
‘HOLD FAST THAT WHICH IS GOOD’

IN EVALUATING THE EFFECTIVENESS OF COUNSELLING WITHIN TRAFFORD PSYCHOLOGICAL THERAPIES, *SUE BALMER*, *DALE HUEY* AND *JEAN MCLAREN* FOUND OUTCOMES WERE ABOVE THE IAPT NATIONAL AVERAGE

The importance of demonstrating the effectiveness of talking therapies is enshrined within the IAPT initiative. The indicator chosen to do this is clinically significant change, often termed 'moving to recovery' or, more simply, 'recovery'. There is an expectation, on all IAPT-reporting services, that 50 per cent of clients entering treatment should show such improvement. The interventions advocated to facilitate change are those currently supported by NICE guidance[1-5]. This 'top-down', or deductive, form of evidence-based practice can be viewed as an extension of the implications within *Treatment choice in psychological therapies and counselling*[6], where the most appropriate psychological therapy available within the NHS for certain presenting problems was stipulated. The implications of this kind of evidence-based practice are profound for the perceived validity and utility of counselling. We now find ourselves in an era when national guidance will be adhered to by individual Clinical Commissioning Groups (CCGs) when specifying the therapeutic options they wish to purchase in order to best meet the needs of their populations. Also national and regional workforce planning addressed centrally through Health Education England, and its regional satellites, will base its decisions on the perceived needs of front line employers. Whilst practitioners able to deliver high and low-intensity CBT feature, as do clinical psychologists and child psychotherapists, there is no mention made of counsellors in the recent workforce plan[7]. In order to alter the perception of the staffing requirements of a quality service, one able to meet the needs of the population, additional empirical evidence is needed to show the acceptability and effectiveness of all possibly relevant interventions and, by association, job roles.

Counselling has had a central position, and long history, within primary care mental health provision. For counselling to maintain this, it seems vitally important to supplement the NICE-recognised effectiveness with more practice-based evidence of the demonstrable benefit of non-directive counselling. We have the opportunity to do so using the same metrics as reported within the IAPT national database. Counsellors within the Trafford IAPT workforce were included within the staffing which formed the basis of the wave 2 service. In this article, we report data from a recent service evaluation which documents the performance of this counselling component of our service. In doing so, we

hope to add to the evidence base and model an evaluative component of the job role which can aid in the collection and dissemination of the potential utility of counselling. Rather than reinforcing a top-down, or deductive, empirical approach to assert the appropriateness of counselling, or any other potentially therapeutic intervention, we are advocating a scholarly approach. Sometimes termed the scholar-practitioner, or scholar-professional, we would define this as taking an approach to professional practice which is founded on scholarly knowledge, and supported by routine balanced reflection and empirical evaluation, an approach which does not envisage counsellors as 'technicians', blindly applying protocols based on the latest RCT, but as professionals applying knowledge in a balanced, reflective way, evaluating their interventions and, where needed, adjusting their practice in the light of the resultant findings; and doing so with full expression of the core conditions and associated human values which have always characterised counselling provision.

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WHAT ARE THE REQUIREMENTS OF AN IAPT-REPORTING SERVICE?

All IAPT services need to provide an efficient, effective way of helping clients to overcome their mental health difficulties. The original four-year plan for IAPT, set out in 2010, anticipated that 3.2 million people would access IAPT, of whom 2.6 million would receive a course of treatment. The kind of commonly occurring mental health difficulties seen as suitable include moderate to severe depression, mixed anxiety and depression, generalised anxiety, panic, all phobias, social anxiety, health anxiety, OCD, PTSD, and adjustment disorders.

Within IAPT services, clients are required to complete outcome measures at every appointment. This is to ensure that, whenever possible, there is a record of self-reported distress from the first to last session of treatment. The Department of Health (DH) considers that 'one of the most important innovations in psychological therapies has been session-by-session outcome monitoring'[8]. This article presents the outcome figures for clients who received a counselling intervention within Trafford IAPT for the period July 2012 to June 2013.

Trafford Clinical Commissioning Group (CCG) is committed to a scientific approach to monitoring and evaluating the provision of its commissioned services. Its forward-thinking *Integrated care system*[9] is based on the same organising principles as the *Intermountain Healthcare* model of care[10] which ensures that, as well as initial compliance with the knowledge base through the usual deductive processes, an inductive feedback loop is also central and valued. Therefore, possibly applicable best practice guidance is filtered through local expertise and experience which, through ever decreasing variation in practice, can then lead to the full establishment of protocols with local ownership and relevance, and in doing so, inform the knowledge base. In essence, it enables us to shape and improve even the most effective clinical decision-making by providing meaningful feedback in an appropriate way; the best of empiricism. Observing local need for counselling and monitoring the counselling provided, and any variation between practitioners or neighbourhood teams, has enabled us to show that the motto chosen for the metropolitan borough of Trafford – *'Hold Fast That Which Is Good'* – is an applicable and useful strapline for the counselling provision within this service. Our commissioners support this and have long stated that, in order to build capacity, it is necessary to continually evaluate the evidence[11] and thereby show relative benefit. Locally, there is also a long-standing acknowledgement from GPs and potential service users alike of the desirability of having counselling provision available and recognition of the need for counselling. We aim to continue our evaluation of routinely collected data to evidence the potential of counselling as a cost-effective way to build capacity, with outcomes comparable to other therapeutic options.

THE PLACE OF COUNSELLING WITHIN IAPT

The national hope for IAPT was that 1.3 million (50 per cent) of those treated would move to measurable recovery[12]. In the first three full financial years to March 2012, IAPT succeeded in implementing a national service which enabled over one million people to enter treatment, of whom 680,000 achieved median recovery rates of 42 per cent. In order to achieve these targets, 4,000 new practitioners have been trained. Whilst experienced counsellors within IAPT have been offered further training in Counselling for Depression, and in Couple Therapy for Depression, all new staff recruited into the service have been trained in modalities other than counselling. There is currently no recognised place for generic counselling within IAPT; only specific interventions for specific problems with an evidence base recognised by NICE have an acknowledged place in such services.

It is widely believed in the counselling world that CBT is the only form of therapy now on offer within IAPT services[13]. However, in August 2012, a total of 5,860

practitioners were employed in IAPT services, with 3,870 of these (76 per cent) working as high-intensity therapists (HITs) or psychological wellbeing practitioners (PWPs), delivering high-intensity and low-intensity CBT respectively. Or, as they're sometimes more colourfully termed, 'full fat CBT' and 'CBT lite'. Therefore, nationally, at least at present, there is a sizeable minority of other roles contributing towards the IAPT data set. NICE commissioning guidance, published November 2011[14], recommends adults experiencing depression be offered counselling only when depression can be defined as 'persistent sub threshold depressive symptoms or mild to moderate depression that has not responded to a low-intensity intervention; initial presentation of moderate or severe depression.' It also recommends that counselling only be offered 'for people who decline an antidepressant, CBT, IPT, behavioural activation or behavioural couples therapy'. The commissioning guide does not recommend that counselling be used as an intervention for clients presenting with generalised anxiety disorder, obsessive compulsive disorder, post-traumatic stress disorder or panic disorder.

The hierarchy of evidence allows NICE to decide which evidence is most effective and therefore most likely to be given when resources are low. Other forms of treatment would be used only when the most effective treatment is unsuitable for a patient. As CBT is the most thoroughly researched form of therapy, it has the most evidence of effectiveness and is the most readily offered within IAPT services across the country. The 2011 NICE guidelines continue to state that when offering counselling we should 'discuss with the person the uncertainty of the effectiveness of counselling... in treating depression'. This is the kind of statement which captures the requirement for researchers to keep an open sceptical mind, but for practitioners, it devalues the currency of the approach offered and, by reducing client confidence and commitment, potentially negatively impacts on the probability of achieving a good outcome. To meaningfully enter the debate on what should be provided, in order to best meet identified need, it would be useful to add to the available evidence of efficacy[15]. In order to best do this, we are sharing our most recent routine service evaluation, and advocating this form of empiricism as a key part of an approach to counselling delivered within the philosophy of a scholar-practitioner model.

COUNSELLING WITHIN TRAFFORD PSYCHOLOGICAL THERAPIES

Counsellors within this service work with clients who present with a complex mix of social, psychological and physical difficulties. Problems related to adjustment to loss and social and physical stressors are common; as is experience of childhood sexual/emotional/physical abuse and neglect. Clients are usually allocated to counselling, which sits within our Step 3 provision, following an initial telephone assessment conducted by a PWP.

This allocation is a collaborative process often influenced by the personal choice of the individual, as well as the nature of the issues which they want to address. Clients tend to come to be directed to counsellors when they present with layers of issues related to transition or adjustment to change. Our counsellors are also accustomed to working with clients who find it difficult to engage and have a history of disengagement from mental health services.

Adjustment difficulties in a client's current life are frequently linked to difficulties in their early life. Processing this in a safe and accepting space gives an increased measure of choice and autonomy. Our counsellors aim to help clients to lessen the damaging impact of their past, and facilitate greater freedom and control in their present. These changes are how we formulate the concept of recovery, or symptomatic improvement.

Whilst we cannot, and indeed wouldn't, seek to suggest that the interventions provided were uniform or followed a set protocol, the counselling aimed to provide a space for clients to process their current difficulties within a humanistic, non-directional, person-centred formulation. Our guiding assumptions are that establishing strong relationships enables therapeutic change and growth to happen from an early stage, allowing the client to benefit in what will, usually, be a relatively brief intervention. Even though the individual episodes of care are brief, there is a degree of choice and freedom for both counsellor and client, as our performance expectations assume an average of nine sessions offered to enable achievement of the requisite number of episodes of care.

Irrespective of the nature of the presenting problems, we have found that this non-directive counselling approach complements the more structured symptom-focused CBT model, providing a better fit for many clients. This seems to help to improve perceived acceptability for clients who have had previous problems engaging in more structured therapy.

WAYS OF MEASURING EFFECTIVENESS

When interpreting the effectiveness of IAPT-reporting services, it is important to understand the basis of the IAPT recovery calculation. Only those at caseness on at least one measure at the point of their first recorded scores are included. To achieve caseness and therefore be included in the IAPT data figures, a patient must score above 10 on the *PHQ-9* (nine questions, maximum score 27) at initial contact and above 8 on the *GAD-7* (seven questions, maximum score 21).

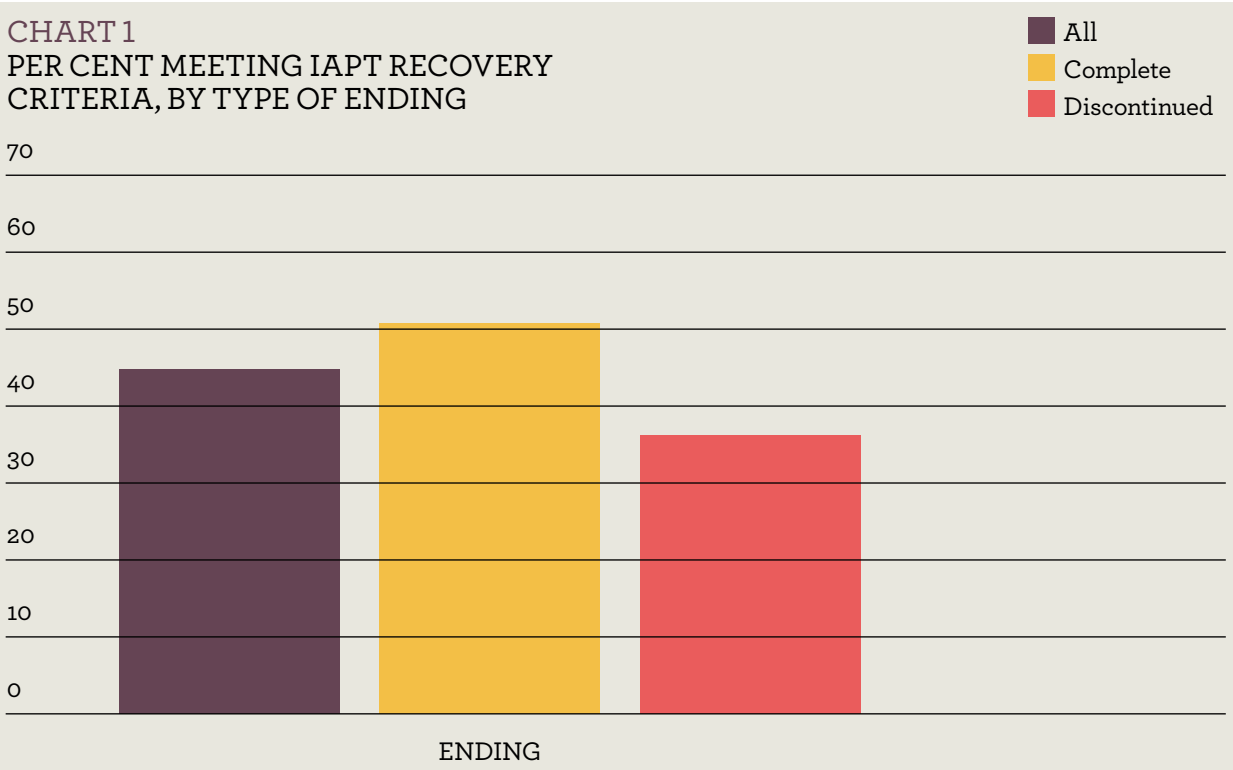
Only those below caseness at their final session, on both measures, are considered recovered, ie it is caseness on either to caseness on neither which signals recovery; a change in caseness on one measure is not sufficient. All service users scoring above caseness on either measure who have had two sessions involving treatment, irrespective of ending, are included. This recovery figure is included in the effectiveness evaluation below, broken down by ending type to illustrate differences. Reliable change, a purely psychometric concept, varies according to the particular measure used, and is considered the most robust way of evaluating effectiveness in a service evaluation[16]. The convention is that a change of six points on the *PHQ-9*, and a change of four points on the *GAD-7* is unlikely to be achieved by chance and thereby is taken to represent a meaningful and statistically reliable change.

MOVING TO RECOVERY: THE IAPT MEASURE OF EFFECTIVENESS

For the whole sample of 533 discharges, there was an average of eight sessions provided (ranging between one and 65, 83 per cent had 12 sessions or less). We collected first questionnaire scores for 497 clients (93 per cent); 392 of these scores were above caseness (79 per cent). Three hundred and sixty-eight clients scored above caseness at their first session and had at least two sets of scores recorded (69 per cent). This group also attended for an average of eight sessions. One hundred and sixty-nine of the 368 had both questionnaire scores below caseness at their final session. Therefore, the recovery figure for the whole sample, of those who could recover, was 46 per cent. This is comparable with figures from May 2013 data[17] which show a recent average for Trafford CCG (also 46 per cent). The percentage of clients recovered is above a recent average for IAPT services in England (44 per cent[17]) and above the median value of 42 per cent reported for IAPT services in the year one review[18].

Variation is apparent when separated into those who had a planned ending, ie completed treatment, and those who had unplanned endings, ie who discontinued. Chart 1 shows the type of endings of counselling in order to illustrate the differences in effectiveness

CHART 1
PER CENT MEETING IAPT RECOVERY CRITERIA, BY TYPE OF ENDING



between completed and discontinued episodes. Of those clients recorded as having completed treatment (246 of the 368), 126 met the recovery criteria (51 per cent). Of the 122 who had discontinued, 42 met the recovery criteria (34 per cent).

RELIABLE CHANGE

All clients for whom there are at least two sets of scores can be included in assessment of reliable change, ie 421 of the 533 discharges. Of these, 205 clients (49 per cent) showed reliable change on the *PHQ-9* (average first *PHQ-9* was 14.52; average final score was 8.90). Two hundred and thirty-three clients (55 per cent) showed reliable change on the *GAD-7* (average first recorded *GAD-7* was 12.32; the average final score was 7.75). One hundred and sixty-seven (40 per cent) of clients showed reliable change on both measures; 271 (64 per cent) showed reliable change on at least one measure.

TREATMENT COMPLETED

For the 299 clients (71 per cent of the 421) who completed treatment, the average number of sessions was 11 (ranging between 2 and 65; 71 per cent had 12 sessions or less). One hundred and fifty-eight (53 per cent) of these clients showed reliable change on the *PHQ-9* (average first recorded *PHQ-9* score was 13.93; average final score was 7.60). One hundred and eighty-two (61 per cent) clients showed reliable change on the *GAD-7* (average first recorded *GAD-7* score was 11.86; average final score was 6.68). The scores of 132 clients (44 per cent) showed reliable change on both measures; 208 (70 per cent) showed reliable change on at least one measure.

DISCONTINUATIONS

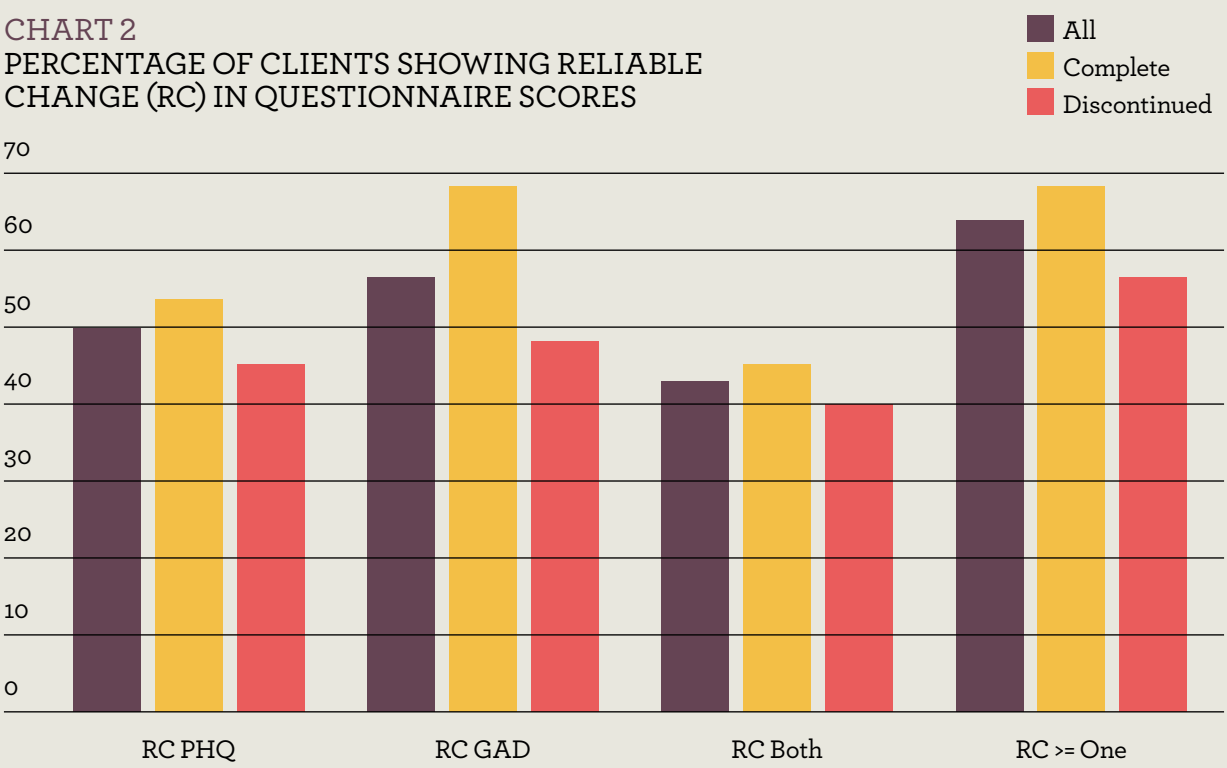
For those clients with an unplanned ending (ie they discontinued or dropped out) – a total of 122 (29 per cent of the 421 – the average number of sessions was eight (ranging between two and 34; 84 per cent had 12 sessions of less). Forty-seven of these clients (39 per cent), showed reliable change on the *PHQ-9* (average first recorded PHQ-9 score was 15.96; average final score was 12.08). Fifty-one (42 per cent) clients showed reliable change on the *GAD-7* (average first recorded GAD-7 score was 13.46; average final score was 10.40). The scores of 35 (29 per cent) clients showed reliable change on both measures. Sixty-three showed reliable change on at least one measure (52 per cent).

Chart 2 shows the relative proportions of clients achieving reliable change on either or both measures, according to the type of ending recorded.

ADEQUATE DOSE

The close evaluation of IAPT-reporting services and tripartite focus on effectiveness (50 per cent recovery target), penetration (15 per cent prevalence met target) and accessibility (28 days target) creates a tension between ensuring a quick throughput and assuring optimal benefit. Chart 3 shows the combined *GAD-7* and *PHQ-9* scores at the first and at the final session, grouped according to number of counselling sessions attended. Although we have not analysed the size of the difference statistically, there is no clear relationship apparent between degree of change in distress measured and number of sessions offered.

CHART 2
PERCENTAGE OF CLIENTS SHOWING RELIABLE CHANGE (RC) IN QUESTIONNAIRE SCORES



Symptomatic change appears most pronounced in the five to eight-session and nine to 12-session groups.

As our access times have fallen – before the increased capacity which came with becoming an IAPT service, the average wait to commence therapy was 40 weeks (September 2009); in March 2014 it was 4.3 weeks – we have found that it is easier to make earlier discharge decisions in the knowledge that, if needed, the client can self-refer and re-access the service within a short period of time. This helps maintain good accessibility and throughput.

CONCLUSIONS

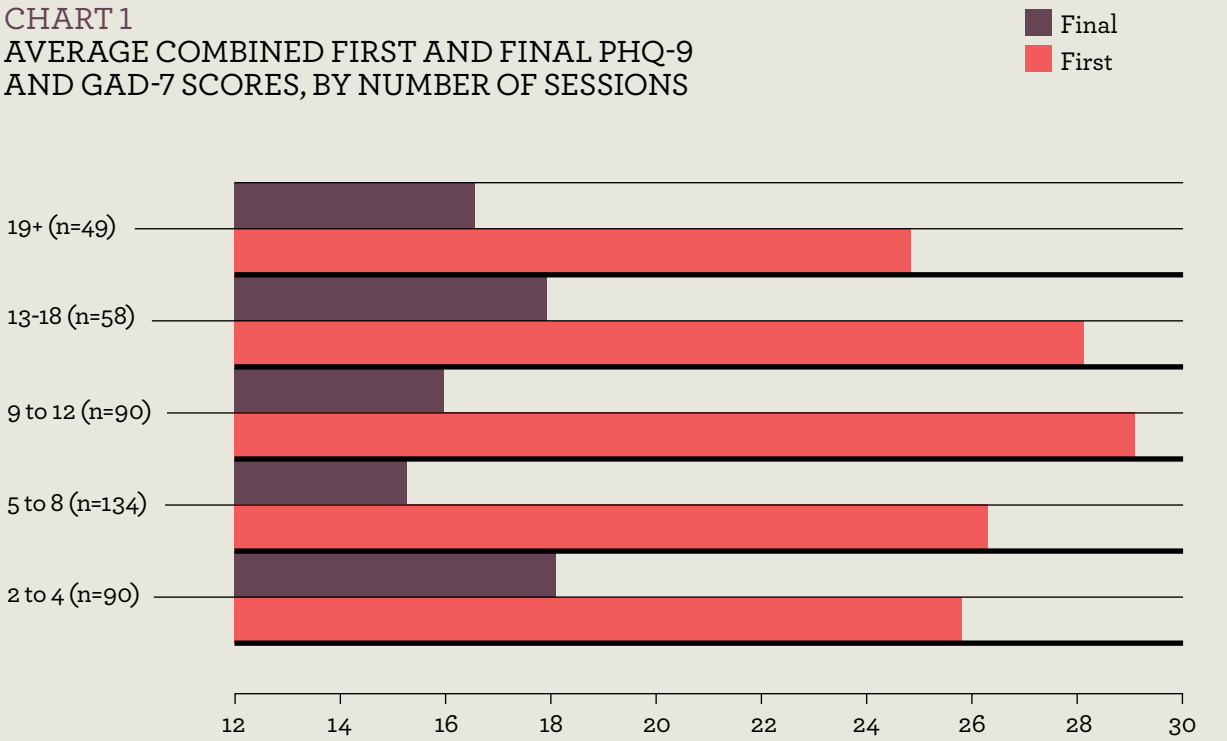
Counselling in our service meets the need for help with issues related to adjustment and loss, and is a choice for clients with depression and mixed anxiety and depression problems, for whom low or high-intensity CBT would not be appropriate or may not have been acceptable. The initial scores of the whole sample of clients within this evaluation, for depression and anxiety, round up to 15 and 12; according to the categorical descriptors, this suggests a moderately severe level of depression (15 to 19 on the *PHQ-9*) and a moderate level of anxiety (>= 10 on the *GAD-7*). The final scores, 9 and 8 respectively, suggest presence of mild depression and anxiety. Separating the counselling team's data from the rest of the service in Trafford, and using a more robust indicator, shows that 46 per cent of counselling clients achieved the standard IAPT recovery criteria; this is above the IAPT national average of 42 per cent.

The percentage showing reliable change was also encouraging: 55 per cent of the whole sample on the *GAD-7* and 64 per cent on at least one measure.

Predictably, variation is apparent between clients who had planned endings and those who dropped out of counselling. Fifty-one per cent of those with planned endings met the IAPT recovery criteria and, somewhat encouragingly, 34 per cent of clients who discontinued also met the recovery criteria. It is easy to assume that clients who drop out of a planned series of sessions, do so as they are voting with their feet. Capturing sessional outcome measures enables the capture of data to soften this assumption.

The differences in demonstrable benefit between type of ending are also apparent using reliable change. Seventy per cent of clients who had a planned ending to their episode of counselling showed reliable change on at least one measure; 44 per cent showed reliable change on both. For those who dropped out, 52 per cent showed reliable change on at least one measure; and 29 per cent on both. The relationship between symptomatic change and amount of sessions attended didn't appear to be linear. The amount of benefit, at least that captured by changes in distress scores, appeared most pronounced in the groups who had between five to eight sessions and nine to 12 sessions. Although easy to over-interpret, it may be a reflection of the complexity and chronicity of some of the problems experienced by clients allocated to counselling within this service. In other words, for many, symptomatic 'recovery' is not a realistic target and the traditional concept of recovery,

CHART 1
AVERAGE COMBINED FIRST AND FINAL PHQ-9 AND GAD-7 SCORES, BY NUMBER OF SESSIONS



ie living well with one's problems, is a more suitable target. This is likely to require a longer intervention. The flexibility and autonomy that counsellors have in deciding how to achieve their required number of episodes of care per year helps to make space for longer interventions, should they be indicated.

The main message, from our perspective, is that the evaluation shows comparable effectiveness between our counselling provision and national IAPT data drawn from all modalities. We're conscious that this is not a like for like comparison, ie we're not inferring the problems treated were the same as those treated within our PWP, CBT or clinical psychology provision. However, people deemed appropriate for counselling, who on average reported scores associated with significant life-limiting levels of distress, irrespective of whether they completed a full course of counselling, reported good outcomes. Sixty-four per cent showed reliable change on at least one measure. Additional data on the nature of the presenting problems included within the outcome figures, eg on chronicity, co-morbidity and previous history of mental health services, would increase the robustness of any conclusions drawn. However, our data suggest that on both the metric chosen to indicate the effectiveness of IAPT-reporting services, and on the arguably more appropriate, reliable change indicator, counselling 'holds fast' against the benefits perceived to be achievable through the implementation of evidence-based practice, in the purely deductive form represented by NICE guidance. The original scripture from which the Trafford motto, *'Hold Fast That Which Is Good*, is derived is preceded by the edict: 'Prove all things...' In order to survive, let alone thrive, within the empirically driven ethos which has evolved for all psychological interventions available in the NHS, we think it is important for counselling as a whole to heed this. ■

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Permission has been gained from Greater Manchester West Mental Health Foundation Trust to publish this information as no patient identifiable data has been used.

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