day.*

## **DNAs**

Another issue we might care to grapple with is those patients who miss their appointments – DNAs ('Did Not Arrive'). My own current DNA rate thus far this year is 11.69, last year 10.97 and, in 2001, 11.92. In our PCCS sample survey the DNA rate was four per cent (almost certainly skewed because with all good intentions, counsellors tended to provide monitoring for clients who showed up). In a national survey of primary care counselling, I believe that the DNA rate was 24 per cent!

If we took a local average of, say, ten per cent, then last year DNAs cost the PCT over twenty thousand pounds! In early October of this year, the government announced that missed GP appointments cost the Health Service in excess of one *billion* pounds!

I would like to see (or even conduct, if anyone offers to pay me) research into DNAs. Over a period of a couple of days I thought of some possible reasons as to why a client might miss a first appointment (the most frequently missed, according to our CORE data): -

The patient forgot; the patient recorded the day/time incorrectly; the counsellor recorded the day/time incorrectly; the patient 'bottled out' feeling afraid; the crisis seemed to have passed; the patient got assistance elsewhere; the patient was talked out of attending; the patient devalued themselves ("I'm not worth it/others have greater need"); the patient just couldn't be bothered; the counsellor was the wrong age/gender/colour; it was an inappropriate referral; the patient felt too ill, too depressed; a different matter took priority; there were circumstantial factors (car breakdown, bus didn't turn up, traffic jam etc); the patient could not get time off work or arrange childcare; the evaluation forms they received in the post put them off; the nature or style of first contact put them off; they heard something detrimental about the counsellor or counselling...

No doubt many more factors could emerge. Perhaps we owe it to ourselves and our potential or actual employers to understand more fully and attempt to minimize the waste of resources DNAs represent (a service manager or counsellors co-operative could, for instance, explore differential DNA rates and learn from that: for instance, one of our own counsellors questioned the data with regard to first sessions being the most frequently missed as her first session DNA rate is close to zero. What might we learn from her approach to first contact?)

On what I feel is a sour note, I offered to run a session on DNAs at our next counsellor training day. The interest rate shown thus far is zero – yet interest in learning about approaches other than the core approach of the counsellors is soaring, together with notions that in some ways seem to serve to pathologies groups of individuals.

I despair...

I put out a plea to all therapists to get their own houses in order and put clients first.

Perhaps this plea can extend to all – to Commissioning Managers, Finance Managers, Practice Managers, our GPs and our Counsellors: -

***Clients First!***