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Holistic Health: The Effectiveness of a Counselling Model in a Primary Health Setting

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Holistic Health: The Effectiveness of a Counselling Model in a Primary Health Setting

Abstract

The interface between mental health services and primary health care is changing, both internationally and within New Zealand. With the shift toward population health principles and funding formulas, as well as health strategies emphasizing primary health care, the incorporation of mental health services within the primary care domain seems a logical step. In New Zealand, there have been and are currently many variations on this theme of integration, most have arisen in response to the need for service integration and all are locally created and sustained. This study examines one of these initiatives, the incorporation of personal counselling in the primary care setting.

This study explores the effectiveness of the counselling model being used by the practitioners providing a primary care counselling service in a provincial town in New Zealand. The counselling model is grounded in social work theory and practice, it incorporates a strengths based perspective with solution focused brief therapy and cognitive interventions. Effectiveness was measured according to whether the participants' initial concerns were met, whether there was global improvement, and the level satisfaction with the therapist. Both quantitative and qualitative measures were used including survey questionnaires, interviews, as well as pre and post intervention measurements. Information was gathered about the experience of participating in counselling in the primary care setting. The results from all these methods indicate that this counselling model addressed the main concerns for participants and there was satisfaction with the therapist. There was not always global improvement for participants, some of whom felt uncomfortable participating in counselling at their General Practitioner's surgery. The interviews reflected these results, and the pre and post measures indicated improvement in symptoms. This model does appear to be effective in this setting with the wide range of issues that present in the primary health domain.

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This project was subject to ethical approval from both the Massey University Human Ethics Committee as well as the Manawatu Whanganui Ethics Committee. I acknowledge with appreciation the support and approval given by both committees.

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My employer, initially Progressive Health Incorporated which morphed along the way into Whanganui Regional Primary Health Organisation has made this research possible by allowing me access to information about the service, and most importantly to their clients. They have been very professional in their respect for the research process, allowing me the freedom necessary to explore this service without influence. In particular, Dr. John McMenemy has breathed life into the counselling service and with the assistance of the Board has continued to resuscitate the service until it is hopefully strong enough to continue without too much of their emergency care skills. Their vision for the service and their belief in the providers and the model of practice utilised has been a huge factor in the continuation of the counselling service. And of course none of this would have been possible without the participants in the research who shared their experiences so openly and honestly.

Combining the academic world and the working world is no easy feat. Although they are meant to inform each other with inclusive relevance, at times they are worlds apart. The bridge between these worlds have been my Massey University Supervisors, Dr. Mary Nash and Mr. Kieran O'Donoghue. Their clear understanding of the academic processes coupled with their vast experience in social work kept this research project relevant and on track. Their professional judgements and thinking will continue to inspire me, but it was their belief in the research and in my ability that

made the most difference. I can never thank them enough for their support and belief in me.

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TABLE OF CONTENTS

Title Page	i
Abstract	ii
Acknowledgements	iii
Table of Contents	v
List of Diagrams, Tables and Charts	vi
CHAPTER 1 Introduction	1
CHAPTER 2 Social Policy and Health Care	8
CHAPTER 3 Primary Health Care Counselling	22
CHAPTER 4 The Project and The Model	45
CHAPTER 5 Methodology	68
CHAPTER 6 Data Results	82
CHAPTER 7 Analysis and Discussion	101
CHAPTER 8 Conclusion	118
Appendix A Ethics Application and Information	125
Appendix B Second Request for Participation	166
Appendix C Supporting Documents	175
References	182

LIST OF DIAGRAMS, TABLES AND CHARTS

Chart 4.1 Statistical Comparison of Wanganui with National Averages	pg. 46
Diagram 4.1 Counselling Model	pg. 61
Ecomap 4.1	pg. 65
Ecomap 4.2	pg. 66
Figure 6.1 Client Identified Concerns at Time of Referral	pg. 83
Table 6.1 Counselling at the Doctors'	pg. 84
Table 6.2 Main Concerns	pg. 84
Table 6.3 Effects	pg. 85
Table 6.4 Counselling Process	pg. 85
Table 6.5 Comparison of Referral Categories between Respondent and Service	pg. 88
Table 6.6 Pre and Post Counselling Data	pg. 97
Table 6.7 Depression Scale Results	pg. 98
Table 6.8 Anxiety Scale Results	pg. 99
Table 7.1 Effectiveness Measures Related to Research Tool	pg. 102
Table 7.2 Results from Effectiveness Measures Related to Research Tool	pg. 104
Figure 7.1 The Counselling Model	pg. 110

CHAPTER 1

INTRODUCTION

Like many services, the Primary Care Counselling Service who created the counselling model evaluated in this study, evolved from a need, and developed ‘on the ground’ without prior research into the counselling model, or indeed into the counselling service itself. So the research question of how effective a specific counselling model is in the particular setting where it was already being used, was a legitimate question to explore. Understanding the thinking and policy directions that have led to the creation of this service is an integral part of the research, as is understanding the eclectic mix that this counselling model represents.

Research Question

Exploring the research question of how effective the provision of short term, solution focused, and strengths based therapy with cognitive interventions in the primary health care setting is or isn’t becomes a journey in and of itself. A journey I believe is necessary if this model in this situation is to continue to be used. This research, therefore, is an effectiveness study and as with any effectiveness study, the findings are important not only for the clients, the referrers, the managers and the funding agencies, but also for the practitioners themselves and hopefully for the wider professional community as well.

As I embarked on this journey of exploration, I had notions of possible directions that I thought this research might take; some of them grandiose, and some minimalist, I have since learned. Any journey happening over time in the “real” world needs to be flexible enough to absorb the changes that will inevitably occur. Not only are the changes occurring within the physical environment within which one is working, but there are changes in one’s internal environment that are equally if not more profound. These include both personal growth and learning, for which research is often a catalyst.

It is necessary, therefore, to understand, acknowledge, and incorporate this change into the overall project. I would surmise that no project ever follows exactly the path that was originally conceptualised. The changes that I encountered on my journey have all had an impact on the research study itself, and all need to be acknowledged as

aspects and influences on this research project. Changes occurred on all levels, from micro to macro. This chapter will explore these changes and the goals for the project, as well as acknowledge the challenges and gifts they brought. It will also highlight the themes of the chapters which make up this thesis.

Micro-level Changes

Although happening on the micro level, some of the greatest change on this journey occurred within me. I had no idea when I began the journey the depth with which I would need to delve into subjects I had not yet realized were such an integral part of the research I was proposing; areas such as effectiveness and empirically validated support, not to mention the world of primary health care and population health. As I learned about one aspect, it inevitably seemed to lead to others, and developing boundaries became a necessary practice.

Working as a counsellor, using the model in question within the primary care counselling service while undertaking this research was the bumpy part of the journey. As my acquisition of knowledge increased, it of course influenced my practice. The opportunity to revisit and review the components of this model and the theoretical underpinnings allowed me to reground myself in the model, and inevitably review my perceived shortcomings and strengths. Supervision, both professional and peer was important as I worked through this. Studying other models and other theories in an effort to place this model within the therapeutic context challenged my beliefs, learnings, and practice.

As I studied the strengths, weaknesses, and uses of other models, and as I read about attempts at validation of those models for particular groups, I was aware that this model had not been scrutinized to the same extent as many I was reading about, and yet we were using it in the real world. I also realised that this research project would not scrutinize this model to the extent that many 'scientists' would find necessary to suggest validation. However, I also learned on this journey that validation is but one means of determining whether a particular model is meeting needs or not. It has been those other means that have allowed me the peace of mind of knowing that what we are doing is valid for the people we work with, is meeting the aims of the counselling scheme, and is ethical in its application. This, to me, is an important first step in scrutinizing any project such as this.

Meso-level Changes

As the research continued, it was necessary to submit my proposals for scrutiny by two ethic committees. This was the first public airing of this proposal to evaluate effectiveness, and it addressed changes that needed to occur within the structure of the planned research to ensure that all rights were upheld and all responsibilities met.

The accountability required by the ethics committees created other changes to the concepts I had when I began this journey. It is an interesting opportunity to subject your ideas and work to independent panels for their opinions on the *appropriateness* of your proposals. As this was research occurring in the health field and being done under the auspices of Massey University, it was required to be reviewed by both the Massey University Human Ethics Committee and the Manawatu/Whanganui Ethics Committee. Both bodies had their own forms and protocols, and both bodies had their opinions. Understanding their views and making minor amendments to the proposal finally gained their approval, which felt like an achievement in itself.

The expert tuition I received from my academic supervisors created many changes to the thesis as I had imagined it initially. Their knowledge sharing and gentle guidance assisted the development of this thesis into a connected whole from the fragments that I pieced together between visits. But it was their belief in the value of this research and their invaluable direction that has shaped this thesis.

Macro-level Changes

Perhaps the most obvious change that occurred during the course of this research was a complete restructuring of the Counselling Service, which uses the counselling model being evaluated. Most of this change was prompted by or in response to the changes in health policy of New Zealand.

The idea for the research grew from observing and participating in a new project initiative that was undertaken in a nearby community. As the project was new to the area, and from what I could tell initially, was also new to New Zealand, I felt it would be a good project to formally explore. There were several unique features of the project, from the context to the structure, but the feature that intrigued me the most was the model that was being implemented in the actual provision of services. This of course was not separate from the context or the structure, so when that context and structure

changed dramatically in the middle of this project, I found myself needing to find ways to honour the research and especially the participants, and to keep it within the framework I had received ethics approval for.

As you will read in more depth in the following chapters, a counselling service was initiated in the primary health sector of a provincial town in New Zealand. The original scheme was initiated by the Independent Practitioners Association and was funded by them in an effort to provide on site counselling services for their patients whom they felt would benefit from such a service. Under this scheme, the General Practitioners in the pilot project practices could refer their patients to counsellors based in their surgeries. The initial appointment was free, and subsequent appointments were subsidised on a sliding scale depending on what the patient/client felt they could pay. No one was denied access to counselling because of finance. The counsellors were employees of the Independent Practitioners Association, and were paid a salary. Appointments were made by the General Practitioners for their patients and administrative support services were undertaken by the administrative staff in the surgeries. This scheme operated for approximately 21 months before it dramatically changed.

During this 21 month period, macro level changes were occurring in New Zealand, and Independent Practitioners Associations became a thing of the past through legislation that in effect replaced them with Primary Health Organisations. No longer did the General Practitioners have the independence they previously had to implement and fund programs in the community, they were now compelled to work through the direction of revamped District Health Boards who were charged with overseeing the provision of health care to the whole community. In the community where the project being studied here was taking place, the Independent Practitioners Association was gradually replaced by the Primary Health Organisation in mid-2003, and the District Health Board for the region declined funding for the counselling project to continue. The counsellors, of which I was one, were made redundant, but the General Practitioners continued to fund the service and lobby the District Health Board for the continuation of the service. The counselling service continued through emergency funding for two months until further funding could be secured that could ensure the continuation of the service in some form. During the interim, the service continued in much the same fashion as it had previously, however significant changes were made to the service following that.

As all of this was happening, I was still trying to gain approval from the two ethics committees I was required to have approval from for my research. Fortunately the design I had proposed was to examine a 'snapshot' of the clients who had used the service. Since I had already gained approval from the Independent Partitioners Association for the research, I decided to use the last two months of the original scheme as the 'snapshot' once ethics approval was granted. I considered that by involving those clients who utilised the service under the original structure, I was examining what I had set out to examine.

Although the actual counselling model, which is the subject of this research, has been the same since the inception of the counselling scheme (despite the changes to that scheme outlined above), it is naïve to think that the structure is not a variable in the research. In fact, the provision of services directly in the surgeries was a unique feature of the original project and has been identified and discussed in this research. This was among the changes that the new scheme brought to some practices, with the provision of counselling being shifted from the surgeries to a separate building in close proximity that housed some other primary health services, but not the doctors themselves. As well as a change of venue for some clients, a more 'user pays' system was introduced. The funding from the District Health Board did not allow for the same level of payment subsidy as was previously available and new funding streams attached to clients' circumstance became necessary. Although the first appointment remained free, all subsequent appointments require payment to a set level.

Goals

As I embarked on this research project, I had both a professional goal and a personal goal in mind. Working from a solution focused paradigm, goals were an important aspect of the process, and it was the centrality of these goals that assisted me when I felt lost on this journey. Both goals were similar, which helped to keep me and the project focused.

The professional goal at the outset was, and continues to be, the exploration and explanation of what we were practicing and why, as well as to begin to measure if that practice is effective for the people it is serving. The evolution of the model was a natural progression from the theories learned through a social work background to incorporating the beliefs and techniques learned through training in Neurolinguistic Programming. The opportunity to use predominantly social work theories in a clinical

setting is unusual in this country, and it is important to me as a Social Worker that we do this well and do it thoroughly, hence my desire to explore and explain theoretically what we are doing, and to try to ascertain its effectiveness.

My personal goal was, and continues to be, ascertaining where this model and my beliefs and values fit within the broader context of counselling, therapy and psychotherapy. The differences in the language used to discuss this whole general area has confused and confounded me for many years, so it was very hard professionally, to find my fit. This has been a personal journey that has required that I become very clear about my beliefs, as well as my understandings of human nature and human development. It has required learning about other theories and therapies, about other structures and contexts and about other bodies of professional knowledge. It has challenged the very core of my practice and my motivation for being involved in this field. And this research has at last allowed me peace with my practice, and confidence in my history, and pride in my journey to here and beyond.

The overriding goal, however, was to begin the process of exploring whether the counselling model I using was valid and beneficial for the situation I was using it in. As is often the case, this research is being done as the model is being used. Although this feels like a backwards way to go forward, we seem to frequently start with what we imagine might work and evaluate it once it is in operation. Doing research from the inside of a work in progress requires special awareness and transparent research practices. Because this is the position I found myself in, I felt it important to incorporate as many research tools as I could so that the triangulated findings might offer a robust scrutiny of this counselling model and hopefully a thorough investigation of its effectiveness.

Chapters

This thesis contains an Introduction, six chapters and a Conclusion. The context of our health services and the context of the counselling project provide important perspectives for this study. An understanding of the counselling, therapy and psychotherapy fields is also necessary for understanding the model and its use. As well, an understanding of the measures of effectiveness is also important to this research, as is the research methodology used and the analysis provided.

The first chapter, Social Policy and Health Care, begins with the exploration of the concept of population health and documents the implementation of this paradigm into

the New Zealand health service. It also explores the provision of primary health care services internationally and within New Zealand. As well, it explores the intersection of mental health services and primary health care.

In the second chapter, Primary Health Care and Counselling, some of the underlying philosophical stances that are prevalent in health are investigated. As well it explores the disciplines traditionally involved in primary health care and primary health care counselling, with particular emphasis on clinical social work. Social work theory and practice as well as brief therapy theory and practice are examined. Included in this chapter is also an investigation of evidence based practice and the issues of efficacy and effectiveness.

The third chapter, The Project and the Model, examines the primary health care counselling project that has developed in a small provincial New Zealand city in response to the community needs, as interpreted by the General Practitioners from that community. It includes demographic data of the community and the history of the current project. It goes on to explain the counselling model that is the subject of this effectiveness study, and explores the interrelationship of the components of the model.

The fourth chapter, Methodology, explains the methodology used in this effectiveness study. It explores some of the prevalent philosophies that underpin both the methodology and the counselling model. It traces the development of the research process and tools, and chronicles the way the research unfolded.

The fifth chapter, Data Results, presents the results of the data which was collected using three distinct research tools. These results are reported according to the tool used and are presented independently of each other to highlight the specific results from each tool. Chapter Six, Analysis and Discussion, links these tools together and embarks on an exploration of the meanings that can be gleaned from the research in the contexts provided in the previous chapters. This chapter examines these results in relation to the literature from both New Zealand and overseas. Following these chapters the concluding chapter summarises the entire research project and highlights the learnings gained and further research directions that may be considered in the future.

For a social worker, context is everything. I hope this brief introduction assists with explaining the research environment, connects this to the broader systems that will be discussed in the thesis, and begins the problem solving process of exploring the effectiveness of this counselling model.

CHAPTER 2

SOCIAL POLICY AND HEALTH CARE

This thesis examines the effectiveness of a particular counselling model in a New Zealand primary health care setting. The provision of health care and the allocation of health care dollars are important political issues which influence the provision of services and the directions taken within New Zealand health care systems. Government social policy documents and current legislation provide a relevant framework within which to develop an understanding of the current delivery systems for health care and the ideas and policies which have brought them about.

Social policy is the way in which governments signal their ideals for welfare provision and design. Social policy primarily incorporates all the policy instruments that affect the distribution of wealth within a society. These instruments typically reflect the philosophical and theoretical positioning of the government. It is through these instruments that governments design the structures and functions by which the various health, education, and welfare agencies operate.

New Zealand is embarking on a new path in the delivery of health care known as population health. It is a path that is prevalent in other western industrialized nations, and a model robust enough to be proposed to developing nations as well. This chapter takes an in depth look at this path and explores population health both globally and in New Zealand. Population health relies heavily on the primary health care system, which will also be investigated in this chapter. Finally, the interaction of primary health care and mental health care is explored together the implications this has for counselling within the primary health care setting.

Population Health

The concept of population health incorporates a broad perspective of health as it attempts to combine both public health initiatives and personal health care. Public health is considered to be the collective action to improve the health of a population, such as community sanitation, safe drinking water, and food safety regulations. Personal

health, on the other hand, is generally thought of as action to improve the health of an individual. The population health approach aims not only to improve the health of an entire population but also to address any inequalities that may exist for groups within that population. This approach utilises a definition of health that looks beyond the absence of disease, to a positive concept of health that identifies it as a state of physical, mental, and social well-being. Health is seen as a resource or capacity, the ability to pursue one's goals and develop on many levels. This recognizes the effects of social, economic and physical environmental factors, and broadens the responsibility of health beyond what has traditionally been thought of as the 'health sector' (Public Health Agency of Canada, 2002).

In a larger frame, the population health approach can be viewed as one point in the political debate over the ever-changing relationship between economic growth and human health. It is an historic debate that can be traced to France and Britain during the Industrial Revolution when population health gave way to epidemiological studies which spawned the early public health movements. The next century brought continual adjustments between liberal democratic interests and more conservative propertied interests which eventually led to the development of the welfare states of the 20th century. These were in effect the political mechanisms to try to convert economic growth into improved health for the populations being served. These adjustments have continued through time with many variations to the themes. In our current climate, as the neoliberal political agenda has gained popularity with its emphasis on downsizing the role of government, the importance of prevention and population health have increased, particularly in this newly globalised world (Szreter, 2003).

This latest embrace of population health can be traced to Canada in the mid-1970's. This population health approach has closely aligned itself with health promotion. With the recognition that socio-economic conditions, personal health behaviour and environmental factors have a greater impact on health than health care services, the direction and concept of the health sector has changed. The Ottawa Charter for Health Promotion developed in 1986 through the World Health Organization has brought some of the basic population health concepts into the international arena. Through the Charter, health promotion was highlighted as a means to improve health outcomes, and several prerequisites for health were proposed. These include: peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equality (World Health Organisation, 1986). This document spread health beyond the traditional

health sector of primary and secondary medical care, to all sectors of society by defining health as a resource for daily living which emphasized social and personal capacity, as well as physical capacity. It challenged governments to work intersectorally to embrace the broader concept of health, and it urged all social agencies, health and otherwise, public and private, to mediate between differing interests to pursue health.

Different countries have embraced population health with differing emphasises and differing enthusiasm. Health Canada has been effective in not only getting this approach on the international stage, but also in implementing these principles within its borders, emphasising health promotion, health research and health determinants (Health Canada, 2005). Great Britain has also adopted much of this approach with the recognition of the links between health and poverty, as well as the importance of prevention. Their National Health Service currently includes intersectoral work to alleviate poverty, endorsing preventative as well as curative health initiatives. Great Britain acknowledges that investment in health is a social investment that ultimately contributes to a healthier economy (Department of Health, 2000). Australia has also followed the population health approach, as has Sweden and some parts of the United States.

Population Health in New Zealand

The population health approach is a relatively new concept in New Zealand. The concept is strongly endorsed in the New Zealand Health and Disability Act 2000, and has been further expanded through the New Zealand Health Strategy (2000) as well as the Primary Health Care Strategy (2001). The New Zealand population approach attempts to combine both personal and public health to improve the health status of the overall population, recognising that there are disparities in health status between various groups within the broader society.

The New Zealand Health and Disability Act 2000 established the mechanisms to fund health on a population basis. Prior to this, the New Zealand primary health sector predominantly consisted of private for-profit general medical practices which received government subsidies to offset costs, as well as regionally established publicly funded secondary health institutions and small private secondary health facilities. There was also a large third sector health scene in New Zealand which consisted of non-government and non-profit organisations that provided services frequently not addressed by private practices. These organisations have generally embraced a very broad definition of health, and have operated parallel to mainstream private practice. In

New Zealand, these were frequently community run, multidisciplinary organisations serving low income, unemployed, or specific populations such as Maori and Pacific Islanders (Sibthorpe, 2001).

The New Zealand population health approach places an emphasis on both individuals and defined populations, and proposes to take collective responsibility for the individual health care needs of defined populations (Ministry of Health, 2001). Toward that end, the population as well as the determinants of health must firstly be defined. The New Zealand Health Strategy (2000) establishes the factors that most influence health as: genetic inheritance, age, gender, ethnicity, income, education, employment, housing, a sense of control over one's life, and access to health care. It goes on to suggest that action across many public sectors is required to adequately address these, which include building healthy public policy, creating supportive environments for health, strengthening community action, encouraging the development of personal skills, as well as reorienting the health services in line with the World Health Organisation's Ottawa Charter (Ministry of Health, 2000b).

The New Zealand Health Strategy (2000) links this intersectoral approach with indigenous Maori beliefs about health and well-being. Acknowledging consultation and community collaboration as well as an holistic approach, this strategy hopes to include Maori in a dialogue about health with the aim of addressing the inequalities of the health status of that population. The Strategy suggests this approach specifically correlates with the model of Te Whare Tapa Whā as articulated by Durie (1998). This model describes the dimensions of well-being and the cornerstones of Maori health as: te taha wairua or spiritual aspects; te taha hinengaro or mental and emotional aspects; te taha whanau or family and community aspects; and te taha tinana or physical aspects. These four concepts can be thought of as the walls or corners of a whare or house. The model proposes that good health is produced by an equilibrium of all these aspects (Ministry of Health, 2000b).

The Primary Health Care Strategy (2001) reinforces the population definition by initiating client enrolment with primary health care providers who are charged with meeting their individual and collective needs, presumably in the broadest sense of the term. According to the Primary Health Care Strategy,

“The vision and the new directions will involve moving to a system where services are organised around the needs of a defined group of people. Primary Health Organisations will be the local structures to achieve this....District Health Boards

will work through Primary Health Organisations to achieve goals locally” (2001, pg. viii).

Primary Health Care

The World Health Organisation defined primary health care in their 1978 Alma Ata declaration as:

“essential health care based on practical, scientifically sound and socially acceptable methods and technology, made universally available to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination” (World Health Organisation, 1978, p. IV).

This sets the standard for primary health care, and in many developing countries this is the goal. Research done for the World Health Organisation indicates that countries with health systems that rely more heavily on primary care as opposed to specialist care have better population health outcomes and lower costs (Atun, 2004).

Primary health care can be an integral part of the formal health care system of all countries, and acts as a means to balance the two primary goals of these health care systems; that of optimising health, as well as the equitable distribution of resources. It does this by providing preventative, curative and rehabilitative services to maximise health and well-being. Beyond this, it can integrate care across multiple problems, it can deal with the context of the illness, and it can influence individuals’ response to their health issues. Its focus is on promoting, maintaining, and improving health. Comprehensive primary health care systems can provide a wide range of services from health education, promotion and prevention to curative, rehabilitative and terminal activities (Atun, 2004).

Primary health care, according to Vuori (cited in Atun, 2004) has four components which include: primary health care as a *set of activities*, as suggested in the Alma Ata declaration; primary health care as a *level of care*, recognising it as the domain of first contact with the health care system and where 90% of health issues are addressed; primary health care as a *strategy for organizing health services* which embrace the concepts of accessibility, relevance, integration, cost-effectiveness, collaboration and community participation; and primary health care as a *philosophy* which underpins intersectoral collaboration and equitable delivery of care.

Differing levels of health care were first defined in Great Britain in 1920 through the Dawson Report, which distinguished three major levels of health services: primary health centres, secondary hospitals and teaching hospitals. Although this structure prevails in many countries, the delivery of primary and secondary services differs. The New Zealand health system is composed of public, private and voluntary sectors which interrelate to provide and fund health care, with over 75% of health care publicly funded. Two levels of care exist in New Zealand, primary care which is accessed through practitioners outside of hospitals, and secondary care which provides services that are hospital based (Statistics New Zealand, 2005). The World Health Organization promotes primary health care as the means to achieving improved health outcomes, citing research which indicates that countries with higher primary care orientations were more likely to have better population health outcomes, at lower cost and with greater user satisfaction (Atun, 2004). Primary health care also offers a lower cost environment than secondary care.

It is important to note that this discussion has been about primary health care, which is different from primary medical care, which has been an integral part of the health system to date. Moving from the delivery of primary medical care to the delivery of primary health care requires a conceptual shift. The focus of primary medical care is generally illness and cure, where the focus of primary health care is health, prevention and care. Where primary medical care content has traditionally been about treatment, episodic care and specific problems, primary health care includes health promotion, continuous care and comprehensive care in its content. Primary medical care is generally organised around specialists, doctors and single handed practice, while primary health care is organised around general practitioners, group practices, as well as health care teams. With primary medical care, the responsibility was predominantly for the health sector alone which maintained professional dominance; with primary health care, the responsibility includes intersectoral collaboration, community participation and self-responsibility (Vuori, cited in Cheah, 1997).

Although general practice and general practitioners are an integral part of primary health care, they are not synonymous with it. The breadth of primary health care is reflected in the levels of care that the general practitioner offers including: prevention, pre-symptomatic detection of disease, early diagnosis, diagnosis of established disease, management of disease, management of complications, rehabilitation, terminal care and counselling (Atun, 2004). This is not to say that specialists and secondary care are not

also important components of the health system, they, too, perform important roles. However, with improved technological advances and training and education, as well as the incorporation of primary health care teams, and the changing social attitudes to health, primary health care can have a greater role to play than was previously recognised. It is hoped that by emphasizing and promoting primary health care, stronger communities with less need for specialist care will be the result (Bowers, Holmwood and McCabe, 2002)

Beyond the shift from primary medical care to primary health care, there are other influences which are also greatly altering the role of primary health care services. General Practitioners in primary care are being required to provide more comprehensive medical services to increasing numbers of people in a shorter time. With the breakdown of many social structures, such as church and family, as well as the change from secondary to community based mental health services, the demand on the general practitioner is escalating (Wiener and Sher, 1998). The medical profession has had to consider some different options to cope with these changes; as well as primary health teams, and group practices, general practitioners are increasingly looking for models to help them address these demands. The model being analysed in the thesis has developed partially in response to this situation.

Primary Health Care in New Zealand

The definition of primary health care proposed in the New Zealand Primary Health Care Strategy (2001) closely reflects the World Health Organisation's definition. This Strategy considers primary health care to be:

“essential health care based on practical, scientifically sound, culturally appropriate methods that is: universally accessible to people in their communities; involves community participation; integral to, and a central function of, New Zealand's health system; the first level of contact with our health system” (Ministry of Health, 2001, pg. 1).

For many New Zealanders, the most frequent contact with the health sector has traditionally been through a General Practitioner.

In New Zealand, it is generally through contact with your local GP that referrals to other services, including secondary and disability services are initiated. Within the secondary and disability health sectors, allied health professions such as physiotherapists, speech therapists, occupational therapists, and social workers are well established. However it is relatively recently that allied health professionals have

become a part of the primary health sector. With the push toward multidisciplinary involvement in patient management, the primary sector is beginning to involve other health professionals. Incorporating multidisciplinary and/or interdisciplinary primary health teams into private general health practices has become a way of sharing the responsibility for patients' care and welfare.

The characteristics of the system created through this policy sees New Zealand moving toward a more regulated primary care system with national policies ensuring the provision of primary care throughout the population. The system is based predominantly around general practitioners rather than specialists, and is supported through a government subsidy. The structure within this system emphasizes longitudinal care through enrolment schemes to ensure a regular source of health care over time regardless of the problems presenting. It also emphasises comprehensive services and community orientation (Cheah, 1997).

The structure of New Zealand health sector, with primary health services, regional secondary health services and the large not for profit organizations servicing broader groups, provides for the paradigm shift from primary medical care to primary health care. The emergence of the not for profit sector, as described in Sibthorpe (2001), can be seen as a precursor to the ideologies which underlie the Health and Disability Act (2000) and the Primary Health Care Strategy (2001).

Primary Health Care and Mental Health

As General Practitioners have long realized, many patients present to primary care services with psychological and/or emotional concerns as well as physical issues (Wiener and Sher, 1998; Bor and McCann, 1999; Bor, Miller, Latz and Salt, 1998; Hemmings, 2000, Fraser, Morris, Smith and Solovey, 2001). With the shifting emphasis from primary medical care to primary health care, this trend will increase, and the primary health policy direction indicates that this is the appropriate system to deal with mental health as well as physical health concerns. Current disease burden as suggested in Hemmings (2000) shows that in most Western Industrialized countries, estimates indicate "that 13% of the adult population is affected by a mental disorder at any given time" (pg.279). He goes on to outline the trend that of those affected, 95% will consult their general practitioner at some stage during the course of their disturbance, with only 10% being referred to secondary care. The implications are that up to 90% of mental health clients are already being cared for in primary care. These patients account for 9%

of all consultations to general practitioners (Hemmings, 2000). Fraser, Morris, Smith and Solovey (2001) suggests that in the USA, 80% of clients with psychosocial problems present to their family doctor with a physical complaint rather than to mental health services, he also cites research indicating that 50% - 70% of mental health patients are seen exclusively in primary health settings with no referral elsewhere (Bray and Rogers, 1997, cited in Fraser et al, 2001). Addressing mental health needs is obviously an important issue for general practitioners.

With the trend of the provision of continuous care through the primary care systems, practitioners are seeking ways to address the mental health needs of their clients. Integrated primary care is a trend that is emerging which incorporates both medical and behavioural health (a term which incorporates mental health, psychological, psychiatric and psychosocial) services in an effort to more fully address the issues that clients bring to their general or primary practitioners. According to Blount (1998, pg.6) integrated primary care has several advantages including:

- Being a reflection of the way clients present their distress, which is generally not **either** biological or psychological but **both**, or in other words, presenting in an undifferentiated way,
- The primary health setting being the appropriate locus of treatment for many psychological and psychiatric conditions such as depression and anxiety,
- Offering clients a good 'fit' with the service they have accessed, which generally flows on to better adherence to treatment regimes which leads to better outcomes,
- Recognition that General Practitioner's can not be expected to address the vast array of psychological and/or psychiatric issues that present to primary care despite the training of the General Practitioner, and that referral to outside sources is frequently a poor alternative,
- Creating an effective way of utilising the skills of primary care providers in dealing with the many aspects of primary care, specifically the psychosocial aspects,
- Creating a setting which provides a happier work environment for practitioners,
- Creating an environment that clients express more satisfaction with,
- Creating a cost efficient in some cases and at least a break even financial option,

- Creating good laboratories for future developments and refinements of services and practices that are utilized in integrated primary care.

Globally, various models of incorporating psychological services in the primary health setting are in use. In the United Kingdom, where much of the research is undertaken, several models have evolved, including: GPs up-skilling and undertaking the counselling themselves; GP practices employing counsellors or therapists; patients being referred to private counsellors; and counsellors hired by District Health Authorities being assigned to general practices (Wiener and Sher 1998). The incorporation of counsellors into the primary health care setting in the United Kingdom was initially begun in the early 1970's. The provision of counselling or psychotherapy within the primary health settings has grown rapidly (Wiener and Sher, 1998; Bor and McCann, 1999; Campbell, 2000). Estimates suggest that in the UK, 50% of GP practices employed a counsellor or psychotherapist in 2001 (Jackson, Bowers, Holmwood, and McCabe, 2002; Keithley, Bond, and Marsh, 2002).

This level of growth has required recognition and management. Since 1999, primary health care counselling in the United Kingdom has been professionalised through the development of the Association of Counsellors and Psychotherapists in Primary Care, and employment standardised with funding to employ counsellors and/or therapists directed to either Mental Health or Primary Care trusts. These trusts are part of the country's National Health Service (Jackson Bowers et al, 2002). Increasingly in the UK, attention is being directed toward employment models and training needs of primary health care counsellors (Wiener and Sher, 1998; Einzig and Curtis-Jenkins, 1995).

By contrast, in the United States, the most widely used model appears to be that of 'preferred providers', a model growing out of the managed care movement embraced by private insurance schemes. Under this scheme, health professionals, including counsellors and therapists, contract to provide approved services at approved costs to clients of funding organisations (insurance schemes) upon diagnosis by a medical practitioner, hence becoming a 'preferred provider' (Rubin and Babbie, 2001). The American Psychological Association has recognised the trend of managed care which places primary care providers, primarily general practitioners, in the 'gatekeeper' role of sanctioning other services, including mental health services. One response to this has been the recognition of the benefits of collaborative care models at the primary care level (Fraser et al, 2001).

The employment model directly influences the aims and expectations of the service, as well as the role, boundaries and scope of practice that counsellors and therapists undertake in primary health care settings. This impacts on, among other things, the types of relationships they have with other health professionals and their clients in the primary health setting. Integrating care in the primary setting happens along a continuum, with the least amount of integration generally having been the norm in the primary medical care paradigm. This usually consisted of simply a courtesy note of involvement between practitioners and others involved with the client. Moving on from this along the integration continuum, professionals can have referral calls to other professionals involved to exchange information, or taking it one step further could develop referral relationships. The continuum continues with the participation of professionals in case meetings, and then on to meeting with the professionals and the client simultaneously. Following on from this is the most integrated end of the continuum where professionals work together regularly to deliver services (Blount, 1998).

Multidisciplinary and interdisciplinary teams offer the counsellor or therapist in primary health settings a structure which can be beneficial in providing support for both the client and the therapist. Working in primary health settings offers the opportunity for collaboration among health professionals with the aim of improved patient management. However, there are also some concerns, particularly around information sharing, or confidentiality. The well established ethic of confidentiality for both medical practice and counselling is challenged by the need to share information with other team members. Some view this as an equity issue, with clients who are able to pay privately for counselling being assured of confidentiality, while clients unable to afford private counselling not having that assurance (Jackson Bowers, et al, 2002). There are pros and cons to both situations and clearly the issue of confidentiality will be addressed in each workplace, reflecting the culture, population and structure of the setting.

Despite these concerns, Fraser et.al. (2001) suggests that the presence of mental health practitioners on site in primary health care settings in the United States increases the likelihood of clients accepting referrals. His figures show a 91% referral acceptance rate to on site providers as compared to a 50% referral acceptance rate to outside providers. Research also shows that the integration of mental health services into primary health settings has improved both outcomes and patient satisfaction in

treatment of mental health issues (Katon, cited in Jackson Bowers, et al, 2002). These findings are of direct relevance to the research question being explored in this thesis.

Primary Health Care and Mental Health in New Zealand

According to the New Zealand Ministry of Health, the prevalence of mental health concerns among New Zealand adults suggests that 3% of the population experience severe mental health problems, with another 5% of the population experiencing moderate to severe mental health problems, and a further 12% of the population experiencing mild to moderate mental health problem (Ministry of Health, 2002). While the National Mental Health Strategy is targeted at the 3% of the population with severe mental health issues through the provision of specialist services, the other 17% of the population with less severe issues and disorders are dealt with in the primary health care system. The World Health Organization identifies that at least 24% of people presenting to primary health services have a major psychiatric disorder, with a further 9% presenting with a subthreshold disorder, while preliminary data in New Zealand suggests this may be slightly higher with up to 35% of people presenting to primary health services meeting the criteria for a mental disorder (Ministry of Health, 2002).

Within New Zealand, it is estimated that over one quarter of the population have or have had a diagnosable mental disorder in the past six months. Of those, three quarters will have attended a health service but only about a third of them would have sought help for their mental disorder. Of those that received any treatment, three quarters of it was provided by their GP, with the other quarter being provided by specialist mental health services. Very few people present mental health concerns as their main reason for consulting their GP which may be a problem of access for people (MaGPIe, 2003).

In New Zealand, the fee for service funding system currently in place for consultations with General Practitioners can create a barrier to accessing assistance. New Zealand ranks second to the United States in people who did not access medical care or who skipped medical tests because of costs, in a survey of five countries (Schoen, Osborn, Huynh, Doty, Davis, Zapert, and Peugh, 2004). This situation then creates a financial incentive for people with mental health issues to utilize specialist services which do not have a charge, rather than their GP. The barriers to the current system include the cost to the service user, the cost to the GP, as well as the GP's competence and confidence in dealing with mental health issues (Ministry of Health, 2002).

Primary mental health care in New Zealand is currently predominantly GP based, while internationally this is changing to incorporate other professional groups such as nurses, counsellors, social workers, and psychologists. Case management is emerging as a significant factor in improvement for people with depression, and case management can be done by professionals other than GPs, with the added benefit of cost effectiveness (Ministry of Health, 2002). While specialist services are necessary for the 3% of the population with severe mental health disorders, other models are being examined to meet the needs of the population with less severe disorders.

New Zealand has trialed several 'pilot initiatives' to explore other models of providing primary mental health care. These have generally been locally driven, with funding and delivery varying greatly, and generally involving models of improving the interface between primary health services and mental health specialist services. Liaison was the key feature of the programmes. Of the 21 District Health Boards in New Zealand, 11 had mental health/primary health shared care programmes, with one District Health Board having two programmes as of March 2003 (Nelson, Fowler, Cumming, Peterson, Phillips, 2003). None of the projects outlined in *Evaluation of mental health/primary care shared services* (2003) incorporate counselling or psychotherapy in primary health settings. However, these programmes have highlighted issues which need to be addressed if the implementation of shared care programmes are to flourish in New Zealand. These issues included sustainable funding, staff workloads, complexity of establishing programmes, staff training and support, ethical issues and attitudes (Nelson et al, 2003). The incorporation of counselling or psychotherapy in primary health settings is therefore a useful area to investigate.

Summary

New Zealand has embraced the population health approach through the Health and Disability Act 2000. This sets up the structures for funding and monitoring health services provided to those living in New Zealand. The provision of health care services is articulated through the various strategies that have been developed to inform the legislation. In particular, the New Zealand Health Strategy (2000) and the Primary Health Care Strategy (2001) provide the direction for primary health care for the foreseeable future. As the government is supporting a strong primary health industry, with broad definitions and determinants of health, the challenge becomes the operationalisation of these ideals.

As the emphasis of health service provision is shifting to the primary care arena, new programs and models of service need to be developed to meet unique community needs. Although the structures and funding are changing, many of the health issues remain unchanged, and the challenge to the primary health care sector will be to manage the issues in different ways with different philosophies. For example, the burden of mental illness on society remains unchanged but the push to treat these issues in the community through primary health care services reflects a trend that has been emerging as mental health concerns have become less institutionalised and more widely recognised and treatable.

CHAPTER 3

PRIMARY HEALTH CARE COUNSELLING

The integration of primary health care and mental health care challenges some of our current structures and philosophies for the provision of health services. It is necessary in any effectiveness evaluation of a particular counselling model within the primary health care setting that some of the influences affecting the various professions that provide these mental health services are considered. As outlined in the introduction, this study is concerned with the exploration of the development of counselling in the primary health setting. It is important to recognize however that the provision of counselling within the primary care setting is just one response to the challenge of integration, and no doubt, as the New Zealand experience matures, so too will the models and levels of integration.

This chapter looks closely at primary health care counselling and some of the influences that impact upon it. It will explore some of the characteristics of the predominant paradigm that has historically defined the medical environment and investigate an alternative. An exploration of the players in the primary health care counselling scene will be undertaken, with particular emphasis on clinical social work. As well as social work theory and practice, brief therapy theory and practice will be addressed and the intersection of these fields will be examined. Finally, a look at evidence based practice and the issues of efficacy and effectiveness will be explored in an effort to understand the demands of the current work environment.

Primary Health Care Counselling

Counselling in the primary health care setting can be a challenging undertaking. For a counsellor or psychotherapist, the work can be demanding simply because of the variety and volume, however working at the 'coalface' and being part of a team can have its rewards. For the client, receiving mental health services in a primary health care setting such as a health centre or the General Practitioners' surgery offers credibility, familiarity, anonymity and location, as well as being non-stigmatising and having a normalizing effect (Bor and McCann, 1999; Jackson Bowers et al, 2002). These are

major benefits which no doubt increase the rate of attendance. Often people accept referrals to counsellors or therapists in this setting as they expect the counsellor to be working closely with their general practitioner. Wiener and Sher (1998), suggest that at times it is “the demand is for the maternal giving of counselling rather than the paternal authority of medicine” (pg. 5), that is required.

With the integration of mental health services and primary health services, clients could have a different, more holistic experience than has been available previously. Depending on the level of integration of the services, clients may experience anything from awareness of and support for the work of both primary care practitioners and mental health practitioners, to a collaborative treatment plan being implemented with both practitioners, and possibly to clients meeting with all the providers involved in their care. Potentially, with integration, a team approach could allow for such a level of information sharing that any of the practitioners involved with the client would be able to represent that unified team (Blount, 1998).

Primary care counselling draws on many forms of counselling and many different theoretical perspectives underpin the skills being used. Bor, Miller, Latz, and Salt (1998) suggest there are four levels of counselling that are undertaken in primary care. These include:

- information giving, with the focus on providing factual information;
- implications counselling, focusing on the implications of information on individuals and family systems and circumstances;
- supportive counselling, focusing on the emotional consequences of information and/or events; and
- psychotherapeutic counselling with the focus on psychological adjustment, coping and problem resolution.

Many health professionals use counselling skills, and it is important that we differentiate these from the provision of counselling. Most health professionals perform some of the levels of counselling listed above as they carry out their roles, but the last two levels discussed above, are generally the domain of trained counsellors.

As well as providing counselling to clients, research suggests that having on site counsellors and/or therapists increases the sensitivity of detection of mental health issues, frequently for clients who were not previously managed at all (Jackson Bowers

et al, 2002). As well as increasing awareness, on site mental health professionals can fulfil an important education role for other members of the primary health care team.

The Medical Model and the Biopsychosocial Model

Incorporating counselling into primary health care requires involvement with the medical or biomedical model (for the purposes of this thesis, the terms are used interchangeably). This is a significant feature of primary care counselling. These domains, counselling and medicine, have at times been considered mutually exclusive. Awareness of the medical model was the highest ranked element primary health care counsellors in the UK mentioned as missing from their initial counselling training (Einzig and Curtis-Jenkins, 1995).

The biomedical model traces its roots back to the Renaissance period with acceptance by philosophers and scientist of Cartesian dualism or 'the mind body split'. Cartesian dualism encouraged practitioners of medicine to increasingly and exclusively specialize in care of the body, while the care of the 'soul' was left to the Church and/or state-provided social welfare systems. This, in time, was accompanied by the use of positivist scientific methodology and the reductionist paradigm, which reduces complex phenomena to smaller and smaller parts, examining each part separately. In this type of approach the body can be viewed as simply a collection of organs which may be examined separately and individually. This is a reductionist approach which provides a medical view of the patient as the object or collection of objects for study, rather than the subject. This approach has achieved tremendous success in addressing acute and infectious diseases, as well as traumatic injuries, which has reinforced its credibility, and in turn, has consistently kept it as the dominant medical paradigm (Bor and McCann, 1999). The medical model continues to emphasise the split between mind and body, as is evidenced in the recent health models which clearly separate mental health services from physical health services. It also continues to be firmly grounded in positivist scientific methodology, with its support for and insistence upon quantitative evidence, especially randomised controlled trials (Hemmings, 2000).

The medical model has been less successful in other areas of medicine however, including chronic illness, disability and mental illness. These areas may be better understood from a biopsychosocial paradigm, which recognizes the interactions between biological, psychological and social factors in health outcomes. Many of our biggest health gains have been made through public health initiatives such as public

sanitation and clean water supply, which acknowledges the importance of some of these factors, as well as environmental factors.

This biopsychosocial model, proposed by George Engel in 1977, requires collaboration between health care professionals. It acknowledges that emotional support, relationships, family and the meaning the client and their significant others ascribe to illness, as well as support networks, are all important ingredients of effective health care (Bor and McCann, 1999). Today we face threats from degenerative diseases and ailments affecting our immune systems and our neurology, with environmental factors thought to be significant contributing elements (McDermott and O'Connor, 2001). Recognition that the diseases which threaten us today are very different from the diseases for which the biomedical model has been so successful, have added weight to the call for a paradigm shift. The collaboration of mental health care with primary health care in the form of primary health care counselling is but one example of the changing paradigms.

Psychotherapy and Counselling

The terms counsellor, psychotherapist and therapist are frequently used interchangeably, and are a source of great discussion in the disciplines that undertake the counselling task. Psychiatrists, psychologists, social workers, psychotherapists, psychiatric nurses, and counsellors are all employed in primary health care counselling roles, each bringing with them the theory and ethics underpinning their particular discipline. Each use different terms for what they provide and no one group has a monopoly on the terms or titles used. It is argued that all counselling provided in primary health settings involves psychotherapy (Bor et al, 1998), so however it is referenced, whether as counselling or psychotherapy, the implications are of an ability to utilize psychotherapeutic skills with clients.

Although there are many psychotherapists and counsellors, there is not a unified psychotherapy profession (Roth and Fonagy, 2005). Several professional disciplines have members who claim the right to practice psychotherapy as specialties within their fields of practice. Psychologists, psychiatrists, psychiatric nurses and clinical social workers all claim this right, and practice in various settings. These include institutional systems such as medical facilities, schools and courts, as well as private practice. These are often the most visible mental health practitioners, but there is also a less visible pastoral care system supported by religious denominations and church structures, and

networks of specialized self-help groups (Orlinsky and Howard,1995). In the United States, “social workers provide more mental health services than do professionals from all other disciplines combined” (Drisko, pg. 81, 2004).

Psychotherapy has historically been the domain of psychologists and psychiatrists who adhere to a specific type of theory-based therapeutic intervention. Orlinsky and Howard (1995) define modern psychotherapies as “involving a professional service that provides personal help in the sphere of private life under the symbolic authority and guidance of scientific knowledge” (pg. 9). The ‘scientific knowledge’ is generally expressed through clinical theory which provides a set of concepts that inform the interventions used to benefit clients, these sets of concepts are all derived from theoretical perspectives of human functioning. According to Orlinsky and Howard (1995), these theoretical orientations can be divided into four broad categories, these are:

- analytic-dynamic which includes psychoanalysis, as well as therapies derived from existential philosophy, and ego psychology;
- cognitive-behavioral which include those therapies based on classical conditioning, operant conditioning and learning theory;
- experiential-expressive therapies including client-centred therapy, gestalt and guided affective imagery; and
- strategic-systemic therapies which incorporate communications and social transaction theories.

Counselling, on the other hand, is often viewed and debated as a point on the continuum of psychotherapy, rather than a separate field of study. Counselling is generally seen as involving less training, and offering less adherence to theory, but with the goal similar to that of psychotherapy (Palmer, Dainow, Milner, 1996).

Counselling can be viewed as the functional process which grew from the schools of thought that attempt to understand human behaviour, rather than from the medical field that spawned psychoanalysis initially. Counselling is often defined by the setting in which it takes place, regardless of the theoretical model employed by the counsellor. It also generally views the relationship between the client and the counsellor as one of equals, and usually deals with current problems facing the individual from a pragmatic approach. Although counselling has been strongly influenced by the client centred approach, more recently it is developing integrative approaches that combine a range of

therapeutic orientations, and has begun to specialize in particular settings, such as primary care, or on particular problems, such as bereavement (Roth and Fonagy, 2005). How much one needs to know about these theoretical orientations to provide ‘personal help in the sphere of private life’ continues to be debated. As well, the degree to which one needs to adhere to only one school of thought is another issue for debate.

Eclecticism and Common Factors in Therapy

Eclecticism and common factors are also debated areas of counselling and psychotherapy. Many helping professions have found eclecticism a necessary world view, stemming from the belief that people are far too complex for any single theory or approach to provide adequate explanations. Research into specific psychotherapy models have failed to find one specific type of therapy which is superior to the others (Seligmann, 1995; Lambert and Cattani-Thompson, 1996; Lambert, 2004; Drisko, 2004). This has strengthened the case for eclecticism and has prompted researchers to investigate the pantheoretical or “common factors” that are embodied in all therapy models (Lambert and Cattani-Thompson, 1996; Hubble, Duncan and Miller, 1999; Wampold, 2001; Drisko, 2004). These common factors are generally considered to include: extratherapeutic factors such as the agency context as well as the client’s context and the client themselves; the therapeutic relationship; therapeutic technique which is also known as special factors; and expectancy (Drisko, 2004).

These common factors, it is suggested, are factors in all psychotherapeutic approaches, and it is these factors that influence outcome, rather than the theoretical orientation of the therapist. Wampold in his book *The Great Psychotherapy Debate* (2001) surmises these common factors into three areas that seem to be the basis for change to occur. These include:

- the global aspects of therapy which are not specific in any one approach such as insight, a corrective experience, the opportunity to express emotions and gaining a sense of mastery;
- interpersonal and social factors including the therapeutic relationship and context; and
- the client’s expectations and involvement in the therapeutic process (Wampold, 2001).

Lambert (1992, cited in Drisko, 2004) breaks these areas into four categories, and suggests that through the examination of outcome research there are differing degrees of variance that can be attributed to each of these areas. He lists the areas or factors as: extratherapeutic factors, the therapeutic relationship, technique and expectancy. He suggests that as much as 40% of the outcome variance is due to extratherapeutic factors, 30% is due to the therapeutic relationship, 15% is due to technique and the remaining 15% is due to expectancy (Drisko, 2004).

The extratherapeutic factors take into account the agency and policy context of the service including such elements as the client knowing the service exists and is likely to help, that the service is accessible, user-friendly, and culturally sensitive, as well as that the service is affordable to the client. The extratherapeutic factors also include the client context and the client himself. The client context considers such elements as family support or lack of it, as well as peer and workplace supports, and spiritual support. The personal attributes of the client are also considered an extratherapeutic factor, considering elements such as intelligence, motivation to change, resilience and capacity to trust, as well as readiness to change. Readiness to change, as opposed to the other client factors is seen as a variable or cyclical phenomenon rather than a stable trait (Drisko, 2004).

The therapeutic relationship or alliance is a factor of psychotherapy that is consistently linked to outcome (Lambert, 2004), and is sometimes considered one of the largest curative factors in psychotherapy. Psychotherapy literature since the 1950's has emphasised the importance of genuineness, caring and empathy (Lambert, 2004). Included in the therapeutic relationship are elements such as mutual affirmation, active encouragement to support change, and clear acknowledgement of change (Drisko, 2004).

The specific techniques are also considered to play a part in outcome, although no one therapeutic approach has been proven to be superior to others. The importance of specific techniques appears to lie not just in the technique but also in the rationale and explanation of the technique and the related strategies that accompany it. Expectancy or the placebo effect of psychotherapy is also considered a common factor. The ritualised format of the therapy, it is suggested, encourages hope and expectancy simply by the client and therapist working together toward successful change (Drisko, 2004).

The common factors model is diffuse and proposes that there is a set of common factors to all therapy and that these factors themselves are therapeutic. Frank and Frank

(1991, cited in Wampold, 2001) suggest six functions that counsellors or therapists fulfil during the course of psychotherapy, regardless of their theoretical orientation.

These include:

- 1 the therapist ameliorating the clients' sense of alienation through the development and maintenance of a relationship despite what the client divulges,
- 2 the therapist maintaining hope and the clients' expecting to be helped through the process of therapy,
- 3 the therapist providing new learning opportunities,
- 4 the therapy arousing client's emotions,
- 5 the therapist enhancing the client's sense of mastery, and
- 6 the therapist providing opportunity for practice.

The common factors debate is often considered to be as much about outcome as it is about eclecticism, another area in this ever-changing landscape of psychotherapeutic change.

Although eclecticism is defined in the Oxford Concise Dictionary (Sykes, 1982) as "borrowing freely from various sources", when applied to psychotherapy or counselling orientations, it is sometimes reputed to be undisciplined and unsystematic. However, many eclectic practitioners would dispute this reputation. Eclecticism takes several forms and can be broken down into classified categories differentiating between the theoretical components that are being used/borrowed/chosen, and the reasons for determining that choice. These include:

- technical eclecticism, or the adherence to a theoretical orientation while using techniques from other theories which is determined by the fit with the client and problem, and/or empirical evidence,
- theoretical integration, or the combining of the strengths of more than one theory to create a more comprehensive explanation or intervention, and
- theoretical eclecticism, which incorporates the use of differing pure theories for different kinds of problems based on empirical evidence of efficacy (Lehmann and Coady, 2001; Wampold, 2001).

Eclecticism itself can be eclectic, and its categories are not mutually exclusive.

Eclecticism is now the most widely reported therapeutic orientation for psychotherapist in the United States, Canada and Great Britain (James, 2003). In fact, several major concepts of eclectic practice have been identified, suggesting that eclectic

practitioners generally subscribe to several premises when working with clients, including:

- that the identification of valid elements within systems and the integration of these into a whole can explain the behaviour;
- that all pertinent theories, methods and standards for evaluating and manipulating clinical data are useful;
- that the lack of affiliation with any specific theory allows for keeping an open mind and continually experimenting with formulations and strategies that produce valid results.

Eclectics generally focus directly on the client's behaviours, goals, problems, and concerns as they deal directly with the client and acknowledge the wider world around him/her and the constantly changing environmental, developmental, social and cultural world, as well as his/her values and beliefs (James and Gilliland, 2003). The emphasis that eclectic practitioners place on the interactions of the client within the wider world as well as the lack of one world view for all, aligns this orientation with several of the basic beliefs that underpin social work theory.

Social Work and Clinical Social Work

The focus of social work is on the interactions between people and environments, a simultaneous focus on individuals and their life situations (Lehmann and Coady, 2001; Germain and Gitterman, 1980). A basic premise recognizes that people are dependent on systems for obtaining the resources they need, be they material, emotional or spiritual, to contribute to their self fulfillment (Pincus and Minehan, 1973). Therefore, social workers have a commitment to social order and social change, so that systems are responsive to the needs of the individuals and maintain useful environments that assist people (Hancock, cited in Munford and Nash, 1994). Social work has a dual role of working with individuals and encouraging societal change for more equitable resource distribution (Goldstein, 1996). This takes social work into many different spheres and requires many different skills, while keeping with the identifiable values, premises and processes which make up social work practice. These values, premises and processes need to be flexible enough to be applicable to various settings and relational systems (individual, family, groups, community), but to define social work on the relational system or the setting with which it is engaged, misses the focus of social work

(Compton and Galaway, 1975). Social work values and premises are valid across all spheres of social work practice, whether it be individual clinical social work, family work, small group work or community involvement.

Clinical social work, as a specialty of the social work discipline, entered the professional language in the late 1960s and early 1970s, and was designed to encompass the 'people helping' part of social work's dual role, rather than the 'society changing' part (Goldstein, 1996). Clinical social work is a term that has its roots in medicine, and basically refers to the act of observing and treating patients (Northern, 1995, Goldstein, 1996), with its focus on individuals, families and groups. It is certainly consistent with modern psychotherapy under the definition used by Orlinsky and Howard (1995) defining the components of modern psychotherapies as a professional service, providing personal help in the sphere of private life, with guidance from scientific knowledge. However, it also recognizes that psychotherapy is "part but not the whole of the intervention process" (Goldstein, 1996, pg. 93). Clinical social work grew out of social casework, which has historically been a primary mode for the delivery of social work services (NASW, 2005a). It challenges social work's traditional mission of social change as the way to improve peoples' lives through the abolition of poverty and oppression, and proposes a function within social work of trying to improve the lives of people who have been profoundly affected by the larger social problems (Cooper and Lesser, 2005).

Within the United States, clinical social work is viewed as a specialist field of social work, and comprises "the largest proportion of social workers in the country" (Goldstein, 1996; NASW, 2005b). Many States require specific qualifications and experience as well as separate licensing procedures for clinical social workers. However, the development of clinical social work as a specialist feature of social work in other countries is harder to trace. The websites of the Social Work Associations in Canada (CASW, 2003), Australia (AASW,), the United Kingdom (BASW,) and New Zealand (ANZASW,) do not list clinical social work as a specialist field. The National Association of Social Workers (United States), offers the following definition of clinical social work:

"Clinical social work shares with all social work practice the goal of enhancement and maintenance of psychosocial functioning of individuals, families, and groups. Clinical social work practice is the professional application of social work theory and methods to the treatment and prevention of psychosocial dysfunction, disability, or

impairment, including emotional and mental disorders. It is based on knowledge of one or more theories of human development within a psychosocial context. The perspective of person-in-situation is central to clinical social work practice. Clinical social work includes interventions directed to interpersonal interactions, intrapsychic dynamics, and life-support and management issues. Clinical social work services consist of assessment; diagnosis; treatment, including psychotherapy and counseling; client-centered advocacy; consultation; and evaluation. The process of clinical social work is undertaken within the objectives of social work and the principles and values contained in the NASW Code of Ethics” [accepted by Board of Directors, 1984] (NASW, 2005a).

Shirley Cooper, in the book *Psychotherapy and Training in Clinical Social Work* (Mishne, 1980) describes the clinical practice model in social work as the sector of social work that is primarily involved with the “world of the mind and its behavior” (pg. 22), how behaviour and thinking are affected by social contexts as well as how they develop, adapt and cope. The clinical social worker primarily focuses on understanding and using these processes to assist clients in functioning and adapting to their environments. Cooper (Mishne, 1980) goes on to suggest that competent clinicians need an understanding of many areas of knowledge, including: human developmental processes, cognitive processes, and interpersonal processes as well as personality functioning, socio-economic theory and current realities, demographic implications, social policy directions, systems theory and functioning, and institutional organization functioning.

A basic premise of social work, including clinical social work, is the idea of choice, and the fundamental belief that people do have choices and can exercise judgment about their behaviour. Some situations allow for more choice, and some allow for less, and sometimes irrational processes are part of human existence, but as social work clinicians, the premise of choice and the ability to change is paramount. While clinical social work aims to assist positive changes in psychological and social functioning of people, with the main ideas being empowerment, person-in-environment interaction and psychosocial functioning (Northern,1995), community development social work aims to assist communities to change environments to best reflect the needs of the population.

Social workers assist people to identify and access their resources and capabilities, and then work on options to apply these to their everyday lives. Emphasis on establishing a collaborative working relationship is a fundamental process for social workers. Cooper (Mishne, 1980) believes it is our social work heritage and history, with

our unique values that set us apart from clinicians of other disciplines. These values include:

- the potential of people to live in personally satisfying and socially constructive ways;
- the recognition that each person has inherent worth and dignity;
- the belief that all people have a right to civil liberties, access to essential resources and equal opportunities;
- identification of the uniqueness of each individual, family, group, and community;
- respect for differences;
- the philosophy of democracy in relationships among people and institutions; and
- reciprocal rights and obligations (Northern, 1995).

These are all reflected in the International Social Work Code of Ethics (IFSW, 2005), as well as the Aotearoa New Zealand Association of Social Workers Code of Ethics (The New Zealand Association of Social Workers, 1990).

Beyond these values, it is also the emphasis on social context that sets clinical social work apart from other disciplines that provide counselling and/or psychotherapy. Social context includes social institutions and organizations, programs, policies, and resources, as well as environmental supports or barriers, social networks, prejudice and discrimination, among other things (Northern, 1995). Social context implies and supports the concept of systems theory which proposes the idea of the interrelatedness of all living things and their interdependence on their environment. It is the ecological systems theory or life model approach that provides an overarching framework for social work practice on both societal and individual levels. This theory emphasizes:

- person-environmental interactions and working at that interface;
- strengths rather than problems;
- helping people with issues of living rather than the disorders or illnesses;
- a more environmental and transactional focus rather than a therapeutic focus;
- organisational and social change (Goldstein, 1996).

Lehmann and Coady (2001) operationalise these values and characteristics into the generalist eclectic social work approach for direct practice/clinical social work. They suggest this approach can be summarized into five elements: recognizing that we are

working with people-in-their environment; emphasizing the development of a helping relationship; using a problem solving process; making holistic assessments which emphasize strengths; and drawing upon an eclectic mix of theories and techniques. Ecological systems theory and the problem solving process are perhaps the two major perspectives that inform social work practice models. Social work has primarily been enmeshed in the practical side of working with people, and has shared and borrowed theory from other similar clinical disciplines (Lehmann and Coady, 2001). Social workers apply and synthesize this theory into the situations and environments they work within. The emphasis for social work is on the outcome for the client rather than adherence to a particular theory, but through the integration of these theories with systems and environments, social work creates its own unique identity and practice (Mishne, 1980).

Clinical social work is well suited for the primary care setting. With the emphasis on environment and systems, it not only adapts easily to multidisciplinary or interdisciplinary teams, it is able to assess and value the role of environment and systems in the lives of the clients. With the fundamental use of a problem solving model, clinical social work empowers clients to identify specific issues and work toward change. And with its use of goal definition and problem specific data, it shares several of the tenets of 'brief therapy', which in the current managed care environment of primary health is becoming increasingly popular.

Brief Therapy

Brief therapy is a relatively new variation in the field of psychotherapy. It is driven by both the managed care business plan approach to health funding and the demands of clients (Shiang and Bongar, 1995; Lambert, 2004; Epstein and Brown, 2002; Cooper and Lesser, 2005). Increasingly clients are seeking resolution to specific problems rather than complete personality makeovers, as was a premise of earlier psychotherapeutic design. The median duration of therapeutic contact is six to eight sessions, regardless of the therapeutic orientation of the therapist and 75% of clients who benefit from therapy do so in the first six months of contact (Cooper and Lesser, 2005; Shiang and Bongar, 1995). A basic tenet of brief therapy is "that growth and change continue beyond termination of the face-to-face interaction with the therapist" (Shiang and Bongar, 1995, pg. 382).

Historically, brief psychotherapy gained impetus with the community mental health movement that was begun in the 1960's (Lambert, 2004). Initially, brief psychotherapies were variations of the theoretical orientations that had grown within the discipline of psychotherapy, but increasingly, brief therapy was also developed as a field independent of the more traditional theoretical orientations. An example of the latter is the development of Solution Focused Brief Therapy which grew from the brief family therapy practiced at the Mental Research Institute in California (Quick, 1996; Corcoran in Lehmann and Coady, 2001; Cooper and Lesser, 2005). The traditional theoretical orientations that have adapted to the challenge of brief therapy include psychodynamic, cognitive-behavioural, eclectic and other verbal therapeutic approaches such as gestalt. Although each of these theoretical orientations vary according to problem formulation, treatment plans and goals; there are several principles of brief therapy that apply to all, according to Shiang and Bongar (1995). These principles include:

- a view that clients are capable of change throughout their lifetimes and therapeutic goals reflect this;
- the time for achieving these goals is limited; and
- the working alliance between therapist and client is paramount to achieve the goals (Shiang and Bongar, 1995).

There are several technical aspects which support these principles, and they include

- the careful selection of clients,
- recognition that not all issues addressed in therapy are conducive to brief treatment;
- rapid and early assessment of the client; and
- therapist's actions that promote these principles such as maintaining focus, high therapist activity, flexibility, promptness of intervention and addressing the termination of therapy (Shiang and Bongar, 1995).

One characteristic of brief therapy that is emerging for all brief therapy practitioners regardless of theoretical orientation is intermittent care (Shiang and Bongar, 1995; Epstein and Brown, 2000, Lambert, 2004). Clients are increasingly engaging in therapy for short periods, terminating with problem resolution, and then re-entering therapy if the problem reoccurs or other problems develop. Not only does this seem to be the pattern of utilization by clients, it is also conducive to good relations with funding

organizations who increasingly are only paying for specific treatments for specific disorders or problems.

Brief therapy approaches have traditionally encompassed two major types of frameworks, the problem-solving paradigm or the interpersonal/interpsychic paradigm. However with the increasing growth in integrative and eclectic therapies, a combination of the two is beginning. Brief therapies, despite their orientations, all share the ideas of planning, focusing and brevity (Epstein and Brown, 2002).

Clinical Social Work and Brief Therapy

Social work clinicians have come to brief therapy by a slightly different route. With their focus on the client, social workers recognized that contemporary clients generally wanted to “put in a reasonable amount of time and money in return for a demonstrable result that seems to ‘do good’” (Epstein and Brown, 2002, pg. 1). While psychology pared down its traditional theories to briefer versions, social work turned to its problem solving model as the basis for brief therapeutic intervention. As Epstein and Brown (2002) suggest, social workers view brief therapy as a means to assist people with their social relations in any sphere, that it is basically about reducing the impact of a problem, or in other words, problem solving.

The prevalence of post modern thinking has impacted on the place long term therapy and intervention has traditionally held. With the evolution of modern psychotherapy, many questions have arisen about its therapeutic ideals and goals. With this, brief therapy has been rediscovered as a means to “tighten up treatment, remove excess baggage, improve it realistically, and make it fit within a lean and cost-conscious modern world that was no longer capable of being easily swayed by romantic ideas about human perfectibility” (Epstein and Brown, 2002, pg. 2). Brief treatment or therapy is about helping people improve social relations in any sphere, and to learn and use the skills that society has to offer in order to achieve a satisfactory way of life. Problem solving is an integral part of this goal.

Social work has a proud history of problem solving, with Helen Harris Perlman identifying it as a basic model of social work practice in the 1950's. Social workers not only give credence to problems identified within the person, but also recognize the involvement of environmental issues and interpersonal issues, basically anything involving personal interactions.

The task-centred approach is perhaps the most widely used problem solving model that has emerged from social work practice. The task-centred approach was initially developed by Reid and Epstein in the 1970's as a model of social work practice. Although the task-centred approach is a problem solving model, it is not limited in its scope. The approach attempts to limit 'problems in living', which may range from interpersonal conflict to emotional distress (Epstein and Brown, 2002). The ideas of task-centred interventions are not necessarily designed to 'cure', but to work out a suitable improvement in the practical life experiences of the client.

As the task centred model is 'theoretically open', this model may be useful for many different types of practitioners, allowing for their view of human functioning. It may be argued though, that the position of theoretical neutrality prevents the task-centred approach from being seen as an actual therapy, rather it is a model that incorporates a theoretical orientation, as opposed to a theoretical orientation that creates a model. It is precisely this argument which fuels the debate about the differences between psychotherapy and counselling.

The task centred approach is an empirical approach in that it has been researched and found to be effective (Epstein and Brown, 2002; Reardon Tolson, Reid and Garvin, 2003). This is an important aspect of any model, and one this research is aiming to address. Empirical validation has taken on even more importance in the managed care environment that dominates much of the health care spending, as well as the demands of increasingly sophisticated clientele and practitioners. The evidenced based practice movement is not a new force in the health field, however it's application to the professions which are entering the primary health domain is challenging some of the underlying beliefs and values of those various professions.

Evidence Based Practice

Evidence based medicine traces its philosophical roots back to the mid-19th century, however, it is currently a hot topic for many health practitioners as well as planners and funders in the health sector. Evidence based practice aims to integrate clinical expertise and external evidence. Clinical expertise is defined as the "proficiency and judgment that individual clinicians acquire through clinical experience and clinical practice" (Sackett, Rosenberg, Gray, Haynes, Richardson, 1996, pg. 71). External evidence is the clinically relevant research that is being done in the field of practice and

related disciplines. It is the integration of both of these elements that make up evidence based practice and not simply the application of current research to practice.

Evidence based practice must take account of the patient's choice in treatment as well as the clinical judgment of the appropriateness of empirical evidence for a particular client situation. There is a place for external clinical information to inform, but never replace clinical experience and expertise. The clinical expertise provides the necessary judgment that decides whether the individual fits with the external evidence, and if so, how it applies and influences the case. As Roth and Fonagy (2005) suggest in relation to psychotherapy, evidence based practice grows from both research and professional consensus, in the form of clinical guidelines influencing clinical practice and with clinical judgment influencing the application of guidelines to individual cases. This is a bottom up approach to integrating the clinical world and the research world. Without clinical expertise our practice risks becoming overwhelmed by evidence and without external evidence our practice risks becoming inappropriate (Sackett et al, 1996).

As social work practitioners, we are professionally obliged to utilize best practice models in all our work. However, for many, this creates a dilemma in defining precisely what best practice is and how it is measured (Milner, 2004). Much of the literature around counselling and psychotherapy would have us believe that unless practice models are empirically validated, they can not be considered best practice (Sexton, 1996; Lambert, Cattani-Thompson, 1996; Kendall, 1998). Increasingly empirical validation is taken to mean that the application of randomized controlled trials to specific models has proven the efficacy of the model. However, as Seligman (1995) suggests "It is easy to assume that, if some form of treatment is not listed among the many which have been 'empirically validated', the treatment must be inert, rather than just 'untested' given this method of validation". It is this "principle of inertness" (Seligman, 1995) that we challenge as we strive to develop and research ongoing interventions.

Within the field of psychotherapy and counselling, there has been an explosion of research to produce the evidence that practitioners seek to validate their practice, clients seek to validate their choice, and funding bodies seek to validate their investment. Psychologists in particular have cast themselves into the scientist-practitioner role, adopting the rigors of scientific investigation and applying these to human behaviour (Lambert, 2004). Through measurement tools and controlled trials they seek to apply

quantifiable research methods to particular interventions with particular categories of human behaviour and/or dysfunction, in an effort to produce evidence of effective techniques for those behaviours and dysfunctions. Through this process the interventions can then be deemed empirically validated, empirically supported or empirically evaluated.

These terms and their implications have had a real impact on the field of counselling and therapy, especially in these days of scrutiny of health care spending. Empirically validated therapy is a phrase that is often criticized as it implies a completed process of evaluation with a pronouncement of effectiveness, while many practitioners believe that validation is never completed and closed, and they recognize that psychological therapies never produce complete success. Empirically evaluated therapy is another phrase which is often criticized as it only implies empirical support but does not set it out explicitly, and may allow for therapies that have been empirically evaluated and found to be ineffective. The phrase, empirically supported therapy, is becoming the phrase of choice as it acknowledges empirical scrutiny with positive outcomes and does not close or limit the evaluation process (Kendall, 1998).

As Roth and Fonagy (2005) warn, basing funding decisions on research evidence, although seeming straight forward and justifiable, needs to be approached with care. They highlight that there are dangers of funding only a limited range of 'treatment packages' that meet efficacy criteria in relation to specific groups or specific diagnostic groups, and suggest that this practice does not consider the issue of comorbidity, or take account of the need for effective second-line treatments, as well, it risks stifling the innovation of clinicians and clients.

One underlying premise to this whole debate about evidence based practice is that of professional knowledge. It appears to be the validation of this professional knowledge that is being required by employing and funding organizations, clients, and indeed practitioners themselves. But what is professional knowledge and how do we prove it? Fook (2004) suggests that professionalisation adheres to this idea of professional knowledge by pointing out that professionalism is "defining, laying claim to, and controlling a distinct body of knowledge and skills, or expertise" (pg. 30). As such, professions could then lay claim to areas of professional dominance, and it is the dissatisfaction with the idea of professional dominance that has given rise to moves to make professions more accountable and transparent. This has done much to propel the movement toward more evidence based practice. Through evidence based practice,

professionals hope to ensure that their practice is based on the best available knowledge of effective methods in their fields. However, within this increasingly complex and constantly changing world the nature of knowledge and its generation is called into question. The modernist view of “generalisable and tested theory developed through ‘scientific research’” is pitted against the postmodernist views of the globalised world which value the “knowledge generated and changed through concrete interactions and experiences of ‘ordinary’ people (Fook, 2004, pg. 32-33).

Linking practice to a research evidence base is but one way to enhance credibility. Payne (2001) discusses the use of knowledge biases rather than knowledge bases as a means to understand the interrelationship of research and practice, particularly within the social work field. Rather than revering a specific knowledge base that is all but impossible to define, he suggests knowledge biases may be more useful. These biases are generated by recognizing the adaptation of knowledge that differing circumstances create. It is a move “towards seeing knowledge as a social process by which understanding is interpreted and applied in a social and political context” (Payne, 2001, pg. 144). So rather than applying research evidence to practice, Payne suggests that practitioners recognize the importance of knowledge generation from each situation, and strive for a practice that is informed by the new developments that are forced by circumstances which create a new and unique uses of theory.

Historically research has been seen by counsellors as irrelevant to their practice as it was perceived to be based on reductionist ideas in settings far removed from clinical practice, the modernist view. However, as practitioners are being increasingly held accountable for their interventions, and as justification of programs to clients, and practitioners, as well as planning and funding bodies becomes more prevalent, research, particularly outcome research, is increasingly valuable (Sexton, 1996). Research itself is changing, and many methods are being employed and advocated to address the questions that practitioners, clients and funding agencies are asking. On one hand, these questions are about the value base of our practice and the generation of knowledge, and on the other they are questions about the legitimacy of our practice and how we measure this. One attempt to answer these questions of legitimacy is through a focus on the efficacy and/or effectiveness of treatment methods and models in use.

Efficacy and Effectiveness

Although efficacy and effectiveness are frequently discussed together, they are very different processes. Each reveal valuable but different information. Although neither is superior, efficacy is generally preferred by the medical field. Some sources, however, are suggesting that it should be effectiveness studies that hold sway when making decisions based on the evidence obtained. When considering evidence, a clear distinction needs to be made between efficacy of a therapy, or the results it gains when studied in a research trial, and the clinical effectiveness of a therapy, or the outcomes a therapy produces in routine practice (Roth and Fonagy, 2005).

An efficacy study is generally designed to demonstrate a difference between one type of psychotherapy or counselling and another, or a comparison of and/or combination of psychotherapy/counselling and pharmacotherapy, under well controlled conditions. These studies generally randomly assign clients to treatment or control groups, impose rigorous controls on these groups and often utilize placebos. Session frequency and duration is often predetermined and many studies utilize manuals to 'script' the therapeutic interventions. They also frequently exclude clients with multiple disorders, and utilize 'single blind' methods (Seligman, 1995). Efficacy studies are becoming synonymous with empirical validation or support, which is fast becoming a basis for policy and administrative decision making (Seligman, 1995; Sexton, 1996; Hemmings, 2000). Efficacy studies are good at determining whether one treatment is better than another for a specific disorder, but they do little to address what is actually happening in the field without controlled conditions.

Effectiveness studies on the other hand try to evaluate therapies that are provided in the field. Effectiveness studies take account of what is happening in the real world, in that they are not of fixed duration, they are usually self correcting (disregarding unsuccessful techniques and trying others), the therapy and therapist is actively sought by the client, who generally has multiple problems, and the focus is on general functioning rather than specific problems. If control groups are used, they are generally naturally occurring wait listed clients and therefore clients are not randomly assigned. Generally all referrals are accepted into an effectiveness study. The frequency and duration is rarely predetermined, but increasingly manuals are being used. Effectiveness studies measure outcome for the clients without efforts to control the variables (Seligman, 1995; Hemmings, 2000).

The largest effectiveness study on psychotherapy was undertaken in 1995 by *Consumer Reports*, an American publication which endeavors to evaluate consumer items/services through consumer feedback. In 1995, the publication included with its annual goods and services survey, an additional survey of counselling and psychotherapy. This is the largest survey of this type ever undertaken (Seligman, 1995) with approximately 22,000 responses. Much can be learned from this study not only pertaining to the results, but also pertaining to the design and methodology used. Because effectiveness is so broad, the researchers felt no one single measure would be enough to gauge counselling effectiveness, and so developed three subscales of the counselling experience for measurement, these include: specific improvement, or whether the presenting problem was addressed; satisfaction with the therapist, or how the respondent felt the therapist treated them and their issues; and global improvement, or how the client rated their overall emotional state at the time of the survey as opposed to at the start of treatment (Seligman, 1995).

There were a number of clear cut conclusions which can be drawn from the survey results. These include:

- treatment by mental health professionals usually worked,
- long-term therapy produced more improvement than short-term therapy,
- no differences appeared between psychotherapy alone, and psychotherapy plus medication (pharmacotherapy),
- while all mental health professionals assist their patients, social workers, psychologists, and psychiatrists did equally well, and better than marriage counsellors,
- family doctors are comparable to mental health professionals in the short term, but worse in the long term,
- Alcoholics Anonymous did well,
- active clients and clients who shopped around for counsellors did better in treatment than passive recipients (those who did not initiate seeking counselling),
- no specific modality of psychotherapy did any better than any other for any problem,
- limiting choice of therapist and duration of care due to systemic issues (insurance schemes) had a negative impact on outcome (Seligman, 1995).

Questions around the use of efficacy studies for psychological treatments are currently being considered. Efficacy studies were originally developed in medicine to evaluate physical treatments and were later adopted by psychiatry to test medication for certain disorders. With General Practitioners tending to adopt the biomedical model of treatment, this fits with their understanding and leaning. However, using efficacy studies to measure psychotherapy and counseling is not necessarily the right tool for the task. Using methods to measure the effectiveness of programmes may be more useful when considering the appropriateness of a treatment model in the clinical setting. Hemmings (2000) suggests that we need to be aware of the three phases of treatment research; theory, efficacy, and effectiveness, and we need to acknowledge the situation when determining which measurements to use for evaluation. While efficacy studies are necessary to determine if theoretical premises are useful, they are limited in their measurement of 'real world' experience. It is suggested that the efficacy study is the wrong method for empirically validating psychotherapy that is done in the field because it leaves out too many crucial elements that impact the results (Seligman, 1995; Hemmings, 2000).

The choice of an effectiveness study for this research project reflects the fact that it is aiming to measure the 'real world' experiences of the clients that are accessing the counselling service that is utilizing the model. This is in keeping with the idea of learning and creating knowledge from experience as opposed to applying generalized knowledge to all situations. As the model is utilizing components that are based on theories that have been empirically supported, it seems most valuable at this point to test the effectiveness of the combination, and to consider the outcomes of the treatment in relation to the context in which they are practiced. This is an important process for all involved, the clients, the practitioners, the referrers and the funding agencies.

Summary

The provision of counselling in the primary care setting is one response to the challenge of integration of mental health services with primary health care. It is a model that has been adopted overseas and has the potential to meet many of the goals of integration. By incorporating counselling/psychotherapy into the primary health setting, we are combining two differing paradigms through the medical model and biopsychosocial model of health. With the advent of brief therapeutic interventions and

their adoption by many practitioners, this is increasingly the model of choice for funding agencies

The fields of counselling and psychotherapy converge in this setting, and although they are considered by some to be points on the same continuum, counselling and psychotherapy each have their own history and traits, as does clinical social work. Although the historical journeys and theoretical bases of each of these disciplines, counselling, psychotherapy and clinical social work, differ from each other, their goals are the same, and their processes are being questioned through the idea of common factors and eclecticism. These fields are in a state of change, as is the idea of professional knowledge and evidence based practice. As professionals strive to prove the legitimacy of their knowledge and practice, we are currently turning to efficacy and effectiveness studies, of which this research is a part.

CHAPTER 4

THE PROJECT AND THE MODEL

This research project, studying the effectiveness of using a strengths based, solution focused therapy model which includes cognitive interventions within a New Zealand primary health setting, grew out of a new service that was begun in Wanganui, New Zealand in 2002. I was employed by the project directors when the project was six months old. Recognising that this counselling model, in this setting, was a new initiative in New Zealand and therefore had not been researched, and to avoid the 'principle of inertness' referred to by Seligman (1995), I proposed this research project.

When the Independent Practitioners Association in Wanganui, Progressive Health Incorporated, began developing their primary health care counselling service, they were seeking to establish a service that not only provided counselling services to clients, but also monitored and responded to the trends that emerged. They were unsure how this service would be utilised by general practitioners and how well it would be accessed by clients. Encouraged by literature from overseas primary health care counselling projects, and embracing the new strategic direction of health care provision in New Zealand, they set out to establish a primary health care counselling service in Wanganui. This chapter outlines briefly the history of the Wanganui project, with an exploration of the model that has been implemented in the provision of this service. A demonstration of the model is included in the form of a typical but fictional case study.

The Community

In order to fully understand the project, an overview of the community of Wanganui, New Zealand is necessary. Statistics New Zealand (Statistics New Zealand, 2005) estimates the urban population of Wanganui at 39,423, from the 2001 Census of Population and Dwellings. The 2001 census also provides a statistical profile of Wanganui and a comparison to national statistics. These include:

Chart 4.1 Statistical Comparison of Wanganui with National Averages

	Wanganui	NZ
People under 15 years of age	23.3%	22.7%
People aged 65 and over	16.8%	12.1%
People with post school qualifications	28.2%	32.2%
Median income	\$14,700	\$18,500
Unemployment rate	10.2%	7.5%
Average household size	2.4	2.7

The Whanganui District Health Board uses regional statistics for their formulations. The health district covers quite a wide geographic region which includes the Wanganui District, the Rangitikei District, and the Waimarino and Waiouru wards of the Ruapehu District (Whanganui District Health Board, 2005). They estimate the district population at 63,594, or 1.7% of the national population. The Whanganui District Health Board estimates the median age of the region at 38.8 years as compared to national median of 34.8 years. They also suggest the ethnic makeup of the Whanganui region as:

- 22% identify as Maori origin, as compared to 15% nationally,
- 2% identify as Pacific Islander origin, as compared to 6.5% nationally,
- 2% identify as Asian origin, as compared to 6.6% nationally, and
- 74% identify as European origin, as compared to 80.1% nationally.

These statistics also indicate that the population of Wanganui urban areas and regional areas is declining, at a rate of -4.1% and -3.3% respectively (Whanganui District Health Board, 2005).

This indicates that Wanganui, when compared to New Zealand national averages, is a centre with higher than average unemployment, resulting in lower than average median incomes. It has a slightly higher Maori population than national averages and lower Pacific Island and Asian populations than nationally. It has a population older than the norm and less qualified. In the 2001 census, the most popular occupational group in Wanganui was service and sales (Statistics New Zealand, 2005).

The Wanganui district has 67.6 active general practitioners per 100,000 people, which ranks 17th out of the 21 District Health Board districts. Research done in 2003 indicated that there were 30 GPs practicing in Wanganui, in both group and individual

practices (Taylor, 2003). This research also gives us an insight into the use of complementary medicine in Wanganui. Through a survey sample of 150 patients from three GP practices (with a survey response of 69.3% [104]), 67.1% of the respondents reported that they had used complementary therapies. Of these, chiropractic, acupuncture, aromatherapy and rongoa Maori were the preferred therapies. All 30 GPs were surveyed, of the 25 (83.3%) who responded, 92% reported that they had previously referred patients to complementary practitioners, with 24% reporting that they practice or have practiced an alternative therapy themselves (Taylor, 2003). These results offer support for the idea that both GPs and their patients in Wanganui are open minded enough to try new things and look for alternatives outside of mainstream medicine, which could indicate a positive environment for new and different initiatives, including the primary health care counselling project.

History of the Progressive Health Incorporated Primary Health Care Counselling Project

The Progressive Health Incorporated (PHI) Primary Health Care Counselling project began in May 2002. It was envisaged as a support for General Practitioners with the growing workload they were facing. With the diminishing numbers of GPs in Wanganui and patients' needs becoming more complex, the PHI began to investigate options. The early intervention emphasis and team approach advocated in the Primary Health Care Strategy (2001) encouraged a new paradigm. This desire to offer these aspects of early intervention and a multidisciplinary team approach, influenced the design of the project. The focus of the PHI Counselling Project is to "develop a service that supports the management of patients/clients in Wanganui general medical practices" (PHI, 2002, pg. 15). The role of the counsellor is to "assist primary care patients/clients maintain health and wellness through personal counselling" (PHI, 2002, pg. 15).

The service began with the employment of a .6 full time equivalent (FTE) counsellor servicing selected general practices. This allowed for 15 appointments per week. The funding for this position was through the referred services funding managed by Progressive Health Incorporated. As it was impossible to know what response there would be to the project, only selected practices, incorporating 13 GPs (of the 25 urban GPs in the PHI), were included in the initial trial. These practices comprised two group practices and one sole practice (Charuk, 2004).

It was not the intention of the project to duplicate any existing counselling services in Wanganui, and indeed, it was hoped it would have limited impact on those services and independent counsellors. The project was specifically designed to provide early interventions for mild to moderate mental health issues arising in primary practice, and to improve case management of complex needs. It was not intended to address issues that were already being covered by other counsellors in the community, such as family counselling, relationship counselling and the counselling funded through the Accident Compensation Commission. Progressive Health Incorporated consulted with the local branch of the New Zealand Association of Counsellors and with local counsellors during the establishment phase of the project (Charuk, 2004).

The project was so successful in the initial six month period that more counselling hours were added with the employment of another counsellor for .2 FTE. This was necessary to meet the need that was generated and reduce the ever increasing waiting times for appointments, which had stretched to a month before assessment by a counsellor was available. This was essentially jeopardizing the early intervention aspect of the project. Counselling need was screened by the General Practitioner or the Practice Nurse and referred directly to the counsellor. Communication about the case is maintained between the GP and the Counsellor with the consent of the client. Assessments, on-going reports and closing summaries are kept on the clients' medical file via the MedTech software system (Charuk, 2004).

During the first year in operation, 1 June 2002 through 31 May 2003, 349 patients/clients were referred for counselling, and 275 of those attended, or 86%. The gender mix was 75% female to 25% male clients, and 92% identified as NZ European with the remaining 8% identifying as NZ Maori. The largest age grouping seen was the 26-45 age group comprising 42% of clients, followed by the 46-64 age group comprising 34% of clients. Anxiety (31%) topped the list of presenting issues, followed by depression (28.3%), with adjustment issues (20.3%) ranking third (Charuk, 2003).

The nature of the counselling proposed by the PHI was short term, ideally not exceeding six sessions. The first session was subsidised, which meant it was free to the client, and subsequent sessions were part charged to the client depending on the client's ability to pay (PHI, 2002). With these guidelines of short term interventions not exceeding six sessions, an appropriate counselling model needed to be explored. Although short term or brief therapy is becoming increasingly popular, the psychotherapeutic definition of brief usually considers at least 10 sessions a brief

period, however in practice, the median duration of therapeutic contact is six to eight sessions (Garfield, 1986 cited in Shiang and Bongar, 1995). With the popularity of short term cognitive behavioural therapy and the support it receives from National Health Committee as evidenced in their publication *Guidelines for Assessing and Treating Anxiety Disorders* (1998), this was no doubt a direction the PHI were investigating for the theoretical underpinning of the service. However, the biggest influence on the theoretical direction of the service was the counsellor/therapist who was hired, and the set of skills, training and experience that defined her practice.

Both counsellors employed by PHI are Social Workers, with similar background training, and both belonging to Aotearoa New Zealand Association of Social Workers. Given their background and training, the model implemented draws heavily on social work perspectives, theories and models. By implementing a clinical social work model of strengths based, solution focussed therapy with cognitive interventions, the therapeutic model the PHI invested in is one that is eclectic in its development and practice, drawing on features of several theoretic orientations and therapeutic techniques. As this counselling model is unique to the Wanganui Primary Care Counselling Service, no research as to its effectiveness has been undertaken, however, Customer Satisfaction Surveys were utilised in 2003 to gauge client and GP response to the service. The results from these surveys were very positive from both the referrers and the participants who responded to the survey request (Charuk, 2004).

The Model

This counselling model is very much grounded in social work theory. It is a compilation of many differing perspectives, theories and models that have grown through social work practice, and is described as 'strengths based, solution focused counselling with cognitive interventions'. Each of the various components has a rich body of literature which informs and highlights its unique characteristics and contributions. We need an understanding of the individual components in order to make sense of the whole, and we need an understanding of their interrelationships in order to measure this combination of components. It is important therefore to explore the individual components and apply a model of integration. The generalist-eclectic approach defined by Lehmann and Coady (2001) allows us to explore these components and have a more thorough understanding of their interrelationships.

The generalist-eclectic approach aims to address the theoretical perspectives for direct social work practice. Using the generalist perspective of social work as a rationale for the eclectic use of theories, one can make sense of the interrelated components. Lehmann and Coady (2001) acknowledge the differing levels of theory which inform direct social work practice, and suggest that these range from perspectives which offer broad ways of viewing human behaviour, to theories and therapies that offer a conceptual framework for explaining human behaviour, through to practice models which suggest specific guidelines to facilitate change in that behaviour. The level of abstraction is a factor that accounts for some of the differences in this range, as does the amount of explanation and prescription included in the perspective, theory, or model. Lehman and Coady (2001) suggest that by recognizing the combinations of the different perspectives, theories and models that we utilize, we can better understand and describe our social work practice and the generation of knowledge that arises from it.

The generalist approach to social work is well documented in social work literature (Sheafor and Horejsi, 2003; Zastrow, 2003; Payne, 1997; Turner, 1996; Compton and Galaway, 1975). Lehmann and Coady (2001) sum up this approach into five elements: recognizing that we are working with people-in-their environment; emphasizing the development of a helping relationship; using the problem solving process; making holistic assessments which emphasize strengths; and drawing upon an eclectic mix of theories and techniques.

Applying this generalist-eclectic approach (Lehmann and Coady, 2001) allows the examination of the underlying perspectives of social work practice, through to the theories and therapies, and on to the specific models that are being used. It also offers us a way of unpacking the layers that inform our practice, from the abstract to the specific. The generalist-eclectic approach proposes that the theoretical base can be broken down into three categories or levels that include 1) high-level perspectives, 2) mid-level theories and therapies, and 3) low-level models, all of which lead to client-specific practice processes. These are all in play at any given time, with each level informing the next, offering a structure for the interrelationship of the components.

Applying this approach to this particular counselling model of strengths based, solution focused counselling with cognitive interventions, allows us to explore the various individual components and their place in informing the whole. Those components for this counselling model are:

- the high-level perspectives of the generalist social work approach, (which incorporates ecological systems theory and the problem solving approach), as well as the strengths perspective;
- the mid-level theories and therapies which include solution-focused brief therapy, neurolinguistic programming, and the task-centred approach;
- the low-level model which acknowledges this specific setting and the client population, and the RESOLVE model (Bolstad, 2001).

The generalist-eclectic model offers us a structure to examine these various components, and acknowledge the connection between them.

High-level Perspectives

High level perspectives encompass the most abstract and least prescriptive views that inform social work practice (Lehmann and Coady, 2000). As Reid (2002) suggests, they offer “conceptual schemes” to help us make sense of the field of social work, and from there to develop theories, therapies and models that can offer more detailed guides to practice. This counselling model is grounded in the social work perspectives of the generalist theory which includes ecological systems theory and the problem solving model. As well as generalist theory, this model is also grounded in the strengths perspective.

The generalist perspective is a major theoretical view that informs social work practice across a wide array of practice settings. It is not only used in clinical social work practice, but is also a component of social work practice in the wider sphere, or the macro level of intervention, such as community organization and advocacy. Literature on the generalist approach is embodied in much social work literature, especially introductory texts on social work (Sheafor and Horejsi, 2003; Zastrow, 2003; Payne, 1997; Turner, 1996; Compton and Galaway, 1975). As a perspective that informs this model it is fundamental, as it is to most of social work. Lehmann and Coady (2001) have reviewed much of the literature on the generalist perspective, and have derived five major elements basic to generalist social work practice, which include:

- an understanding of the person in the environment (directly from systems theory),
- establishment of a good helping relationship,

- use of the problem solving model as a framework,
- provision of a comprehensive, multilevel assessment of diversity and strengths, and
- utilization of an eclectic mix of theories and techniques.

Beyond providing loosely structured boundaries and underlying premises, these elements pave the way for the eclectic use of theories and techniques which is a feature of the model that is the focus of this research.

In order to understand the person-in-environment perspective, an understanding of systems theory is imperative. As Reid (2002) suggests all approaches that social workers use incorporate some form of systems theory, either general systems theory or ecological variations such as ecosystems or the ecological framework. Turner in his text *Social Work Treatment* (1996) describes systems theory as a “methodological approach to understanding the world”. It is a theory applicable to many disciplines, and one which informs the wider arena of social work practice. Systems theory offers the field of social work a uniqueness that other helping professions haven’t always adopted, that of recognizing the interconnectedness of individuals with each other and with their environments. As Dan Andrae (Andrae cited in Turner, 1996) states:

Regardless of the particular methodology or combination of approaches employed, social workers possess an in-depth understanding of the relationship of the individual to various environments and the synergistic relationship that each entity has to the other.... Social workers are taught to recognize that all parts of any system are interrelated, interconnected, and interdependent and therefore it is imperative to take into account the influence of various systems and subsystems on client functioning. (pg. 601)

Originally an approach which was applied to astronomy, systems theory has been applied to many sciences. Combining ecological theory with systems theory in the 1970’s enhanced systems theory in the social environment by recognizing and valuing the adaptive fit that organisms make to their environments. Ecological systems theory as the combination has become known, allows for the transactional nature of our lives and the balance between demands and resources (Germain and Gitterman, 1980; Lehmann and Coady, 2001). Social work has long held the belief that humans do not exist in isolation and that issues must be viewed in the context where they exist, recognising the interrelatedness and transactional nature of the systems that comprise that environment.

The problem solving model, also a component of the generalist perspective proposed by Lehmann and Coady (2001), was identified by Helen Harris Perlman in 1957.

Although, over the years, many variations to this model have been created, it still remains relevant today. The problem solving model purports that people have a “natural capacity to use their cognitive powers of reason and logic to attain the goals they value” (Turner and Jaco in Turner, 1996, pg. 503). The problem solving model consists of a series of stages which begin with the process of the social worker and client identifying the problem through a thorough, comprehensive assessment, followed by identifying the person’s experience of the problem as well as their strengths and diversity, which then leads to examining the causes and effects of the problem in the persons life. The problem solving model goes on to the consideration of courses of actions, and then choosing and enacting a course of action. It ends with the assessment of the effectiveness of the action (Perlman cited in Lehmann and Coady, 2001). Perlman’s model continues to be part of many current models in use in social work practice, often with an emphasis on the partnership between worker and client, as well as with more specific goals defined for each stage. This model offers a structure or a framework that is broad and flexible enough to allow for an eclectic mix of theories and techniques while providing a focus and direction (Lehmann and Coady, 2001). This model advocates the formation of the good helping relationship by defining its purpose and establishing boundaries. It is fundamental to most social work being practiced, from community organization to direct practice.

The ‘strengths perspective’ is another perspective which has been widely adopted in the social work field. With the recognition that many of the premises that social workers and other helping professionals used when assessing their clients were problem oriented and focused on deficits within the clients as well as their environments, a new paradigm was proposed. Rapp (1998) suggests this awareness became evident in the 1950’s when the Commission for Social Work Practice suggested that a main objective of social work was to identify and strengthen the potential of individuals, as well as groups and communities This perspective of focusing on peoples strengths rather than deficits, initially developed within the mental health field, appeals to several of the tenets of social work and so has been easily assimilated into the field of social work practice (Rapp, 1998). These tenets include the social work professions’ commitment to social justice, their commitment to the recognition of the dignity of every human being, which leads to an emphasis on client strengths and resources (University of Kansas, School of Social Welfare, 2005). As Saleebey (1997) proposes “The formula is simple: mobilize clients strengths (talents, knowledge, capacities, resources) in the service of

achieving their goals and visions and the clients will have a better quality of life on their terms” (pg. 4). It acknowledges the power of language, and the role words play in our definitions of ourselves, our clients and our practice. Important in the vocabulary of the strengths perspective are the words and concepts of: empowerment, membership, resilience, healing and wholeness, as well as dialogue and collaboration. Some of the principles of this perspective include:

- recognition that everyone has strengths,
- recognition that our struggles can also be a source of opportunity and challenge,
- recognition that the process of collaboratively building and identifying strengths is also the process of building solutions, and the
- recognition that every environment is full of resources (Saleebey, 1996).

The strengths perspective acknowledges the ecological and environmental influences that impact on people and focuses on integration and normalization for all, resilience, hope and community strengths. Rapp (1998) defines the strengths perspective as:

“The strengths theory posits that a person’s quality of life, achievement, and life satisfaction are attributable in large part to the type and quality of niches that a person inhabits. These niches can be understood as paralleling a person’s major life domains such as living arrangement, work, education, recreation, social relationships, etc. The quality of the niches for any individual is a function of that person’s aspirations, competencies, confidence and the environmental resources, opportunities, and people available to the person” (pg. 42).

So, both high level perspectives that inform this model each bring a unique element to the whole, and ground this model firmly in social work values and beliefs. The generalist model of social work offers both the ecological systems approach and the problem solving model, while the strengths perspective brings the focus on strengths and solutions through recognizing people’s resilience, resources and opportunities. Each of these perspectives, while having a rich history, are also challenging, evolving and expanding some of the tenets on which social work practice has been based.

Mid-level Theories and Therapies

Mid-level theories offer a less abstract view of social work practice but are not as specific as therapies and/or models. They grow from the more general perspectives discussed above, but begin to focus these perspectives into processes which may be utilized in examining and understanding the helping relationship. They are less abstract and more prescriptive, a feature discerning the differing levels of this model (Lehmann

and Coady, 2001). The combination of theories that are utilized in this counselling model are closely aligned to the theoretical integration category of eclecticism, where differing techniques from various sources are combined to create a more comprehensive explanation. The mid-level theories being used in this counselling model include solution focused brief therapy, neurolinguistic programming, and the task centred approach.

There is much literature on solution focused brief therapy which has been published since its development in the late 1970's (Cooper and Lesser, 2005). The prominent authors in this field include de Shazer, Berg, and O'Hanlon, with many new ideas and variations being published in recent years. Ellen Quick, in her book *Doing What Works in Brief Therapy* (1996) suggests that solution focused brief therapy grew out of brief strategic therapy as developed at the Mental Research Institute in California in the mid-1960's. Incorporating the work of Milton Erickson, a noted psychiatrist and hypnotist, therapists began to investigate time limited therapy which focused on the chief complaint that was defined by the client, not the therapist. De Shazer and Berg, at their Brief Family Therapy Centre in Milwaukee, Wisconsin, USA, developed this further when they began to look for exceptions and solutions, rather than problems.

Although initially focused on a problem orientation and emphasising problem patterns, solution focused brief therapy has evolved from the problem focus to one of searching for exceptions to the problem and finally on to searching for solutions to problems (Cooper and Lesser, 2005). Solution focused brief therapy is rooted in postmodern thinking, that views people as able to create and live new narratives about their lives that are beyond the problem focused narratives. This requires a collaborative process with the client and therapist working toward constructing solutions. It is this theory and the principles behind solution focused brief therapy that is incorporated in this counselling model.

Today, solution focused brief therapy is defined as a goal oriented, future focused therapeutic approach with an emphasis on creating change by looking for solutions, rather than focusing on problems. The techniques used in solution focused brief therapy include the miracle question, scaling questions, presuppositional questions and exception questions, as well as collaborative problem identification and goal setting (Cooper and Lesser, 2005). Solution focused therapists believe that clients have strengths and abilities as well as resources and skills to apply to the situations which create problems in their lives, and that they have made attempts to solve the problem

previously. The future orientation of this method allows clients to develop a picture of their potential future, how the client would like it to be. Solution focused therapy is based on the belief that change is inevitable and that people genuinely desire change and can achieve it. Solution focused therapy acknowledges the client as the expert on their problems and values them as a partner in exploring solutions (de Shazer, 1985; Berg,; Hoyt, 1996; Quick, 1996; Hawkes, Marsh, and Wilgosh, 1998; Cooper and Lesser, 2005).

Another field influenced by Milton Erickson and included in this counselling model is that of Neurolinguistic Programming (NLP). NLP was developed by Richard Bandler and John Grinder in the mid-1970's. Bandler and Grinder set out to investigate success rather failure and try to 'model' what was working for people. Toward that end they studied successful therapists of the time including Virginia Satir, Milton Erickson, Gregory Bateson and Fritz Perls. Modeling is at the heart of NLP, whereby attention is paid to an action so that the action can, if one wishes, be systematically reproduced to get the same behavioural outcome (Bandler and Grinder, 1979). NLP emphasizes communication, and by focusing on an individual's subjective experience it suggests that human behaviour is a response to how we receive, interpret and transmit sensory stimuli, and therefore promotes behaviour change through communication modification.

The techniques developed for effecting change utilize visualization, reframing and metaphors, with their goal being the influence of the meaning that an individual gives an experience (Angell cited in Turner, 1996). NLP can be broken down into three elements: 'neuro' referring to the link between the mind and body through the nervous system, linguistic or language and the influence of language on our worlds, and programming or behaviour/actions – repeated sequences of thought and behaviour (McDermott and O'Connor, 1996).

NLP is based on several suppositions which recognize that the client's world view is paramount and that each of us have different world views, it also recognizes that we all have strengths and resources to meet our needs, and that processes within a person, and between a person and their environment are linked together in one system (Bolstad and Hamblett, 2001). NLP is not technically considered a theory, as Bandler and Grinder explain, NLP is trying to offer things that are 'useful' rather than offering something that is 'true'. It is primarily the techniques of this field that offer the cognitive interventions being incorporated in the counselling model being researched, and the premises that NLP adopts that are incorporated into the framework of the model. As

Angell (1994, pg 481, cited in Turner, 1996) suggests, “many of the concepts and techniques of NLP have been merged with other approaches whose devotees are committed to time-limited, cost-effective, efficient, client-empowering, technique-driven approaches”, as is the case with the counselling model this research is exploring.

As mentioned earlier, the task-centred approach is perhaps the most widely used approach that has emerged from social work practice. This approach, initially developed by Reid and Epstein in the 1970’s through the Task-Centred Project sponsored by the University of Chicago, is a model of social work practice. The mission of the Task-Centred Project was to develop technologies that were easily learned, that increased the effectiveness of direct intervention, and were able to provide research on treatment practice. The task-centred approach has the following characteristics:

- it is based on the problem-solving method of intervention;
- it is structured, which indicates that it has specific procedures;
- it focuses on solving problems as clients perceive them;
- it is time limited;
- it is theoretically open and can be used with many theoretical orientations;
- it proposes that change occurs through the use of tasks, which are activities designed to ameliorate the identified problems;
- tasks can be developed from an array of practice approaches, as well as from problem-solving activities with clients;
- it is present oriented; and
- it is an empirical approach to practice in that it (a) was developed from research about practice, (b) was constructed with researchable concepts, (c) has been tested and found effective, and (d) contains within it, procedures and activities for the evaluation of case outcomes (Reardon Tolson, Reid and Garvin, 2003).

The task-centred approach emphasizes the target problem, which is determined by the client. Client involvement and collaboration with the social worker in identifying the target problem is intended to ensure both the client and the practitioner are working toward the same focus, and to maximize client motivation. Congruence with the client’s interests is an integral part of the task-centred approach and an ethical guideline for social workers, incorporating respect for the clients’ independence and right to exercise choice (Epstein and Brown, 2002). The task-centred approach establishes a systemic

process that consists of a start-up and four sequential but overlapping steps, these include:

- identification of client target problems’,
- contract,
- problem solving, task achievement, problem reduction, and
- termination (Epstein and Brown, 2002).

The ideas of task-centred interventions are not necessarily designed to ‘cure’, but to work out a suitable improvement in the practical life experiences of the client. The systematic, ordered manner of the task-centred approach minimizes waste of time, effort, and money and has been linked to improved outcomes (Epstein and Brown, 2002).

The mid-level theories and therapies incorporated in this counselling model of solution focused brief therapy, neurolinguistic programming and the task-centred approach all combine to add shape to the model. The focus on solutions when combined with the task-centred approach adds hope, highlights previous successes and assists in determining the path toward problem reduction that may be most beneficial. The involvement of NLP adds the tools and techniques that can assist in overcoming barriers and building resources that are an integral part the change process.

Low-level Models

Low level models are generally the most detailed and prescriptive of the theories that inform social work practice. With so many models and therapies in existence, this is the level that often delineates the differences between them. These are frequently the ‘practice models’ that are referred to in social work literature, and are often responses to the environments or contexts that we find ourselves practicing within.

In the context of this counselling model, the environment is an important element that creates a structure and applies its own methods which clinical social work practice must interact with. Working in primary health care practices with clients directly referred by their General Practitioners offers a validation of counselling or therapy and recognizes the holistic nature of health. Clinical social work or counselling in the primary health care setting offers an opportunity to participate on the level where most mental health issues are presented and identified. The inclusion of direct social work practice in the form of counselling into general medical practice offers a “holistic and

non-medical approach to the treatment of psychological and emotional problems alongside the conventional medical approaches” (Popadopoulos and Bor, 1995, pg. 291).

The low level model which this counselling design utilizes is the RESOLVE model, developed by Bolstad and Hamblett (Bolstad, 2001; Hall, Bodenhamer, Bolstad and Hamblett, 2001). It is a specific model of therapy that offers a structure to direct client interaction. The RESOLVE model grew out of the field of Neurolinguistic Programming, recognizing the need for a structure to monitor the stages of the helping relationship. RESOLVE is an acronym that describes a ‘helping sequence’ for the practitioner to use to keep track of the process. The stages of the RESOLVE model are:

- 1) R – Resourceful state for the practitioner,
- 2) E – Establish rapport,
- 3) S – Specify the outcome,
- 4) O - Open up the clients model of the world,
- 5) L – Lead to desired state,
- 6) V - Verify change,
- 7) E – Ecological exit (Bolstad, 2001; Hall et.al., 2001).

This model incorporates many of the characteristics of the previous theories discussed, and offers a framework for the stages of the relationship. It acknowledges the need for a good helping relationship in the first two stages, and acknowledges collaboration in the third stage. The fourth and fifth stages incorporate the change processes being used, while the final two stages acknowledge the accomplishments and projects the changes into the future while disengaging from the process.

Client Specific Practice Processes

Combining the previous levels of perspectives, theories and models, defines for us the premises that validate our involvement with clients. We need to recognize all the layers that inform our practice, from the perspectives that offer world views to the models that offer interpretations of behaviour and thinking. From this we can develop specific processes for our clients. Lehmann and Coady (2001) suggest that within these processes we may wish to choose an intuitive-inductive approach, which recognizes the uniqueness of each of the cases we are involved with by creating an individualized

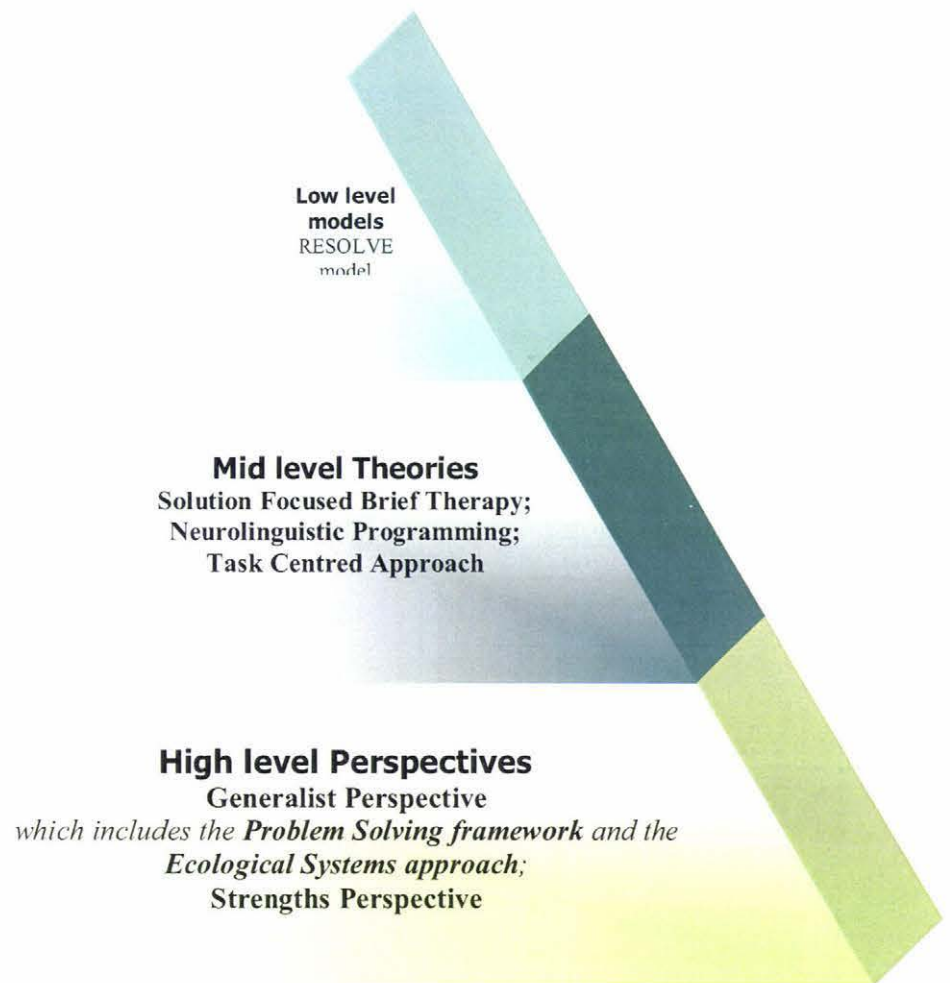
process. It also recognizes the flexibility and creativeness we use as we interact with each client and situation.

These unique processes are developed out of what Fook (in Smith, 2004) considers our professional expertise. As social workers, this comprises an emphasis on:

- contextuality, or the ability to work in and with the whole of a situation, which requires knowledge of differing and at times competing factors, with an emphasis on recognition of the importance of the whole context or situation;
- connectedness, in which the practitioner recognises the need to acknowledge and have an understanding of the viewpoints and experiences of the other players impacting on the situation;
- knowledge and theory creation that is unique to and relevant to the changing contexts, and
- transferability of the contextual knowledge creation from one situation to another, rather than relying on generalised knowledge to be applied;
- openness to the client's experiences by engaging in a process that assists the client in communicating their experiences and expectations; while
- remaining grounded in the here and now while holding on to a 'transcendent vision' which makes the practice meaningful in the bigger picture.

With the combination of these perspectives, theories and models incorporated in this counselling approach, the client specific processes that develop, although individualised to each client, should have similar characteristics that combine uniquely in each case. They will have an emphasis on identifying client strengths, and a focus on client identified solutions. They recognize that language plays an integral part in interactions and especially in the change techniques that are designed to address some of the cognitive patterns, as well as behaviours. A positive, future oriented perspective is created which acknowledges the clients view of the world and takes account of the other systems at work in their world. The establishment of a collaborative relationship which encourages client ownership of outcome is an integral part. Recognition of the problem solving model, the task centred approach, and the structure of the RESOLVE model provide the framework that keeps this collaboration on track. Within all of this it is important that we acknowledge the individuality of our practice. It is this individuality that adds the finest point to the wedge that started with perspectives.

Diagram 4.1 Counselling Model



Case Study

Perhaps the best way to illustrate the model is with a study of a hypothetical case, the names and the demographics have been created. Two ecomaps, one depicting the initial situation and the other the situation upon completion of the counselling sessions follow the case study.

Ms. B is a 65 year old widow, who presented with concerns about her ability to cope with her life at present. In the assessment, she revealed that she had previously been

able to cope with 'most things', and her recent tearfulness and fear of going out to places was new and unexpected. It first surfaced during the celebrations for her 65th birthday, when she noticed she began to increasingly feel uncomfortable at the party and became very emotional and tearful. When the symptoms of disturbed sleep, tearfulness and worry about going out, as well as fear of being alone, continued over the next few weeks, Mrs. B sought help through her GP who referred her to our service.

Her history, which was explored during the assessment, painted a picture of an independent and capable woman who had endured many tough times in her life, including an unfulfilling marriage which she committed herself to until her husband's death 15 years previously. That marriage produced two children who she reared virtually single-handedly, and although very supportive of her, her children had also had tough times which had impacted on her life. She had worked many years ago as a nurse aid in a hospital, which she had enjoyed. She had worked most of her life, mostly in a variety of different jobs, and was now retired. Ms. B had remarried 6 years ago and had had a wonderful relationship and friendship with her second husband. These she described as the best years of her life. He had died suddenly, but not unexpectedly 18 months ago. She thought she had coped well with his death initially, however she was questioning this with these recent symptoms. Prior to this emotional upset, she had begun to re-involve herself with several voluntary organisations she had been a part of years ago, but was finding it increasingly difficult with her current issues. She was also part of the local Scrabble club which she was struggling to attend although it had previously been a source of great enjoyment and socialising for her. Ms B also attended church regularly and generally found this a source of support, however, her enthusiasm for this too was waning.

Ms B hoped counselling could help her 'get her old life back', which she described as being able to feel comfortable in social situations again, being comfortable on her own again, being able to sleep without medication, and reducing her worry and tearfulness. I discussed her previous independence as evidenced throughout her history, her perseverance as evidenced in her first marriage, her expectation and belief that things could change as evidenced by her seeking help and trying counselling, and her previous happiness as strengths that would serve her well and assist her process of change. She was frustrated with her inability to cope, and was reluctantly taking the prescribed anti-

anxiety medication when she felt overwhelmed, and sleeping tablets when she was unable to sleep. We agreed that these issues were appropriate issues for counselling and Ms B was given the choice to continue counselling through this service or seek assistance elsewhere. I explained the type of counselling that this service offered and Ms B was happy to continue counselling with myself through this service. The initial orientation to the service, explaining our case management approach and the impact of that on confidentiality was explained and agreed to. This served as an indication to me of the rapport that had developed through the assessment session. Ms B was given homework following the initial assessment session, which consisted of keeping a note of the situations that she felt okay in, when the symptoms she was struggling with were not happening, and also to notice when she found things difficult; when, where, how long they lasted, the thoughts and pictures and sounds etc. that accompanied both of those times. A follow up session was scheduled in a fortnight.

The second session began with re-establishing and continuing to build rapport. We examined the notes Ms B had taken over the previous fortnight to try to notice any patterns or themes, both positive and negative. This was done with curiosity and collaboration as we embarked on this journey together, she the expert in her own world and me the interested assistant. Through this, Ms B recognised that her confidence was very low, not a normal state for her, and frequently when she was feeling low she found herself thinking of a new property she had bought to shift into, but had recently begun to regret. Mention of this property brought visible tension to Ms B through her body language and her words. Exploring this further allowed us insights into her model of the world. It transpired that Ms B, feeling pressure from her family and friends and realizing that it was a practical idea, had decided that the house she had shared with her second husband was now too big and too much work for one person. She had looked for more suitable properties and had found one which she had impulsively bought, fearing she would miss out if she did not purchase it immediately. She liked the new house, but not the feelings it brought up for her when she was there. She knew she needed to begin shifting from her old house, but just couldn't find the motivation. Financially the situation of having two houses was unsustainable and she was feeling pressured to shift and sell her old house. She was beginning to feel she had made a mistake in purchasing the second house, and was embarrassed to admit it to family and friends. She had normally been a very decisive person and had never changed her mind on decisions of

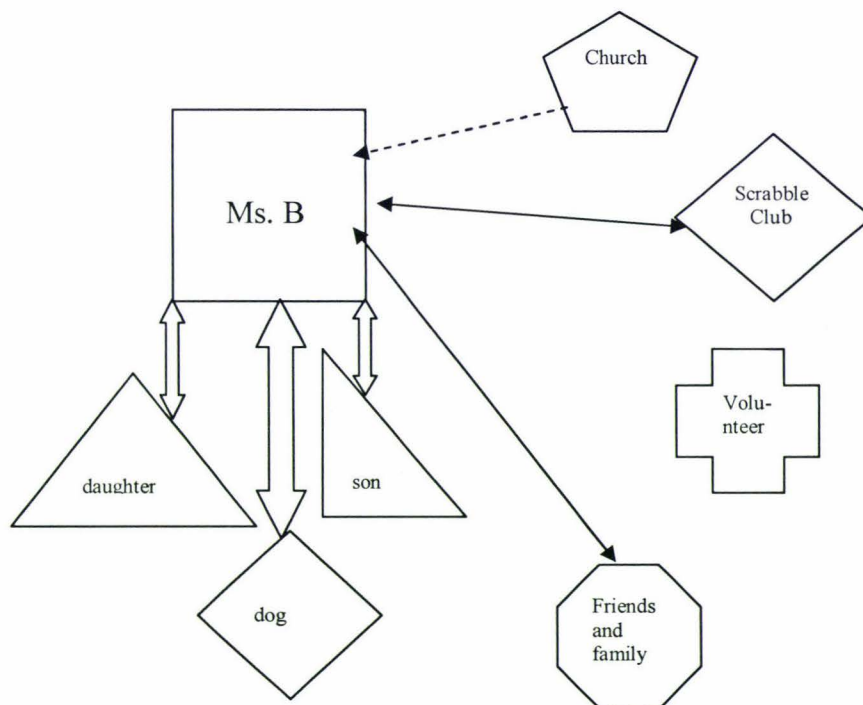
such magnitude. She was not sure how to undo the situation even if she wanted to. Using a technique from NLP, I assisted Ms B on setting some resource anchors for herself so she could feel more resourceful as she thought about her housing dilemma. We set an anchor for confidence and an anchor for relaxation. Ms B had a familiarity with NLP and was comfortable with the process. More homework was discussed, and this time Ms B was to write down the pros and cons of shifting house or staying where she was, as well as noting her feelings and cognitions. Another appointment was scheduled for a fortnight.

Ms B reported during her third session that she was feeling more able to participate socially again and was not as tearful. She was not anxious about social situations and had begun to involve herself in several voluntary agencies she had previously been involved with. She also reported fewer incidents of needing her anti-anxiety medication but was still taking her sleeping tablets as she was afraid not to. She was still in a dilemma about her housing situation, but had written the pros and cons as discussed. She was embarrassed about the situation and the picture of buying it went round and round in her head which was accompanied by feelings of anxiety and worry. We decided to try another NLP technique to work on this, and Ms B quickly learned the Trauma Cure. It seemed effective in session and Ms B was comfortable with being able to repeat it at home if she felt the need. We revisited the resource anchors and strengthened the confidence one. Another session was scheduled for a fortnight.

The fourth and final session with Ms B began with a progress report on the house. She had sold the new house when a buyer approached her about wanting it, and she was going to remain in the old house despite concern from friends and family. She felt she could cope with it and the size had never been an issue to her. She was sleeping again without medication and was back to her routine of walking the dog and participating socially. Reflecting on this episode, Ms B feels she was perhaps not ready to move on and had listened to others rather than herself. Now that she had herself back she was resolved to continue to heed her own counsel. With her confidence restored, this was an easier proposition. She was pleased with the outcome and grateful for the support, and very relieved to have her 'old life back'.

We discussed whether the goals initially established in the counselling sessions had been achieved to Ms B's satisfaction, and she assured me that they had been and that she felt strong enough to carry on without further counselling. She reported that she was pleased with the outcome and pleased to have some new tools in the form of the NLP techniques to use in the future if she needed. We also discussed how to access further counselling in the future if she felt she needed it, and ended by acknowledging the work that Ms B had done, her strengths, and her plans for the future.

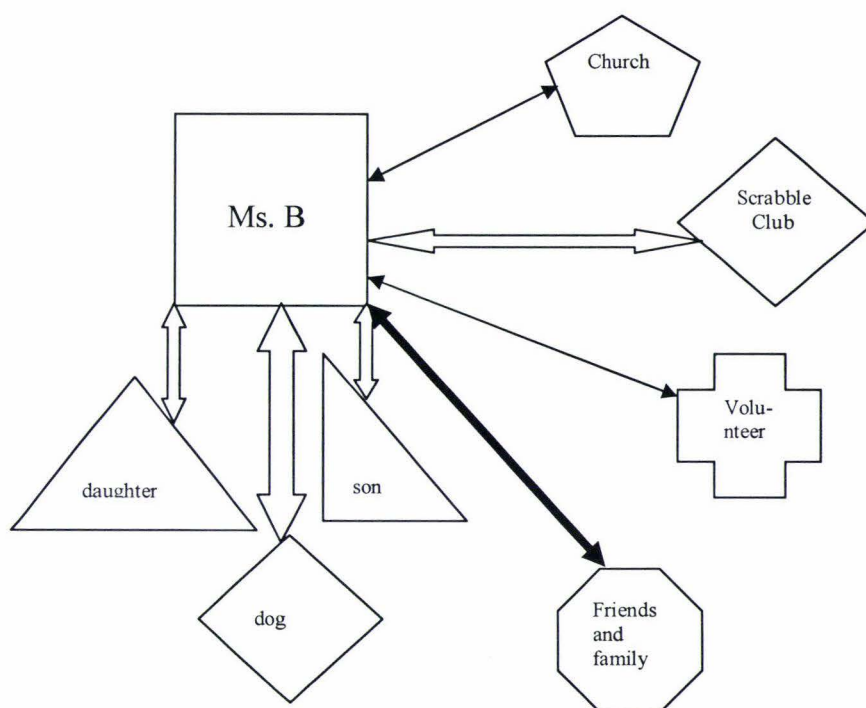
Ecomap 4.1



Ecomap 4.1 Indicates the situation Ms B presented when she first attended counselling, with the large hollow arrows indicating a strong connection and support, and the smaller, line arrows indicating a weaker connection, with the dashed line indicating a

very weak connection. The line arrows also indicate the direction of the flow of connectedness and support as Ms B felt it was.

Ecomap 4.2



Ecomap 4.2 indicates the how Ms B felt about her situations at the end of counselling, again with the larger, hollow arrows indicating a strong connection and support, and the smaller, line arrows indicating weaker connections. The solid black line also indicates a strong connection and support, intended to indicate a connection level between the large hollow arrows and the line arrows.

This case study illustrates the counselling model described, working from the generalist perspective and incorporating the ecological systems approach and the problem solving framework as well as a strengths based approach. The focus on solutions as well as the task-centred approach were utilised, and Neurolinguistic Programming techniques taught. This was all wrapped in the RESOLVE model which provided the framework for the individual sessions and the overall case. The setting of the counselling in the

General Practitioners' surgery impacted on the sessions, as did the unique strengths and concerns the client brought and chose to deal with.

Summary

The Primary Health Counselling Project grew from the ideas and wishes of the General Practitioners involved in the Wanganui independent practitioners association, Progressive Health, Inc. They had a vision to incorporate 'personal counselling' within their primary care practices. As they moved forward with this idea, they hired a social work trained counsellor to develop the project and provide the counselling. The shape of the counselling provided within the project was a clear reflection of her skills and knowledge, and it was this that shaped the counselling model used and the model this research explores.

That counselling model grew from social work perspectives and theories, as opposed to the theories and perspectives of psychology or specific counselling courses. Those were influential, but the base of this counselling model is firmly grounded in social work, being built on the generalist social work perspective and the strengths based perspective, with added elements of solution focused brief therapy, neurolinguistic programming and the task-centred approach, which are all incorporated and applied through the RESOLVE model.

This model is a truly an eclectic therapy, combining elements of different theories to inform the counselling process. Lehmann and Coady (2002) propose the framework of the generalist eclectic model as a structure to understand and acknowledge the interrelationships of the model's parts. They also suggest that as well as the perspectives, theories and models, we acknowledge the specific processes that happen for each of our clients in an intuitive-inductive way.

Being an eclectic therapy, the effectiveness of this combination of elements has not been tested. It is precisely this question that the research aims to inform: how effective is the use of a strength based, solution focused therapy with cognitive interventions in the primary health care setting?

CHAPTER 5

METHODOLOGY

The exploration of the effectiveness of strengths based, solution focused counselling with cognitive interventions in a primary health care setting, is, as the statement implies, an effectiveness study. Effectiveness can be studied in several ways and this research offers just one way to examine part of the dynamics of using such a model in a specific setting. Effectiveness studies of specific models are becoming increasingly popular with the demand for both evidence-based practice and recognition of the individual nature of specific environments, groups, and structures. These variables are not mutually exclusive, and both need to be acknowledged when examining what is effective. The way the research was undertaken and how the process unfolded is explained in this chapter, as are some of the underlying premises about knowledge generation and research strategies.

Methodology is the procedure which defines the intent and process of the research. These do not develop in a vacuum. Research methodology reflects not only the broader theoretical underpinnings of the period and discipline in which it occurs, but is also obliged to address acknowledged practice theories and modes, whether adhering to them or not. As well as examining the research undertaken, this chapter explores the theoretical framework of the research and the research design. It examines some of the broader theoretical paradigms that influence and inform the aim of the research. It concludes with the ethical considerations which guide this research.

Broad Theoretical Influences

This project investigates the effectiveness of a counselling model being used in a primary health care setting. As such it is not only an effectiveness study, but also sheds light on the whole program of which the counselling model is a part. While not specifically a program evaluation in purpose, the need to consider the environment while examining the model allows some insights into the broader program and through this some evaluation can be undertaken.

In the political environment that governs health care spending, program evaluations can be useful for funding agencies and service providers alike. One definition of an evaluation suggests it “is a type of research that determines value by applying scientific procedures involving empirical data” (Cone, 2001, pg. 18). Science is primarily about generating new knowledge that advances the field of inquiry, and outcome evaluation is primarily about the effectiveness of the application of scientific knowledge to a practical problem (Cone, 2001). This research, by exploring the effectiveness of the counselling model will explore the application of ‘scientific knowledge’ to this model. It is therefore necessary to understand some of the broader theoretical influences that define, or attempt to define concepts such as scientific knowledge and empirical data, as well as explore where these fit within the context of this research.

Our current work practices and work situations can not and have not escaped the processes of the more globalised world in which we live. The impact of this can be seen in the ways we work and the tasks we do. Our practice takes place in more complex, and uncertain environments, in which our old paradigms of culture, social institutions and structures seem in a constant state of change. This uncertainty of our social environment is increasingly acknowledged, as is the response to it with more managed work environments relying increasingly on technology. The competition that globalisation brings requires that goods and services become more measurable and marketable. The value based services are a challenge to this view, and as such are being challenged to become competitive and therefore marketable. One way of doing this is to break down the traditional knowledge bases that have defined and protected professional knowledge. Smaller parts of traditional knowledge bases are being separated and delivered by less qualified workers, or by machines, therefore creating more competition through service and costs. There are many examples of this in many fields including health, which was once only the domain of doctors. As well as changes to the way we bank and pay bills, we now have mid-wives able to prescribe medications and pharmacists screening for and dispensing some previously prescription only medications (Fook, in Smith, 2004) .

This undermining of professional knowledge bases and professional expertise also has an impact on the concept of knowledge and the legitimate forms of generating and measuring knowledge (Fook, in Smith, 2004). Globalisation has challenged our very core concepts of knowledge and has been part of the shift toward post-modern thinking. The practices that have resulted from the our increasingly globalised world challenges

the traditional hierarchical divisions between generalised, tested theory that was developed by 'scientific research' by specialist researchers, and knowledge generated through experience, specifically the experience of ordinary people as they interact with their ordinary world (Fook, in Smith, 2004; Fook, 2002).

Postmodernism is a move away from the previous views of the modernist era which were very much grounded in the positivist framework, looking for empirical rationale to establish structures that could use the knowledge discovered (Fook, 2002).

Postmodernism challenges the assumptions of hierarchical structures and universal knowledge. As Fook (2002) points out, it questions the legitimacy of professional knowledge against the legitimacy of the experience of the consumer, and through this highlights the "widening gap between theory and practice" (pg. 82). Postmodernism allows us to question the previously taken for granted authority of non-practitioner researchers and the theories they have espoused.

The post-modern view, having challenged us to look beyond the empirical and provable theories that have been so dominant in our history, has given voice to the more personal and intimate experiences of people living in and trying to make sense of this ever changing world we now find ourselves in. As we try to find ways of understanding, interacting with and accounting for this practical knowledge of experience, we need to find new ways of encouraging it's expression, operationalising it's suggestions, and valuing it's contribution. With the growth of this post modernist perspective comes the growth of models that aim to acknowledge and honour the tenets of individual experience and unique circumstances as well as theories that avoid generalisation but focus on context and transferability (Fook, 2002). The rise of constructionist therapies and qualitative research methods coinciding with this shift from modernist to post modernist thinking makes sense.

Constructivism, very simplistically, is a way of understanding human behaviour that stresses the importance of an individual's internal processes, especially cognition and perception. Basic to constructivist thinking is the idea that nothing in the world is universally true, there are only different ways of interpreting it, and that each of us have our own interpretations. Given this, constructivists do not attempt to validate their effectiveness by means of positivist empirical studies, instead they value the use of interpretive methods that explore the meanings rather than seeking causality or the generation of universal knowledge (Carpenter, 1996, in Turner). The tenets of constructivism suggest that:

- individuals are active in the construction of their own reality,
- there is an interaction between affect, cognition and behaviour,
- we all develop significantly over our lifespans,
- our internal cognitive and affective structures, such as our meaning systems, narrative and life stories, are important in determining our behaviour and behaviour change (Cooper and Lesser, 2005).

Constructivism places an emphasis on subjective experience and subjective perception, it is concerned with the nature of reality and being, and the nature and acquisition of knowledge. Constructivist research gives voice to the ordinary, and values it for the unique knowledge that it brings, with out the need to generalise from it.

Postmodernism and constructivism are often criticized for being too broad, and adopting an ‘anything goes’ attitude. While postmodernism and constructivism value qualitative research methods which interpret, postmodernism can also understand the use of quantitative research as well. Although quantitative research was a feature of the modernist era, with its emphasis on statistical measures and controlled trials of hypotheses, it can also provide valuable information in the evaluation of theory from practice in the post-modern era. By changing the emphasis on generating universal knowledge from research to investigating the legitimacy of models for consumers, the use of quantitative methods continues to have a place in gathering data. Survey methodology and statistical analyses are important types of quantitative research that can contribute to an holistic research design. Both types of research, qualitative and quantitative, are valid depending on one’s world view, but the combination of both may appeal to an even broader audience.

These broad theoretical frameworks underpin the counselling model and the research proposed for this thesis. The postmodernist view and constructivist theories can be seen in the counselling model mainly through mid level theories and therapies, which include solution focused brief therapy and neurolinguistic programming. While they both acknowledge and value the client as the expert in their world, solution focused brief therapy searches for client driven solutions while neurolinguistic programming explores how we acquire and interpret knowledge and the impact that has on our cognitions, affect and behaviour. These broad theoretical frameworks are seen in the research primarily through the methodology, with the inclusion of both quantitative and qualitative research tools, and the triangulation of these. However, the importance of the

context as a variable and important aspect of the counselling model, and therefore part of the research is also important in this discussion, as it highlights the operationalisation of these theoretical frameworks in the counselling models' development. The size of this research project and the selection criteria for the research participants also lends itself more to the interpretive traditions of the postmodernist era than the generalisable traditions of the past.

Theoretical Framework

The use of knowledge, however it is generated, is useful to the policy makers, as it is this knowledge that is operationalised through policy. Our current paradigm in the policy field views research as the fact finding part of the policy process. The 'facts' that research uncovers are then made available to policy makers for their use. This clearly delineates the separate and sequential activities of fact-finding and decision making (the application of value judgements). These two spheres are kept well apart with different people doing the different tasks with different time frames. In this paradigm, quantitative research fits most easily into the process with information being directed to answer the specific queries incorporated into the research tools such as questionnaires and surveys. Qualitative research, on the other hand is more likely to offer findings which disturb the status quo and with tools that can not claim credibility on the grounds of objectivity (Finch, 1986). However, policy makers are also recognizing the need for a balance between these two perspectives. Research can contain both types of methodology, exploring both objective and subjective aspects of the question. Recognition of the importance and interrelatedness of both these aspects is important when considering design.

Good programme evaluation involves both objective and subjective forms of process and outcome variables, or quantitative and qualitative research methods (Patton, 1990; Cone, 2001). Outcome, in relation to counselling, is generally considered to be the ultimate goal that the client wishes to address, in other words, the reason for seeking assistance. Process is generally taken to mean the activities we use to achieve the ultimate goal (Rosen and Proctor cited in Cone, 2001). This suggests that subjective measures of client satisfaction be considered as well as objective measures of change in the client when evaluating effectiveness (Cone, 2001). This requires the use of both quantitative and qualitative methods of research.

By using both types of research methods, we are acknowledging the larger paradigms of positivist and interpretivist thinking. As Rubin and Babbie (2001) suggest, and as has been explained previously, positivism is based on the belief that society is logical and rational and can be studied scientifically, which includes generalisable laws about the nature of society. Interpretivism on the other hand, is based on trying to find a deeper meaning to society and everyday experiences by trying to gain an empathetic understanding of how people perceive and understand the world on a subjective basis. Quantitative research is generally associated with the positivist paradigm, while qualitative research is primarily associated with the interpretivist paradigm. Quantitative research methods emphasize precise and statistically provable findings, by using tools which produce these measurements, such as surveys and controlled trials. Qualitative research emphasizes depth of understanding of a phenomenon using tools which attempt to tap the deeper meaning, such as interviews and focus groups. Quantitative research can be seen as seeking the truth, while qualitative research can be seen as exploring interpretations of differing realities. However, ultimately, both methods are attempting to make sense of a very complex world (Babbie, 1989; Connolly, 2002). Although measuring differing aspects, both quantitative and qualitative methods can be complimentary and offer a more rounded picture of the research question when used together. By combining these methods, it is hoped that a more thorough exploration of the phenomenon will occur.

Blending both quantitative and qualitative methods allows access to wider sources of knowledge from differing paradigms. According to Connolly (2002), this method is increasingly gaining favour. Triangulation is one method of mixing methods which has the aim of cross checking information and interpretations in an effort to enhance accuracy and validity of the conclusions (Patton, 1990; Connolly, 2002). Other reasons for combining research methods include: the opportunity to explore different aspects of the phenomenon; the possibility that the methods can inform each other; the possibility of raising contradictions and new perspectives; as well as the opportunity to increase the scope and vision (Connolly, 2002).

Cresswell (cited in Connolly, 2002) identifies three models for combining research designs. These are:

- the two phase design approach which involves conducting two phases of research, each with different methods;

- the dominant-less dominant design in which one method is clearly preferred and the other method offers a smaller contribution to the research; and the
- mixed methodology design in which the methods are truly mixed and both methods are used at most, if not all, phases of the research.

The two phase design allows the researcher to keep the two methods clearly separate and maintain their differing aims. The dominant-less dominant design allows the researcher to maintain a clear focus on the aim and purpose of the study, but risks a lack of support for the subservient method in the conceptual design of the study. The mixed methodology design reflects a common thinking process, that of movement between inductive and deductive thinking, and perhaps more realistically reflects the complexities of the research process. However, it requires the researcher to consistently conceptually link the two research paradigms on theoretical, philosophical and practical levels. This effectiveness research study will follow a mixed methodology design, utilizing both inductive and deductive thinking.

As well, both summative and formative evaluation methods will be used in this research. Summative assessment will be useful in evaluating outcome or the ultimate goal. As Patton (1990) suggests, “summative evaluation research tests the effectiveness of some human intervention or action for the purpose of deciding if that program or policy is effective within its limited context and under what conditions it is likely to be effective in other situations or places” (pg. 155). Formative assessment examines the methods that are being used to attain the outcome or the ultimate goal. Formative evaluation techniques focus on the process of intervention rather than the outcome. Both formative and summative evaluations will be useful for this research question.

Grounded theory, as developed by Glaser and Strauss in the mid 1960s, was also investigated as a method of research to address what was happening with the counselling model being researched. Grounded theory was initially developed as a research process to develop theory, rather than a process which was based on previous theoretical constructs. It was a reaction to the functionalist and structuralist theories that were dominant at the time of its development in the mid 1960s. Grounded theory is useful when developing sociological explanations for variability in social interactions (Wells, 1995). It is a deductive type of qualitative research, and in this application could assist in informing the variability of the counselling process which would be useful in this context, as this combination of counselling components make it a unique model.

However, as it is the effectiveness of a model which is already in existence that this research is exploring, program evaluation methods were felt to be more appropriate and were chosen for this research study.

The research methods chosen for the research project are quantitative and qualitative, summative and formative, deductive and inductive. Combining methods in a mixed methodological design, reflects the situation that is being researched and offers the potential to cross check information and interpretations in an effort to enhance both accuracy and validity of the findings.

Design

In the investigation of the effectiveness of the specific counselling model in the specific setting both quantitative and qualitative research methods were used, triangulating the methods to provide a robust design. Quantitative methods included a survey questionnaire to clients, and a standardized psychological measurement tool completed before and following therapeutic interventions. The qualitative research method included interviews with clients willing to participate and open ended questions included with the survey questionnaire. It was planned to do much of the research over a time limited period (two months) to get a 'snapshot' of the service.

The basis of the quantitative research was a survey questionnaire, as well as pre and post intervention measurements. The survey questionnaire was available to all clients who complete counselling with the service over a two month period. The information generated by the survey questionnaires is important in understanding the clients' views on the effectiveness of the service, specifically in relation to the aspects of global improvement, satisfaction with therapists' treatment and improvement in their presenting problem, as well their feelings about the service being based in the medical practices of their primary health care provider. Three of these areas on the survey questionnaire included questions that address the three aspects of effectiveness as suggested by Seligman (1995); these being improvement in presenting problem, satisfaction with therapists' treatment, and global improvement.

The administration of the Hospital Anxiety and Depression Scale pre and post intervention was planned to be offered to up to five clients during the two months of this research. The Hospital Anxiety and Depression Scale is a standardized set of 14 questions that measure levels of anxiety and depression within individuals. It is a self reporting tool. This tool is designed to measure symptom change rather than client

opinions. The sample size of five seems a fair reflection of the potential new cases that the service might see in the time period. It is impossible to know how many new cases might be seen during the research time frame, but the total number of therapy sessions available during the research time frame of two months was 84 per month. It was envisaged that the tool would be offered to the first five new cases that presented to the counselling service in which presenting issue identified on the General Practitioners' referral was anxiety or depression. It was also envisaged that this part of the research may be completed outside the timeframe proposed because the interventions may continue longer than two months, and it is imperative that the therapeutic interventions be completed before the scale is re-administered. The information generated from this method was designed to primarily address the presenting problem and the global improvement aspects of effectiveness.

The basis of the qualitative research methods was the invitation for clients to participate in an interview with the researcher, as well as four open-ended questions included at the end of the survey questionnaire. The same participants who were invited to complete the survey questionnaire were also invited to participate in an interview with the researcher for a more in depth examination of the client's experience. It was envisaged that the first three positive responses to the interview invitation would be interviewed for the research, with the possibility of including up to five interviews should the need arise, with time and resources being the limiting factor. This selection criterion was explained to all survey participants through an information sheet (see Appendix A). As Patton (1990) discusses, with qualitative types of research, sample size depends on "what you want to know, the purpose of the inquiry, what's at stake, what will be useful, what will have credibility, and what can be done with the available time and resources" (pg. 184). The sample size of three is a reflection of the purpose of the inquiry and is not intended to inform the notion of generalization. The interviews were also focused on the three aspects of effectiveness as suggested by Seligman (1995).

The open-ended questions on the end of the survey questionnaire gave participants and opportunity to expand on any of the aspects of the counselling experience they chose. It allowed clients who did not chose to be interviewed a means of expressing their views in a less structured way than by just answering the survey questions.

As with all research, the analysis of the data is dependant on the method of collection. For the more quantitative data; that generated through the survey, and the pre

and post standardized measurements, statistical analysis was applied. For the qualitative data; that generated through interviews and open-ended questions, a content and thematic analysis was applied.

The Data Collection

Using a 'snapshot' sample for the surveys, a time frame of two months was decided upon. With 84 counselling sessions available per month, it was envisaged that up to 30 clients may finish counselling during that two month period and would therefore be eligible to be considered in the survey pool. In actuality, 21 clients finished counselling during the two months chosen and were not re-involved with the counselling service when the surveys were sent out in June 2004. This is when approval was gained for the research from the Massey University Human Ethics Committee and the Manawatu/Wanganui Health Ethics Committee. Included in the mail out to these clients was the survey and the Information Sheet about the survey (see Appendix A), as well as an interview invitation and an Information Sheet about the interview (see Appendix A), also included were two self addressed envelopes to return either the survey, the interview invitation, or both.

The survey mail out was done in late June 2004 and by late August 2004, six surveys and two interview invitations had been returned. A subsequent mail out in early September 2004 to all participants except the two who had been interviewed and two who were now re-involved with the counselling service, netted another seven surveys, as well as one personal contact declining participation and one unanswered returned survey.

The administration of the Hospital Anxiety and Depression scale was done in August, September, and October 2004 when my colleague was available to administer these. The Hospital Anxiety and Depression scale was decided upon as the pre and post assessment tool as it was the tool that had occasionally been used by the General Practitioners who refer to the service, and included with a referral. It was obviously a tool that was available and one that had been used to assist with assessment and diagnosis, as well as referral.

Ethical Issues

The major ethical issues pertaining to this research were informed consent, anonymity and confidentiality, access to clients, and conflict of interest. As with any research, the researcher must be aware of, and make provision for the power imbalance that could potentially exist between the researcher and those being researched. It is the responsibility of the researcher to ensure that safety for clients is of paramount importance. To that end, several provisions were undertaken and approval from both the Massey University Human Ethics Committee and the Manawatu/Whanganui Health Ethics Committee was gained prior to commencing the research.

Recruitment of participants is one area that can potentially create concern. The research for this study began with an anonymous survey sent to clients who had completed their involvement with the counselling service. Clients could choose to complete the survey or not. As the researcher was not aware of actual client participation and participants were no longer involved in the service, there was no chance that participation would have any impact on the provision of services. Included with the survey but on a separate sheet, clients were invited to participate in an interview with the researcher if they wished. It was explained (through the approved Information Sheet) that responding to the invitation would be taken as their consent to participate and would reveal their identity.

Informed consent was ensured through the use of Information Sheets and Consent Forms (Appendix A) which gained approval from both the Massey University Human Ethics Committee and the Manawatu/Whanganui Health Ethics Committee. Informed consent was also discussed with clients who are approached to be part of the pre and post intervention assessments and the interviews.

The researcher recruited a fellow practitioner to assist with the research processes in an effort to keep the researcher removed from directly working with clients who offered data that was not anonymously gained. Again, recruitment, this time of the practitioner, is on a purely voluntary basis. If a practitioner was not forthcoming, the research could continue but with an altered methodology design. The use of a practitioner independent of the researcher to invite participation of clients for some of the research minimizes the power imbalance and protects the confidentiality of the clients. Using a practitioner independent to the researcher also addresses the concerns of conflict of interest, as the researcher was not directly involved in those specific research techniques.

The use of unique identifiers for the pre and post assessments is another provision designed to address confidentiality and anonymity. Through the use of unique identifiers confidentiality is maintained, which eliminates the concerns of coercion and/or altered service provision by the researcher. All participation was voluntary, and participants were able to withdraw at any time during the research. Participants had access to any personal record compiled as part of the research, and they will be provided with information about the research through a report on the research findings.

Being both simultaneously an employee and a student who is undertaking academic research, it was imperative that I have an agreement with my employer that granted me access to approach their clients and the other practitioner and to undertake the research, while at the same time protecting the integrity of my research. I have an agreement with my employer that entitles them to a copy of the research in exchange for me retaining complete academic freedom and the copyright to the research. It is imperative that my processes remain transparent to address the concerns of conflict of interest.

Conclusion

As with all research design, there is no perfect formula. One must determine the purpose of research and keep that in focus when designing. It is not until the data is collected that we can evaluate if our original questions were addressed, or to what degree, if any, they were answered.

This research project certainly tested the robustness of the design, and challenged some of the initial design aspects, but generally proved to be feasible. It was initially envisaged that once ethical approval from the respective ethical committees was gained, the research would use the previous two months as the 'snapshot' sample. However, as the approval process lengthened, and the counselling project evolved through differing funding arrangements which impacted on both clients as well as counsellors, it became clear that a more historical sample would be most appropriate so as not to encounter these changes. Once ethical approval was gained, the 'snapshot' sample became the last two months the counselling project operated as it had initially been established, so that the context could remain consistent. This, then, meant that the pre and post counselling measuring tools would be applied to a client group well removed from the initial survey and interview group, and to a group who were participating in a marginally different service structure. The pre and post measurements were a quantitative measure of the counselling process only and did not include other aspects of the counselling

experience. It was felt that this measure would be valid, despite the changes that had occurred with the service, as the counselling model had not changed, the counsellor administering the measurements had not changed and the presenting problems of the clients met the criteria.

There are several definitive aspects of this research methodology. As explained below, triangulation is one aspect, the size another and the specificity another. The use of triangulation is one way of trying to collect data through different means in an effort to capture a more rounded picture of the experience being researched. It is an attempt to measure variables using more than one method, and in this case, more than one research ideology. By combining quantitative and qualitative research methods, it was hoped that a more comprehensive exploration of the effectiveness of the counselling model would be obtained. If nothing else, this design at least allowed participants different ways of expressing their opinions about the model and the service, but was limited by the size of the samples. The information that was obtained through quantifiable means, the survey questionnaire and the pre and post measurements, were too small to apply much analysis to. However, the analysis that was done reveals some positive results. The size of all the types of research tools, survey questionnaire, interview, open ended questions and pre and post measures, had a big impact on the research project as a whole. While the triangulation is a positive aspect on one hand, by offering choice and measuring different aspects, it may also be seen as a drawback to the bigger picture by fragmenting an already small project.

Choosing to use a non-random type of survey sample, a 'snapshot' sample, the data generated from the research cannot be generalized. However, even if a random sample selection was utilized the size would have again precluded much generalization. Although it was an appropriate type of sample given the research question, the limitations are significant. Without random selection of participants, we can not begin to take the results further than this project, however, the project may serve as an effective pilot for further research. Had the survey questionnaire sample included a random selection of participants, generalization may have been possible, but one could question whether the research was informing the question of effectiveness, or whether it was beginning to address the question of efficacy by placing more controls and limits on the inclusion of clients into the survey sample.

Another aspect of the research design was the specificity, or the focus on the client. All the methods utilized in this project were measuring client response to the model, but

this is only one aspect of effectiveness. Other aspects that could have been included in this research project to inform the question of effectiveness would be data from the General Practitioners and other health professionals who have utilized the service by referring clients, as well as information from the counsellors themselves. Neither of these aspects were included in this research project, which again limits the results. Cost effectiveness of the model was also not considered, nor was administrative or managerial input. Although several differing types of client data were obtained, there are no other viewpoints to balance them with. Again, the impact of limited time and resources were a factor in this, just as they were in choosing the sample model.

Although both qualitative and quantitative research methods were utilized in the project, the results must really be considered as qualitative research findings, offering more in-depth but less generalisable results. However, with the context of the counselling model being included in the research, transferability (Fook, 2002) of the information can be argued, which provides another useful aspect to the data. Despite this, the project essentially becomes a case study of the model rather than a statistical review due to the size of the samples.

Roth and Fonagy (2005) sum up this type of research method well by recognising it as a phase of development imperative to most psychotherapies. They point out that most research into clinical therapies begins with a phase of small scale research that is focused on developing the theory and practice of the technique. This research is generally less stringent methodologically which reflects both the exploratory nature of the research and the constraints on resources. The next phase of research, they suggest, is to move on to more rigorous methods. This explains and contextualises this research project well.

Looking back on the completed research, the time and resources were indeed limiting factors. However, the inclusion of a broader range of opinions about the counselling model may have been beneficial. Including opinions from the other participants in the counselling model, the counsellors, would have no doubt added more depth and texture to the results. Including the opinions of others involved in the overall primary care mental health project, risks shifting the focus of the research from the specific model to research on the overall project. Although the two are not inseparable, having a clear indication of the model's effectiveness provided by the participants is valuable, but does little to inform the effectiveness of the wider project. Research on the wider project could well be the subject of future research projects.

CHAPTER 6

DATA RESULTS

The data for examining the effectiveness of this counselling model combining strengths based, solution focused counselling with cognitive interventions in a primary care environment was collected using three very distinct tools. These included a survey questionnaire which included Likert type questions as well as open ended questions, interviews, and a pre and post intervention measurement. This research study used a mixed methodology design, with the idea of utilizing the benefits of triangulation to strengthen the study. The results from each of these instruments are presented separately with a brief summary of their results.

Survey Questionnaire Results

The surveys were sent out in late June 2004 after approval was gained from the Massey University Human Ethics Committee and from the Manawatu/Whanganui Health Ethics Committee. The survey pool comprised clients who had completed counselling at the end of the original structure of the primary health care counselling project, and who were not re-involved with the service as of June 2004. This provided a pool of 21 survey recipients. A poor initial response prompted a repeat mail out of surveys with a further request for participation (Appendix B). The follow up mail out was sent in early September 2004 to the entire survey pool, excluding two participants who had revealed their identity and participation in the research with the first survey responses (by making themselves available for the interview) and two who had re-engaged in counselling through the counselling service, bringing the total mail out of repeat requests to 17.

Of the 21 surveys sent out initially, only 6 responses were received, however the follow up request netted a further 8 respondents, two of whom declined to participate. So overall, 12 surveys were returned answered, one was returned unanswered, and one respondent rang the interviewer declining to be involved. This gives an overall response rate of 66.67% (14) and a response rate of answered surveys of 57.15% (12). On

analysis, there appears to be little difference in the demographics or responses of the participants who responded to the second request as compared to those who responded initially.

Demographically, 83% (10) of the participants were female with 17% (2) male. The age range was evenly split at 25% (3) for the age groups 20-29, 30-39, 40-49, and 50-59. Eleven of the twelve participants were referred to the service by their General Practitioner, with one self-referral. Six of the participants had received counselling previously, mostly through other services, with only one respondent having previously attended this service. All reported that they would recommend the service to others.

Seventy five percent (9) of the participants were on anti-depressant or anti-anxiety medication at the time of responding to the questionnaire. Of these, 22% (2) had been on the medication for over one year, 33% (3) had been on the medication for 9 months to one year, 11% (1) had been on the medication for 6 to 9 months, 22% (2) had been on the medication for 3 to 6 months and another 11% (1) had been on the medication for 1-3 months.

When asked to classify the concerns that brought them to counselling, depression rated the highest, followed by anxiety and relationship issues, then stress, physical illness, loss and financial issues, which was specified in the 'other' option. These concerns are shown in Figure 6.1.

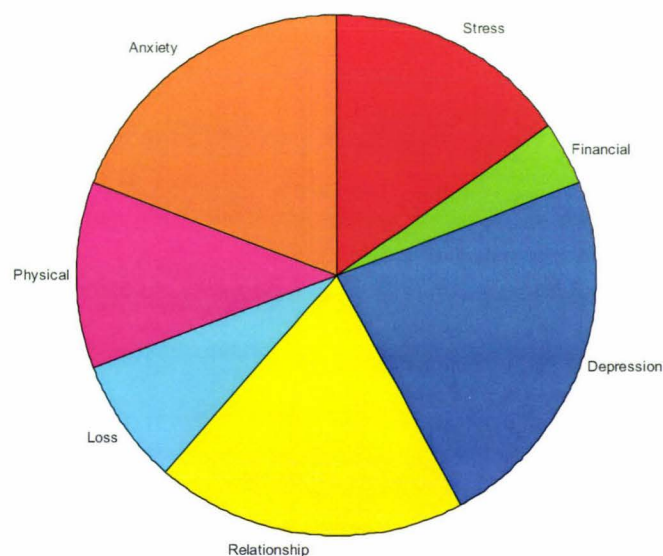


Figure 6.1. Client identified concerns at time of referral

The survey included a Likert type questionnaire which was divided into four sections which included: Counselling and the Doctors', Main Concerns, Effects, and Counselling Process. Each of the sections had four statements to be rated (Appendix A). The statements were rated on a scale from 'Not at all', through 'Somewhat' to 'Yes, definitely'; on a 1 to 5 scale with 1 being 'Not at all' and 5 being 'Yes, definitely'. The sections had different focuses for the research, each aiming to measure a different aspect of the counselling experience. These included participants' opinions of the provision of counselling in the primary health care setting, whether counselling had addressed the participants' main concerns that brought them to counselling, whether the counselling had more global effects for the respondent, and finally opinions about the specific counselling techniques.

The mean, median and range responses to these statements within each of the sections are included in tables below. The widest range occurred on the statement "I feel better about myself now than I did before counselling" from the Effects section, and the narrowest range was on the statement "The counselling was focused on solutions to my concerns" from the Main Concerns section, as well as on the statement "I liked the way my counsellor worked with me" from the Counselling Process section.

Table 6.1 Counselling at the Doctors'

Statement	Mean/Median/Range		
I felt comfortable going to a counsellor in the Doctors' rooms.	3.46	2	2-5
The Doctors' rooms were convenient.	4.59	5	3-5
It makes sense to have a counsellor at the Doctors' Surgery.	4.42	5	3-5
It is good to have my Doctor and Counsellor working together.	4.67	5	3-5

Table 6.2 Main Concerns

Statement	Mean/Median/Range		
The counsellor helped me identify and clarify my concerns.	4.59	5	3-5
The counsellor and I developed goals for counselling.	4.19	5	2-5
The counselling was focused on solutions to my concerns.	4.59	5	4-5
The counselling helped me resolve my concerns.	4.34	5	3-5

Table 6.3 Effects

Statement	Mean/Median/Range		
I feel I can cope with most aspects of my life now.	3.92	4	3-5
Counselling has helped me increase my skills for dealing with issues that concern me.	4.17	4	3-5
I feel better about myself now than I did before counselling.	4.25	5	1-5
I feel more in control of my life now than I did before counselling.	4.25	5	3-5

Table 6.4 Counselling Process

Statement	Mean/Median/Range		
I liked the way my counsellor worked with me.	4.67	5	4-5
I learned some useful skills in counselling.	4.17	5	3-5
I felt the counsellor understood my concerns and made useful suggestions.	4.42	5	3-5
I understood what the counsellor was talking about.	4.25	4	3-5

The responses indicate that although people approve of having their General Practitioner and their counsellor working together, they are not all comfortable participating in counselling in the primary care setting. The responses also suggest that people like the counselling model and processes, and although their initial concern were addressed through counselling this did not necessarily have a direct impact onto their global or overall wellbeing.

Survey Questionnaire Analysis

The survey results are useful in examining the central question of the effectiveness of this counselling model with this population at this place and time. According to Hemmings (2000), counselling effectiveness should explore three things: improvement in the presenting problem or issues, satisfaction with the therapists' treatment; and global improvement. This survey was designed to briefly explore these areas, as well, an additional exploration of the provision of counselling in the primary health care setting was included. This was done with a Likert scale type questionnaire which incorporated statements pertaining to these four sections. These sections were 'Counselling at the Doctors' Surgery' which aimed to measure opinions about the provision of counselling in the primary health care setting, 'Main Concerns' which

aimed to gauge opinion about whether the presenting issues had been addressed by the counselling, 'Effects' which aimed to measure improvement in global wellbeing, and the 'Counselling Process' which aimed to gauge the satisfaction with the therapists actions within this counselling model. Of the four sections, the section about the presenting problem (Main Concerns) had the overall highest average of 4.43 for the four statements, followed by satisfaction with the therapists' action (Counselling Process) with a 4.38 average. The primary health care setting (Counselling at the Doctors') rated next, averaging 4.29, while global improvement (Effects) had the lowest average of 4.15.

The section with the highest average, Main Concerns, suggests that clients felt their presenting issues, or the concerns that brought them to counselling in the first place had been acknowledged through the counselling. The statements in this section with the highest averages were: "The counsellor helped me identify and clarify my concerns" and "The counselling was focused on solutions to my concerns"; which each averaged 4.59. The statement "The counselling helped me resolve my concerns", was the next lowest averaging at 4.34, with the statement "The counsellor and I developed goals for counselling" the lowest averaging statement from this group at 4.19.

The section exploring the therapists' action, Counselling Process, was the next highest averaging of the sections. The statement "I liked the way my counsellor worked with me" was first equal in the averages of the statements and had the narrowest range of responses, with all participants choosing either a 4 or 5 (4 being between Sometimes and Yes, definitely, and 5 being Yes, definitely) response to this statement (four responses at 4 and eight responses at 5). The statement "I learned some useful skills in counselling" received the lowest average for this section at 4.17. The other two statements, "I felt the counsellor understood my concerns and made useful suggestions" and "I understood what the counsellor was talking about" were in the middle of the field of averages with a 4.42 and a 4.25 respectively.

The survey results in the primary care section, Counselling at the Doctors', suggest that there is a split in opinion about the provision of counselling in the primary health care setting, with one of these statements receiving the survey questionnaires' lowest mean and median score, as well as one statement receiving the highest mean and median scores. The median rating of 2 and the mean score of 3.46 to the statement "I felt comfortable going to a counsellor in the Doctors' rooms" is the lowest in the survey questionnaire and indicates this split. Of the 11 responses (one survey form left this

question unanswered), five rated that statement a 2 (between Not at all and Sometimes), while two responses rated it a 4 (between Sometimes and Yes, definitely), and four responses rated it a 5 (Yes, definitely). While that statement received the lowest average score, another statement in the same section shared the highest ranking of the mean and median ratings in the survey questionnaire. This statement, "It is good to have my Doctor and Counsellor working together" had an average score of 4.67 and a median of 5, with one of the 12 responses rating it as a 3 (Sometimes), five participants rating it at 4 (between Sometimes and Yes, definitely) and six participants rating it at 5 (Yes, definitely). The other two statements in this section "The Doctors' rooms were convenient" and "It makes sense to have a counsellor at the Doctors' Surgery" also averaged highly in the rankings receiving a second equal and third equal average when compared to the other statements in the overall survey questionnaire, these being 4.59 and 4.42 respectively. Although the split is interesting, due to the sample size, we can not generalise, however the similar weighting at each end of the range (5 responses at 2 and 4 responses at 5) indicates it is not just a single low score that is reflected in the statistics, but a genuine concern from the survey participants. It is not possible to surmise if these opinions would be as variable in the broader population of counselling clients, however it may indeed be an interesting aspect to follow up.

The section designed to assess whether a global improvement had occurred for the participants, the Effects section, resulted in the lowest overall average. The statement "I feel I can cope with most aspects of my life now" was one of only two statements in the survey that averaged below a four. The spread of responses included: four responses of 3 (Sometimes), five responses of 4 (between Sometimes and Yes, definitely), and three responses of 5 (Yes, definitely). This statement had the highest incidence of 3 responses of any in the survey. The next lowest ranking statement in this section was "Counselling has helped me increase my skills for dealing with issues that concern me" which averaged 4.17. The other two statements shared an average of 4.25 with the statement "I feel better about myself now than I did before counselling" receiving the only response of 1 (Not at all) in the survey. The respondent that selected the 1 to that statement indicated on the survey form that his/her responses were based on a single session with the counsellor and besides this response gave an overall positive opinion of the counselling experience as evidenced by his/her selection of 5 for several other statements on the survey form and included a positive comment to the open ended questions included on the survey questionnaire.

The demographics of the sample are not dissimilar to the demographics from the counselling service as a whole, although there were some differences. The counselling service statistics show a 75% and 25% gender split of female to male in the whole service (Charuk, 2004), this overall survey sample had an 80% to 20% female to male split and amongst the responses the gender split was 83% (10) female to 17% (2) male. The age range among the participants was evenly split between four age groups that ranged between ages 20 to 59, where as for the service as a whole, the age range is spread from ages 14 to 65+ with 88.3% of clientele falling within the age range of the participants (Charuk, 2004).

The breakdown of types of issues that people were referred to the service for is somewhat different for the sample as compared to the counselling service statistics, however, the survey questionnaire participants were able to self select their issue types and were able to choose more than one, where as the service statistics are counsellor or General Practitioner generated and limited to one category per case. The service as a whole, from June 2002 to the end of January 2004 recorded anxiety and depression as the main referral reasons with each accounting for 26.7% of the referrals, this was followed by stress at 19% and adjustment at 17%, with relationship issues at 6.7% and other reasons comprising 3.7% of the total (Charuk, 2004). The comparison between the service referral types and the participants' referral types are in Table 6.5.

Table 6.5. Percentage comparison of referral categories between the participants and the service

Referral type	Participants	Service
Depression	23.05% (6)	26.7%
Anxiety	19.23% (5)	26.7%
Stress	15.39% (4)	19%
Relationship	19.23% (5)	6.7%
Adjustment	19.23% (5)	17%
Other	3.85% (1)	3.7%

Ten of the twelve participants added comments to the open-ended questions at the end of the survey form. Answers to the request for things that were most helpful included the following statements:

“Immediately able to trust and relax even though a new experience for me”
“Relaxation techniques”
“Being able to sit down and really cry”
“Being able to talk to someone who had no connection with me (that I could trust) and who listened without judgement”
“Feeling comfortable”
“She was a complete stranger and a very good listener”
“Understanding myself and not being so hard on myself. I wasn’t ‘nuts’ and my reaction to events were okay.”
“Someone non-judgemental to talk to.”

Answers to the request for what was least helpful included:

“I had to wait to get in and had solved some of my issues myself.”
“Nil”
“Having to go into the actual doctors surgery and wait in public – I found this very uncomfortable – it felt like everyone knew what I was there for from the receptionist to all the others.”
“That the bill would no longer be subsidised after my first consultation.”
“Nothing really.”

The comments that participants added included:

“I found counselling good being able to talk to someone other than family and friends.”
“Would have no hesitation in using this service again.”
“This is a great service that should continue.”
“Would recommend this service, being one who never opens up to anyone – I was amazed at the level of confidence I gained talking to a counsellor.”
“At the time I needed to reach out to someone, she was there for me.”

A couple of participants included the number of visits they had had with the counsellor on which they were basing their answers.

These answers to the open ended questions give more depth to the survey. Of the 12 questionnaires, 10 included a statement of some form or another. The majority of the responses were to the request: “The thing I found most helpful was:” with eight responses. The second most responses were to the request: “Any other comments you would like to make?” with seven responses, and the request for “The thing I found least helpful was:” netted five responses.

Content analysis of the responses to the questions suggests that what people found most useful followed several themes. These included having someone confidential and

trustworthy to talk to, the relaxation techniques and being able to talk to someone who was not involved. As well as these themes, other responses indicated the importance of rapport, and the counsellor being non-judgemental.

The themes emerging from the statement of what was 'least helpful' are less clear cut. Of the five responses, two indicated that nothing had been 'least helpful', one felt uncomfortable going to the Doctors' surgery, one had to wait to get an appointment and one respondent found the payment for sessions other than the first least helpful. Similar disparity is evidenced in the 'comments' that were received. Two responses simply indicated the number of counselling sessions the participants had attended, two stated the service was good, one stated they would use the service again and one respondent would recommend the service to others, with several adding what they had gotten out of the sessions, such as confidence, and someone being there to listen.

Survey Questionnaire Summary

The survey questionnaire results revealed much information about the counselling service, and allowed for some comparison on statistics that define the counselling service in general. The survey closely correlates to the statistical data of the service as a whole which adds to the transferability of these findings. As mentioned previously, the sampling method and sample size both preclude any generalization from these results. However, taking this research as a case study, it provides useful information.

With the 'Main Concerns' section of the survey receiving the highest mean score, it would suggest that people generally felt they were able to work on the main issues that prompted their referral to counselling. With the 'Counselling Process' section the second ranked section of the survey, indications are of comfort between client and counsellor, and would suggest good rapport and a good therapeutic relationship. All components are generally thought to contribute to effective counselling practice.

The section about the provision of counselling in the 'Doctors' Surgery' produced the greatest diversity among the participants. The statement about the level of comfort with attending counselling at the Doctors' Surgery had the lowest overall mean of any of the statements, while the statement about feeling good about having the counsellor and General Practitioner working together shared the highest overall mean (first equal with one other statement). On the surface, this may indicate comfort with the case management model and the multidisciplinary approach but discomfort with the venue, however further investigation would be necessary before this could be clarified.

The lowest ranking section, the 'Effects' section, suggests that there was not as much global improvement for clients as there was specific issue resolution. Just because the presenting problem was addressed did not directly correlate with improved overall functioning. However, participants did indicate that they felt more in control of their lives following counselling which offers a positive longer term effect than is indicated in the other statement responses. Again, this phenomenon may require further investigation.

Generally these results paint a positive picture of the counselling service and offer indications of further avenues for investigation. The comments added to the open ended questions support the survey results and expand, often more specifically, on areas of the counselling experience. The experience for most of the participants seems to have been a positive as evidenced in the 100% response rate to the question of whether the respondent would refer others to the counselling service. This positive experience is in keeping with the Customer Satisfaction Survey that was done in August 2003 (Charuk, 2004).

Interview Results

Two clients agreed to be interviewed by the researcher. Both of these clients/participants had previously been clients of the researcher, but neither were involved in counselling with the researcher at the time of the interviews. The implications of participating in the research with their previous counselling provider was discussed with them both prior to undertaking the interviews. Both interviewees clearly indicated they were comfortable with the situation. The interview schedule was aimed to explore the interviewees counselling experience in more depth than the survey questionnaire allowed. Both interviewees agreed to have their interviews taped and neither asked to have the tape recorder turned off at any stage during the interview.

The interviews were done at a place and time convenient for the interviewees. One was at her home and the other at the counselling office. Both interviewees were female and both women expressed their desire to 'give back something' as motivation for participating in the interviews, as they both felt they had gained something from their counselling experience. One interviewee added that she was quite accustomed to assisting students as she had undergone numerous medical tests and interventions in her lifetime and appreciated the opportunity to help someone else. She seemed at ease with whole interview process. The other interviewee stated that she had never participated in

a taped interview before and was initially a bit nervous. Neither one wanted a copy of the taped interview or a copy of the typed transcript, they both expressed faith in the interviewer to correctly represent their answers. Both interviews were done in as relaxed a manner as possible, and neither interviewee expressed difficulty with the process. They both expressed their opinion that if anything it had been a positive experience, reinforcing the change and improvement they had made.

Both interviewees were on antidepressant or anti-anxiety medication, although one interviewee qualified this statement by adding that the medication was to assist her with sleeping and that she had only recently been prescribed the medication. The other interviewee had been on the medication for a number of years. Neither could remember exactly how many sessions of counselling they had attended, one thought it has been perhaps 3 sessions and the other thought she had attended perhaps 8 sessions. Neither interviewee felt they had to wait long for an appointment, and both were referred to the service by their respective General Practitioners. One interviewee had previously attended counselling and one interviewee had not.

When asked what had brought the interviewees to counselling, both indicated stress related issues. One interviewee stated "Well, I was very stressed out, I couldn't handle it, and (my Doctor) thought it would be helpful just to talk about it because I was keeping a lot in at the time and I wasn't good at dealing with stress". Both indicated that the counselling did help with their presenting issues. In describing their memories of their first sessions, one interviewee found it "terrible, I cried for the first hour, but it was obviously opening up", the other interviewee remembered it as "really good actually ... I actually felt really hopeful you know that we were going to be able to help me". The interviewee who found the first session 'terrible', reported that subsequent sessions were "much better", and the interviewee who found the first session hopeful reported that she found subsequent sessions "really good".

When asked what had been the most helpful part of the counselling experience one interviewee talked about the techniques she had learned to assist with her stress, and the other interviewee felt it was having someone safe to talk to and a place to explore her concerns. Neither could articulate anything that had been unhelpful about the experience, one stating "I don't think there was any part (that was unhelpful), honestly, everything was just what I needed at the time".

Both interviewees were able to remember specific techniques that they learned in counselling and both reported they were still using them, although not as frequently

now. One mentioned breathing techniques that she learned and still used, and the other remembered several of the cognitive techniques she learned and continued to use. She also remembered many of the relaxation techniques used in the sessions.

The interviewee that had previously had counselling was able to compare this experience to her earlier counselling experience and felt that while both were beneficial, she appreciated the learning side of this counselling experience. She stated “Well it gave me ways to deal with it. Like normally with counselling it was a case of talk about it, leave it, that’s it. Whereas learning the techniques to help deal with it meant that I didn’t have to be in for years and years kind of thing”. She added that she felt she was now in a better space because of “knowing a bit better how to deal with the stress, and I’m learning not to stress out so much and having the techniques to fall back on if I need them, and (the counsellor) giving me them on paper helped too. You know, cause I’ve still got the paper and so if I need to update myself kind of thing, I just have a read over, and yea which helps a lot cause I’m a visual person as well”.

When asked about the overall experience, one interviewee discussed her discomfort of seeing a counsellor in the Doctor’s surgery stating “I was coming in and coming to see a counsellor so I felt the first time that everybody knew that I had a problem but they didn’t know what. So to start with I did feel a bit awkward”. When asked if she would recommend the service to others she felt it was a touchy subject and not one she talked about openly with everyone. The other interviewee stated that the overall experience was “very positive”, and that she had already recommended people to the service and she would again in the future.

When asked for other comments, one interviewee discussed the rapport that she felt was important, stating “you have to have somebody that you can relate to, which I felt I could relate straight away. (The counsellor) showed empathy, and I don’t know whether on a one to one whether that would happen ever again; whether if I had someone else whether it would be the same rapport”. The other interviewee also added, “I felt really positive coming out of it, too. That I was going to be okay. So that’s really good. ... it was such a good experience for me. ...”.

Interview Analysis

With only two interviews to consider, a content analysis is limited in its results, however, there are several themes which can be identified within the two interviews. The relationship, or a sense of feeling at ease with the counsellor was mentioned in

both, as was the use of techniques in the counselling model. As well, both interviewees found the sessions helpful in the long run, if not initially for one, as both now felt they were better able to deal with their presenting issues.

Relationship building through rapport is an integral part in Neurolinguistic Programming which is an element of this counselling model. Relationship is also acknowledged in other elements of this counselling model as a component of social work's generalist perspective, as well as in solution focused brief therapy. The relationship is also identified as one of the common factors of all counselling/psychotherapy which has been credited with creating 30% of the change that occurs through the use of 'talk therapies' (Drisko, 2004). Obviously for these interviewees, the relationship was an important aspect of their counselling experience.

One important characteristic of the task-centred approach is the idea of learning techniques by having something to 'do', and the task centred approach is also an influential element in this model. Not only were the physical tasks such as breathing techniques and relaxation exercises useful here, but the cognitive tasks such as thought stopping and visualisation were also reported to be useful tools by the interviewees.

Interview Summary

Although it was planned that three interviews would be undertaken, with a provision for up to five if time permitted, only two interviews were completed. This was due to a poor response rate to the interview invitation. These two women were the only participants to the interview invitation, which was included with the survey questionnaire mail out. They both responded to the first mail out of surveys and invitations, and although the second mail out doubled the survey questionnaire response rate, no new interview participants were gained through this mail out. Both interviewees were from the same primary health group practice and both were seen by the same counsellor.

Much of the information explored through the interview process was simply a more in depth look at the basic questions which were included in the survey. This was valuable for adding depth to the survey categories, but could have perhaps included questions from other aspects of the counselling process as well. Such as whether the participants felt their involvement with counselling services had impacted on their involvement with their General Practitioner, whether they felt their issues were more comprehensively dealt with through the case management model of involving their

General Practitioner and their counsellor, and whether there were any flow on effects of the counselling into their lives in other areas besides just the presenting problem resolution.

Although more could have been included, in terms of evaluating the effectiveness of the counselling model used, the responses were very helpful. They indicate that for these two clients of the service, the model was effective, and the concerns about participating in counselling in the primary care setting that were highlighted through the survey questionnaire were also reflected in this interview group, with one interviewee feeling comfortable in the venue and one not.

Hospital Anxiety and Depression Scale Results

The Hospital Anxiety and Depression Scale (HADS) was designed by 1983 by R. P. Snaith and A.S. Zigmond and published in *Acta Psychiatrica Scandinavica* (1983, cited in Snaith, 2003). It was designed as a tool for assessing mood disorder, particularly anxiety and depression in the medical setting. It is a self assessment tool of 14 statements, seven that are relevant to either depression, primarily the state of anhedonia (loss of pleasure response), and seven that pertain to generalized anxiety.

The Hospital Anxiety and Depression Scale takes approximately 2 – 5 minutes to complete. It asks participants to respond to the questions as they have felt in ‘the past week’. As a self assessment tool it is a useful screening tool, and has been “established as a much applied and convenient self-rating instrument for anxiety and depression in patients with both somatic and mental problems, and with equally good sensitivity and specificity as other commonly used self-rating screening instruments” (Mykletun, Stordal, and Dahl, 2001). Internal consistency using Cronbach alpha calculates rates at 0.89 on both subscales (Savard, Laberge, Gauthier, 1998 cited in Mykletun, et. al. 2001).

The Hospital Anxiety and Depression Scale was used for pre counselling and post counselling assessment in an effort to measure if any change had occurred for the participant during the course of counselling. This particular scale was chosen because it is the most consistently used screening tool by the referring General Practitioners. When referring clients to the counselling service, General Practitioner’s sometimes include the results from the HADS in their referral. It was also chosen because it is a self reporting tool as opposed to a counsellor generated tool, which is in keeping with the constructivist paradigm that underpins the counselling model used. It had added benefits

of convenience, particularly in time taken to complete the assessment and time required to score the assessment.

The two subscales, depression and anxiety, are divided along numerical lines, with the even numbered statements pertaining to depression and the odd numbered items pertaining to anxiety. There are seven statements in each subscale which are rated on a four point scale from 0-3. The subscales are scored separately with a score of 0-7 on either scale indicative of no depression or anxiety, a score of 8-10 indicative of 'borderline' depression or anxiety, and a score of 11-21 indicative of 'probable' significant depression or anxiety. The statements on the anxiety subscale ask your response to the following statements:

- 1 I feel tense or 'wound up'.
- 2 I get a sort of frightened feeling as if something awful is about to happen.
- 3 Worrying thoughts go through my mind.
- 4 I can sit at ease and feel relaxed.
- 5 I get a sort of frightened feeling like butterflies in my stomach.
- 6 I feel restless as if I have to be on the move.
- 7 I get sudden feelings of panic.

The statements on the depression subscale ask your response to the following statements:

- 1 I still enjoy the things I used to enjoy.
- 2 I can laugh and see the funny side of things.
- 3 I feel cheerful.
- 4 I feel as if I am slowed down.
- 5 I have lost interest in my appearance.
- 6 I look forward with enjoyment to things.
- 7 I can enjoy a good book or radio or TV programme.

This research study used HADS as pre and post counselling assessments in three cases. The results overall indicate improvement in two of the three cases with the third case showing little change between the pre and post assessments. The results are presented in Table 6.6.

Table 6.6. Pre and Post Counselling Data

	Pre counselling	Post counselling
Client 001	Anxiety 19 Depression 15	Anxiety 8 Depression 4
Client 002	Anxiety 9 Depression 2	Anxiety 8 Depression 2.5
Client 003	Anxiety 17 Depression 18	Anxiety 11.5 Depression 7

It is unusual to have a part score on the HADS rating, such as 2.5, but these clients felt their symptoms were best represented between two scores. Two of the three HADS had part scores for several statements and these have been calculated as a .5 score.

Hospital Anxiety and Depression Scale Analysis

According to the HADS scoring interpretation, Client 001 had ‘significant’ levels of anxiety and depression when assessed before counselling was begun, and had scores indicating ‘borderline’ anxiety and ‘no’ depression in the post counselling assessment. Client 002 showed very little change between the two assessments; scores indicate ‘borderline’ anxiety and ‘no’ depression prior to counselling and the same on the post counselling assessment, with a marginal drop in the anxiety score from 9 to 8, and a marginal increase in the depression score from 2 to 2.5. Client 003 had scores that indicated ‘significant’ anxiety and ‘significant’ depression in the pre counselling assessment, and ‘no’ depression but continued ‘significant’ anxiety despite a drop in the anxiety score from 18 to 12.5.

With the two clients who showed the most change, Client 001 and 003, their greatest improvement was on the depression scale, with Client 001 improving from 15 to 4 and Client 003 improving from 18 to 7. Client 002 on the other hand went from a score of 2 on the depression scale to a score of 2.5, both scores within the ‘no’ depression range. The depression scale results for both Client 001 and Client 003 for both pre and post counselling assessments are included in Table 6.7.

Table 6.7. Depression Scale Results

Statement	Client 001		Client 003	
	Pre	Post	Pre	Post
2. I still enjoy the things I used to enjoy.	3	1	2	1
4. I can laugh and see the funny side of things.	1	0	2	1
6. I feel cheerful.	1	0	2	1
8. I feel as if I am slowed down.	3	1	3	2
10. I have lost interest in my appearance.	1	1	3	.5
12. I look forward with enjoyment to things.	3	1	3	.5
14. I can enjoy a good book or radio or TV programme.	3	0	3	1
TOTALS	15	4	18	7

For Client 001, the most significant change was recorded for the statement ‘I can enjoy a good book or radio or TV programme’, and no change was recorded for ‘I have lost interest in my appearance’, while all other statements had less diversity between assessments, changing only one or two points. For Client 003, the most significant change was recorded for the statements ‘I have lost interest in my appearance’ and ‘I look forward with enjoyment to things’, the next largest variance was with the statement ‘I can enjoy a good book or radio or TV programme’, with the other statements all recording the same margins of difference between pre and post assessment. For Client 002, half point changes occurred on three statements, making up the .5 increase, these statements were ‘I have lost interest in my appearance’ with a one point change from a 1 to a 0, ‘I look forward with enjoyment to things’ with a 1.5 change from 0 to 1.5, and ‘I can enjoy a good book or radio or TV programme’ with a change from 0 to 1. All of this accumulated to a .5 increase in depression measurement between assessments.

As for the anxiety scale, there was improvement for both Client 001 and 003, while Client 002 showed a change of just one point, which was not enough to shift Client 002 between the categories of interpretation, so Client 002 remained in the ‘borderline’ category. Client 001 more than halved his anxiety score between the pre and post assessment, from 19 to 8, while Client 003 also showed significant improvement with a pre counselling score of 17 and a post counselling score of 11.5. The anxiety scale

results for both Client 001 and Client 003 for both pre and post counselling assessments are included in Table 6.8.

Table 6.8. Anxiety Scale Results

Statement	Client 001		Client 003	
	Pre	Post	Pre	Post
1. I feel tense or wound up.	3	1	2	1.5
3. I get a sort of frightened feeling as if something awful is about to happen.	3	2	3	2
5. Worrying thoughts go through my mind.	2	1	3	1
7. I can sit at ease and feel relaxed.	3	0	2	1
9. I get a sort of frightened feeling like butterflies in my stomach.	3	1	2	1.5
11. I feel restless as if I have to be on the move.	2	2	3	3
13. I get sudden feelings of panic.	3	1	2	1.5
TOTALS	19	8	17	11.5

For Client 001, the most significant change was recorded on the statement, 'I can sit at ease and feel relaxed', and there was no change for the statement 'I feel restless as if I have to be on the move', the remaining statements changed either one or two points between the assessments. For Client 003, the most significant change was recorded on the statement, 'Worrying thoughts go through my mind', with the statement 'I feel restless as if I have to be on the move' remaining the same. For Client 002 the most significant change on this scale was on the statement, 'Worrying thoughts go through my mind', which dropped from a 2 on the first assessment to a 1 on the second assessment.

Hospital Anxiety and Depression Scale Summary

It was hoped that five Hospital Anxiety and Depression Scale pre and post counselling assessments would be available for this research project. Unfortunately, due primarily to timeframes, only three have been completed in time for inclusion in the project. As was planned, my colleague administered the scales, in order to keep the clients' identity confidential. Although this was useful for ethical reasons for this project, it meant that the results are for only the clients of one of the counsellors practicing in the counselling service, which has implications for transferability.

However, as client anonymity is an important factor in research, this was deemed to be the more important factor.

The criterion for inclusion in the HADS measurement was a referral to the service indicating that the reason for the referral was either anxiety or depression or both. It was hoped that the HADS would be administered during the same two month 'snap shot' that was used for the survey questionnaire, as the surveys were only going to clients whose contact with the service was finished during those two months. However, as the survey was back dated to the last clients of the original service structure, it was not possible to administer the HADS at that time as ethical approval has not yet been granted. Once ethical approval was granted, my colleague who had agreed to participate was unavailable, so the scales were not administered until spring 2004.

The three scales that were completed show significant improvement for 2 of the 3 clients, with the third client remaining fairly constant. It should be noted that the client whose assessments showed little change was only in the 'borderline' category for anxiety and in the 'no' category for depression initially. One wonders if the issues for which the client was seeking assistance were other than anxiety or depression, but this were perceived as anxiety or depression by the referrer or the client. Again, the size of the sample makes it difficult to do much with these results but it is encouraging that there is improvement showing.

Data Summary

When the data presented and summarised in this chapter is explored in the context of the literature which informs it, the data offers some insights and implications for the counselling model and the service as a whole. The lack of global improvement and the comfort level of clients participating in counselling in the primary care setting are two points that need further exploration. Exploring the model and the participants opinions about it, as well as their opinions about combining mental health and primary health care, allows us a starting place for further development. These issues will be examined further as the data is discussed in a wider context and the implications explored.

CHAPTER 7

ANALYSIS and DISCUSSION

The results reported from this study have generated some very useful information to inform the central question of the effectiveness of this particular counselling model in this particular setting. Although the size of the samples are limited, the consistency of the information across the three different research tools adds weight to the findings. Each tool, the survey questionnaire, the interviews and the pre and post intervention measures all indicate that change is occurring for participants. The survey questionnaire and the interviews also suggest that the participants are satisfied with the counselling they are receiving. The research design, triangulating both qualitative and quantitative methods allows for a more thorough investigation than just one method might have offered (Patton, 1990). In this chapter, this discussion will explore the similarities and differences within the results from all three research tools and the implications this has on informing the research question. It will also align this research project to theoretical components which help to define the model.

Measures of Effectiveness

According to Seligman (1995), the researcher who undertook the *Consumer Report* effectiveness survey of counselling and psychotherapy, the largest such survey ever undertaken, effectiveness should be measured on three aspects, which are:

- Specific improvement, or in other words, measuring whether the client felt the specific issues that prompted the need to seek counselling had been addressed,
- Satisfaction with the therapist and treatment, or in other words, measuring how comfortable the client was with the counselling/therapy as well as how the therapist dealt with their issues,
- Global improvement, or how the client felt at the time of completing the questionnaire as opposed to how they felt at the start of counselling, and whether the client felt the counselling/therapy had improved their overall wellbeing.

These aspects provided an outline for the measurement of effectiveness in this study. As well, a fourth category was also measured, which concerned satisfaction with the involvement of counselling within the primary health care setting. Table 7.1 illustrates how these aspects were included in the research tools.

Table 7.1 Effectiveness Measures Related to Research Tool

Research Tool	Specific improvements	Satisfaction with therapist	Global improvements	Satisfaction with primary health involvement
Survey questionnaire	Includes four statements to rate about resolving clients' main concerns. Includes open ended questions about most and least helpful things.	Includes four statements to rate how client related with counsellor and the techniques used. Includes open ended questions about most and least helpful things.	Includes four statements to rate about whether client felt improvements in other aspects of life due to this counselling.	Includes four statements to rate on how client felt about counselling being part of GP services. Includes open ended questions about most and least helpful things.
Interview	Includes questions about what brought client to counselling and whether these were resolved.	Includes questions about whether client remembered any techniques or skills learned during counselling. Asked how effective this counselling was compared to other counselling tried.	Includes questions about whether client still used anything gained from counselling in other aspects of their life.	Includes questions about who referred the client to service as well as questions about most and least helpful things with counselling.
Hospital Anxiety and Depression Scale (HAD)	Includes questions to rate about specific symptoms such as tension, fear, worrying, restlessness.		Includes questions to rate about more global feelings such as feeling as cheerful as previously and rating enjoyment of things as well as measuring laughter and the funny side of things.	

This template was used for the design of the survey questionnaires in this research project. The survey questionnaire for this research project (Appendix A), included these category headings:

- **Counselling at the Doctors'**, which was designed to measure respondents opinions about the combination of primary health care and counselling,
- **Main Concerns**, which was designed to measure whether respondents felt their primary concerns that had brought them to counselling had been addressed,
- **Effects**, which was designed to measure the global effects of counselling, and
- **Counselling Process**, which was designed to measure satisfaction with the counselling techniques and with the therapist.

As well, the survey questionnaires also gathered demographic data and included three open ended questions.

The data from the survey questionnaires revealed an overall positive response to the counselling, as evidenced by all 12 (100%) of the respondents indicating they would recommend this service to someone else. From an analysis of the responses it was revealed that the highest mean score of the effectiveness aspects occurred for the category measuring clients' presenting issues or 'Main Concerns', followed by the category measuring the therapists' actions or 'Counselling Process', which received the next highest mean score. This was followed by the aspect of the primary care involvement or the 'Counselling at the Doctors'' category, which ranked third highest in the mean scores, with the 'Effects' category or the global improvement aspect being ranked the lowest of the categories in mean scores.

These survey results were corroborated with the interviews and the pre and post test measures. The consistency of the information across all the research tools and methods adds credibility to the findings, especially when viewed from the post modern influenced constructivist paradigms of knowledge generation. These influences value the creation and validation of experience, which is precisely what these tools measure, as well as the transferability of that information to other similar contexts, which is also a feature of this study.

Indications from the Research

The results from the study are summarised in the Table 7.2 below:

Table 7.2 Results from Effectiveness Measures Related to Research Tool

Research Tool	Specific improvements	Satisfaction with therapist	Global improvements	Satisfaction with primary health involvement
Survey questionnaire	A mean score of 4.43 out of a possible 5, ranking highest of the sections. Open ended questions did not comment on specific problem resolution.	A mean score of 4.38 out of a possible 5, second highest ranking. 6 of 10 responses to open ended questions had positive comments about therapist.	A mean score of 4.15, the lowest ranking of the sections. One of the comments to the open ended questions indicated global improvement.	A mean score of 4.29. Second lowest ranking of the sections. One comment in the open ended questions indicated discomfort with the setting.
Interview	Both interview participants felt their specific concerns were addressed.	Both interview participants commented favourably on rapport with therapist and the therapeutic relationship.	Both interview participants indicated global improvement.	One interview participant found the setting comfortable, the other did not.
Hospital Anxiety and Depression Scale (HAD)	Improvement in the anxiety section of the survey indicates some improvement with specific issues (relaxed, less frightened). The cumulative scores decreasing (indicating improvement) by 14.5 points.		Improvement in the depression section of the survey indicates more marked improvement with more global issues (cheerful, enjoyment). The cumulative scores decreasing (indicating improvement) by 21.5 points.	

These results indicate that most respondents felt their initial concerns were addressed through the counselling experience, and that they generally liked the therapy and therapist. Both of these aspects of counselling are considered important when evaluating outcome, with resolution of the clients' presenting concerns generally felt to be the most

important indicator of outcome (Cone, 2001), with the therapeutic relationship also considered a major indicator of outcome (Lambert, 2004).

The data about accessing counselling in the primary health setting offers some interesting findings. Respondents indicated that they felt comfortable with their General Practitioner and their counsellor working together, but almost half were not comfortable going to the General Practitioners' surgery to participate in counselling, although most considered that it was convenient. Research currently available on this aspect of primary health care counselling is all conducted overseas and indicates that more clients access counselling when it is combined with the familiar environment of the General Practitioners' surgery than when referred by their health care professional to other services for counselling (Fraser et al, 2001; Bor and McCann, 1999; Jackson Bowers et al, 2002). The statistics of the Wanganui Primary Health Care Counselling Service of 81% attendance rate tends to support this, however, what statistics don't show is the comfort level associated with the measurement.

This level of comfort/discomfort was reiterated with the interviews, with one participant feeling uncomfortable at their General Practitioners' surgery, and the other feeling comfortable there, a fifty-fifty split. Often the reasons given for the high attendance rate at primary care associated counselling/therapy is that the General Practice environment offers credibility, familiarity, anonymity and location, as well as being non-stigmatising and having a normalizing effect (Bor and McCann, 1999; Jackson Bowers et al, 2002), however, the findings here seem to indicate that although there is a high attendance rate, there is also discomfort. One of the participants interviewed indicated that this discomfort was due to the lack of anonymity of the General Practitioners' Surgery, as the interviewee was familiar with the reception and auxiliary staff and felt as if the staff all knew that she was having difficulties that required assistance from a counsellor. Given this, her feelings may be more a reflection of the size of the community and the general practice or the training of the staff than a dissenting opinion to the general premises. Current definitions of health and legislative mandate insist that the provision of health services be "universally accessible to people in their communities" (Ministry of Health, 2001), which the provision of counselling in the primary health setting is trying to accomplish, however, this data is indicating that in these particular circumstances, this may not always be the most useful site for addressing this.

Research participants did approve of the multidisciplinary collaboration, also mandated in the Primary Health Care Strategy (2001), with a positive mean score to the statement, "It is good to have my Doctor and Counsellor working together". One of the considerations when developing a model for multidisciplinary collaboration is the issue of confidentiality. Confidentiality is a fundamental ethical principle of most helping relationships and definitely a fundamental ethical principle of counsellors and therapists, as well as medical practitioners; however for social workers, confidentiality is always qualified. The principle of confidentiality in this situation is challenged by the need to share information with the General Practitioner and primary health care team and vice versa. Some view this as an equity issue, with those clients who are able to pay privately for counselling and able to seek it elsewhere being assured of confidentiality, while those clients unable to afford private counselling denied that luxury (Jackson Bowers, et al, 2002). This mode of counselling, having been established with a case management focus, seeks permission from clients for information sharing between the counsellor and the General Practitioner, as well as the primary health care team when appropriate. This is explicitly established at the outset of counselling and negotiated into the verbal contract for the service. The response to the statement about the General Practitioner and counsellor working together validates the practice, despite the equity concerns raised in the literature (Jackson Bowers, et al, 2002).

The lowest ranking category, the 'Effects' category, suggests that even though the primary concerns have been addressed, there is not necessarily a flow on to other aspects of the clients' life. This may well be an indication of the nature of the counselling model, specifically the brief therapeutic interventions that are utilised, with their primary emphasis on the micro systems of the individual. Saleebey (2002, pg. 282) supports this interpretation with his observations contrasting the differences between his strengths based perspective and solution focused or brief therapy approaches, stating that, "Although it (solution focused brief therapy) does not pointedly attend to strengths, it does have an implicit and abiding interest in the strengths of individual and families...And, as yet it (solution focused brief therapy) has not, in my view, really concentrated on the resources and solutions in the environment." His adept observation may well be at least a contributing factor to these findings.

This counselling model is designed to be short term, which aligns it with discussions in the brief therapy literature which indicate that increasingly clients are seeking resolution to specific problems rather than complete personality makeovers, as was a

premise to some previous psychotherapeutic design (Epstein and Brown, 2002; Shiang and Bongar, 1995). Emerging as another characteristic of brief therapy is intermittent care, where clients engage in therapy for short periods, terminate with problem resolution, and then re-enter therapy if the problem reoccurs or other problems develop (Shiang and Bongar, 1995; Epstein and Brown, 2002). This could be the case with this model as well, given that half of the respondents had participated in counselling previously (with one of those having been previously involved in this counselling service), and with the fact that two respondents had re-entered the counselling service between the first and second postings of the survey questionnaires. Even with this being the lowest ranking in the mean scores of the survey data, the 'Effects' category still rated a 4.15 out of a possible 5. This can be seen as a credible rating for this category despite it being the lowest of the four categories. With the median scores all being a 4 or 5 for the four statements in this category it also indicates that flow on is happening for some clients in some situations.

The interviews supported the survey questionnaire findings on the split about the comfort or otherwise of seeing a counsellor at the General Practitioners' Surgery, however both interview participants indicated they were still using techniques learned in counselling which could be indicative of a flow on effect. The data from both interview participants emphasised the importance of rapport as a major aspect in the therapeutic relationship, and they both highlighted the learning done in therapy, and the use of this learning post therapy. The overall experience was a positive, learning one for both interviewees, which highlights several of the components of the model, including the development of good relationships as emphasised in NLP, solution focused brief therapy and strengths based perspectives, as well as learning theory which is a component of the task centred approach. The interviews complemented the quantitative results gathered from the survey questionnaire, by adding qualitative information which provided depth and informed all four aspects of effectiveness being used in this project.

The pre and post counselling assessments were an attempt to identify any change made by the client during the course of counselling. As well as, being a quantitative measure, the assessments showed positive responses to the therapy for both anxiety and depression. As anxiety and depression make up the bulk of the referrals to the counselling service, 53.4% combined (Charuk, 2004), this finding is important. The improvement shown through the pre and post measurements was evident through the

responses to specific problem resolution and the more global wellbeing statements that make up the HADS assessment.

With a 57% (12) response rate from a survey sample of 21, this research project must be kept in context. Due to the sample selection being one of convenience sampling as opposed to random sampling, and given the size of the samples, these results can not be generalized; however, the consistency of the results enhances their transferability to the wider project.

When this study is compared with the *Consumer Report* (Seligman, 1995) survey mentioned previously, we can see both favourable and unfavourable aspects. The Seligman (1995) survey identified several clear cut results from their data, and when applied to this model and these results, some interesting aspects of this model emerge. This counselling model fared favourably with the following results of the Seligman (1995) survey:

- 1 that there is no difference in outcome between psychotherapy alone and psychotherapy and medication, which reinforces the use of psychotherapy for mental health concerns and validates the inclusion of psychotherapy as a treatment provision for clients/patients seeking assistance.
- 2 while all mental health professionals were found to aid their clients, social workers, who are an integral part of this primary health care counselling service, are rated among the most helpful.
- 3 no difference was found between therapeutic modalities, which many see as adding impetus to the common factors theory of counselling/therapy (Drisko, 2004), and which allows for the use of counselling models that reflect aspects of the environment and skills available within the community, with out preference for a specific modality.

This counselling model fared unfavourably with the following results of the Seligman (1995) survey:

- 1 a clear preference for long term counselling/therapy over short term was preferred in the larger study; this is a main point of divergence with the model this study is investigating, which is quite clearly a short term model,
- 2 that barriers to duration of participation in counselling/therapy have a negative effect on counselling; again duration of participation is a feature of the counselling model being studied,
- 3 a lack of choice of therapist has a negative impact on outcome, which can also

be seen as a feature of this model under investigation, however, processes are in place to attempt to mitigate this feature of the model.

The short term nature of the counselling model used by the Wanganui Primary Health Care Counselling Service, as well as limits on duration and lack of choice of therapist are aspects that diverge from the Seligman (1995) results. With the emphasis on short term counselling, some clients may feel this is indeed a barrier, and if referrals by General Practitioner's are made to the counselling service without options for other counselling types being discussed with the client, choice of therapist may be overlooked. However, the service tries to mitigate this situation with the initial appointment used as both an assessment to evaluate client issues as well as an orientation to the service, including a discussion about the appropriateness of otherwise of this service for the clients needs. It is a designated time where other agencies and therapies are considered openly with the client, culminating in the client making an active choice about continued involvement in the Wanganui Primary Care Counselling service if that is agreed to be appropriate.

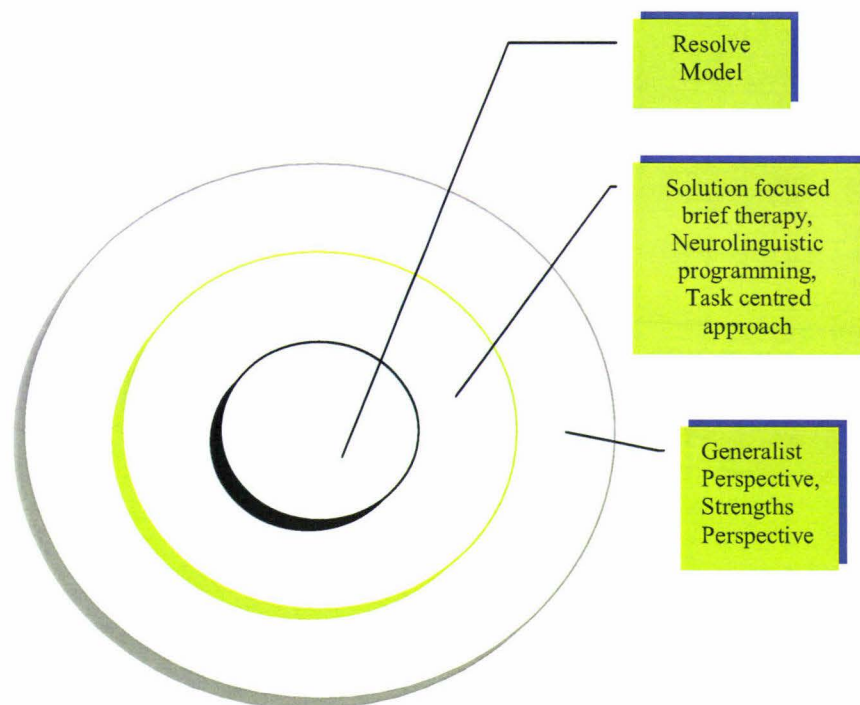
The counselling model used by the Wanganui Primary Health Care Counselling Service, is similar on three of the points and different on three of the points the results from the *Consumer Reports* (Seligman, 1995) study highlighted. The impact of these differences on the effectiveness of this model may indicate the need for further inquiry in these areas.

The Model

Although this research is aimed at examining the effectiveness of the counselling model that was used in the Wanganui Primary Health Care Counselling Service pilot project, the context of the model plays an important part in its development. The context of providing counselling services in primary health care settings created some of the boundaries that the model needed to consider. Specifically, the counselling model needed to be short term, not only in keeping with current trends in therapy (Shiang and Bongar, 1995; Lambert, 2004; Epstein and Brown, 2002), but also to reflect the volume of the work on offer. It also needed to be focused on problem resolution, again for sound therapeutic reasons (de Jong and Berg, 2002; McDermott and O'Connor, 2001), as well as for clear boundaries of case definition and duration.

The model used involves solution focused, strengths based therapy with cognitive interventions which draws heavily on social work theory and practice, with specialist skills in neurolinguistic programming. It is both short term, and focused on problem resolution. It uses the RESOLVE Model (Bolstad, 2001) of service provision, which incorporates all of these elements into the actual process of counselling. Collectively the model grows from the more abstract perspectives to the specific RESOLVE model, including solution focused and task centred interventions along the way.

Figure 7.1 The Counselling Model



With its basis in social work theory and practice, this model does not fit easily into the categories of 'scientific knowledge' that underpin the theoretical orientations found in psychology and proposed by Orlinsky and Howard (1995), as it has elements of several

of the orientations he categorizes. This model includes aspects of his category of cognitive-behavioural therapies with the inclusion of learning theory, as well as aspects of his category of experiential-expressive therapies through the use of guided affective imagery (an important element of NLP techniques), and it also has aspects of his category of strategic-systemic therapies which incorporate communications and social transaction theories.

With the combination of all of these theoretical orientations, this model can be truly seen as eclectic. As such, it is most aligned to the theoretical integration category of eclecticism (Lehmann and Coady, 2001); however it is not attempting to establish a new therapeutic orientation but rather to incorporate the strengths of the perspectives, theories and models that are combined. This category of eclecticism suggests that the integration or combining of the differing orientations is done using the strengths of the different theories to create a more comprehensive explanation or intervention (Lehmann and Coady, 2001). This model does not pretend to be a new model in and of itself, instead it is combining the strengths of several theories and perspectives that fit reasonably well together to explain and empower clients' change and understanding.

Although the elements that make up this model all have similar premises which include the ability of people to change and make changes within their lives, the use of personal resources and focusing on solutions and strengths, as well as active client participation in the change processes that result from the examination of patterns and goals, there have been some differences exposed through this research. This is highlighted in the research results which indicate a limitation of the flow on effects of the counselling into the broader sphere of participants lives. As discussed, while proponents of the strengths perspective view global improvement as an outcome goal of their perspective, the specific nature of problem resolution emphasised by solution focused brief therapy may mitigate this effect (Saleebey, 2002).

With the combination of all the theoretical orientations and the lack of dominance of any one orientation, the common factors debate could be applied. This would suggest that all of the change that has been documented for clients has occurred not because of any particular technique or modality, but because of the pantheoretical or common factors that are present in all therapeutic modalities (Wampold, 2001; Drisko, 2004). This is frequently referred to as the Dodo bird effect (Wampold, 2001).

Certainly the research done on this model fits into this explanation well and screening for these factors may account not only for the improvement shown but also

the high attendance rates and the high levels of satisfaction with the therapists and the therapy. The extratherapeutic effects (Drisko, 2004) are significant to this model, especially the agency context, which was a measured variable within this research. With referrals coming directly from the General Practitioner, the client is informed of a service that is available and is likely to help, a service that is accessible and user-friendly, as well as a service that is affordable. As well as informing clients about the service, General Practitioner's are also in a position to assess for client elements such as family support or lack of it, as well as peer and workplace supports, which may also have a beneficial effect on outcome for the client. General Practitioner's are also in a position for gauging a clients' readiness to change when considering a referral.

The significance of the responses to the survey category about satisfaction with the counsellor as well as the recognition of the rapport between both clients and the therapist in the interviews, suggest that good therapeutic relationships are established, another important element of the common factors. Using this model, the therapist is active in the therapy through the use of NLP and other techniques, which offer the client an explanation of the change process and the experience of actively working toward change. The expectancy element of the common factors is also enhanced by the referrals system, as many clients have presented to their General Practitioner for assistance and are virtually 'prescribed' counselling as the intervention of choice. For many, this enhances the reputation of counselling/therapy and at the same time enhances their expectation for improvement.

New Zealand Models

Turning to the New Zealand primary health care situation, shared care, or the combining of mental health services with primary health services, is a new and growing trend. To date, examples of programs have predominately been locally produced and funded pilot projects proposing unique programmes to bridge the gaps between services. Currently in New Zealand there are no national standards for shared care, so this localised creation of services is a phenomenon that looks set to continue for the meantime (Nelson et al,2003).

While the model this research project explores is utilized in a type of shared care arrangement, it differs from the other pilot projects that have been reported in the Health Research Council's *Evaluation of mental health/primary care shared services* (2003). Most other models focused on liaison between primary and specialist services. This

project, by contrast, focuses on providing treatment for the mild to moderate mental health clients who have in the past not been a priority in either system. The Primary Health Care Counselling Service is just one part of a larger Early Intervention project that includes liaison between primary and specialist care within the primary care setting, as well as a social work programme which offers services to clients with multiple needs including, but not exclusively, mental health needs. The service is currently working with local iwi to support the development of a Kaupapa Maori early intervention service as well, in a form that is appropriate for Maori, in order to be able to provide a choice for all clients. Although this research is exploring only one aspect of a larger service, it appears to be a unique aspect which is community designed and owned, in keeping with the definitions of health care mandated by the government (Ministry of Health, 2001).

Funding is frequently an issue for local projects (Nelson et al, 2003), and this is no exception. Staff support can also be an issue for developing programmes and services. This model of service most closely resembles the models in practice in the United Kingdom (Wiener and Sher, 1998; Bor and McCann, 1999; Campbell, 2000), where counsellors are incorporated into the primary health care setting. With the growth of this model of early intervention for mental health in the UK, many of these issues have had to be addressed, including the 'professionalization' of the counselling/therapy providers through the formation their own organisation and the standardisation of their employment (Wiener and Sher, 1998; Einzig and Curtis-Jenkins, 1995).

Currently, New Zealand's primary health care access is good (Schoen et al, 2004), but the partial payment by clients for each visit, can be seen as a barrier to treatment for ongoing mental, or indeed other chronic conditions. This situation is presently providing a financial incentive for mental health clients to access services through the specialist mental health services rather than through primary care. With the specialist services primarily mandated to provide treatment of the 3% of the population which suffer from severe mental disorders (Ministry of Health, 2002), people with less severe mental health concerns accessing their service puts an added strain on that service. With the prevalence of mental health concerns currently estimated at 20% of the New Zealand population (Ministry of Health, 2002) and with estimated increases in this burden worldwide (World Health Organisation, 2004), this is an area that needs to be addressed. With the implementation of population funding through the Primary Health Organisations that were mandated through the Health and Disability Act 2000, the mechanisms are in place for improved funding for both clients and providers and may

provide the incentives necessary for more appropriate structures to cater for many of the more chronic health conditions, including mental health.

The Research Methodology

This research must be placed in the context of several debates that have an impact on the implications that can be drawn from the results as well as the application of these results. These debates involve the issues of effectiveness and its measurement, as well as evidence based practice and knowledge development.

This research, being undertaken in a health environment, without the use of randomised controlled trials may immediately arouse suspicion for some. The 'gold standard' for research within the medical model is the randomised controlled trial, which is generally part of efficacy research (Seligman, 1995; Hemmings, 2000). Efficacy studies are regarded as the standard for establishing empirical validation, a term increasing necessary to gain funding agency approval. While efficacy studies are useful in comparing different treatments in highly controlled situations, they do little to inform practice in the 'real world' situations where most practitioners find themselves. Increasingly, there is a call for effectiveness studies to be used when examining the use of psychotherapy, as it is felt psychotherapy needs to be tested in 'real world' situations rather than artificially controlled environments (Seligman, 1995; Hemmings, 2000).

This highlights some of the differences between in the medical model and the biopsychosocial model of health. Where the medical model values the scientifically controlled, reductionist elements inherent in randomised controlled trials, the biopsychosocial model values the all encompassing, self-correcting methods of the 'real world' study. This may also signal some of the shifts that may be beginning to occur as the primary health system moves from the delivery of primary medical care to the provision of primary health care.

The debate over efficacy or effectiveness leads to and is in part driven by the debate for evidence based practice, another catch phrase that is attracting the attention of funding agencies. This debate encompasses the nature of knowledge and its forms of generation (Fook in Smith, 2004). As we question the reductionist, modernist thinking that has consistently upheld generalisable, tested theory which was developed through 'scientific research', and begin to value the knowledge that is generated and modified through experience in the 'real world', we begin to question professional knowledge and professional dominance. The response to this has required professionals to be

transparent and accountable in their operation, hence the demand for evidence based practice. However, this push has not defined what evidence based practice is, or what constitutes evidence. But it is generally accepted, that evidence based practice is “professional practice that this based on the best available knowledge of what constitutes effective methods” (Fook in Smith, 2004, pg. 33).

This brings us back to the debate about which approaches to research are most useful and relevant. Fook (Smith, 2004, pg. 34) sums the situation up well, stating: “What professionals need therefore in the current environment is a legitimate form of knowledge, and legitimate forms of generating knowledge, which allow for effective and responsive practice in changing, complex and uncertain environments”. Fook (2004) goes on to suggest that the way professionals do this is by recognizing the context of the situations they work within, and therefore create knowledge and theory that is relevant to that context and to the changing contexts of practice. And it is the transferability of this knowledge within the context and the changing contexts they encounter that is relevant, rather than generalisable knowledge.

This research design reflects several of the elements of these debates. It is an effectiveness study which emphasises the experience of the participants, acknowledging the ‘real world’ environment of primary health care counselling. Combining elements of social work perspectives and theories, the model is based on validated elements, lending itself loosely to the definition of evidence based practice. The research design does not lend itself to generalisable knowledge, but it does take account of the context the model is used within and lends itself to transferability as described by Fook (Smith, 2004).

So, although this research is not large enough nor does it employ a selection criteria that would allow generalisable knowledge creation, it does have relevance to the situation it is researching. As Roth and Fonagy suggest “It is important to have a formulation of evidence based practice that does justice to the complexity and addresses the interplay between different elements of the system” (2005, pgs.54-55). The use of triangulation of both quantitative and qualitative research methods, as well as the attention to context within which the research is being undertaken, allow for transferability of knowledge which contributes to the notion of relevance and informs effectiveness.

Key Findings

The results from the research suggest that the clients are supportive of the counselling model. As a group, their attendance rate is high, and the survey questionnaire and the interviews both tell the same story of benefits gained through attending counselling. The pre and post measurement results also corroborate the finding of the counselling being beneficial. The literature suggests that extratherapeutic features such as client initiation and choice of therapist impact on the satisfaction rates. With these features being ambiguous in this setting, one can not surmise the impact these features played in this situation. Despite that, one can conclude that this model is meeting the needs of the clients who have accessed it.

Waiting times and cost were factors that were mentioned in the open ended questions on the survey questionnaire. These are factors which clearly impacted the experience of accessing counselling for individual clients and may offer some direction in shaping the service further. Both factors are variables that fluctuate depending on available resources, and highlight some of the problems encountered in programme trials and pilot projects such as this.

There was indication from the research that although the General Practitioner's surgery was a convenient place to participate in counselling, it was not always a comfortable place for clients. The results may be a reflection of the size of the community or the need for staff training, amongst other things, however this discomfort factor warrants further investigation. These results, while not differing from the literature on statistical terms (response rate), adds information to the premise that the familiar, convenient, non-stigmatising environment of primary health promotes attendance. This research suggests while that it may indeed be true that attendance is high, the feelings about accessing counselling in that setting may have negative connotations for some.

The results from all the research tools indicate an overall positive response from the clients who have accessed the service and responded to the request to participate in the research. Although the response rate was low across all the research tools used, the consistency of the information can not be overlooked. However, we must also acknowledge the findings from this research that indicate that a flow on effect from problem resolution to global improvement may not occur. This may be a feature of the 'brief' type of therapy that this model utilises or it may be specific to the combination of elements that constitute this model, either way, this aspect of this model needs to be

acknowledged. Even with this recognition, given the above average response ratings to the effectiveness measures, including global improvement, as well as the change measurements, this model appears to be a sound model to implement in primary health care settings.

Having a successful counselling model in the pilot project overcomes one of the hurdles in the creation of an ongoing service. As the Whanganui Regional Primary Health Organization reviews this counselling pilot scheme, it may find this research of use in determining the value of the project. Given the positive research results about the model, one of the variables which needs to be considered when evaluating the larger project has been addressed. Recognizing this research as Roth and Fonagy (2005) suggest, as a phase of psychotherapeutic development that is designed as small scale and exploratory but which may lead on to further research provides an appropriate context.

CHAPTER 8

CONCLUSION

Each research project requires different combinations of knowledge to inform the question being explored, as well as the actual research being undertaken. Gleaning relevant information from sources dedicated to similar fields of knowledge which inform part but not all of the research, and accurately representing them while tying them into the research project, is an art. It is this art of explaining and making sense of the influences that impact on the research as well as highlighting the gaps in available information that validates the need for the exploration of this particular research question. It is an art that hopefully is gained from experience.

Research Question

Exploring the effectiveness of short term, solution focused, strengths based therapy with cognitive interventions in the primary health care setting required an understanding of many, seemingly quite divergent fields of knowledge. Undertaking an effectiveness study such as this, implies certain boundaries and certain directions in order to draw a conclusion, however it does not limit the influencing fields that impact on the research question. These have included information about primary health care and its underpinning paradigms and structures, the interface of mental health care and primary health care, the provision of therapy or counselling and the players involved, the measurement of effectiveness itself and specifically within this context, the theoretical base for the combination of the components that make up the counselling model, as well as an understanding of the wider influences happening on micro, meso and macro levels that converged to allow this project to occur and flourish.

The purpose of this research was to ascertain whether this counselling model of short term, solution focused, strengths based therapy with cognitive interventions was effective for the clients that present for counselling in primary health care settings. The emphasis for this research and the research tools were therefore centred on the experience of the client. With an understanding of the purpose, the measurements of

effectiveness could be defined. It is these effectiveness measurements that allow us to draw a conclusion, which is indeed a goal of any effectiveness study.

Conclusions From the Research

The effectiveness measurements which were used in this research project were modelled on a much larger study of counselling effectiveness done by *Consumer Report* magazine in the United States in 1995 (Seligman, 1995). The suggestions from that study indicate that counselling effectiveness should measure:

- specific improvement,
- satisfaction with the therapist and treatment, and
- global improvement (Seligman, 1995; Hemmings, 2000).

As well as these aspects of effectiveness, this research question also included a specific setting, that of primary health care, which was also included as variable to measure.

Using both quantitative and qualitative research methods, the experiences of some clients receiving counselling in the primary health care setting were explored. The findings were overall very positive for the counselling model, with all the ratings averaging between a 4.15 and a 4.43 out of a possible 5 score, using a Likert type questionnaire administered through a survey. These findings were supported by client improvement post counselling, which was evident through pre and post counselling measurements. As well, the findings were also consistent with the opinions expressed in the interviews of clients, which were also a feature of the research design.

The research results, while positive, also highlighted some unique features of this counselling experience. Two areas in particular stand out, the first is around the area of comfort with participating in counselling in the General Practitioner's surgery, and the second is around the global wellbeing aspect of counselling for clients. Both of these findings indicate a need for further research in these particular areas.

The first aspect, that of client comfort or otherwise of participating in counselling in the primary health care setting seems at odds with literature from other countries. This literature suggests that providing counselling in the primary care setting actually increases client participation rates by utilising an environment that has credibility, familiarity, anonymity and location, as well as being non-stigmatising and having a normalizing effect (Bor and McCann, 1999; Fraser et al, 2001; Jackson Bowers et al, 2002). Literature also suggests that the lack of confidentiality in counselling because of

the case management model of collaboration between the General Practitioner and the counsellor may be an issue (Jackson Bowers, et al, 2002), however, neither of these seem to be the case here. While most participants reported being comfortable with their General Practitioner and their Counsellor working together, it was the setting that seem to be the issue. This view was corroborated with both the survey questionnaire and the interviews; it was not measured in the pre and post counselling measurements.

The Likert measurement in the survey questionnaire contained four statements about participating in counselling at the General Practitioners' surgery which allows a breakdown of this result. This section of the survey questionnaire was the second lowest ranking of the sections. The statements in this section of the survey questionnaire rated the General Practitioner and counsellor working together as the highest, followed by the convenience of the General Practitioners' surgery. The statement rating whether the General Practitioner and counsellor working together made sense to the client was the third highest ranking statement out of the four, with the lowest ranking statement being about feeling comfortable going to a counsellor at the General Practitioners' surgery. One of the responses to the open ended questions at the end of the survey questionnaire addressed this directly stating that the participant 'felt uncomfortable' waiting at the surgery as it was 'public' and this person felt other people would know why they were there. This was also reiterated in one of the interviews with an interviewee expressing much the same opinion.

These responses are not reflected in any of the literature that has supported this research project, and signal a need for further exploration. These responses could be a reflection of the size of the community or the size and familiarity of the primary health care practice, or indeed a need for further staff training. Whatever the reason, if this is creating a barrier to participating in counselling for some clients, it is worth exploring further.

The second aspect of this research that needs further investigation is that of the flow on effect of the counselling being done. This is measured through the global wellbeing section in the effectiveness measures. This aspect speaks directly to the model that is being explored, and may therefore, indicate the need for a revision of or an adjustment to the model. This section ranked the lowest of the sections in the survey questionnaire, and again has four statements that allows for a further examination of the result. The statements about feeling more in control and feeling better about oneself were the highest ranking statements in this section, followed by a statement about the counselling

assisting with developing skills to cope with issues. The lowest ranking statement, a statement about feeling more able to cope with most aspects of ones life following counselling sums up this lack of flow on effect.

The lack of flow on from problem resolution to global wellbeing is a concern for the model, and one that must be investigated further. However, the model must also be taken in the context of which it is being used, and the boundaries that the context imposes. The short term nature of the counselling involvement with the emphasis on specific problem resolution is perhaps the biggest determining factor for this aspect. The availability of the counselling service and the opportunity to re-engage with the service at a later date may also be contributing to these results. This is discussed in the literature about brief therapy, being an example of 'intermittent care' where clients engage in counselling for specific problem resolution and re-engage at a later date if the issues return or others develop (Epstein and Brown, 2002; Shiang and Bongar, 1995).

These two aspects that were highlighted through this research project both deserve follow-up so that the results can be understood and if necessary changes made to the model and/or the setting to make them more useful. However, when taken as a whole, the counselling model in the setting rated credibly. The survey questionnaire results rating problem resolution and satisfaction with the therapist and the techniques used as the highest, confirm that the model is useful. This combined with the predominantly positive interview responses and the improvement evidenced with the pre and post counselling measurements, lead to the conclusion that the model is effective in this particular setting.

Conclusions About the Research

Incorporating both quantitative and qualitative research methods into a project allows for a robust and hopefully thorough exploration of the subject being researched. Through triangulation, the results can be combined offering an holistic picture and understanding. Mixed methodology research designs that incorporate tools from both methods allow for evidence from both statistical means and experience, which theoretically adds breadth and depth to the findings, and strengthens the conclusion.

This research project, with its mixed methodology design attempted to do just that, and did indeed incorporate both quantitative tools through the use of the survey questionnaire and the pre and post counselling measurements, and qualitative tools through the use of open-ended questions and interviews. The size of the research project

was a variable that impacted on the results from each however, and a variable that was not widely considered when designing the project.

It must be acknowledged that with the small scale of this research, it can really only be viewed as a case study of the counselling model being explored. One of the strengths of the study, the mixed methodology design, can also be viewed as one of the limiting factors, in that incorporating several different research tools limited their size to what time and resources allowed. While the mixed methodology offered different means to data collection, the energy and effort for the research was fragmented into smaller parts. One wonders if in a research project of this size, it might be more beneficial to limit the number of research tools and concentrate on generating the data from fewer larger samples rather than more smaller ones. However, on the positive side, the consistency of the data across all the research tools adds to the credibility of the information, especially when considered in the post modern influenced, constructivist paradigm which values transferability of knowledge and knowledge generation (Fook, 2004).

The research focus on the experience of the client is another variable of the research design that deserves mention, as it provides a very narrow viewpoint. While focusing on just one perspective of the counselling experience offers depth to that perspective, it is limiting in tying this model into a larger whole. That this model is effective for the research participants is a good and necessary starting point, however, the perspectives of others involved with the counselling project, such as referrers, funders and providers, are also important. They, too, have perspectives which speak to the effectiveness of this model. The research question, how effective is the provision of short term, solution focused, strengths based therapy with cognitive interventions in the primary health care setting has been answered from the participants perspective, the next logical step would be to broaden the scope and begin to get answers from the other perspectives involved. Is the model effective for the counsellors who are using it? Is the model effective for the General Practitioner's who are referring to it? Has the incorporation of this model in the primary care setting had any measurable flow on benefits to variables such as:

- a reduction in General Practitioner consults for counselling clients?
- fewer referrals to secondary mental health services?
- reduced costs in the management of clients involved in the service?

These are all questions that are important when placing this model into the broader context, and definitely an area for further research. This may indeed require a

exploration of the whole primary care mental health project of which the Primary Care Counselling Service, who developed and utilize this counselling model, are a part.

Recommendations

The recommendations therefore reflect the findings from both the conclusions drawn *from* the research and the conclusions drawn *about* the research. Both suggest further paths that would add to and enhance this initial research. These include:

- further research into the comfort or otherwise of incorporating counselling into the primary care environment, specifically exploring the nature of the discomfort expressed and investigating ways of mitigating the discomfort;
- further research into the flow on effect from problem resolution to global well-being of the counselling that is being provided, measuring if global improvement is what clients are seeking and if so, whether amending the model can improve this variable of effectiveness,
- research into the effects of the counselling model on other participants of the scheme, such as referrers (General Practitioner's and Practice Nurses), funders (District Health Boards, Government departments and PHO), and providers (the counsellors);
- research into the whole programme of which the counselling service is a part, exploring the impact of this programme on variables such as General Practitioner consultations for clients involved in the service, referrals to secondary and community mental health services, as well as the costs involved for clients of the service, among others.

Learnings

With research hopefully comes learning, not necessarily where or what one thinks it might be, but learning nonetheless. For me on my journey there was one learning in particular that stood out, the answer to my overriding goal of whether what I was practicing was valid and beneficial for the situation. It was very pleasing, then, to unpack the layers of a project that evolved in 'real time, real world' circumstances and find that it *is* theoretically sound, structurally integrated, and effective.

It was also very pleasing to discover that one of the strengths of the counselling model design is that while it informs the counselling practice that is currently being

delivered through the counselling service, it can be adapted to incorporate other theories and techniques as well, particularly in the 'cognitive interventions' aspect of the model. As the counselling service grows, the model can incorporate the skills and strengths of other clinical social workers who work from the social work paradigm with other specific counselling skills and techniques. But the characteristic I value the most is that this model allows for growth within the counsellors who are working with it, as well as within the clients who participate in it. It has space for more learnings and new meanings to be incorporated as they develop out of the unique, individual client processes that are part of every case, for both the client and the counsellor. It is expansive within a structure that encourages and allows for the acquisition of more skills and techniques, and the growth that so often is a part of this type of involvement.

This journey has been a valuable and life changing experience for me. Having the opportunity to focus on my own professional and personal goals and begin to find answers has been very rewarding. From a professional viewpoint, exploring the effectiveness of a model of practice while using it has been incredibly challenging, but the validation that has come with the research is unbelievably rewarding. From a personal viewpoint, finding my fit in the fields of social work, counselling and psychotherapy has been a relief, and has given me a sense of groundedness and confidence that sustains me and flows into all aspects of my life.

Knowing that this part of the journey is nearing an end, it is pleasing to know that there are other paths to explore and other dimensions to investigate, which indicates to me that the model and project are both dynamic and continue to be valid. It is also pleasing to know that the primary care counselling service, which uses the model, is being expanded beyond the initial pilot practices to all of the primary health sites in the Whanganui Regional Primary Health Organization, and is being supported by other government departments. That the model is effective is not only validated through the research, but also by the support it is receiving.

Appendix A

NATIONAL APPLICATION FORM FOR ETHICAL APPROVAL OF A RESEARCH PROJECT

PART I : BASIC INFORMATION

Protocol number and date
received (for office use only)

1. Full project title

Holistic Health: The Effectiveness of a Counselling Model in a Primary Health Setting

2. Short project title (lay title)

Counselling Model Effectiveness

3. Lead Principal Investigator's name and position

Cindy Gibbs, MSW Student, Massey University

4. Address of lead Investigator

PO Box 3	Work phone No.	06 388 0940
TAIHAPE	Emergency No.*	
	Fax	06 388 0940
	E-mail	lazygranch@ihug.co.nz

5. Lead investigator's qualifications and experience in past 5 years (relevant to proposed research)

The research is being undertaken as partial fulfilment of the requirements for the Master of Social Work degree through Massey University, Palmerston North. The researcher has a Bachelor of Social Work degree, and has worked as a Community Health Social Worker in Taihape and the Waimarino for 3 ½ years, and is currently working as a counsellor in primary health care settings (1 year). She is also involved in providing Supervision to several health professionals in the Taihape area.

6. Co-investigators' name(s) and position(s) or, if multicentre, Principal Investigator at each site

A	N/A
B	
C	
D	

7. Address of co-investigator A

N/A	Work phone No.	
	Emergency No.*	
	Fax	
	E-mail	

8. Address of co-investigator B

N/A	Work phone No.	
	Emergency No.*	
	Fax	
	E-mail	

9. Address of co-investigator C

N/A	Work phone No.	
	Emergency No.*	
	Fax	
	E-mail	

10. Address of co-investigator D

N/A	Work phone No.	
	Emergency No.*	
	Fax	
	E-mail	

(* option for Committee's information only)

11. Where this is supervised work

- 11.1 Supervisor's name
Position
Day time phone number

Dr. Mary Nash	Kieran O'Donoghue
Senior Lecturer	Lecturer
06 350 5799 x 2827	06 350 5799 x 2818

- 11.2 Signature of supervisor (where relevant)
Declaration: I take responsibility for all ethical aspects of the project

Mary Nash *Kieran O'Donoghue*

12. List any other New Zealand Ethics Committees to which this project has been submitted and attach their letters of approval where available

Massey University Ethics Committee

13. I wish the protocol to be heard in a closed meeting
If the answer is yes, provide reason why you wish it to be heard in a closed meeting

<input type="checkbox"/>	Yes	<input checked="" type="checkbox"/>	X	<input type="checkbox"/>	No

14. Proposed starting date (dd/mm/yy)
15. Proposed finishing date (dd/mm/yy)
16. Duration of project (mm/yy)
17. Proposed final report date (mm/yy)

01/02/04
31/07/04
6 months
11/04

PART II : PROJECT SUMMARY

1. Multicentre proposals

(Important: read the guidelines, Appendix 1)

1.1 Is this a multicentre study? (if no, go to question 2) Yes No

1.2 If yes, name the primary ethics committee for New Zealand

1.3 Has the protocol been submitted to any other ethics committees in New Zealand? (If yes, attach copies of relevant correspondence) Yes No

1.4 Who is the lead investigator or institution in New Zealand?

1.5 List the other New Zealand sites involved

1.6 Have the Principal Investigators from secondary sites agreed to participate? (attach copies of signed Part V Declaration for each site) Yes No

1.7 If the study is based overseas, which countries are involved?

2. Gene Studies

Does this research involve any gene or genetic studies? Yes No

If yes, complete section 16.

3. Scientific Assessment

Has this project been scientifically assessed by independent review? Yes No

If yes, by whom? (name and position)

A copy of the report should also be attached

If no, is it intended to have the project scientifically assessed, and by whom?

It is not intended to have the project scientifically assessed.

4. Data and Safety Monitoring Board (DSMB)

3.1 Is the trial being reviewed by a data and safety monitoring board? Yes No
If yes, who is the funder of the DSMB? Sponsor HRC

5. Summary

Give a brief summary of the study (not more than 200 words, in lay language)

The study will explore the effectiveness of the specific counselling model that is being implemented in the primary health setting in Wanganui. Effectiveness will be measured using three different methods. Initially by survey, in which an anonymous questionnaire will be given to clients who complete counselling over the course of up to two months. Up to thirty (30) survey questionnaires are proposed to be distributed. Secondly, an attachment to the survey will invite clients to participate in a one to one interview with the aim to gather more in depth information about their counselling experience. Up to ten interviews are proposed to be undertaken. Thirdly, a standardized measurement tool (Hospital Anxiety and Depression Scale) will be administered in up to ten cases on entrance to the service and on completion of the counselling, in an effort to gauge change.

PART III : PROJECT DETAILS

SCIENTIFIC BASIS

1. Aims of Project

1.1 What is the hypothesis/research question(s)? (state briefly)

How effective is the provision of short term, solution focused, strengths based therapy with cognitive interventions in the primary health care setting?

1.2 What are the specific aims of the project?

To measure the effectiveness of this specific integrative therapeutic model in the primary health care setting in an effort to improve services.

2. Scientific Background of the Research

Describe the scientific basis of the project (300 words maximum). Where this space is inadequate, continue on a separate sheet of paper. *Do not* delete page breaks or renumber pages.

This study is an effectiveness study to examine a specific therapeutic model in a specific setting. As with any program evaluation, the aim is to understand the variables and evaluate the need for change. Program evaluation needs to measure both the outcome and the process. To do this both quantitative and qualitative measures will be used. It is proposed to measure the outcome with a survey, asking clients to self report, as well as using an entrance and exit measure. Process will be measured through the survey and in more depth through interviews with clients willing to participate. The survey will use a non-probability sample, and will examine the associative relationships between variables using a computer programme similar to the Statistical Package for the Social Services or the SAS to analysis the data. The interviews will be analysed using content analysis.

3. Participants

3.1 How many participants is it intended to recruit?	<ol style="list-style-type: none"> 1. Survey approximately 30 2. Interviews up to 10 3. Entrance and Exit Measure up to 10
3.2 How will potential participants be identified?	Clients who present for counselling through the Progressive Health (NZ) Inc. counselling service over a defined period of time (up to two months).
3.3 How will participants be recruited? (e.g. advertisements, notices)	<ol style="list-style-type: none"> 1. Survey – The survey will be distributed to all clients who complete counselling over the period of up to two months. 2. Interviews – Attached to the survey will be an invitation to participate in a one to one interview with the researcher. 3. Entrance and Exit Measure - Some clients will be directly approached at the commencement of counselling by a therapist not involved the research and invited to participate in an entrance and exit measure. This therapist will be directly approached through a letter (attached) by the researcher to participate in the study in this way.
3.3.1 Where will potential participants be approached? (e.g. outpatient clinic) If appropriate, describe by type (e.g. students)	Clients presenting for counselling in the participating Health Centres and GP Surgeries in Wanganui.
3.3.2 Who will make the initial approach to potential participants?	<ol style="list-style-type: none"> 1. Surveys – Surveys will be distributed by both therapists when clients have completed counselling. 2. Interviews - An invitation is attached to the survey for interested participants to fill out. 3. Entrance and Exit Measures – The therapist not involved in the research will approach potential participants at the commencement of counselling.
3.3.3 Is there any special relationship between the participants and the researchers? e.g. doctor/patient, student/teacher	<ol style="list-style-type: none"> 1. Survey – Therapist and clients who have completed contact with the service, many of whom will have been counselled by the other counsellor. 2. Interviews – Therapist and clients I have counselled and/or clients counselled by the other counsellor. 3. Entrance and Exit Measures – Only clients receiving counselling from the other therapist not involved in the research. <p>Collegial relationship between the researcher and the other therapist.</p>
3.4 Briefly describe the inclusion/ exclusion criteria and include the relevant page number(s) of the protocol or investigator's brochure	<ol style="list-style-type: none"> 1. Survey - The survey will be offered to every client seen by the service within a two month period. As some clients may be seen more than once in the two month period, they will only be offered the survey on the completion of their involvement with the service during the survey time period. Participation is voluntary.

2. Interviews - The interviews will be on a 'first come first serve' basis, with a limit of up to ten.

3. Entrance and Exit Measures - The entrance and exit measure will again be on a 'first come first serve' basis for clients who are referred for depression and/or anxiety. As clients are referred by their GP's for a wide variety of reasons, only those written referrals that indicate depression and/or anxiety will be approached, and only those referred for these reasons to the therapist that has been recruited to assist with the research.

3.5 If randomisation is used, explain how this will be done

N/A

4. Study Design

4.1 Describe the study design. Where this space is inadequate, continue on a separate sheet of paper. *Do not delete page breaks or renumber pages.*

The study is designed to use both qualitative and quantitative research methods. An anonymous survey will be offered to all clients on completion of their involvement with the counselling service over a period of two months. The sample is one of convenience and is not randomised. An invitation for an interview will be attached to the survey, with a separate response procedure and envelope. The interview will be arranged between the researcher and the participant at a convenient time and place, with the aim to gather more in depth information about the counselling experience. Entrance and exit measurements will be utilised in up to ten cases that meet the inclusion criteria to measure whether change has occurred.

4.2 How many visits/admissions of participants will this project involve? Give also an estimate of total time involved for participants.

Apart from the interviews, this project will involve no more visits than would normally be assessed and negotiated between the client and therapist. For this service, this is generally between 4 and 8 sessions. Interviews are expected to take up to one hour at a separate place and time.

4.3 Describe any methods for obtaining information. Attach questionnaires and interview guidelines.

1. Survey – A questionnaire specifically designed for this study will be used, a copy is attached.
2. Interviews – Interviews will follow a brief interview schedule, a copy is attached.
3. Entrance and Exit Measure – The Hospital Anxiety and Depression Scale will be used to measure any change, a copy is attached.

4.4 Who will carry out the research procedures?

1. Survey – The questionnaire is self-administered.
2. Interviews – Interviews will be undertaken by myself.
3. Entrance and Exit Measures – The Hospital Anxiety and Depression Scale will be administered by the other therapist, Barbara Charuk (pending her agreement).

4.5 Where will the research procedures take place?

In the place of practice, which are various Health Centres and GP Surgeries in Wanganui, New Zealand. An office the therapists use separate from the Health Centres and Surgeries is also available. Interviews will be conducted where it is convenient for and negotiated with the participant.

4.6 If blood, tissue or body fluid samples are to be obtained, state type, use, access to, frequency, number of samples, total volume, means of storage and labelling, length of proposed storage and method of disposal.

N/A

4.7 Will data or other information be stored for later use in a future study? Yes No

If yes, explain how

The data will be stored in a locked filing cabinet in my home for up to five years, in accordance with Massey University Policy of Research Practice.

4.8 Will any samples go out of New Zealand? Yes No

If so where, and for what purpose?

5. Research Methods and Procedures

5.1 Is the method of analysis : quantitative or qualitative?

If the method of analysis is qualitative, go to question 5.2.

If the method of analysis is **wholly or partly quantitative**, complete the following :

5.1.1 Describe the statistical method that will be used

Attention will be paid to means, frequency distributions, and cross tabulations with chi squares. This will be carried out with a computer programme similar to the Statistical Package for the Social Services.

5.1.2 Has specialist statistical advice been obtained? Yes No

If yes, from whom?

(A brief statistical report should be included if appropriate)

5.1.3 Give a justification for the number of research participants proposed, using appropriate power calculations.

The sample is one of convenience and is proposed to be taken over a maximum of two months. There are 84 counselling sessions available per month, of which many will be with ongoing clients and some will be 'no shows'. It is proposed to give out 30 questionnaires (the service averaged 23 cases per month over the past 12 months) and interview up to ten participants and do entrance and exit measures on up to a further ten cases.

5.1.4 What are the criteria for terminating the study?

The study will be terminated when 30 questionnaires have been distributed, and at the completion of two months from the start date for the recruitment of cases to use entrance and exit measures. The termination criteria for the interviews will be when they have been completed as they are dependent on arranging a suitable place and time for participants. It is envisaged that the research will begin in February 2004 and be completed (including interviews) by June 2004.

- 5.2 If the method of analysis is **wholly or partly qualitative**, specify the method. Why is this method appropriate? If interviews are to be used include the general areas around which they will be based. Copies of any questionnaires that will be used should be appended.

It is proposed to use interviews to gain a more in depth understanding of the therapy process for participants. The interviews will explore the participants' experience of the therapeutic experience, the results, their feelings about the model and recommendations. An interview schedule is attached.

6. Risks and benefits

- 6.1 What are the benefits to research participants of taking part?

The survey and the interview offer an opportunity for clients to more fully explore their experience with the therapeutic process which may in itself have a therapeutic benefit. The entrance and exit measurement offer a standardised measure of change which may also be useful for participants.

- 6.2 How do the research procedures differ from standard treatment procedures?

Research procedures include a survey and further participation through an interview if the participant chooses. It also requires an entrance and exit measurement for some cases which is not routinely used.

- 6.3 What are the physical or psychological risks, or side effects to participants or third parties? Describe what action will be taken to minimise any such risks or side effects.

1. Survey – No risk
2. Interviews – Interviews could potentially be emotionally uncomfortable for participants. The interviewer will be monitoring the situation to detect levels of discomfort, and will discuss this with the client at the outset of the interview. The information sheet lists participants' rights to discontinue the interview at any time, and this will be reiterated to the participants at the outset. Should distress occur, the researcher will discontinue the interview, comfort the participant, investigate what immediate assistance the participant would like, and ensure that the participant is safe and referrals made for follow up assistance if the participant wishes. Arrangements have been made for a free follow up session with a local Psychologist if the participant feels this would be beneficial.
3. Entrance and Exit Measures – This could also be potentially disturbing to clients, if concern is expressed, it will most probably be within the counselling session and will be addressed by the therapist at the time.

- 6.4 What arrangements will be made for monitoring and detecting adverse outcomes?

Observation by the therapists and the researcher during the administration of the research procedures. The General Practitioners and their Practice Nurses will be aware that the study is taking place and will be aware of their referrals. The researcher is available for contact during the evenings and referral information for other counselling services will be available for participants should they require these. The researcher has made arrangements for a free follow up session with a local Psychologist if the need arises.

- 6.5 Will any potential toxins, mutagens or teratogens be used?

Yes No

If yes, specify and outline the justification for their use

6.6 Will any radiation or radioactive substances be used? Yes No

Note: If any form of radiation is being used please answer the following. If no, go to question 6.8

6.6.1 Under whose license is the radiation being used?

6.6.2 Has the National Radiation Laboratory (NRL) risk assessment been completed?

Yes No

If yes, please enclose a copy of the risk assessment, and the contact name and phone number

If no, please explain why

6.7 What facilities/procedures and personnel are there for dealing with emergencies?

6.8 Will any drugs be administered for the purposes of this study? Yes No

If yes is SCOTT approval required?

Yes No

Has SCOTT approval been given? (please attach)

Yes No

7. Expected outcomes or impacts of research

7.1 What is the potential significance of this project for improved health care?

New Zealand is embarking on providing multidisciplinary care at the primary health level. This study examines the effectiveness of one programme that is attempting to do this. This information may contribute to identifying effectiveness with similar programmes in similar settings.

7.2 What is the potential significance of this project for the advancement of knowledge?

Many therapeutic models are integrative in their approach, however most have not been researched. This particular integrative model has not been previously researched in the primary health care setting in Aotearoa New Zealand so information about its effectiveness will be useful. It is also a robust model that is readily available to many social work practitioners, so if it is shown to be effective, it may be useful for advancing social work knowledge.

7.3 What steps will be taken to disseminate the research results?

An article in the Social Work Review, with a circulation of approximately 1500 members of the Aotearoa New Zealand Association of Social Workers is proposed, as well as a conference presentation on the use of this model in primary health in New Zealand.

PART IV: BUDGET AND USE OF RESOURCES

8. Budget

8.1 How will the project be funded?

By the researcher, as well an application to the Massey University Graduate Research fund to cover the cost of statistical assistance.

8.2 Does the researcher, the host department or the host institution, have any financial interest in the outcome of this research? Please give details.

The researcher is currently a paid provider of the service being evaluated. Ongoing funding for the service may be assisted or not by the results of the study.

8.3 Will the researcher personally receive payment according to the number of participants recruited, or a lump sum payment, or any other benefit to conduct the study? If so, please specify:

No

8.4 What other research studies is the lead investigator currently involved with?

None

9. Resource Implications

9.1 Does the study involve the use of healthcare resources?

Yes No

If yes, please specify:

The counselling service is subsidised by the Independent Practitioners Association and is undertaken in the Health Centres and Surgeries of the General Practitioners.

9.2 What effect will this use of resources have on waiting list times for patients ie., for diagnostic tests or for standard treatments?

None

10. Financial Costs and Payments to Participants

10.1 Will there be any financial cost to the participant? Give examples including travel.

1. Survey - No cost
2. Interviews – Potentially the cost of travel to the interview venue depending on where the venue is that the researcher and participant negotiate.
3. Entrance and Exit Measures – No cost for the administration of the Hospital Anxiety and Depression Scale, but regular charges apply for the counselling (First session free, subsequent sessions \$5-\$20 for Community Card holders, \$20-\$40 for non-card holders; sliding scale at clients discretion within those limits). The counselling per se, is not part of the research.

10.2 Will the study drug/treatment continue to be available to the participant after the study ends? Yes No N/a

If yes, will there be a cost, and how will this be met? Yes No

The cost is the same with or without the study.

10.3 Will any payments be made to participants or will they gain materially in other ways from participating in this project? Yes No

If yes, please supply details

11. Compensation for Harm Suffered by Participants

(refer to Appendix 3 of the Guidelines)

Is this a clinical trial under accident compensation legislation (see form guidelines) Yes No

If yes, please answer the following:

11.1 Is the trial being carried out principally for the benefit of a manufacturer or distributor of the drug or item in respect of which the trial is taking place? Yes No

(a) If the answer to 11.1 is yes, please complete **Statutory Declaration Form B** and answer questions 11.2, 11.3 and 11.4

(b) If the answer to 11.1 is no please complete **Statutory Declaration Form A**

11.2 What type of injury/adverse consequence resulting from participation in the trial has the manufacturer or distributor undertaken to cover? (please tick the appropriate box/es)

	Yes	No
a) any injury (mental or physical)	<input type="checkbox"/>	<input type="checkbox"/>
b) only serious or disabling injuries.	<input type="checkbox"/>	<input type="checkbox"/>
c) only physical injuries	<input type="checkbox"/>	<input type="checkbox"/>
d) only physical injuries resulting from the trial drug or item, but not from any other aspect of the trial	<input type="checkbox"/>	<input type="checkbox"/>
e) physical and mental injury resulting from the trial drug or item, but not from any other aspect of the trial.	<input type="checkbox"/>	<input type="checkbox"/>
f) any other qualification (explain)	<input type="text"/>	

11.3 What type of compensation has manufacturer or distributor agreed to pay?

	Yes	No
a) medical expenses	<input type="checkbox"/>	<input type="checkbox"/>
b) pain and suffering	<input type="checkbox"/>	<input type="checkbox"/>
c) loss of earnings	<input type="checkbox"/>	<input type="checkbox"/>
d) loss of earning capacity	<input type="checkbox"/>	<input type="checkbox"/>
e) loss of potential earnings	<input type="checkbox"/>	<input type="checkbox"/>
f) any other financial loss or expenses	<input type="checkbox"/>	<input type="checkbox"/>
g) funeral costs	<input type="checkbox"/>	<input type="checkbox"/>
h) dependants' allowances	<input type="checkbox"/>	<input type="checkbox"/>

11.4 Exclusion clauses:

a) Has the manufacturer or distributor limited or excluded liability if the injury is attributable to the negligence of someone other than the manufacturer or distributor? (such as negligence by the investigator, research staff, the hospital or institution, or the participant). Yes No

b) Has the manufacturer or distributor limited or excluded liability if the injury resulted from a deviation from the study protocol by someone other than the manufacturer or distributor? Yes No

c) Is company liability limited in any other way? Yes No

If yes, please specify

12. Information and Consent

Consent should be obtained in writing, unless there are good reasons to the contrary. If consent is not to be obtained in writing the justification should be given and the circumstances under which consent is obtained should be recorded. Attach a copy of the information sheet and consent form.

12.1 By whom, and how, will the project be explained to potential participants?	<p>1. Survey – The survey will be introduced upon distribution of the questionnaire to the client, an information sheet is included with the questionnaire.</p> <p>2. Interviews – The interview invitation is attached to the survey with a separate information sheet that explains this portion of the study.</p> <p>3. Entrance and Exit Measures – These are initially introduced by the therapist who administers the measure, and an information is then used to explain this portion of the study.</p>
12.2 When and where will the explanation be given?	<p>1. Survey - At the end of the final counselling session for clients who fall within the study time frame for the survey.</p> <p>2. Interviews – The information sheet and invitation are attached to the survey questionnaire which is distributed as above.</p> <p>3. Entrance and Exit Measures - At the beginning of the first counselling session for clients considered eligible for the entrance and exit measures.</p>
12.3 Will a competent interpreter be available, if required?	Yes
12.4 How much time will be allowed for the potential participant to decide about taking part?	<p>1. Survey – A cut off date of 31/07/04 will apply, surveys received after that date will not be included in the study.</p> <p>2. Interviews – A cut off date of 31/07/04 will apply, only interviews completed prior to that date will be included in the study.</p> <p>3. Entrance and Exit Measures – A cut off date of 31/07/04 will apply, only cases that have been completed before that date will be included in the study.</p>
12.5 Will the participants be capable of giving consent themselves? - if not, complete Part VI	Yes
12.6 In what form (written, or oral) will consent be obtained? If oral consent only, state reasons.	<p>1. Survey – Completion of the questionnaire implies consent, this is written on the questionnaire and in the Information Sheet.</p> <p>2. Interviews – A consent form will be signed by all participants prior to the interview. The consent form is attached.</p> <p>3. Entrance and Exit Measures – A consent form will be signed by all participants prior to the first measure being administered. The consent form is attached.</p> <p>A written consent to participate in the research will also be obtained from Barbara Charuk. The consent form is attached.</p>

12.7 Are participants in clinical trials to be provided with a card confirming their participation, medication and contact phone number of the principal investigator?

Yes No

13. Confidentiality and Use of Results

13.1 How will data including audio and video tapes, be handled and stored to safeguard confidentiality (both during and after completion of the research project)?

In a locked filing cabinet in the researchers' home.

13.2 What will be done with the raw data when the study is finished?

It will be stored for five years and then destroyed according to the Massey University Policy of Research Practice. If participants request a copy of the audio taped interview or a transcript of the interview, a copy will be sent to them by the researcher.

13.3 How long will the data from the study be kept and who will be responsible for its safe keeping?

The researcher will store the data for five (5) years in accordance with the Massey University Policy of Research Practice.

13.4 Who will have access to the raw data and/or clinical records during, or after, the study?

The researcher and her supervisors.

13.5 Describe any arrangements to make results available to participants, including whether they will be offered their audio tapes or videos.

Results will be available through a newsletter available at the Health Centres and Surgeries. Results will be sent directly to interview participants if they request (an interview question) in the form of a summary of the findings. If participants request a copy of the audio taped interview or a transcript of the interview, a copy will be sent to them by the researcher.

13.6 If recordings are made, will participants be offered the opportunity to edit the transcripts of the recordings?

Yes No

13.7 Is it intended to inform the participant's GP of individual results of the investigations, and their participation, if the participant consents?

Yes No

If no, outline the reasons

GP's will only be informed if there are adverse affects for the client which may require follow up from the GP.

13.8 Will any restriction be placed on publication of results?

Yes No

If yes, please supply details

14. Treaty of Waitangi

- 14.1 Have you read the HRC booklet, "Guidelines for Researchers on Health Research involving Maori"? Yes No
- 14.2 Does the proposed research project impact on Maori people in any way? Yes No
- 14.3 Explain how the intended research process is consistent with the provisions of the Treaty of Waitangi

This study is aimed at the general population of which Maori are a part. The study is envisaged to be sensitive to the needs of all participants, including cultural sensitivity. All sessions are open to whom ever the client wishes to have participate and are structured around the issues identified by the client.

- 14.4 Identify the group(s) with whom consultation has taken place, and attach evidence of their support

N/A

- 14.5 Describe the consultation process that has been undertaken **prior** to the project's development

N/A

- 14.6 Describe any ongoing involvement the group consulted has in the project

N/A

14.7 Describe how information will be disseminated to participants and the group consulted at the end of the project

N/A

15. Other Issues

15.1 Are there any aspects of the research which might raise specific cultural issues? Yes No

If yes, please explain

15.1.1 What ethnic or cultural group(s) does your research involve?

This research involves the general New Zealand population in the Wanganui area and is not culturally or ethnically specific.

Describe what consultation has taken place with the group prior to the project's development

N/A

15.1.2 Identify the group(s) with whom consultation has taken place and attach evidence of their support

N/A

15.1.3 Describe any ongoing involvement the group consulted has in the project

N/A

15.1.4 Describe how you intend to disseminate information to participants and the group consulted at the end of the project

N/A

16. Genetics Check List

16.1 Does the proposed research study involve use of products made by genetic modification, analyses of DNA or clinical genetics?
If it does not, proceed to question 17.

Yes No

16.2 Have you read, and does your research comply with, the Guidelines "Ethical considerations relating to Research in Human Genetics? *Applicant responses to these questions may initiate a request from the Ethics Committee for more detailed information.*

Yes No

16.3 Will the study involve administration of any products produced by genetic modification, other than licensed medicines?
If yes, has approval from GTAC been obtained?

Yes No

Yes No

If yes please describe.

16.4 Information on Samples :

16.4.1 Is tissue or body fluid samples for DNA analysis to be taken for :

- a) immediate analysis
- b) storage for future analyses
- c) analyses outside New Zealand
- d) analyses by individuals or organisations other than the study investigators

(tick all boxes which apply)

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

16.4.2 Describe processes for storage and disposal of samples taken for DNA analyses

16.4.3 Up to what point would withdrawal of the sample or the data at the request of the participant be possible?

16.5 Is personal and health information from individuals and DNA analysis to be linked?

If yes, please describe how confidentiality will be assured.

Yes No

16.6 Are samples to be obtained from Maori?

If yes, please describe any relevant issues additional to Section 16.4.1

Yes No

16.7 Will the study involve participant contact with a clinical geneticist?

If yes, please provide :

- the name of the clinical geneticist, and
- describe the purpose

Yes No

16.8 Will provision be made where appropriate for genetic counselling?

If yes, please describe the process.

Yes No

17. Ethical Issues

17.1 Describe and discuss any ethical issues arising from this project, other than those already dealt with in your answers?

Conflict of Interest-As I am acting as both a student and an employee of the programme I am researching, a conflict of interest could be argued, however I have provided a copy of the letter to my employers seeking their support and defining the terms of this research (academic freedom and copyright in exchange for a copy of the thesis). My current contract expires in June 2004 which is before this research is proposed to be completed, so it will not directly affect my prospective employment renewal.

Informed Consent-As I am a therapist and the researcher, clients may not feel as free to express their reluctance to participate in the research. I have arranged that I will only be involved in research processes which allow anonymity or self disclosure to clients, other processes that require clients' identity will be undertaken by another therapist who is not involved in the research, or will be through client self-disclosure by volunteering to participate in processes that requires their identity.

Anonymity and Confidentiality-I will only be aware of client participation through client self disclosure (interview). The other research methods will use unique identifiers (entrance and exit measures) or will be anonymous (survey).

Access to Clients-As I am involved in the provision of the service I am researching, I will seek permission from my employer for access to the participants and access to the other therapist to assist in data collection. I will only directly approach clients following the completion of therapy by offering them a survey questionnaire. The only other clients I will be directly involved with are the participants who take up the invitation to be interviewed.

Thank you for your assistance in helping us assess your project fully

Please now complete:

- the declarations (Part V)
- a drug administration form (if applicable)
- Form A or B relating to accident compensation

PART V: DECLARATIONS

Full Project Title : Holistic Health: The Effectiveness of a
Counselling Model in a Primary Health Setting

Short Project Title : Counselling Model Effectiveness

1. Declaration by Principal Investigator

The information supplied in this application is, to the best of my knowledge and belief, accurate. I have considered the ethical issues involved in this research and believe that I have adequately addressed them in this application. I understand that if the protocol for this research changes in any way I must inform the Ethics Committee.

NAME OF PRINCIPAL INVESTIGATOR (PLEASE PRINT): Cindy Gibbs

SIGNATURE OF PRINCIPAL INVESTIGATOR: C.H. Gibbs

DATE: 26.1.04

A separate declaration will be required for each multi-centre site, signed by the principal investigator for that site.

2. Declaration by Head of Department in which the Principal Investigator is located or appropriate Dean or other Senior Manager

I have read the application and it is appropriate for this research to be conducted in this department. I give my consent for the application to be forwarded to the Ethics Committee.

NAME AND DESIGNATION (PLEASE PRINT): MARY NASIK

SIGNATURE: [Signature]

DATE: _____

INSTITUTION: School of Sociology
Social Policy And Social Work
Massey University
Private Bag 11-222
Palmerston North

DESIGNATION: SUPERVISOR

- *Where the head of department is also one of the investigators, the head of department declaration must be signed by the appropriate Dean, or other senior manager.*
- *If the application is for a student project, the supervisor should sign here.*

3. Declaration by the General Manager of the Health Service in which the research is being undertaken (if applicable)

I have reviewed the proposal for cost, resources, and administrative aspects and issues regarding patient participation and staff involvement. The proposal has my approval subject to the consent of the Ethics Committee.

NAME OF GENERAL MANAGER (PLEASE PRINT): _____

SIGNATURE: _____ INSTITUTION: _____

DATE: _____



Progressive Health (NZ) Incorporated
195A Wicksteed Street
WANGANUI

25 September 2003

Dear Board Members,

As some of you may be aware, I am currently studying for a Master of Social Work degree through Massey University. Part of the requirements for this degree is a thesis, which I am presently working on. My thesis topic is exploring the effectiveness of the counselling model that Barbara Charuk and I use in the provision of the PHI counselling service.

I would like to undertake some research for this thesis and am seeking your approval for this. I am supervised through Massey University by Dr. Mary Nash and Kieran O'Donoghue, who are available for contact through the School of Sociology, Social Policy and Social Work, Massey University, Palmerston North. I am applying for ethical approval through the Massey University Human Ethics Committee and the Health Research Council Ethical Committee for Manawatu Wanganui, under the national health research guidelines. Subject to their approval and yours, I would like to survey the clients that present for counselling over the period of up to two months, with the aim to distribute 30 questionnaires. With that questionnaire will be an invitation to participate in an in depth interview with myself. I am hoping to complete up to five interviews. I also propose to use a standardized measure (the Hospital Anxiety and Depression Scale) for an entrance and exit measurement in an attempt to gauge the effectiveness of the interventions for up to five cases. I am hoping to do the bulk of the research in February/March 2004, with the aim of completing the entrance and exit scales and the interviews over whatever time frame they requires.

As one of the Counsellors and the researcher, I am aware that there is the potential for clients to feel coerced into participating. To prevent this, I would like to ask Barbara Charuk, Counsellor, to undertake the research that directly identifies client participation during the sessions. This would entail the administration of the entrance and exit scale measures. As she is not involved in the research, she is in an ideal position to collect some of the data required and maintain client confidentiality with the use of unique identifiers. I envisage that we will both distribute the questionnaires, which are anonymous, and only those clients who choose to disclose their identity through being interviewed will be known to myself.

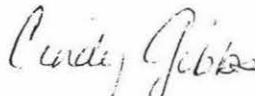
Informed consent is paramount and I will have information sheets for all participants and potential participants, as well as consent forms for all participants except those being surveyed as their anonymous participation is indicative of consent. Participation is strictly voluntary, and confidentiality is assured. Appropriate storage of the data is arranged by myself and will be monitored by my supervisors.

As conflict of interest can be argued in this case, it is important that I am seen as both a student and an employee. While I am undertaking the research, I am acting in the role of student, and this will predominantly be out of working hours. It is important that this research is seen as independent of my employment and that I have academic freedom and copyright to the research project. In exchange for the opportunity to undertake this research under these conditions, I would like to offer you a copy of my research when completed, and I am happy to keep you informed of the progress along the way.

In order to proceed with this project, I would like to request your permission to undertake the study on your premises and with your clients who consent. I also request your permission to approach Barbara Charuk to be involved in data collection. I would also like to use some of your documentation, specifically the information about the establishment and goals of the counselling project, and the statistical information from the GP and Customer Satisfaction Surveys as well as the statistical information collated from the first year of the project. This research will only proceed with your permission and with the approval of the both ethics committees.

The focus of the research is the effectiveness of the counselling model we are implementing, which is of course contextual to the setting and the parameters of the counselling. I am hopeful that you will find this project both interesting and relevant. Should you wish to discuss this further, I am happy to meet with you individually and/or collectively, or you can contact me on 06 388 0940.

Sincerely Yours,



Cindy Gibbs



Massey University

COLLEGE OF HUMANITIES & SOCIAL SCIENCES



School of Sociology, Social Policy

and Social Work

Private Bag 11 222,

Palmerston North,

New Zealand

Telephone: 64 6 350 5799 extn 2821

or extn 7877

Facsimile: 646 350 5681 or 5627

Email: SPSWPN_Reception

@massey.ac.nz

<http://www.massey.ac.nz/>

~wwpsw

Barbara Charuk
Counsellor
Progressive Health (NZ) Incorporated
Suite 17
Wicksteed Terrace
WANGANUI

25 September 2003

Dear Barbara,

As you are aware, I am proposing to undertake some research for my thesis project toward the completion of my Master of Social Work degree. The focus of my thesis is to explore the effectiveness of the counselling model we are implementing as PHI counsellors. The title of the research is Holistic Health: The Effectiveness of a Counselling Model in a Primary Health Care Setting. I am hoping that you may be able to assist with the data collection for this research.

My proposal includes surveying all the clients that present for counselling for up to two months with the distribution of approximately to 30 surveys. This will be an anonymous survey that we will distribute following completion of the therapeutic contract, which the clients can take with them and post back to me. Attached to the survey will be an invitation for clients to participate in a one to one interview with me to collect more in-depth information about their counselling experience. As well as this, I would like to measure any change in clients by using a standardized measure at entrance and exit to the service. I am proposing the use of the Hospital Anxiety and Depression scale for up to ten clients upon entrance and then when the counselling sessions are complete.

As both a counsellor and the researcher, I am trying to maintain my objectivity by remaining as unaware as possible of the participants in the research. As the questionnaire is anonymous and accepting the invitation for an interview allows self-disclosure, I feel I can comfortably be involved with these tasks, however, it is the research tasks which require participation during the delivery of the service that I am concerned about. As you are not involved in the research, I feel you may be in the best position to collect this type of data. As well as distributing surveys to clients, I would like to ask you to consider administering the Hospital Anxiety and Depression scale to up to ten clients on entrance and exit to and from the service. This will allow you to use unique identifiers for these cases to maintain client confidentiality.

If you choose to participate in this way, I will provide you with Information Sheets (copy attached) and Consent Forms (copy attached) for participants, so we can be assured of informed consent. If you choose not to participate in this study in this way, the study can still go ahead with the survey and interviews only, so please give careful consideration to your level of involvement.

I am seeking Massey University Ethics Committee as well as Manawatu Wanganui Ethics Committee approval for this project. If approval is forthcoming, I will approach the PHI board for their permission to undertake this research on their premises and with their clients. I will also seek their permission to involve you in this project. My supervisors through Massey University are Dr. Mary Nash and Kieran O'Donoghue, and they can be contacted through the School of Social Policy and Social Work, Massey University, Palmerston North.

I look forward to your reply, and I look forward to sharing this project with you on whatever level you choose.

Sincerely Yours,

Cindy Gibbs



Holistic Health: The Effectiveness of a Counselling Model in a Primary Health Care Setting

A research project by Cindy Gibbs

INFORMATION SHEET FOR COLLEAGUE

As you are aware, I am undertaking some research toward a thesis project to fulfil the requirements of the Master of Social Work degree through Massey University. Please note that I am doing this research as a student, my employer has not commissioned this research. I am a registered member of the Aotearoa New Zealand Association of Social Workers. I am doing research on the counselling that we provide at the Health Centres and GP Surgeries in Wanganui.

I may be contacted in the evenings between 7 – 9pm, by telephoning 06 388 0940. My supervisors at Massey University are Dr. Mary Nash, and Kieran O'Donoghue, they may be contacted through the School of Sociology, Social Policy and Social Work, Massey University, Palmerston North, during business hours. Their phone numbers are 06 350 5799 ext. 2827 and 06 350 5799 ext. 2818 respectively and their e-mail addresses are: M.Nash@massey.ac.nz and K.B.ODonoghue@massey.ac.nz.

What is the Study About?

This research aims to investigate the effectiveness of the model of counselling that we are providing for Progressive Health (NZ) Incorporated. As you are aware, counselling in Health Centres and GP Surgery's is a relatively new feature of health care in New Zealand. Changes to the way our health care is being administered and subsidized by the government, and requirements that health care become more holistic through the inclusion of other professionals in case management, has prompted the implementation of counselling in health centres and surgeries.

What will will you be invited to do?

If you agree to be part of this study, you will be invited to distribute an anonymous questionnaire to your clients who have completed counselling, over a two month period. I envisage the distribution of 30 questionnaires. Participation is completely voluntary. This questionnaire is completely anonymous and will **not** impact in any way on the services clients are receiving, and it will not be part of their medical

records. Information sheets are attached to the questionnaire, explaining the study and giving contact details for myself and my Supervisors should there be any concerns. Completing and posting the questionnaire will be taken as their consent to participate in this study.

You will also be invited to administer an entrance and exit measure for up to ten (10) clients who are presenting for counselling with a referral from their GP indicating anxiety and/or depression issues. This will entail explaining the study (an Information Sheet is provided), gaining written consent if they agree to participate (a Consent form is provided) and administering the Hospital Anxiety and Depression Scale (also provided) prior to the first session, and again at completion of the counselling contract. As well, you will be asked to attach a unique identifier to the scales so that client anonymity in the research is maintained. Clients presenting with identified anxiety and/or depression will be approached on a first come, first served basis during a two month period, with the aim of measuring ten (10) participants. Client participation will **not** impact in any way on the services clients are receiving, and it will not be part of their medical records.

What can you expect from the researcher?

If you take part in the study, you can expect that any information you provide will be treated confidentially. All information gathered through this research will be kept separately and securely by the researcher.

If you take part in this study, you can expect to be treated with respect and to have your opinions valued. **You will have the right:**

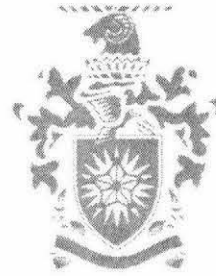
- To decline to participate;
- To withdraw from the study at any time;
- To participate in only the parts of the study that you choose;
- To ask any questions about the study at any time during participation;
- To have access to the findings of the study when it is concluded.

Thank you for considering participation in this research study. The findings will be available through the Health Centres and GP Surgery's at the conclusion of the study in late 2004 for all participants, and you are welcome to a copy of the whole study if you wish.

This project has been reviewed and approved by the Massey University Ethics Committee, PN Protocol 03/120. If you have any concerns about the conduct of this project, please contact Professor Sylvia V Rumball, Chair, Massey University Campus Human Ethics Committee: Palmerston North, telephone 06 350 5249, email humanethicspn@massey.ac.nz.

A consent form for your participation is attached. If you choose to be part of this study, please complete the form and indicate which portions of the study you are willing to undertake, and return the form to me. Thank you.

Cindy Gibbs



Holistic Health: The Effectiveness of a Counselling Model in a Primary Health Care
Setting

CONSENT FORM

THIS CONSENT FORM WILL BE HELD FOR A PERIOD OF FIVE (5) YEARS

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions anytime.

*Please delete the portions you **do not** wish to participate in.*

I agree to distribute the survey questionnaires as outlined in the Information Sheet.

I agree to administer the Hospital Anxiety and Depression Scale as outlined in the Information Sheet.

I agree to participate in this study under the conditions set out in the Information Sheet.

Signature: _____ Date: _____

Full Name – printed: _____



Holistic Health: The Effectiveness of a Counselling Model in a Primary Health Care
Setting

INFORMATION SHEET
Survey

Who is the Researcher?

My name is Cindy Gibbs. I am a student at Massey University. I currently work for Progressive Health (NZ) Incorporated, as a counsellor. I have worked for several years in the health field. I am a registered member of the Aotearoa New Zealand Association of Social Workers. I am doing research on the counselling being provided at the Health Centres and GP Surgeries in Wanganui. This research is a thesis project to fulfil the requirements of the Master of Social Work degree. Please note that I am doing this research as a student, my employer has not commissioned this research.

I may be contacted in the evenings between 7 – 9pm, by telephoning 06 388 0940. My supervisors at Massey University are Dr. Mary Nash, and Kieran O'Donoghue, they may be contacted through the School of Sociology, Social Policy and Social Work, Massey University, Palmerston North, during business hours. Their phone numbers are 06 350 5799 ext. 2827 and 06 350 5799 ext. 2818 respectively, and their e-mail addresses are M.Nash@massey.ac.nz and K.B.ODonoghue@massey.ac.nz.

What is the Study About?

This research aims to investigate the effectiveness of the model of counselling being provided by the counsellor you have seen at your Doctors' office. Counselling in Health Centres and GP Surgery's is a relatively new feature of health care in New Zealand. Changes to the way our health care is being administered and subsidized by the government, and requirements that health care become more holistic through the inclusion of other professionals in case management, has prompted the implementation of counselling in health centres and surgeries.

In Wanganui, the General Practitioners association has been proactive in providing a broad range of services to their patients. In April 2002, they hired a Counsellor to provide counselling services to the patients they referred. The demand quickly grew and the service was expanded to include two part-time counsellors. This study will explore the effectiveness of the counselling methods being used.

What will participants be invited to do?

If you agree to be part of this study, you will be invited to complete an anonymous questionnaire and post it (in a postage paid envelope provided) to the researcher. Participation is completely voluntary. This questionnaire is completely anonymous

and will **not** impact in any way on the services you are receiving at your Health Centre or GP Surgery. This questionnaire is being distributed by the Counsellors, but they will have no way of knowing who has or has not participated. Completing and posting the questionnaire will be taken as your consent to participate in this study, but will not identify you in anyway.

Attached to the questionnaire is an invitation to participate in a one to one interview with the researcher. A separate Information Sheet about the interview is also attached. You are welcome to only complete the questionnaire or to only participate in the interview or to take part in both if you wish; your involvement is completely up to you.

What can participants expect from the researcher?

If you take part in the study, you can expect that any information you provide will be treated confidentially. It will not be possible to identify you in any reports that are prepared from the study. All information gathered through this research will kept separately and securely, it will **not** be part of your health records held at the Health Centre or Surgery.

If you take part in this study, you can expect to be treated with respect and to have your opinions valued. **You will have the right:**

- To decline to participate;
- To refuse to answer any particular question;
- To withdraw from the study at any time;
- To ask any questions about the study at any time during participation;
- To have access to a summary of the findings of the study when it is concluded.

Thank you for considering participation in this research study. The findings will be available through the Health Centres and GP Surgery's at the conclusion of the study in late 2004.

This project has been reviewed and approved by the Massey University Ethics Committee, PN Protocol 03/120. If you have any concerns about the conduct of this project, please contact Professor Sylvia V Rumball, Chair, Massey University Campus Human Ethics Committee: Palmerston North, telephone 06 350 5249, email humanethicspn@massey.ac.nz .

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COUNSELLING QUESTIONNAIRE

This is an anonymous questionnaire designed to get feedback on the counselling service being offered through your Health Centre or GP Surgery. It is completely voluntary and completing it will indicate your consent to participate anonymously in this research. Please tick the appropriate boxes next to the questions, or circle the appropriate number next to the statements. The boxes on the far right of the questionnaire are for use by the researcher. **Thank you for your time and assistance with this research study.**

- 1 Are you? Male Female
- 2 Age? under 20
- 20 – 29
- 30 – 39
- 40 – 49
- 50 – 59
- 60 – 69
- 70 – 79
- 80 and above
- 3 Who referred you to the service?
- GP Practice Nurse Self Other _____
- 4 Have you ever attended counselling previously?
- No Yes
- If yes, through this service?
- or elsewhere?
- 5 How would you classify your concerns that brought you to counselling?
- Stress
- Anxiety
- Depression
- Relationship issues
- Loss/Grief
- Physical Health issues
- Other (please specify) _____

COUNSELLING QUESTIONNAIRE

6 Are you currently on any anti-depressant or anti-anxiety medication?

No

Yes if yes, how long have you been taking it?

Less than one month

One to three months

Three to six months

Six to nine months

Nine months to a year

Over one year

7 Would you recommend this service to someone else?

No

Yes

8 Please rate the following according to the scale provided, circling the number that best describes your experience.

Not at all		Somewhat		Yes, definitely	
1	2	3	4	5	<input type="checkbox"/>

Counselling at the Doctors'

1 2 3 4 5 I felt comfortable going to a counsellor in the Doctors' rooms.

1 2 3 4 5 The Doctors' rooms were convenient.

1 2 3 4 5 It makes sense to have a counsellor at the Doctors' Surgery.

1 2 3 4 5 It is good to have my Doctor and Counsellor working together.

Main Concerns

1 2 3 4 5 The counsellor helped me identify and clarify my concerns.

1 2 3 4 5 The counsellor and I developed goals for counselling.

1 2 3 4 5 The counselling was focused on solutions to my concerns.

1 2 3 4 5 The counselling helped me resolve my concerns.

Effects

1 2 3 4 5 I feel I can cope with most aspects of my life now.

1 2 3 4 5 Counselling has helped me increase my skills for dealing with issues that concern me.

1 2 3 4 5 I feel better about myself now than I did before counselling.

1 2 3 4 5 I feel more in control of my life now than I did before counselling.

COUNSELLING QUESTIONNAIRE

Counselling process

1 2 3 4 5 I liked the way my counsellor worked with me. []

1 2 3 4 5 I learned some useful skills in counselling. []

1 2 3 4 5 I felt the counsellor understood my concerns and made useful suggestions. []

1 2 3 4 5 I understood what the counsellor was talking about. []

9 The thing I found most helpful was:

_____ []

The thing I found least helpful was:

_____ []

10 Any comments you would like to make?

_____ []

_____ []

Thank you for your assistance with this survey, your input is very much appreciated.



Holistic Health: The Effectiveness of a Counselling Model in a Primary Health Care
Setting

INFORMATION SHEET

Interview

Who is the Researcher?

My name is Cindy Gibbs. I am a student at Massey University. I currently work for Progressive Health (NZ) Incorporated, as a counsellor. I have worked for several years in the health field. I am a registered member of the Aotearoa New Zealand Association of Social Workers. I am doing research on the counselling being provided at the Health Centres and GP Surgery's in Wanganui. This research is a thesis project to fulfil the requirements of the Master of Social Work degree. Please note that I am doing this research as a student, my employer has not commissioned this research.

I may be contacted in the evenings between 7 – 9pm, by telephoning 06 388 0940. My supervisors at Massey University are Dr. Mary Nash, and Kieran O'Donoghue, they may be contacted through the School of Social Policy and Social Work, Massey University, Palmerston North, during business hours. Their phone numbers are 06 350 5799 ext. 2827 and 06 350 5799 ext. 2818 respectively, and their e-mail addresses are M.Nash@massey.ac.nz and K.B.ODonoghue@massey.ac.nz.

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This research aims to investigate the effectiveness of the model of counselling being provided by the counsellor you have seen at your Doctors' office. Counselling in Health Centres and GP Surgery's is a relatively new feature of health care in New Zealand. Changes to the way our health care is being administered and subsidized by the government, and requirements that health care become more holistic through the inclusion of other professionals in case management, has prompted the implementation of counselling in health centres and surgeries.

In Wanganui, the General Practitioners association has been proactive in providing a broad range of services to their patients. In April 2002, they hired a Counsellor to provide counselling services to the patients they referred. The demand quickly grew and the service was expanded to include two part-time counsellors. This study will explore the effectiveness of the counselling methods being used.

What will participants be invited to do?

If you chose to participate in this part of the study, you are invited to take part in an interview with the researcher, Cindy Gibbs. You will be requested to sign a consent form

provided by the interviewer. This interview will take approximately one hour, and will be audio taped. You can ask that the tape be turned off at any time in the interview. The interview will be transcribed from the tape by an independent assistant who has signed a confidentiality agreement, and will be kept in a locked filing cabinet. You may edit the transcript. You may have a copy of the tape or the transcripts if you wish. You will not be identified in the research, your data will remain confidential to the researcher and her Massey University Supervisors. The interview will be arranged at a time and place to suit you. The interview will focus on your experience with the counselling you received at your GP Surgery or Health Centre. Participation in this interview will remain confidential between you and the researcher. Five interviewees will be selected on a 'first come first served' basis. This information will not be part of your medical record.

What can participants expect from the researcher?

If you take part in the study, you can expect that any information you provide will be treated confidentially. It will not be possible to identify you in any reports that are prepared from the study. All information gathered through this research will be kept separately and securely, it will **not** be part of your health records held at the Health Centre or Surgery.

If you take part in this study, you can expect to be treated with respect and to have your opinions valued. **You will have the right:**

- To decline to participate;
- To refuse to answer any particular question;
- To have the tape recorder turned off at any time;
- To withdraw from the study at any time;
- To ask any questions about the study at any time during participation;
- To provide information on the understanding that it is completely confidential, unless the information reveals plans to self harm or harm to others, in which case the researcher is obliged to act to ensure safety;
- To check and edit the transcript of the interview;
- To have access to a summary of the findings of the study when it is concluded.

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Holistic Health: The Effectiveness of a Counselling Model in a Primary Health Care
 Setting

Consent Form
 Interview Invitation

If you are interested in participating in an interview with the researcher, Cindy Gibbs, as set out in the information sheet, please complete the details on this invitation. You will be contacted within ten days of receipt of this invitation response.

I have read the information sheet and agree to be interviewed by Cindy Gibbs. I can be contacted at:

Name: _____

Address: _____

Contact phone number: _____

When is the best time to make contact with you? _____

Signature: _____ Date: _____

Holistic Health: The Effectiveness of a Counselling Model in a Primary Health Care Setting

INTERVIEW SCHEDULE

Background Information

- Currently on anti depressant or anti anxiety medication?
If yes, how long?
- Who referred you to this counselling service?
- How many sessions of counselling did you attend with this service?
- Did you have to wait long for an appointment?
- Have you had any previous involvement with counselling?
When? Where? Beneficial?

PHI Counselling Experience

- What brought you to counselling? Did counselling help with this?
- What was the first session like for you?
- Subsequent sessions?
- What was the most helpful part?
- What was the least helpful part?
- Do you remember any specific techniques or skills used during counselling?
- Do you still use anything you gained from counselling?
- How effective was this method compared to other things you have tried?
Meds?
Community Mental Health Team?
Other counselling services?
Friends/family/informal support?
- What did you think of the overall experience?
- Would you recommend it to anyone else?
- Any other comments you would like to add?



Holistic Health: The Effectiveness of a Counselling Model in a Primary Health Care Setting

INFORMATION SHEET Hospital Anxiety and Depression Scale

Who is the Researcher?

My name is Cindy Gibbs. I am a student at Massey University. I currently work for Progressive Health (NZ) Incorporated, as a counsellor. I have worked for several years in the health field. I am a registered member of the Aotearoa New Zealand Association of Social Workers. I am doing research on the counselling being provided at the Health Centres and GP Surgery's in Wanganui. This research is a thesis project to fulfil the requirements of the Master of Social Work degree. Please note that I am doing this research as a student, my employer has not commissioned this research.

I may be contacted in the evenings between 7 – 9pm, by telephoning 06 388 0940. My supervisors at Massey University are Dr. Mary Nash, and Kieran O'Donoghue, they may be contacted through the School of Social Policy and Social Work, Massey University, Palmerston North, during business hours. Their phone numbers are 06 350 5799 ext. 2827 and 06 350 5799 ext. 2818 respectively, and their e-mail addresses are M.Nash@massey.ac.nz and K.B.ODonoghue@massey.ac.nz.

What is the Study About?

This research aims to investigate the effectiveness of the model of counselling being provided by the counsellor you have seen at your Doctors' office. Counselling in Health Centres and GP Surgery's is a relatively new feature of health care in New Zealand. Changes to the way our health care is being administered and subsidized by the government, and requirements that health care become more holistic through the inclusion of other professionals in case management, has prompted the implementation of counselling in health centres and surgeries.

In Wanganui, the General Practitioners association has been proactive in providing a broad range of services to their patients. In April 2002, they hired a Counsellor to provide counselling services to the patients they referred. The demand quickly grew

and the service was expanded to include two part-time counsellors. This study will explore the effectiveness of the counselling methods being used.

What will participants be invited to do?

If you chose to participate in this study, you are invited to complete a Hospital Anxiety and Depression Scale (a questionnaire with 14 questions that measure your level of anxiety and/or depression) at the initial counselling session, and again at the final counselling session. The completion of the questionnaire usually takes approximately five minutes or less to complete. This information will be useful in determining the effectiveness of this model of counselling. The Hospital Anxiety and Depression Scale will be administered by a counsellor not involved in the research, and the before and after scales will be used to determine any change that took place during the time of counselling. Client information will remain confidential from the researcher through the use of 'unique identifier' numbers assigned to the data that only the counsellor administering the scale will know.

What can participants expect from the researcher?

If you take part in the study, you can expect that any information you provide will be treated confidentially. It will not be possible to identify you in any reports that are prepared from the study. All information gathered through this research will be kept separately and securely, it will **not** be part of your health records held at the Health Centre or Surgery.

If you take part in this study, you can expect to be treated with respect and to have your opinions valued. **You will have the right:**

- To decline to participate;
- To refuse to answer any particular question;
- To withdraw from the study at any time;
- To ask any questions about the study at any time during participation;
- To provide information on the understanding that it is completely confidential, unless the information reveals plans to self-harm or harm to others, in which case the researcher is obliged to act to ensure safety;
- To have access to a summary of the findings of the study when it is concluded.

Thank you for considering participation in this research study. The findings will be available through the Health Centres and GP Surgery's at the conclusion of the study in late 2004.

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Holistic Health: The Effectiveness of a Counselling Model in a Primary Health Care
Setting

ENTRANCE AND EXIT MEASURES
USING THE
HOSPITAL ANXIETY AND DEPRESSION SCALE

CONSENT FORM

THIS CONSENT FORM WILL BE HELD FOR A PERIOD OF FIVE (5) YEARS

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions anytime.

I agree to participate in this study under the conditions set out in the Information Sheet.

Signature: _____ Date: _____

Full Name – printed: _____



Holistic Health: The Effectiveness of a Counselling Model in a Primary Health Care
Setting

TRANSCRIBERS AGREEMENT

I _____ (full name printed) agree to transcribe
the tapes provided to me.

I agree to keep confidential all the information provided to me.

I will not make any copies of the transcripts or keep any record of them other than
those required for the project.

TRANSCRIBER: _____

Signature: _____ Date: _____

WITNESS: _____

Signature: _____ Date: _____

Full name printed: _____

Appendix B



9 September 2004

Hello,

My name is Cindy Gibbs and I have written to you previously asking for your assistance with some research I am undertaking through Massey University. My research is about the counselling that is being provided at the GP surgeries in Wanganui. As I did not receive many responses with the first request, I am writing to ask for further assistance. I have enclosed a copy of the survey that I posted to you earlier in the year. If you have not filled it out, I would very much appreciate it if you could complete it and return it in the envelope provided. If you have already returned it, I thank you very much for your assistance, please ignore this letter.

In the initial posting I included an information sheet and invitation for an interview about the counselling process. I have not included that here, but if you are interested in being interviewed about your counselling experience, please indicate this and give contact details on the bottom of the survey form and I will make contact with you and send you further information.

Thank you for your assistance. I appreciate your time and effort. If you have any queries my contact details are on the enclosed information sheet.

Sincerely Yours,

Cindy Gibbs



Holistic Health: The Effectiveness of a Counselling Model in a Primary Health Care Setting

INFORMATION SHEET
Survey

Who is the Researcher?

My name is Cindy Gibbs. I am a student at Massey University. I currently work for Progressive Health (NZ) Incorporated, as a counsellor. I have worked for several years in the health field. I am a registered member of the Aotearoa New Zealand Association of Social Workers. I am doing research on the counselling being provided at the Health Centres and GP Surgeries in Wanganui. This research is a thesis project to fulfil the requirements of the Master of Social Work degree. Please note that I am doing this research as a student, my employer has not commissioned this research.

I may be contacted in the evenings between 7 – 9pm, by telephoning 06 388 0940. My supervisors at Massey University are Dr. Mary Nash, and Kieran O'Donoghue, they may be contacted through the School of Sociology, Social Policy and Social Work, Massey University, Palmerston North, during business hours. Their phone numbers are 06 350 5799 ext. 2827 and 06 350 5799 ext. 2818 respectively, and their e-mail addresses are M.Nash@massey.ac.nz and K.B.ODonoghue@massey.ac.nz.

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What will participants be invited to do?

If you agree to be part of this study, you will be invited to complete an anonymous questionnaire and post it (in a postage paid envelope provided) to the researcher. Participation is completely voluntary. This questionnaire is completely anonymous

and will **not** impact in any way on the services you are receiving at your Health Centre or GP Surgery. This questionnaire is being distributed by the Counsellors, but they will have no way of knowing who has or has not participated. Completing and posting the questionnaire will be taken as your consent to participate in this study, but will not identify you in anyway.

Attached to the questionnaire is an invitation to participate in a one to one interview with the researcher. A separate Information Sheet about the interview is also attached. You are welcome to only complete the questionnaire or to only participate in the interview or to take part in both if you wish; your involvement is completely up to you.

What can participants expect from the researcher?

If you take part in the study, you can expect that any information you provide will be treated confidentially. It will not be possible to identify you in any reports that are prepared from the study. All information gathered through this research will be kept separately and securely, it will **not** be part of your health records held at the Health Centre or Surgery.

If you take part in this study, you can expect to be treated with respect and to have your opinions valued. **You will have the right:**

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- 3 Who referred you to the service?
- GP Practice Nurse Self Other _____
- 4 Have you ever attended counselling previously?
- No Yes
- If yes, through this service?
- or elsewhere?
- 5 How would you classify your concerns that brought you to counselling?
- Stress
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- Depression
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- Physical Health issues
- Other (please specify) _____

COUNSELLING QUESTIONNAIRE

Counselling process

1 2 3 4 5 I liked the way my counsellor worked with me. []

1 2 3 4 5 I learned some useful skills in counselling. []

1 2 3 4 5 I felt the counsellor understood my concerns and made useful suggestions. []

1 2 3 4 5 I understood what the counsellor was talking about. []

9 The thing I found most helpful was:

_____ []

The thing I found least helpful was:

_____ []

10 Any comments you would like to make?

_____ []

_____ []

Thank you for your assistance with this survey, your input is very much appreciated.



Holistic Health: The Effectiveness of a Counselling Model in a Primary Health Care
Setting

INFORMATION SHEET

Interview

Who is the Researcher?

My name is Cindy Gibbs. I am a student at Massey University. I currently work for Progressive Health (NZ) Incorporated, as a counsellor. I have worked for several years in the health field. I am a registered member of the Aotearoa New Zealand Association of Social Workers. I am doing research on the counselling being provided at the Health Centres and GP Surgery's in Wanganui. This research is a thesis project to fulfil the requirements of the Master of Social Work degree. Please note that I am doing this research as a student, my employer has not commissioned this research.

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provided by the interviewer. This interview will take approximately one hour, and will be audio taped. You can ask that the tape be turned off at any time in the interview. The interview will be transcribed from the tape by an independent assistant who has signed a confidentiality agreement, and will be kept in a locked filing cabinet. You may edit the transcript. You may have a copy of the tape or the transcripts if you wish. You will not be identified in the research, your data will remain confidential to the researcher and her Massey University Supervisors. The interview will be arranged at a time and place to suit you. The interview will focus on your experience with the counselling you received at your GP Surgery or Health Centre. Participation in this interview will remain confidential between you and the researcher. Five interviewees will be selected on a 'first come first served' basis. This information will not be part of your medical record.

What can participants expect from the researcher?

If you take part in the study, you can expect that any information you provide will be treated confidentially. It will not be possible to identify you in any reports that are prepared from the study. All information gathered through this research will be kept separately and securely, it will **not** be part of your health records held at the Health Centre or Surgery.

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- To ask any questions about the study at any time during participation;
- To provide information on the understanding that it is completely confidential, unless the information reveals plans to self harm or harm to others, in which case the researcher is obliged to act to ensure safety;
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Holistic Health: The Effectiveness of a Counselling Model in a Primary Health Care
Setting

Consent Form
Interview Invitation

If you are interested in participating in an interview with the researcher, Cindy Gibbs, as set out in the information sheet, please complete the details on this invitation. You will be contacted within ten days of receipt of this invitation response.

I have read the information sheet and agree to be interviewed by Cindy Gibbs. I can be contacted at:

Name: _____

Address: _____

Contact phone number: _____

When is the best time to make contact with you? _____

Signature: _____ Date: _____

Appendix C



8 January 2004

Cindy Gibbs


Dear Cindy

**Re: HEC: PN Protocol – 03/120
Holistic Health: The Effectiveness of Counselling in a Primary Health Care
Setting**

Thank you for your letter dated 31 December 2003 and the amended protocol.

The amendments you have made and explanations you have given now meet the requirements of the Massey University Human Ethics Committee: Palmerston North and the ethics of your protocol are approved. Approval is for three years. If this project has not been completed within three years from the date of this letter, a new application must be submitted at that time.

If the nature, content, location, procedures or personnel of your approved protocol change, please advise the Secretary of the Committee.

A reminder to include the following statement on all public documents "This project has been reviewed and approved by the Massey University Human Ethics Committee, PN Protocol 03/120. If you have any concerns about the conduct of this research, please contact Professor Sylvia V Rumball, Chair, Massey University Campus Human Ethics Committee: Palmerston North, telephone 06 350 5249, email humanethicspn@massey.ac.nz"

Yours sincerely

A handwritten signature in cursive script that reads "Sylvia Rumball".

Professor Sylvia V Rumball, Chair
Massey University Campus Human Ethics Committee: Palmerston North

cc Dr Mary Nash
School of Sociology, Social Policy
and Social Work
PN371

Mr Kieran O'Donoghue
School of Sociology, Social Policy
and Social Work
PN371

14th June 2004

Manawatu Whanganui Ethics Committee

C/- Palmerston North Hospital
P.O. Box 5203
Palmerston North
Phone/Fax (06) 356 7773

Cindy Gibbs
[REDACTED]

Study Title: Holistic Health: The effectiveness of a counselling model in a primary health setting
Ethics Reference No: 04/02/01

The above study has been given ethical approval by the Manawatu/Whanganui Ethics Committee.

Approved Documents

Protocol No 04/02/001 dated February 2004
Amendment No 1 dated May 2004
Information sheet version 3 dated June 2004
and consent form version 3 dated June 2004

Accreditation

This Committee is accredited by the Health Research Council and is constituted and operates in accordance with the Operational Standard for Ethics Committees, March 2002.

Progress Reports

The study is approved until June 2005. The Committee will review the approved application annually. A progress report is required for this study on June 2005 if your study is not completed. You will be sent a form requesting this information prior to the review date. Please note that failure to complete and return this form may result in the withdrawal of ethical approval. A final report is also required at the conclusion of the study.

Amendments

All amendments to the study must be advised to the Committee prior to their implementation.

General

It should be noted that Ethics Committee approval does not imply any resource commitment or administrative facilitation by any healthcare provider within whose facility the research is to be carried out. Where applicable, authority for this must be obtained separately from the appropriate manager within the organisation.

Please quote the above reference number in all correspondence relating to this study.

Manawatu/Whanganui Ethics Committee
P.O. Box 5203
Ph 06/ 350 8199
Email: centralethics@xtra.co.nz

Please note a new version of the application form (EA0502) is now available either by email from the Administrator or from the Health Research Council website, www.hrc.govt.nz. Form EA0699 will not be accepted after 31 December 2002.

Yours sincerely



Sheryl Kirikiri
Administrator
Manawatu/Whanganui Ethics Committee
centralethics@xtra.co.nz

Manawatu/Whanganui Ethics Committee
P.O. Box 5203
Ph 06/ 350 8199
Email: centralethics@xtra.co.nz



TE ORANGANUI
Iwi Health Authority

27 April 2004

Our Ref: GH:WN:A1

Re: Support for Research

To Whom It May Concern:

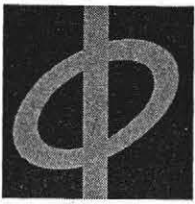
I write at this time to confirm support for the research programme that Cindy Gibbs is presently completing.

As a commitment to the Treaty of Waitangi, it is clear to me that Cindy is committed to the three principles of partnership, participation and protection. In the first instance as a measure of partnership, our organisation has been kept informed of the counselling initiatives established by the PHI.

Whilst I understand that the involvement of Māori participants within this research is minimal, there has been every endeavour to encourage Māori clients to participate. Alongside this, as a commitment to 'protection, some Māori clients who have been approached to participate have declined on the understanding that a kaupapa Māori approach is a preferred choice.

Noho ora mai
Nāku noa nā

Jennifer Tamehana
Toihau/CEO
Te Oranganui Iwi Health Authority



PROGRESSIVE HEALTH

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20 November 2003

Cindy Gibbs



Dear Cindy

THESIS RESEARCH

We are in receipt of your letter of 23 September regarding your research thesis for which you proposed exploring the effectiveness of the counselling model presently used in the provision of the PHI counselling service and your request for permission to undertake the study on PHI premises and with PHI clients who consent to participating in this research.

Your letter was tabled and discussed at the PHI Executive meeting on Tuesday 18 November 2003 and a unanimous decision of approval to your request was reached. The Executive also approved the use of data and all information including establishment and statistical as you outlined in your correspondence.

The PHI Executive totally supports you in this endeavour and wishes you every success with your research project and we look forward to receiving a copy of your research when completed.

Yours sincerely

Jacqui Powell
EXECUTIVE OFFICER



Holistic Health: The Effectiveness of a Counselling Model in a Primary Health Care
Setting

CONSENT FORM

THIS CONSENT FORM WILL BE HELD FOR A PERIOD OF FIVE (5) YEARS


I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions anytime.

*Please delete the portions you **do not** wish to participate in.*

I agree to distribute the survey questionnaires as outlined in the Information Sheet.

I agree to administer the Hospital Anxiety and Depression Scale as outlined in the Information Sheet.

I agree to participate in this study under the conditions set out in the Information Sheet.

Signature:  Date: 25/3/04

Full Name – printed: BARBARA CHARUK.

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