Workplace counselling:

building an evidence base from practice

Barry McInnes explores the role of the new CORE National Research Database for Workplace Counselling

The more research-minded among those of you who are BACP members may recall that last March's *Counselling and Psychotherapy Research* journal (CPR) was given over to a special CORE edition, which profiled a series of benchmark studies for six key performance indicators for primary care. These were based on data donated from 34 primary care services for over 35,000 clients which helped develop the CORE National Research Database (NRD) for Primary Care. Drawing on that experience, this article describes the development of the new CORE NRD for Workplace Counselling, and explores its potential to help workplace counselling services develop an evidence base that demonstrates their contribution to employee health and organisational effectiveness.

Having been involved in the world of workplace counselling provision for nearly 15 years I have come to keenly appreciate what a uniquely precarious position we can sometimes find ourselves in. This position is recognised by Professor John McLeod in his 2001 systematic review of the research evidence base for workplace counselling:[1] *The provision of workplace counselling and EAPs is not part of the core business of employers and companies. The availability of these services to employees is a cost to the employer, to be set against profits. Thus the cost of an EAP needs to be balanced against the benefits it may bring, and against other costs, such as occupational health, personnel, training, etc.*

In other words, we have to justify not just what we do, but whether it is done at all. Central to this is the need for a more or less consciously perceived fit between what we are seen to provide and the aims, values and processes of the organisation. We can influence both the perception and the reality of that fit, but if our position is to be anything more than peripheral this is something we need to work at and provide evidence of.

With a second edition of McLeod's review imminent, what is the current state of the evidence base for workplace counselling and what does it suggest for our long-term prospects?

Two contrasting views of the evidence for workplace counselling

On the face of it the picture can seem confusing and contradictory. From one perspective McLeod's review concludes that workplace counselling is a generally effective intervention which helps to improve employees' psychological health as well as contributing positively to organisational indicators such as sickness absence (*see figure 1*). In coming to these broadly positive and supportive conclusions, he also finds no evidence for the superiority of any one model of therapy over another. The review was warmly welcomed by the workplace counselling community and has been used extensively by services

Counselling in the workplace: the facts – a systematic review of the research evidence

An extract of report conclusions

- The majority (over 90 per cent) of employees who make use of workplace counselling are highly satisfied.
- Two-thirds of studies have shown that following counselling, levels of work-related symptoms and stress return to the 'normal' range for more than 50 per cent of clients.
- Counselling interventions have been found, in the majority of studies that have examined this factor, to reduce sickness absence rates in clients by 25-50 per cent.
- Counselling interventions have a lesser, but still significant, positive impact on job commitment, job satisfaction, and substance misuse.

Figure 1: Selected extracts from Counselling in the workplace: the facts[1]

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as evidence in support of their existence.

The British Occupational Health Research Foundation (BOHRF), however, in its 2005 review of workplace interventions for people with common mental health problems[2], comes to rather different conclusions. The review seeks to identify effective interventions in three areas, namely prevention, retention and rehabilitation. The discussion section identifies the limited range of interventions for which the authors find stronger evidence of effectiveness. For employees who have had periods of mental ill health related sickness, it concludes: *The evidence from the included studies demonstrates that, for people already experiencing common mental health problems at work, the most effective approach is brief (up to eight weeks) of individual therapy, especially cognitive behavioural in nature (CBT).*

The key role of occupational health physicians, supervisors, and primary care practitioners in managing employees with common mental health problems is highlighted. Nowhere in the discussion, however, is there any mention of workplace counselling or counsellors – we are simply not on the radar. The fact that the review required that to be included – studies needed to include employment among their outcome measures – may have resulted in many of the higher quality studies in the McLeod report being excluded.

The findings of these two studies highlight how different approaches to deciding research relevance and rigour produce different findings. This is not the place to go into the 'why' of the these contrasting conclusions, however, so perhaps a better question is 'so what?' McLeod himself identifies the lack of linkage to organisational priorities in workplace counselling research as a critical gap. This matters because so much of workplace counselling provision sits under occupational health, whether internally hosted or externally managed, and if our research does not credibly speak to organisational priorities we have a major problem.

What matters more – therapy or therapist?

How do we reconcile these contrasting findings and know what's best to do? Is it one model or any? What counts more in outcomes – therapy or therapist? These themes lie at the heart of an intense struggle in psychotherapy research between those who believe that the therapy model and its specific ingredients contribute more to therapy outcomes, and those who propose that the therapist is the more significant factor.

One area where there seems to be some degree of consensus developing, however, is that to date randomised controlled trials (RCTs) are inadequate to test effectively for therapist effects. This is because the numbers of therapists, and numbers of clients per therapist, in even the largest RCTs, are of insufficient size to test for therapists as a variable in outcomes. Authors such as Elkin[3] and Soldz[4] argue that much larger databases, of the type found in more naturalistic or practice-based settings, are required to address this question.

One such database, arguably unique in the UK, is the CORE NRD. The following sections describe its characteristics and highlight its potential contributions to research, service delivery and practice.

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What is the CORE National Research Database?

The CORE National Research Database (NRD) is essentially a large pool of data donated anonymously by services using the CORE System and CORE PC software, to develop an immensely valuable research resource and offer an insight into the quality and effectiveness of therapy provision.

The primary care studies in last March's *CPR* represent a unique UK practice-research collaboration described by former BACP President Mark Aveline as 'a British success story but one with international benefit'[5].

The data that comprises the NRD is generated by practitioners and clients within individual services and stored within CORE PC – software that holds, analyses and reports on CORE System data. The NRD is held and managed on behalf of data donors by the CORE System Trust (CST)[1], which negotiates research studies using NRD data with potential research partners. As well as being a resource for academic study it has always been intended that the NRD should generate pragmatic research, thus giving back to donating services answers to questions they themselves have asked.

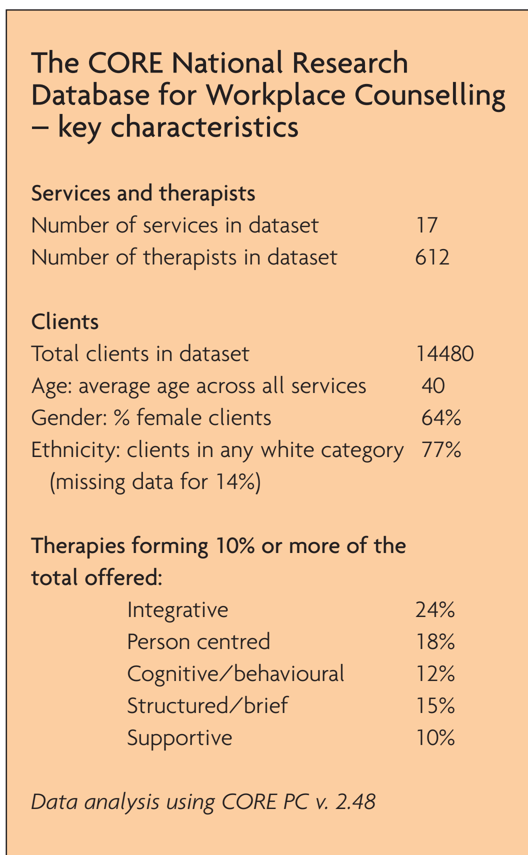
Building on the success of the primary care NRD, in recent months a range of services in the workplace counselling sector have contributed data to assemble the CORE NRD for Workplace Counselling. In all a total of 17 services, both internally provided services and EAPs, have donated data for nearly 15,000 clients. The CST, on behalf of the services which donated their data, is negotiating analysis and research on the data with potential partners.

Figure 2 highlights some of the main characteristics of the NRD for Workplace Counselling. In order to grasp what it may contribute to our understanding of the workplace counselling sector and its quality, it is helpful to have a basic grasp of the key generic and work-specific components of the CORE System that help to capture this practice-based data.

The CORE 'hub' and workplace spoke

As a paper-based evaluation system, CORE is free to use and comprises a 'hub' of three generic A4 inter-dependent tools:

- The CORE Outcome Measure is a client self-report questionnaire designed to be used before and after therapy. The client is asked to respond to 34 questions (such as 'I have felt OK about myself' or 'I have felt criticised by other people') about how they have been feeling over the last week on a five-point scale from 'not at all' to 'most or all of the time'. Comparison of the pre and post therapy scores offers a measure of 'outcome', that is whether or not the client's level of distress has changed, and by how much.
- The Therapy Assessment Form is completed by the practitioner and helps profile the client, their presenting problems/concerns, their level of risk, and their pathway into therapy
- The End of Therapy Form is also completed by the practitioner and helps profile the client's pathway through and out of therapy, alongside a review of their presenting issues and level of risk.



The CORE National Research Database for Workplace Counselling – key characteristics

Services and therapists	
Number of services in dataset	17
Number of therapists in dataset	612
Clients	
Total clients in dataset	14480
Age: average age across all services	40
Gender: % female clients	64%
Ethnicity: clients in any white category (missing data for 14%)	77%
Therapies forming 10% or more of the total offered:	
Integrative	24%
Person centred	18%
Cognitive/behavioural	12%
Structured/brief	15%
Supportive	10%

Data analysis using CORE PC v. 2.48

Figure 2. Key characteristics of the CORE NRD for Workplace Counselling

Around this generic 'hub' exist a range of 'spokes', including one designed to capture a finer level of detail of work-related issues using two practitioner completed forms:

- The Workplace Counselling Assessment Form profiles the client's work-related problems/concerns across 11 broad categories (each with its own sub-categories), their impact on the client's work performance, and the number of days absent in the past four weeks.
- The Workplace End of Counselling Form reviews the client's work-related problems/concerns, their impact on work performance and absence, as well as asking in what specific ways counselling has helped the client in their workplace.

Using benchmarks to inform service improvement

So how might services use this kind of data, together with benchmarks derived from the Workplace NRD, to inform issues of service quality and profile their contribution to organisational health?

One of the key themes to emerge from the benchmark studies of the primary care NRD was the wide variation in service performance against all six of the indicators profiled:

- waiting times (16-182 days)
- outcome measurement completion rates (20 per cent – 100 per cent pre therapy)
- assessment and intake into therapy (34-100 per cent accepted for therapy)
- differential risk assessment between clients and practitioners (1-32 per cent)
- unplanned endings (4-65 per cent declared)
- improvement rates (54-86 per cent).

The range for each indicator is presented in the form of a coloured quartile 'thermometer'. To illustrate, Figure 3 shows the quartile ranges for improvement

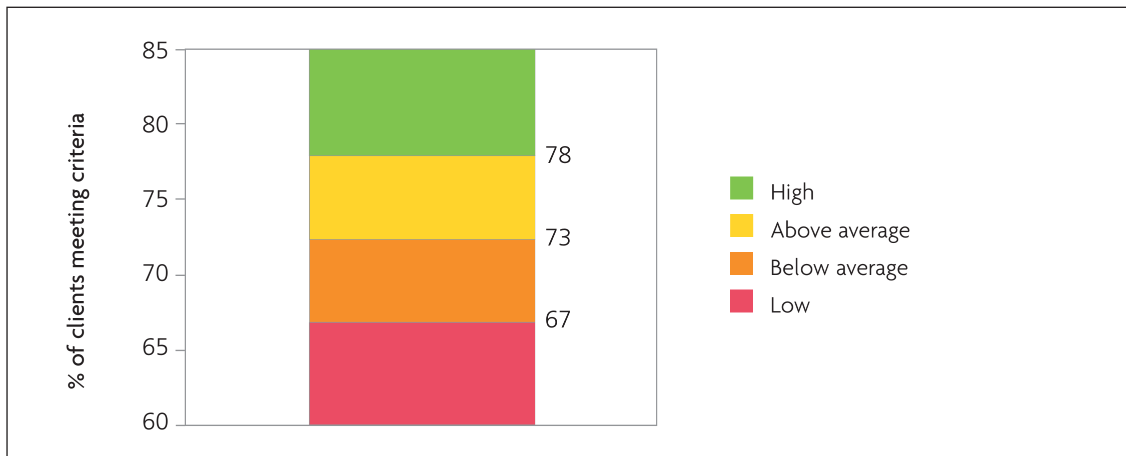


Figure 3: Recovery and/or improvement across primary care services[6]

rates from the primary care study[6]. Across all services the range is 54-86 per cent, with a mean of 72 per cent. The quartile range of the highest performing (green) services is 78-86 per cent, in contrast with that of the lowest performing quartile (red) of 54-67 per cent. (Note that the ranges shown are illustrative and do not precisely mirror the range given above.)

Preliminary findings from the CORE NRD for primary care indicate an even wider range of improvement rates across individual therapists. Taking into account only those therapists with 10 or more clients in the dataset, the range is between 11-94 per cent. In the absence of any evidence to the contrary, there is no reason to suppose that the kind of ranges in service and practitioner performance seen in the primary care NRD will not be replicated in the workplace data.

When the benchmark data for services in the workplace sector is developed in the coming months, a service might use these to contrast its own data and get a sense of its own relative performance. As well as data on improvement rates, for example, it might be interested in exploring how its rates of unplanned endings compare nationally (the range in primary care services is 4-65 per cent).

The service will hopefully use this information for careful reflection in the context of its own unique circumstances, to determine whether it merits cause for celebration or concern; monitoring or action. Using the common methodology provided by the CORE System and CORE PC, it will also be able to explore its own data in greater detail – for example to examine what client variables (eg gender, age, ethnicity) or service delivery variables (eg how much therapy clients are offered) may affect outcomes.

The data captured by the CORE workplace spoke will also offer us a rich source of data which will be of considerable interest from an organisational perspective. We will, for example, be able to identify whether particular workplace presenting issues appear to be associated with poorer psychological health or indeed poorer outcomes. We will be able to assess to what degree clients' work functioning is affected and whether their work functioning improves after counselling, and whether rates of pre and post sickness absence appear to show improvement. And we will also be in a position to explore, from a practice-based perspective, the relative contributions of therapy and therapist to outcomes.

By using CORE System data in this way, services and practitioners can hopefully begin to develop a sense of their own relative performance and contribution to those organisations whose employees they serve, and we can collectively be part of addressing the deficit in organisationally relevant research identified by McLeod six years ago. ■

References

1 McLeod J. Counselling in the workplace: the facts – a systematic review of the research evidence. Rugby: BACP; 2001.

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