SENCS

Survivors' Experiences of the National Counselling Service

For adults who experienced childhood abuse

The Health Boards Executive
Working Together for Health

n|c|s

Conducted by Royal College of Surgeons in Ireland
On behalf of The National Counselling Service

Acknowledgements

Our first and most important acknowledgements go to those who have lived through the experience of childhood abuse both in institutional care and in other contexts and who shared their experience of the National Counselling Service (NCS) with us. As well as being an emotionally challenging process for some participants, many gave generously of their time and travelled long distances to contribute to this project.

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We hope that the efforts of all those involved in the study will bring benefits for the care of clients in the NCS and in similar services in the future.

Preface

This study was commissioned by the National Counselling Service. The Health Services Research Centre (HSRC) at the Department of Psychology, Royal College of Surgeons in Ireland conducted the research. The HSRC is a multidisciplinary centre established in 1997 to promote high quality healthcare delivery in Ireland through research. The study was co-ordinated by Ms Colette Leigh in association with Ms Rebecca Garavan and Ms Kay Rundle (research officers). Ms Francis Foley, Ms Catriona Ellis and Ms Denise O' Shea worked as study interviewers. The study director was Professor Hannah Mc Gee (HSRC Director). The study was completed between April 2002 and July 2003.

We have produced the report on the basis of the information provided to us. The account as presented and inferences drawn are those of the Health Services Research Centre.

Executive Summary

Background

The National Counselling Service (NCS) is a new service established in September 2000. It is provided under the auspices of the ten regional health boards who work together to deliver a nationally consistent service locally. The service offers individual counselling sessions, without charge, to those who have experienced abuse in childhood. The term 'abuse' covers emotional, physical and sexual abuse and neglect. While initially established in order to provide counselling for those abused in institutional care in Ireland, the service has, since its inception, provided counselling for all adults presenting with abuse in childhood. The NCS uses local advertising where appropriate to make the public aware of services available. Decisions to advertise are considered carefully in terms of the potential impact of any advertising and the capacity of the service to respond to calls that may be made. Since the NCS was established in 2000, more than 5,000 people have been referred for counselling. In 2002, there were 2,132 referrals to the service; an increase of 12% on the previous year (total numbers for 2001 were 1,897 and for 2000 were 463).

As the first national counselling service of its kind, the NCS was established in consultation with support groups representing those who had been abused in institutional care. In this context, and with the increasing focus on quality and public accountability of health and other services, a model of service delivery was developed to guide the NCS. The most important guiding principles of the NCS are to provide a service that is accessible, client-centred and high quality.

The NCS has a number of service provision policies in operation. These have been outlined in a first account of the activities of the service (NCS: The First Report, 2002). These include: (a) prioritisation of the allocation of counselling appointments for clients who have experienced abuse in institutions, (b) agreed national policy in relation to the limits of confidentiality, (c) commitment to making the service accessible for clients from minority groups, (d) supervision of staff, (e) linking with other services to offer as seamless a service as possible to clients, (f) working across boundaries within and across the different health boards to provide a service of choice to best suit the client and (g) facilitating choice of counselling location, gender of counsellor etc. for clients insofar as resources allow.

Initiatives currently being undertaken by the NCS to manage service provision and waiting lists include : (a) providing a freephone contact line, (b) providing out-of-hours services where resources permit, (c) offering clients an initial meeting while awaiting counselling, (d) establishing a waiting list management working group, (e) training and supporting administrative staff in dealing with this quiet distressed client group, and (f) completing a national database/information system to assist in service planning.

Aim of the present study

This study aimed to assess the quality of services provided by the NCS. The overall experience of service use was to be evaluated with particular emphasis on the extent to which the three most important guiding principles of the service have been met. Client experiences of services is an essential component of a quality service. In this study, service quality was evaluated from the perspective of survivors of child abuse who have used the service. An independent research agency, The Health Service Research Centre at the Department of Psychology, Royal College of Surgeons in Ireland were commissioned to conduct the study and were supported by an NCS-appointed Steering Group.

While there is an extensive international and Irish 'patient satisfaction' literature, there is a dearth of evidence on service experience from users of abuse counselling services. Thus, this project has the potential to address important issues about this particular service but also to more generally promote a structured approach to ensure that the perspective of clients in abuse and other types of counselling services are given a say in shaping the services they expect and deserve.

Methodology

Sample size: A sample size of 300 interviews with survivors was proposed to permit analysis of findings across a number of important parameters: demographic factors (e.g. age, gender), abuse-related factors (e.g. whether the person was abused in an institution or abused in another context), and counselling status (e.g. in counselling or no longer in counselling (i.e. completed counselling or terminated counselling prematurely)).

Measure: A semi-structured interview method was used to obtain information. Questions were developed by extensive consultation with survivor groups, selected service clients, counsellors and the Steering Group.

Ethics: The Research Ethics Committee of the Royal College of Surgeons in Ireland (RCSI) gave approval for the project. Some boards also requested local ethical review, which was obtained.

Sample selection: An overall list of clients representing all 10 health boards was created at health board level in order to select a random nationally representative sample. Random selection from anonymous lists was completed by researchers and returned to boards. At this point there was an option to exclude/replace names on the list where contact was seen as inappropriate by the NCS. Clients deemed to have acute physical or psychological problems at the time of the study or those where written contact risked breaching their confidentiality were excluded.

Contact Procedure: With regard to participants currently in counselling, the standard procedure was that a letter of invitation was given directly to each selected client by their counsellor. Clients who were no longer in counselling were sent a letter of invitation from the local director of counselling explaining the study. In order to facilitate client choice to take part or not, both groups were given a freephone number to contact the research team directly; rather than inform the service, if they were interested in taking part. One study invitation reminder, approximately two weeks later, was given to all invitees who had not responded to the original invitation.

Interview locations: Interviews were conducted from August to December 2002. Nineteen site visits were made to 14 individual locations outside Dublin for face-to-face interviews. RCSI offices were used as a base for those near to Dublin. Many participants (62%) opted to be interviewed by telephone. Interviews took approximately 45 minutes.

Research Process

Consultation: While client consultation is an integral part of the remit of the NCS, it has not traditionally been a part of the remit of counselling services. The challenges of balancing research and therapeutic roles in a service became apparent during the research process. The study highlighted the need for all concerned to work to agree what is necessary and desirable to achieve the goal of offering clients a possibility to comment on services they use and to determine how research can be balanced with ongoing therapeutic practice. Greater consultation is advised for future projects to achieve a balance across the therapeutic needs of clients, the concerns of counsellors in how research and audit opportunities are represented to clients, and the need of service planners for information about the quality of service provision.

Results

Response rate: Of those invited (n=814), 268 agreed to take part and were interviewed, 44 refused, 445 did not respond to the invitation and 49 expressed an interest in being interviewed but did not subsequently make themselves available (i.e. 33% response rate overall). While the response rate for the study was low, the sample obtained represents an important achievement in consultation with a very vulnerable group of service users. The information available thus provides the first service-wide feedback from clients to a national counselling service in Ireland.

Demographic profile

Overall 59% were women and 41% were men. Participants ranged in age from 19 to 74 years. Those aged 36 – 50 years comprised 41% of the sample, while those aged over 65 years were the smallest group (4%). In terms of the type of abuse experienced, 36% had experienced institutional abuse with 64% experiencing abuse in a non-institutional setting. Comparisons reveal very similar profiles in this sample and the NCS population as outlined in the NCS: First Report (2002).

Client satisfaction with service accessibility

Satisfaction ratings with specific aspects of accessibility were generally high. For example:

- Freephone service (91% satisfied), initial interview (80%), location of the centres in terms of the distance travelled (79%)
- While the freephone was seen as a useful tool for accessing the service, many individuals were not aware of the freephone before starting counselling (65%) with 33% of the overall group still not aware of its existence when interviewed for the study. Others misunderstood its purpose (with 37% believing it to be a crisis helpline).
- The initial interview, while perceived as a positive experience by many participants, caused distress for some individuals if it was followed by a waiting period (33% had to wait after intake). It was seen in terms of having to endure a 'second' waiting time after disclosing painful childhood experiences.
- Privacy and anonymity when going to and from counselling centres were important for some participants. GP clinics, shopping centres and health centre/hospitals were not seen to offer appropriate levels of privacy and anonymity.
- Transport to and from centres also caused difficulty for participants. In some cases this was about easily accessible transport. In others it was about getting to and using transport when clearly distressed following counselling.
- Satisfaction with waiting to be seen by the service for the first time was 73%. However, only 46% of those who had to wait before starting counselling after the initial interview were satisfied with this additional waiting period.
- Satisfaction with service publicity was lowest at 31%. Qualitative data on dissatisfaction identified the following themes: lack of awareness of the service associated with lack of advertising per se and lack of sensitive and encouraging advertising to overcome the stigma attached to counselling services.

Client satisfaction with the quality of service recieved: Exceptionally high satisfaction ratings were given to most aspects of a quality service.

Client satisfaction with Quality Aspects of Service

- Confidentiality (94%)
- Professionalism of office personnel (95%)
- Duration of individual counselling sessions (76%)
- Counsellor knowledge and expertise (84%)
- Level of trust (93%) Privacy / anonymity (65%)
- Availability of appointment times (85%)
- Total duration of counselling (60%)
- Ability of counsellor to listen (95%)
- Appearance & condition of centres (86%)
- Frequency of counselling sessions (90%)
- Counsellor sensitivity (92%)
- Ability of counsellor to understand client problems (85%)

The main themes explaining the minority of non-satisfied participants were: lack of feedback/interaction during the counselling session and participant perception that professionals who have not experienced abuse themselves lack an understanding of the life experiences of those who have been abused as children, i.e. they have' textbook knowledge' only. Meeting what the participant described as a 'real' or 'genuine' person was seen by many (both satisfied and not satisfied) as being of central importance to the counselling relationship.

Satisfaction with duration of counselling (for those who had completed counselling/ 'dropped out') yielded the lowest satisfaction rating in this section of the study (60%). The explanation given by most participants was that they had left the counselling service with 'unresolved issues'. These included participants unable to continue with counselling due to personal, family or work commitments; counsellors suggesting they should finish up; or participants choosing to finish as they felt that counselling was not benefiting them.

Client satisfaction with the client-centred nature of the service

Topics addressed included additional support, linkages/referrals to other services or other health professionals, and satisfaction with the ' overall effects of counselling'. Participants were asked to select what type of support they thought would have been the most useful while on the waiting list from a prepared list. Having access to a crisis help-line was selected as the most useful support (42%), while general telephone contact was seen as the next most useful support (26%). Many (45%) indicated that they felt the need for some additional support while attending counselling with half of these (25% of the overall group) indicating that they had been offered additional support. If needing support, the most frequently selected additional support was a crisis helpline, followed by therapeutic groupwork, telephone contact with the service, links to external support groups, alternative therapies, and 'reflective space'.

Participants were asked how their experience of the NCS had affected them overall. The majority (83%) indicated that they were satisfied that counselling had helped them deal with the difficulties that made them seek help in the first place. A similar proportion (80%) were satisfied that counselling helped increase their confidence. More than three quarters (78%) reported that counselling had helped them become a more independent person. Those abused in an institution were less satisfied that counselling had helped increase their independence (71% institutional vs 82% non-institutional abuse). Lastly, 81% of participants felt that counselling had improved their ability to make life choices. Thus, across questions about promoting autonomy, approximately four-fifths of participants were satisfied with the outcomes of counselling. The other fifth must be the focus of quality improvement initiatives.

A series of brief statements that summarised the principles put forth by the NCS were rated by participants. Participants were most likely to agree that the service respected the dignity of its clients (96%) and that the service maintained high professional standards (91%). Other principles that were seen to be met by a high number of participants were: confidentiality and privacy (90%), taking a holistic view (87%) and promoting independence (82%). Participants were more likely to

disagree that the service met the principles of accessibility (25% disagreed) and choice (24% disagreed).

Understanding the dynamic and evolving nature of the NCS is important when considering this report's recommendations. As outlined in the introduction of this report and in the NCS's own First Report (NCS, 2002), many new policies and initiatives have been developed and implemented as the service has evolved over the past three years. These may not have been fully in place when the participants in this study availed of the service. On the other hand, waiting lists have developed over time and client experiences now may differ from those in 2000 to 2002 when study participants contacted the NCS. Thus the report must be seen as a snapshot in time and its findings and recommendations considered within the context of the service today.

Recommendations

Recommendation 1: Providing an accessible service

1.1: That the NCS develops its advertising and publicity profile to increase awareness of its counselling service for those who have experienced abuse as children.

1.2: That NCS advertising campaigns are scheduled at coordinated and nationally agreed intervals.

1.3: That any advertising campaign involving the NCS will endeavour to reduce the stigma associated with counselling service use and a history of child abuse.

1.4: That any advertising campaign involving the NCS will consider the various means of advertising its services, i.e. through public and health professional routes.

Recommendation 2: Providing a timely service

2.1: That the NCS puts in place ways to manage the access process for potential clients to minimise distress. If required (i.e. if the client is deemed to be very distressed), the immediate needs of the client should be assessed and appropriate intervention offered when a client first discloses childhood abuse to the service. This assistance is to support the client until such time as counselling can begin.

2.2: That the NCS reviews the current access process with particular emphasis on the initial interview and subsequent waiting time to commence counselling.

2.3: That the NCS provides the optimum number of counselling sessions for positive outcomes as agreed between counsellor and client, rather than as determined by resource constraints.

2.4: That the NCS co-ordinates evidence within and across health boards annually to predict staffing levels needed; this is to be used as a basis for requesting resources to enable timely delivery of services.

Recommendation 3: Providing an easily-contactable service for distressed clients

3.1: That NCS management, in consultation with administrative staff, review current levels of training to establish if adequate and appropriate training and support is provided to staff to respond appropriately to distressed callers and first-time callers to the freephone service.

3.2: That the NCS specifies a timeframe for establishing a national telephone helpline, as recommended in its First Report (NCS, 2002).

Recommendation 4: Providing an out-of-hours service where necessary

4.1: That the NCS assesses the need for provision of counselling sessions outside the 9-5 o'clock working day schedule to facilitate those clients who have work or family commitments during this period. Where available, an out-of-hours service should be made known to clients.

Recommendation 5: Providing services in an accessible and acceptable environment

5.1: That the NCS reviews current premises to ensure that counselling centres are accessible for clients with disabilities. Account should be taken of the various types of disability including hearing and visual impairments.

5.2: That the NCS reviews premises on an ongoing basis to ensure that each counselling location is physically conducive to the counselling process in terms of seating, sound proofing and other such physical conditions.

Recommendation 6: Providing choice of service to clients

6.1: That the NCS endeavours, through clarification of the options and service choices available to clients, to maximise choice for those wishing to avail of its services.

6.2: That the NCS ensures each client receives both written and verbal information regarding the service complaints procedure. This should be an integrated part of the introductory sessions, and related written materials, for clients.

Recommendation 7: Providing clients with an opportunity to participate in service evaluation and quality improvement activities

7.1: That the NCS solicits client feedback for service quality improvement purposes in a structured and co-ordinated manner at regular intervals and then integrates recommendations into practice as a matter of course.

Recommendation 8: Providing staff with an opportunity to participate in service evaluation and quality improvement activities

8.1: That the results of the study, including the very high levels of satisfaction with the counselling process, be communicated to all NCS staff.

8.2: That the NCS outlines mechanisms to consult with staff on how best to advance its quality agenda.

Recommendation 9: Providing clients with assistance needed in contacting services other than counselling

9.1: That the NCS explores, in consultation with survivor support groups, those mechanisms of service delivery which aim to meet client needs for additional support.

9.2: That the NCS further develops and disseminates information to staff on a regional and national basis regarding links and working collaborations with other relevant sectors, e.g. addiction, mental health and childcare.

9.3: That the NCS, as outlined in the First Report (2002), disseminates information to clients regarding the nature, method and limits of referral to other agencies.

9.4: That the NCS investigates the potential need and role of an advocate and of 'befriending' and 'volunteer mentoring' positions within the service

9.5. That the NCS, in consultation with other agencies and groups who provide services for survivors of childhood abuse, makes available a directory of available services and support groups nationally and regionally.

Recommendation 10: Providing clients with the opportunity to attend group therapy

10.1: That the NCS assesses service demands for/interest in group therapy, plan and develop provision on this basis.

Recommendation 11: Providing opportunities for service providers and users to consider and advise on the findings of service evaluations

11.1: That the NCS consults with relevant constituencies and agree what actions to take based on the findings of the present study.

11.2: That key results of the study and subsequent actions committed to by the NCS be provided in summary form as a public notice to inform staff and clients in counselling centres.

Recommendation12: Providing opportunities for future research

12.1: That the process of consultation for future research be as inclusive as possible and represent all relevant parties.

12.2: That the NCS, in consultation with survivor groups and staff, identifies areas for future research. Specific areas of importance as highlighted by this report include counselling outcomes for those abused within institutions as children compared to those abused in other contexts.

Summary

This service evaluation is a 'snapshot' of a service at a specific time. Across three core principles as set out by the NCS when it was established, the study identified that participants reported high levels of satisfaction with the service. The results clearly show that from the perspective of service users, considerable success has been achieved in translating these principles into practice. This has been achieved within a system of limited resources; in an area where there has been a vacuum in terms of statutory service provision of this type of counselling service up to the year 2000; and in a context where the service was established as a result of vociferous public campaigning by a group who felt wronged, unacknowledged and unsupported because of their institutional abuse and subsequent lack official recognition and retribution. Thus, the NCS started with the requirement to demonstrate government follow-through on public commitments to deliver high quality services to a particularly vulnerable and sensitive client group. The results of this study provide evidence that many of the commitments made to ensure a high quality, accessible and client-centred service have been met in these early years of its establishment. The time and effort of all those involved in the study: service administrators, counsellors and (particularly) clients, will have been well spent if the achievements to date are acknowledged and if evidence on areas for further improvement are incorporated into a quality improvement system for the coming years.

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Foreword

I am pleased to present this study, *Survivors Experience of the National Counselling Service* (SENCS). The study was commissioned by the National Counselling Service (NCS) and conducted by the Health Service Research Centre at the Department of Psychology, Royal College of Surgeons in Ireland.

The National Counselling Service was established in September 2000 to provide counselling and support services to those who experienced childhood abuse in particular those who were abused in institutions. The guiding principles of the NCS are to provide a service that is accessible, client-centred and of a high quality. The service is provided through the ten regional health boards, working together under the auspices of the Heath Board's Executive to deliver a nationally consistent service locally. Since its establishment almost 6,000 people have availed of counselling and support from the NCS.

The National Health Strategy *Quality and Fairness, A Health System for You* sets out as part of its vision the development of a health system 'that encourages you to have your say, listens to you, and ensures that your views are taken into account'. From the outset survivor groups have been involved in the development of the NCS. As part of this ongoing commitment it was decided to commission an independent evaluation to establish the views and experience of surviors using the counselling service, to establish the quality of the services provided and to evaluate how the NCS was meeting its guiding principles in practice. This report, the first of its kind, details the findings of this study and reflects the vision of the National Health Strategy of service user involvement.

The SENCS study finds that participants reported high levels of satisfaction with the service. The results clearly show that, from the perspective of service users, considerable success has been achieved in translating NCS guiding principles into practice. The NCS started with the requirement to demonstrate government follow-through on public commitments to deliver high quality services to a client group which can be particularly vulnerable given the sensitive nature of the issue of childhood abuse. The results of this study provide evidence that many of the commitments made to deliver a high quality, accessible and client-centred service have been met by the NCS in the early years of its establishment. The study also identifies areas that service users are not fully satisfied with and makes recommendations to address these issues and to further improve the quality of the service clients receive. Work has already commenced to implement many of these recommendations.

On behalf of the NCS I would like to thank all of the service users who took part in this study in particular for your forthright and honest views on how you experience the counselling service. Your feedback is very important in our to improve and enhance the quality of the NCS in the future. I particularly want to thank the survivor groups and to acknowledge their contribution to this study. Special thanks go to Mr John O Dwyer for allowing us to use his painting for the cover and to Trish Kelly, Art Teacher for helping to make this possible. I would also like to thank the research team from the Health Services Research Centre at the Department of Psychology, Royal College of Surgeons in Ireland - Professor Hannah McGee, Colette Leigh, Kay Rundle and Rebecca Garavan - for carrying out the study.

Further, I would like to thank the Research steering group, Ros Moran, Jackie Kavanagh, Christine Buckley, Noreen Harrington, Gerard O Neill, Fiona Ward, Dawn Nance, Robert Kahl and David Byrne for their assistance to the researchers. I would also like to pay tribute to the Directors of Counselling and all the staff, clinical and administrative of the NCS for their dedication and commitment, which is evident from this report. Finally, I want to thank the Minister for Health and Children and his Department for funding and supporting this study.

In conclusion, the importance of this study is well summarised by the report when it states:
"The time and effort of all those involved in the study: service administrators, counsellors and (particularly) clients, will have been well spent if the achievements to date are acknowledged and if evidence on areas for further improvement are incorporated into a quality improvement system for the coming years".

Pat Donnelly, *Chair*
National Counselling Service Steering Group

Chapter I

INTRODUCTION

This chapter aims to provide the reader with an insight into the main issues which have informed the development of this report. A contextual understanding of the study from the perspective of survivors of childhood abuse and from the perspective of the service itself is crucial. For example, an awareness of the stigma which is associated with child abuse will reinforce for the reader the importance placed on the definition and provision of a high quality, accessible service which meets the needs of the NCS client group. Likewise, prevalence figures for childhood abuse provide a context in which service demand and service provision can be viewed. Information regarding the NCS provides the reader with a broader context in which participants experiences of using the NCS can be interpreted. Finally, comparative data from other studies and similar services, insofar as they can be made, allow for comparisons to be drawn in terms of the study response rate and its findings.

1.1 Background

Child abuse has received increasing attention in recent years in Ireland. Among the revelations of the late eighties and the 1990s has been evidence of the existence of abuse of children in institutional settings in the past. The extent of the abuse which has become apparent has resulted in public outcry with demands for support for those abused and accountability for those responsible. During the late 1980's and throughout the 1990's, individual survivors of institutional abuse began to speak publicly of their abusive experience as children within State institutions. Paddy Doyle told of his experiences of institutional abuse from the age of four in "The God Squad" (1988), Christine Buckley described childhood in the Goldenbridge 'orphanage' in the television documentary "Dear Daughter" (1996) and Paddy Touher described experiences in Artane Industrial School in his book "Fear of the Collar" (1991). Survivors groups began to lobby government ministers to gain acknowledgement and a response to their plight. The Irish public was increasingly confronted with disclosures of individual cases of survivors of institutional abuse and some high profile cases of familial child abuse such as the Kilkenny Incest Case and Investigation in 1993 and the case of Sophia McColgan (1998). The television documentary "States of Fear", broadcast in 1999, described the type and scale of abuse and neglect across institutions. It was a catalyst for a Government apology to those abused and for the establishment of both a legal process to investigate claims of abuse (The Laffoy Commission to Inquire into Childhood Abuse) and for a counselling service to support those who had experienced abuse.

1.2 The context of institutional abuse

Raftery and O'Sullivan (1999) provide the following estimates of the numbers of children in State care from 1868 – 1969:

- 105,000 children were placed in 'industrial' schools by Irish courts.
- 25,000 children who were born in county homes (workhouses) were also placed in these industrial schools.
- Approximately 150 children per annum were sent to spend several years in reformatories.
- A substantial number of children were also placed in the care of private orphanages.

While these large numbers of children in State institutions spanned over a century, there were approximately 7,599 children in residential care at the time of the foundation of the state. The Kennedy Report, published in 1970, reviewed the care of children by state institutions and called for the closure of these industrial schools. In 1970 the Health Act was passed which meant that child welfare and protection became the responsibility of health boards. By 1980 the number of children placed in care had dropped to approximately 1,000 (Raftery and O' Sullivan, 1999). However, many of the children who were placed in these institutions throughout the twentieth century are still alive today and many of these bear the legacy of an abused childhood.

Research indicates that children who are placed into care are more vulnerable to abuse and neglect because of their dependency on their carers to have their needs met. Without experiencing a wilful abusive act by an adult carer in an institution, children placed in care still face many difficulties:

> *" Children in care are especially vulnerable since they suffer a three fold risk of abuse. The first level they face is on the basis of their status as a child, the second level of risk relates to the abuse or traumatic experiences, which led to their entry into care and which are likely to have provoked or deepened a sense of powerlessness or worthlessness. These in turn heighten their vulnerability to abuse, exploitation, or unscrupulous domination. The third relates to their dependence and isolation in care."* (Gilligan, 1994)

International research into the prevalence of institutional abuse of children suggests that while the numbers involved may be small, it is nevertheless a significant social issue (Nunno, 1992; McFadden and Ryan, 1992; Finkelhor et al, 1988).

> *" While there are no reliable estimates for the prevalence rates for abuse in these institutions, it seems that such abuse is not uncommon and an alarming aspect of institutional abuse is the greater number of children affected. Thus hundreds of children passing through an institution can be damaged by repeated abuse committed by a handful of abusers, with devastating long-term effects for children. This is not to say that all care institutions is detrimental to the child."(*Bifulco and Moran, 1998)

1.3 Prevalence of abuse

Gallagher (2000), in his study of institutional child sexual abuse across eight local authority areas in Britain, found that while this type of case constituted a small number of child protection cases (65 substantiated cases of institutional abuse over five years (1988-1992)), some cases involved large numbers of perpetrators and victims. This constitutes 1% of all child protection referrals to social services and 3% of referrals for child sexual abuse.

Alongside the population of survivors of institutional abuse in Ireland are adults who have experienced childhood abuse in other contexts such as the family. The recent SAVI Study (McGee et al., 2002), a national prevalence study of sexual abuse and sexual violence in Ireland, shows that 21% of girls and 16% of boys aged under 17 have experienced some form of contact sexual abuse. In the SAVI study, a very small number (39 individuals (1.3%)) reported being 'in care' as children. In all of these cases, their experience of abuse pre-dated them going into State care. It is important to note however that community type surveys such as SAVI will underestimate the experiences of very vulnerable people in society as they do not typically include those residing in institutional settings such as psychiatric hospitals or prisons. Another group currently being studied in the context of abuse are those sexually abused by the clergy as children (Goode et al., in press 2003).

Department of Health and Children national figures collated by the Child Care Legislation Unit on referred and confirmed cases of childhood abuse show that a substantial number of Irish children have experienced abusive life events. The following tables (tables 1.1 and 1.2) show the numbers of referred cases for the years 2000 and 2001. Figures for the year 2001 are provisional but are interesting in that they show a significant decrease in the number of confirmed cases between 2000 and 2001.

Table 1.1 Number of child abuse cases referred to the health boards in 2000

Primary Type of Abuse	Number of Reported Cases	Number of Children	Confirmed Abuse	Confirmed Non-Abuse/ Unfounded	Inconclusive Assessment	Assessment Ongoing
Physical abuse	1620	1519	548	149	416	507
Sexual abuse	2104	1991	517	182	561	844
Emotional abuse	1244	1192	567	95	248	334
Neglect	3301	3037	1453	352	679	817
Total	8269	7739	3085	778	1904	2502

Table 1.2 Number of child abuse cases referred to the health boards in 2001

Primary Type of Abuse	Number of Reported Cases	Number of Children	Confirmed Abuse	Confirmed Non-Abuse/ Unfounded	Inconclusive Assessment	Assessment Ongoing
Physical abuse	1252	1180	419	130	261	442
Sexual abuse	1842	1707	397	170	476	799
Emotional abuse	814	753	270	72	149	323
Neglect	2086	1937	774	232	390	690
Total	5994	5577	1860	604	1276	2254

This decline in reported and substantiated cases is in contrast to national child abuse cases reported and confirmed during the 1980s. In the period 1983–1989 the annual number of confirmed cases of child abuse increased eleven fold, from 156 cases in 1983 to 1,658 in 1989. Further analysis of these figures shows that within the broad category of child abuse, sexual abuse increased by a factor of fifteen, from 37 in 1983 to 568 in 1989 (Gilligan, 1991). The Department of Health and Children figures for the number of children placed in the care of the state for the period 1983–1991 also show an increase from 1.95 children per 1,000 in 1984 to 2.24 per 1,000 in 1989 (Gilligan, 1991). While over the past two years Department of Health and Children figures show a decline in the number of reported and confirmed cases to the health boards, these figures and the findings of the SAVI Study show that there exists a very substantial number of people in Irish society who have been abused and who may need therapeutic services. While Department of Health and Children figures on child abuse provide an insight into the occurrence and type of abuse being experienced by Irish children, it is difficult to establish accurate prevalence for physical and emotional abuse and neglect. Corby (2000) estimates 2-30% of children experience physical abuse depending on the definition of physical abuse used. Department of Health and Children confirmed cases of child neglect for the year 2000 show that this type of abuse accounted for over 40% of all ‘types’ of confirmed child abuse.

1.4 The impact of childhood abuse

It is important to consider the experiences of people who have been abused. The effects of abuse are dynamic and interact with each other. Thus, experiences and adaptations children make as a consequence of abuse become part of their overall developmental process, shaping their view of their world and themselves (Hanks & Strattan, 1995). Childhood trauma is therefore likely to affect the child immediately and also to contribute to distorted concepts about themselves and the world. Children may develop ways of coping in order to keep themselves safe, which may prove to be maladaptive in the long-term and may contribute to difficulties in adulthood (Corby, 2000).

1.4.1 Impact on psychological functioning – coping strategies

Trauma may also affect an adult in the long-term. The effects of this may become an intrinsic part of the adult’s psychological functioning. Thus, the coping mechanisms adopted by an abused child may significantly influence their behavioural, emotional and psychological well-being as adults. Difficulties may result in many aspects of life such as the ability to parent their own children; to form and maintain close healthy relationships from a reduction in the ability to trust or to empathise with others and the self; or to cope with the stresses of normal life events. Many survivors may also experience low self-esteem (Corby, 2000; Lynch, 1988; Martin and Elmer, 1992).

1.4.2 *Revictimisation*
In relation to those who have experienced sexual abuse as children, there is evidence that they may be at risk to further sexual assault or rape than their same aged peers without a history of abuse (McGee et al, 2002; Travers, 1999; Russell, 1986). A commonly experienced difficulty for many survivors of abuse is with regulation of emotions and impulse control. This maybe expressed in terms of addiction problems, inability to control anger, aggression, eating difficulties (Welch and Fairburn, 1996), depression, self-harm, suicide attempts and criminal activities (Chu, 1998; O'Connor, 1986).

1.4.3 *Link with mental health difficulties*
A large body of evidence demonstrates that those who have been abused as children are more likely to use psychiatric services as adults. For example, in the Irish context, the National Conjoint Committee, which helped form the NCS in 2000, surveyed health board mental health services. They found that approximately 30% of adult patients were survivors of childhood abuse in addition to their mental health difficulties. The SAVI Study showed that those who were sexually abused as children were eight times more likely to have subsequently been inpatients in a psychiatric hospital. Read (1998) found that patients who had been physically or sexually abused or both were more likely to be suicidal, to have longer stays in psychiatric hospitals, and to show the most severe disturbances in symptoms and behaviour.

1.4.4 *Impact on quality of life and potential*
Research has consistently found a history of institutional care to be associated with long-term educational and vocational disadvantage and unemployment, as well as a higher incidence of criminal behaviour. Adult survivors frequently report that they are not and were not given the opportunity to reach their full potential. This may result in strong feelings of loss, resentment and low self esteem in many survivors, as well as having poor general coping skills and difficulties in taking on responsibilities in life (Corby, 2000; Dept. of Health; UK, 1999; Lynch, 1988; Martin & Elmer, 1992; O'Connor, 1986).

1.4.5 *Factors which influence the impact of childhood abuse*
Duration of abuse is one factor influencing the scale of the impact of abuse on a child. Longer experiences of abuse/neglect are generally associated with more severe sequelae in adulthood. More severe abuse in childhood also increases the impact in adulthood (for example in relation to sexual abuse, experiencing penetrative abuse tends to be more damaging than abuse which involves being fondled. This however is modulated in relation to the closeness of the abuser to the child (Courtois, 1999)). The context of abuse also needs to be considered. Research indicates that when a child is abused in their family setting by a trusted carer, their ability to form relationships across the life span is impaired. This is however, mediated by the level of support and emotional nurturance they have received and are receiving at the time of the abuse. In the context of growing up in an institution, the experience of abuse may be exacerbated by the lack of protective adults available to the child.

1.5 Assessing the service needs of survivors of childhood abuse
The Inter Agency Group on Sexual Abuse in Northern Ireland is a group of eleven statutory and voluntary sector agencies who provide services and care to adult survivors of sexual abuse within the Western Health & Social Services Board area. In 1998 the Inter Agency Group commissioned the Heather Report. The aims of the report were to ascertain the views of adult survivors of sexual abuse about their needs and their experiences of services and to elicit the knowledge and experience of a range of professionals working with adult survivors. Recommendations were made in six main categories: (1) Access to services, (2) Practice standards, (3) Therapy, (4) Provision of care for adult survivors, (5) Inter Agency working and (6) Public awareness. In total, 39 specific recommendations were made, ranging from the provision of immediate help to survivors in the period between disclosure and the commencement of therapy to displaying sensitivity towards gender in the allocation of counsellor to clients. While the Heather Report has a focus which is much wider than the provision of counselling/therapeutic services, it does highlight the range of service needs for survivors of childhood abuse.

The Fife Report (Centre for Health and Social Research, 2001) outlined a pilot service called 'Breakfree' for survivors of childhood sexual abuse in England. While this parallels some of the principles of the NCS (i.e. community based and committed to providing an accepting, safe, stable and available service), the package of care differs from the NCS as it provided a drop-in facility, an out-of-hours paging service, a befriending service, a respite service and support for the client's family and friends if requested alongside individual therapy. The Fife Report provided an assessment of the service needs of survivors of childhood sexual abuse and provided recommendations to develop a model of improved service delivery for adult survivors. Report recommendations included improvements in communication and collaboration between service providers and the provision of accessible and widely available information regarding services.

1.6 Counselling

1.6.1 Definitions of counselling

Explanations and definitions of counselling are many and varied. Many individual organisations and theorists have contributed their own understanding of the concept.

Counselling is:

> *" a principled relationship characterised by the application of one or more psychological theories and a recognised set of communication skills, modified by experience, intuition and other interpersonal factors, to client's intimate concerns, problems or aspirations. Its predominant ethos is one of facilitation rather than advice giving or coercion. It may be very brief or long duration, take place in an organisational or private practice setting and may or may not overlap with practical, medical and other matters of personal welfare"*
> (Feltham & Dryden, 1993)

Continuing on:

> *"It is both a distinctive activity undertaken by people agreeing to occupy roles of counsellor and client... and it is an emergent profession… It is a service sought by people in distress or in some degree of confusion who wish to discuss and resolve these issues which is more disciplined and confidential than friendship, and perhaps less stigmatising than helping relationships offered in traditional medical or psychiatric settings."*
> (Feltham & Dryden, 1993)

The NCS "First Report" cites Jacob's (1929) as an explanation of what counselling can contribute:

> *"Counselling is one way of opening up the past in a safe environment so that it can be faced, renegotiated, and in some respects even relived, but with 'a new ending'."*

One NCS health board counselling centre explains counselling in its service information as:

> *" Counselling is the process of creating a confidential space where people can begin to heal with the help of their counsellor. It is concerned with the whole person and gives the client time to talk about feelings, thoughts and concerns. The counsellor provides a safe, confidential service which is non-judgemental".*

Many textbooks endeavouring to represent the field of counselling focus on mainstream approaches. However, the number of different theoretical approaches generally agreed upon are about 300 (Feltham, 1995). Whatever the theoretical approaches, many writers in this area note the primary importance of the actual relationship between counsellor/therapist and client:

> *" Whatever the counselling style or psychotherapeutic orientation, most practices involve two people who meet, talk and form a relationship structured around a system of ideas purporting to explain human behaviour".* (Howe, 1993)

1.6.2 Effectiveness of Counselling

There is now a strong body of research evidence and a general acceptance that psychological therapies are effective for minor and major psychological disturbances and illnesses. A key study

was carried out by the National Health Service in the UK to address these issues. It was entitled *"What works for whom? A critical review of psychotherapy research"* (Roth and Fonaghy, 1996). The authors demonstrated the effectiveness of a number of treatments, especially Behaviour Therapy, Cognitive Therapy and Psychoanalytic Psychotherapy for a range of psychological problems. They concluded that psychological therapies were the first line treatments of choice for a number of disorders including anxiety, depression, addictions and eating disorders.

Hubble, Duncan and Miller (1999) in a review of psychotherapy and counselling, reported that the average treated person in counselling was better off than 80% of the untreated sample. The magnitude of the benefit has been identified as equivalent to the level that justifies interruption of clinical trials on the grounds that it would be unethical to withhold such an effective treatment from patients in need (Ursano and Silberman, 1994). Similarly, a review of the findings of four studies concerning the effectiveness of counselling in primary practice, established that patients who receive counselling showed an improvement in symptom level compared to patients who receive routine GP care. Levels of satisfaction with counselling services were high (Rowland et al, 2000, c.f. Mellor Clarke, 2000).

1.6.3 *What works in counselling / psychotherapy?*

Factors contributing to positive outcomes in counselling / psychotherapy

Factors that contribute to change in the therapeutic process can be categorised into four main areas:

- Client/Extra-therapeutic factors
- Relationship factors
- Placebo, hope and expectancy
- Therapeutic model or technique.

A review of meta-analytic research (Hubble et al 1999) which examined the factors that contribute to change in clients attending counselling or therapy, has identified that:

- 40% of change was accounted for by extra-therapeutic factors, i.e. external events and supports. This includes individual resources as well as intellectual ability, ability to tolerate emotional affect and ability to self-soothe.
- 30% of change was accounted for by relationship factors between the counsellor and the client. Key aspects of the relationship were the importance of a collaborative alliance with the client. The client needs to see that their own efforts are part of the solution and where a therapist is able to engage with a client own theory of change, better outcomes are generally identified.
- 15% of change was accounted for by placebo or the client's expectation regarding the potential impact of counselling or therapy.
- 15% was accounted for by the actual therapeutic model, orientation and techniques.

In summary, the value of counselling/therapy appears to be well supported and a primary measure for success would appear to be the relationship between counsellor and client. Clients need a trusting relationship and a client's level of involvement in the therapeutic process is the best predictor of outcome from psychotherapy.

1.6.4 *Duration of counselling*

When estimating the length of therapy required for a person, research indicates that some clients (such as those who have an addiction, personality disorder etc.) are more vulnerable to relapse and will require a longer duration of counselling/therapy. For this group of individuals, therapy may last for between 1 to 4 years with therapy being spaced at longer intervals over time to reduce dependency on the process (i.e. moving from weekly sessions, to two weekly, to monthly, etc.).

A survey of 2,900 individuals who had received psychotherapy from mental health professionals showed that longer duration of treatment was associated with better outcomes (Seligman, 1995). Wampold et al (2001), from a meta analytic review, found that reliable change generally begins after 7-9 sessions and is optimal after 13-20 sessions.

In relation to clients who have experienced trauma, the optimum length of time in therapy has been identified as 18-24 months. About two thirds of clients in general require this length of time in a therapeutic context. In addition, research has identified that clients who present as most distressed generally demonstrate the most significant gains. However, they are unlikely to enter a normal range of functioning and may require 30% longer in therapy than clients with less severe difficulties. Wampold et al (2001) identified that for the majority of clients (75%), at least 40 sessions are required in order to reach a reliable level of change.

The UK's Department of Health has developed a set of clinical practice guidelines to aid professionals in decision making regarding which forms of psychological therapy are most appropriate for which patients. The following is recommended in relation to the length of counselling/therapy required:

> *"Therapies of fewer than eight sessions are unlikely to be optimally effective for most moderate to severe mental health problems. Often 16 sessions or more are required for symptomatic relief, and longer therapies may be required to achieve lasting change in social and personality functioning. Specific phobias and uncomplicated panic disorder (without agoraphobic symptoms) can respond to brief interventions."* (Department of Health, 2001)

These recommendations are pertinent in the context of providing a service for a problem as significant as child abuse or neglect. The majority of NCS clients are likely to require longer term intervention given the nature of their problems.

1.6.5 Cost effectiveness of psychological therapies

The effectiveness of psychological therapies has been shown, not just in benefits to the client, but also in terms of reducing the cost of alternative care. A review of the literature on clinical trials, concluded that psychotherapy appeared to have a beneficial impact on a variety of costs when used in the treatment of the most severe psychiatric disorders and that much of this impact resulted from reduced in-patient admissions and reduced work impairment (Gabbard et al., 1997). Elsewhere, twice weekly psychotherapy over a 12-month period was found to be cost-effective with patients diagnosed with 'borderline personality disorder' as it decreased the use of in-patient and emergency room care. Substantial savings were demonstrated (Linehan et al, 1991).

Mellor-Clark (2000), in a review of the impact of counselling in primary care settings identified that patients who received counselling demonstrated a consistent reduction in psychiatric symptoms that was maintained for at least three months after counselling ended. In addition, there was evidence that counselling interventions led to healthcare resource savings as measured by a reduction in referral on to NHS outpatients services and fewer consultations with their GP in the year following counselling.

Practitioner handbooks stress the importance of allowing an appropriate length of time for the client to heal and that this 'appropriate' duration of counselling should be agreed by both therapist and client. Counselling/therapy can be characterised as either that of global, i.e. long-term counselling or short-term, i.e. time-limited therapy. During the pre-counselling assessment stage, discussion between counsellor and therapist regarding the suitability and preference for a particular term of counselling is recommended (MacDonald et al 1995; Sanderson 1995).

Clients may discontinue counselling prematurely for a number of reasons. In some cases practicalities such as difficulty in scheduling appointments alongside other work or family commitments may be the issue. Finances (where services are paid for privately) may also result in discontinuation. Clients may also discontinue because they are unable to make a good connection with their particular counsellor or therapist. Finally, clients may discontinue because they find the process too distressing. It is important to understand the extent and causes for discontinuation in any evaluation of counselling service provision. Much of the literature regarding clients who prematurely discontinue counselling use the term 'drop-out'. Pekarik (1985b), in a paper on counselling termination classifications, cautions about using the term drop-out. He argues that

simply using number of visits attended or duration of counselling will not necessarily accurately identify drop-out. For instance, two clients who have attended for the same length of time may have attended a different number of sessions. It is also possible that appropriate and mutually agreed termination of counselling can occur after one or two visits. A study of attendance and drop-out rates from an outpatient psychotherapy service in New Zealand found that approximately 17% of clients did not attend their first appointment and 13% dropped out of therapy within the two month follow-up (Deane, 1991). However, Baekland and Lundwall's (1975) classic review of 362 studies on dropping out of treatment found much higher drop-out rates: between 30 to 60% of outpatient psychotherapy clients terminated by dropping out of therapy. A Northern Ireland survey found that 51% of the counselling organisations and individual counsellors said less than 10% of clients dropped out before counselling was complete (Park, 2002). McCarthy et al (2000), in a study of outpatient clinic waiting times and non-attendance rates in two Irish adult general hospitals found that 31% of 2,134 appointments in one week resulted in non-attendance. Thus the problem is not exclusive to mental health services.

1.7 The National Counselling Service

1.7.1 Setting national standards for the provision of a quality service

The service established for those abused in institutional care in Ireland is entitled the 'National Counselling Service' (NCS). Before the service was formally established, a national health board working group was created and consultation with abuse survivor groups took place. As a result a 'National Model of Service' was devised. The priorities of survivor groups and professionals in the formation of a national counselling service concerned quality principles such as professionalism, choice and standardisation. A set of five key principles were agreed to inform the NCS as follows: accessibility, quality, choice, responsiveness and integration (NCS First Report, 2002). Each principle is operationalised through specific service delivery components, which will be examined in detail later.

The NCS is a new service (established in September 2000). This service is provided under the auspices of the ten regional health boards but operates using a conjoint health board approach. Agreement regarding national standards for practice are achieved through a National Steering Group. All counselling/therapy staff employed to work with the NCS must have a primary health care qualification in either nursing, social work, medicine or psychology together with an accredited professional qualification in psychotherapy or counselling or a relevant post graduate qualification. In addition, all staff are required to have two years relevant work experience working therapeutically with adults. Good practice and nationally agreed policy dictate that counsellors engage in no more than 16 counselling contact hours per week. Therefore, with six counsellors per service, the maximum counselling hours available per week per service is 96. The Director of Counselling in each health board has an important role in implementing national policy. Alongside efforts at standardisation, each region has developed its service to address the specific needs of the 'local' client group. Services are available in 57 locations (13 main offices and 44 outreach centres) nationally with almost 70 counsellors in place.

1.7.2 Publicity and advertising

The service is advertised in a number of ways: through local newspapers and radio and by posters in hospitals, GP clinics, etc. Advertising of the counselling services in the various health boards has taken place at different times and in response to situations that may arise locally. Decisions to advertise are considered carefully in terms of the potential impact of any advertising and the capacity of the service to respond to calls that may be made.

1.7.3 Referral routes and waiting times

The service offers individual counselling sessions, without cost, to those who have experienced abuse or neglect in childhood. The term 'abuse' covers emotional, physical, sexual abuse and neglect. Potential clients can self-refer to the NCS or may be referred by health or social services professionals. Service contact can be made by freephone. Each health board has an individual

freephone number. Those seeking services are first offered an 'intake interview' to assess suitability of the service for the particular client's needs. Following this, the client may be transferred to a waiting list for counselling. The number of counselling sessions available are not pre-determined. While the NCS was established to provide counselling to those abused in institutional care, its publicity (in the absence of visible services for others experiencing abuse) meant that many individuals who have experienced abuse in other settings made contact to seek services. Because of this, it was agreed that the NCS counselling be now available to all adults who have experienced any form of abuse during childhood.

Initiatives currently being undertaken by the NCS to manage service provision and waiting lists include:

- Coinciding with discussions with the survivors groups, a subgroup of the NCS has been working on the provision of a telephone helpline in order to meet client needs outside of the therapy setting and out-of-hours.
- Out-of-hours services are being provided across the country at various locations. All boards provide some level of out-of-hours provision on a case by case basis while a number of services have a dedicated out of hours service. The NCS would like to extend this part of the service as part of its ongoing development but staff numbers and geographical spread of service provision, impact on the potential development of this option.
- Offering clients an initial meeting while awaiting counselling. This involves a brief screening in order to identify any current needs and put in place any additional interventions which can be offered in the interim period prior to onset of counselling.
- The NCS has established a working group to examine best practice in relation to the management of client waiting lists.
- Training and support of administrative staff in dealing with a distressed client group with special needs is being provided through national training days for administration staff as well as via local support arrangements.
- Work on a national database/information system is at an advanced stage and is expected to assist greatly in service planning.

1.7.4 Demand for counselling

The process of repairing the damage caused by the various types of abuse which may have been suffered for years throughout childhood can be extremely complex. There is increasing demand for counselling services. Since the NCS was established in 2000, more than 5,000 people have been referred for counselling. In 2002 there were 2,132 referrals to the service; an increase of 12% on the previous year (total numbers for 2001 were 1,897 and for 2000 were 463), (see figure 1.1, for an annual outline of referrals per health board over the past three years). The implications of this intense service demand (i.e. increase in numbers seeking counselling to address complex problems which typically require weekly therapy for at least a year) for waiting lists are evident, given that the average rate of referrals per month per service is 21 cases. As the service is now in its third year, counsellors are engaged in long-term work with many ongoing clients. This, alongside increasing numbers presenting, has a significant impact on the waiting list. At the end of 2002, the waiting list nationally was approximately 590 people, with an estimated average waiting time of one year for a counselling place in many health boards.

The fact that criteria for referral to the NCS are quite broad, i.e. any person over the age of 18 who has experienced any kind of abuse can avail of the service, means there is a high level of referral to the service and thus an increasing waiting list.
The NCS encourages self-referral for counselling (more than half of all clients nationally refer themselves for counselling). This 'open' policy further impacts on demand for the service and contributes to pressure on the waiting list. It must also be acknowledged that the NCS is operating in the context of a system that offers very few other counselling/therapy options.

Demand for the NCS has grown considerably since its establishment (see Figure 1 for referral figures). Over the last two years there has been a greater public awareness of the issue of childhood abuse amongst the public facilitated by increasing media coverage of issues related to abuse. This

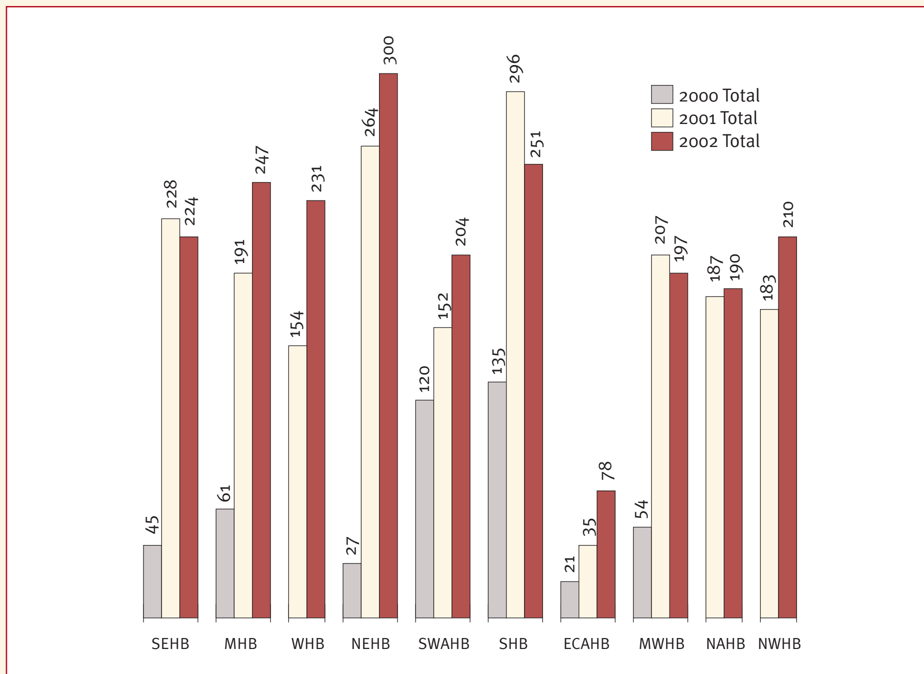


Figure 1. Number of referrals for child abuse and neglect to the National Counselling Service by health board for the period 2000-2002.

has impacted on the NCS and has resulted in additional demands on the service. The NCS is therefore attempting to respond to a great unmet need.

1.7.5 Current NCS policies

At the present time, the NCS has a number of service provision policies in operation (*First Report,* 2002). These include:

- A commitment to making the service accessible for clients from minority groups. This includes provision for transport to counselling where needed.
- An agreed national policy in relation to the limits of confidentiality.
- Prioritisation of the allocation of counselling appointments for clients who have experienced abuse in institutions.
- Supervision of staff (this has been in place since the onset of the service). Supervision encompasses a number of elements including line management, clinical and peer supervision.
- Linking with other services, both within the health boards and externally, in order offer as seamless a service possible to clients with multiple care needs. This includes a formal liaison relationship with the Commission to Inquire into Child Abuse and other agencies in order to facilitate the needs of clients. A significant proportion of counsellor/therapist time is spent linking with other professionals such as GPs, psychiatrists, social workers, etc. in relation to client needs.
- Working across boundaries within health board sectors and across the different health boards, in order to provide a service of choice to best suit the client.
- Facilitating choice of location, gender of counsellor etc. for clients in so far as resources allow.

1.7.6 The NCS and client consultation

The NCS 'National Model of Service' acknowledges the need for 'ongoing consultation and client feedback' as part of a quality service. In 2002, two years after its inception, the NCS invited tenders and commissioned the Health Services Research Centre at the Royal College of Surgeons in Ireland to evaluate the service from the perspective of service users. As outlined in the NCS tender document, the purpose of this study is:

> *" To assess the quality of services provided by the National Counselling Service (NCS). The overall experience of service use will be evaluated with particular emphasis on the extent to which the three most important guiding principles of the service have been met. These principles are to provide a service that is accessible, client–centred and perceived to be of a high quality. This will primarily be judged from the perspective of survivors of child abuse who have used the service with additional input from other service stakeholders".*

1.8 Client evaluation of services

Client or patient satisfaction has been found to be an important indicator of quality, which has implications for adherence to health recommendations and continued use of health services. The construct of satisfaction is multi-dimensional. For example, in evaluating a system of healthcare delivery, the person may consider the technical quality of care, the physical surroundings where care was provided and the interpersonal manner of the care provider (Fitzpatrick, 1997). Surveys providing information on user satisfaction, with services received and views on service delivery, is a means of moving 'closer to a model of patient involvement in planning and evaluation of health care' (McGee, 1997). The Irish government's current health strategy document 'Quality and Fairness' (2001) gives high priority to a patient-centred approach. This involves:

> *'A health system that encourages you to have your say, listens to you, and ensures that your views are taken into account'.*

A strategic priority for the development of health care services emphasises client-centred care and the development of a more structured customer feedback mechanism:

> *"The need to capture customer feedback in a more structured way has been identified as an essential input to policy planning".*

Although established in September 2000, in advance of the most recent Government health strategy, the National Model of Service and the service principles of the NCS reflect the ethos of this new health strategy document:

> *"Mechanisms for ongoing consultation with and feedback from clients including evaluation of the individual experiences of the service and formal consultation would be built into the service".* (NCS, 2002)

While international literature on service user satisfaction is extensive, service evaluation of counselling type services is more unusual. A number of studies of counselling in primary care have been conducted, e.g. Mellor-Clark (2001). However, there is virtually no research on evaluation of counselling services for those who have been abused. A number of factors contribute to this: firstly, as the 'consumer' perspective in healthcare in general is a relatively recent one, even where high quality evaluations of services have been completed, they are often treated as sensitive in-house documents and are not made widely available. Secondly, international scientific journals have often regarded much of this work as being of a local 'audit' nature. Thus, it can be difficult for those wishing to publish information to do so. Finally, many service providers are cautious about evaluation in highly sensitive areas (e. g. hepatitis C and palliative care from our own research experience). Given the dearth of evidence available from the users of abuse counselling services, this project has the potential to address important issues about this particular type of service but also to more generally promote a structured approach to ensuring that clients in counselling services receive the service they expect and deserve.

This project complements the underlying NCS principles of accessibility, quality and client centredness by providing an opportunity to evaluate progress to date and by planning for the future on the basis of information from service users. It also fits with the focus of the National Health Strategy, i.e. a partnership approach between service providers and users. It is a good opportunity to evaluate service user perspectives on health services for uniquely stigmatising and challenging life experiences.

Howe (1993) emphasises the potentially positive impact of 'following the client's perspective' for the counselling process:

> *"By asking people to say what they feel about counselling, we tap the experience in its own terms as well as from the subject's point of view. We are likely to learn a good deal about the nature of counselling by entering the frame of reference of the client - a view from the inside."*

1.9 Comparative data

While many studies of counselling and counselling services focus on measuring therapeutic outcome, a recent report on counselling in Northern Ireland " *Counselling in NI: Report of the Counselling Review*" (Park, 2002) provides information on the experience of counselling service users and on defining a high quality service. This report includes three surveys: (1) The nature and standards of counselling organisations and individual counsellors, (2) The nature and availability of counselling training and (3) The views and experiences of users of counselling services. In order to ascertain the views of service users, a total of 763 questionnaires were issued to counsellors and counselling organisations. In addition, a further 37 questionnaires were issued to the general public in response to the advertisement of the survey. A number of questionnaires (32) were returned by organisations saying they were ineligible for the survey. The views and experiences of 133 users of counselling services were obtained. Over half the service users had attended a counsellor in a voluntary organisation and 43% had seen a counsellor who was working in a health service. The main findings of the survey include:

- The majority (45%) of service users waited from 1 week to 1 month to see a counsellor, while 32% of service users saw a counsellor within one week and 8% had to wait more than 6 months.
- Over 85% of service users were fairly or very satisfied with the counselling received.
- One-third of service users felt that they had not received sufficient counselling sessions, while 59% were satisfied with the number of sessions they had attended.
- The majority (41%) of service users no longer in counselling had received 6 –10 sessions with 6% of clients having attended 21 or more sessions.

A number of specific questions asked in the Northern Ireland report were similar to the questions asked in this study. These included participants being asked to rate the sensitivity of the counsellor (65% reported 'always'), feeling understood (57% reported 'always') listened to by their counsellor (70% reported 'always'), treated with dignity (77% reported always) and whether or not the counselling received was helpful (62% reported 'very helpful').

In terms of recommendations for the provision of quality counselling services in Northern Ireland, 24 individual recommendations were made. This report states that the establishment of a statutory regulation body which would agree a set of national standards based upon "the best features of the current representative organisations' code of ethics and practice" is central to ensuring quality counselling services are provided in Northern Ireland. While the majority of recommendations focus on accreditation of practitioners and statutory regulation of counselling practices a number have a particular focus on the service user. Recommendation 16, 17 and 18 state (respectively):

> *"Service users should be encouraged to enquire about their prospective counsellor's or psychotherapists qualifications."*
>
> *"Practitioners should always negotiate and draw up a clear written contract with their clients... ...terms and conditions on which counselling is offered should be made clear to clients before counselling begins."*
>
> *"All practitioners must provide written information for service users that outlines key information such as: charges; frequency of contact; how to end the relationship; policies on cancellation, confidentiality, record keeping and complaints; the practitioner's qualification."*

It is also recommended that a quality service provided by Department of Health and Social Services and other statutory bodies is: 'easily accessible', has a policy which prioritises waiting lists and ensures that counselling practice is evidence based and 'appropriate for their client's assessed needs'.

The SAVI Study (2002) provided policy makers with prevalence figures for sexual abuse and sexual violence in Ireland for the first time. While the number of SAVI Study participants who said that they availed of counselling was small (3%), it nevertheless provided some insight into how randomly selected members of the general public who have used a counselling service/therapist viewed the quality of the service offered. A total of 83 participants from the SAVI sample went for

counselling (63 women and 20 men). Over half the women attended for abuse which was experienced both as a child and adult. A similar proportion of men attended for child abuse only. The overall satisfaction rating with counselling services was very high at 93%. In particular, participants were satisfied with the confidentiality with which their situation was treated. The main source of dissatisfaction concerned the time SAVI participants had to wait to obtain counselling (16% reported dissatisfaction with waiting time).

In an evaluation of a primary care counselling service in Dorset, Baker et al (1998) reported that 84% of clients (n=117) who participated in the study were satisfied with the counselling service provided. They found that clients most valued the opportunity of talking to a person who was professional, non-judgemental and who helped them gain an understanding of their problem. In another client satisfaction study of two outpatient psychotherapy clinics in New Zealand, Deane (1993) reports that approximately 90% (n=93) of all clients surveyed gave a rating of three (out of a total score of 4), on seven of the eight items on the Client Satisfaction Scale. These results indicated high satisfaction rating for the therapy centres in New Zealand. These studies demonstrate that service satisfaction surveys tend to elicit high satisfaction ratings. They also provide percentage ratings with which the findings of this study can be compared.

Chapter 2

METHODOLOGY

The methodology of the project was determined largely by the NCS - through the aims of the project, the guidelines put forth in the tender document, and the timeframe stipulated for the project. As stated in the Introduction, the aims of the project were to explore the experience of service delivery from the perspective of those using services and to ascertain whether the founding principles of the service are being met in practice from the perspective of service users. An interview methodology was viewed as best meeting these aims, with the sample drawn from service users. Initial consultations with both service users and service providers was agreed to provide a framework for the development and refinement of a project research instrument.

2.1 Sample considerations

The study size was negotiated through a combination of considerations, including the NCS client profile, timeframe and cost. The NCS wanted samples drawn from each health board area (n=10). A nationally representative sampling strategy was agreed. The sample size needed to permit analysis of findings across a number of important parameters: demographic factors (e.g. age, gender), abuse-related factors (e.g. whether the person was abused in an institution or abused in another context), and counselling status (e.g. completed counselling, terminated counselling prematurely, or in ongoing therapy). A sample size of 300 was initially proposed to facilitate these analyses. In order to achieve a final sample size of 300 (150 in counselling and 150 no longer in counselling), it was decided to significantly over-sample from both groups in anticipation of a moderate response rate. Three hundred people in counselling were to be invited (twice as many as needed). Since those no longer in counselling would only be invited by letter (many in counselling would be asked by counsellors and/or could discuss participation issues with counsellors). As a lower response rate is to be expected with this form of contact, 600 people were to be invited (four times as many as needed). Thus 900 separate individuals were to be identified for contact. The sample was drawn to represent the national distribution of service attendees (rather than a specific number from each health board).

2.2 Safety and ethical considerations

As the service users of the NCS were viewed to be a particularly vulnerable group, and as an "outside" agency was to conduct research with clients while respecting considerations of confidentiality, a number of ethical challenges to the project were anticipated. These challenges were addressed through two separate channels – a Project Steering Group, and research ethics committees.

2.2.1 *Project Steering Group*

A Project Steering Group was formed at the onset, the purpose of which was to critically advise, support and monitor the conduct of the study, through to completion. The group was composed of members who had a particular knowledge or interest in the outcome of this study. The Group comprised three Directors of Counselling (NCS), three representatives from abuse survivor support groups, two representatives from counsellor/therapists working in the NCS, a representative from the Department of Health and Children and an independent senior researcher (from the Health

Research Board) (See Appendix 1 for membership of the group). The Steering Group met on an ongoing basis with the research team as the need for consultation arose.

The RCSI research interview team comprised qualified health professionals or social science graduates with training and/or previous research experience in the area (e.g. 4 of 5 had worked as researchers on the SAVI (Sexual Abuse and Violence in Ireland) prevalence study interviewing approximately 200 members of the public each for this work). Research training for the study included active listening skills, monitoring and responding to participant distress. Close contact among team members was maintained throughout the project. Two interviewers attended all face-to-face interview locations held outside the RCSI college premises.

2.2.2 Research ethics committees

All projects involving human participants and conducted by the Health Services Research Centre are required to gain ethical approval through the Royal College of Surgeons in Ireland (RCSI) Research Ethics Committee or equivalent group. Approval for this project was granted in July 2002. In addition, however, because the sample would be drawn from health board client lists, and boards differ in ethical approval requirements, each health board was approached to determine if and what ethical approval was required. Seven boards agreed to recognise the RCSI procedure and approval, while the remainder (n=3) requested local ethical review, which was sought and obtained. The main safety and ethical considerations considered by both the Project Steering Group and the Ethics Research Committees are outlined next.

2.3 Maintaining client confidentiality

As with all health service users, clients attending the NCS services have an assurance of confidentiality. For an issue such as childhood abuse, such assurances may be particularly crucial. Thus how potential participants would be invited, when and how their personal information (i.e. name, address, or phone number) would be passed to the research team was of utmost concern. To maintain service confidentiality, all clients were initially approached by the NCS. Names of clients were only released to researchers when clients gave consent for participation to their counsellor. Clients could also contact the research team directly. Further details of this process are provided in the section entitled “Data collection and interview process.”

Further measures were put in place to maintain client confidentiality. For example, it was decided to use plain envelopes without any identifying postmarks in the event that others, e.g. a family member might query their purpose or content. The letter of invitation was also carefully worded so that it did not contain any reference to abuse if inadvertently seen by others (see Appendix 10).

2.4 Obtaining consent

Written consent was obtained for face-to-face interviews at the time of interview by asking the participant to sign a consent form. For those participating by telephone, consent and an opportunity to ask questions was checked at the start of telephone interviews. The fact that the counsellor/director had initially confirmed consent and passed on a name to the research team and that the person subsequently contacted by telephone agreed to participate was taken as adequate proof of consent.

2.5 Participant wellbeing

2.5.1 Inclusion and exclusion criteria

Several measures were put in place to ensure participant well-being. This included making decisions about which clients were extended an invitation to participate. Only clients who were either currently in counselling or had completed/finished counselling with the NCS were considered for inclusion in the study. Clients on the waiting list at the time of the selection process were excluded. Although it was agreed that these two groups of clients might voice unique concerns, it was decided that clients at this time are likely to be particularly vulnerable, as they are not fully connected with the service and the support it can offer. Their potential well-being was considered more important and thus, they were not included in the study. Instead, retrospective

information from other clients was to be used to gain information about the experience of this waiting period.

Clients were also excluded if the counsellor or director of the service deemed the client as too vulnerable to participate, e.g. for acute medical or psychological reasons (suicide risk, family trauma, etc.) This also extended to circumstances where client confidentiality might be breached (for example, where a client had requested that no mail be sent to their home address, or no home telephoning was requested). In order to achieve a representative sample, it was stressed that such exclusions should be kept to a minimum and the reasons for exclusion were recorded in every case.

2.5.2 *Protecting the participant during the interview process*

The interview was specifically set up and worded so that it did not probe details of any abuse experiences, but focused on participants' experiences of using the counselling service itself. However benign these questions appeared to be, it was felt that some participants might still become upset because of some difficulty they experienced with the service itself, or because the process of discussing therapy in itself may bring up other emotions related to their experiences. Therefore, measures were put in place to ensure the well-being of participants during the interview process.

First, the interview was structured in such a way as to lead the participant through more benign "warm-up" questions such as their views on advertising the service, to more potentially difficult questions such as evaluating the counsellor's ability to understand them. Second, the interview allowed several opportunities for the interviewer to "check in" with the participant to see how they were coping with the interview process. Interviewers were given discretion to exclude questions if they were deemed inappropriate to ask, or to stop the interview altogether if it proved distressing. Lastly, each service ensured a counsellor was available on call to respond to any participants who became upset during interviews and who, on questioning, indicated an acute need to talk to a professional (i.e. before their next scheduled counselling session). An external counsellor was available in each health board area in the event that a client required professional support but did not wish to re-contact the NCS. Additionally, if considered necessary, interviewers could alert the relevant counselling service if they were seriously concerned about client well-being (preferably with prior client consent).

Most interviews went smoothly. In researcher ratings following interviews, 33 interviews (12%) were reported as been of a 'difficult' nature (scored on a four point scale from 'smoothly' to 'very difficult'). This for the most part was as a consequence of either participant emotion (anger/sadness) or where participants did not fully understand the questions. Four participants were advised that they could contact the NCS by telephone and speak to a counsellor if they felt that they needed to as a result of any emotional issues raised in the research interview. Of the participants who were no longer being seen by the NCS, two were advised of the contact details of an external counsellor. While no questions were asked concerning details of the participants past childhood abuse, some chose to speak of distressing life and childhood events during interviews - this was particularly true of those who had been placed in institutional care as children. A small number of participants chose to express their satisfaction with being able to discuss their particular experience of the NCS.

2.6 Phase 1: Initial consultations

The NCS had outlined its key principles in early service documents. These needed further discussion and exploration in order to operationalise specific ideals or goals that could be evaluated as specific research questions. The fact that service users might operationalise these principles slightly differently also posed a challenge to making them explicit. However, as understanding the service from the perspective of service users was the primary aim of the project, client views on what was meant by these principles was viewed as a vital component of the project. A range of key stakeholders were therefore consulted in order to operationalise the guiding principles. Those consulted included service providers and service users. This was complemented with an overview of relevant academic literature. Primary consultation with service users took place in four focus

groups (discussed next). Further consultation took place with NCS staff in four counselling centres nationally.

2.6.1. Focus groups with clients

In planning focus groups, it was decided that the most strategic and achievable option was to hold separate focus groups for service users and staff. Four diverse locations, geographically accessible to a large number of people and on main transport routes, were selected for the service user focus groups: Athlone, Cork, Dublin and Sligo (see Appendix 2).

Ideally, the focus groups would include a mix of people who could represent either those that had experienced institutional abuse or abuse in another context, such as the family, and had attended counselling through the NCS. Invitations were also extended to those who did not attend the counselling service for specific reasons related to the service. It was thought that this 'extension of invitation' would provide an opportunity to explore issues relating to service access (e.g. a potential client who would have liked to avail of counselling but encountered some barrier). Invitations to take part in the focus groups came mainly from NCS Directors of Counselling and survivor group representatives on the Project Steering Group. Researchers also contacted other abuse-related support groups and invited them to send one or two people to represent their members at the relevant focus groups. To maintain confidentiality, letters of invitation were forwarded (by post and fax) to the survivor group leader to give to the invited member. A small token of 32 euro was offered to all who attended the focus groups in order to offset any costs incurred in travelling to the meeting.

The four focus groups were held between May and June 2002. Given the confidential nature of the client group, researchers had no specific details of who and how many were invited and who attended the groups. Nationwide, a total of 41 people attended focus groups. Each of the four focus groups met for at least an hour and a half, and were located in what were deemed 'neutral' public places, such as a conference room in a centrally-located local hotel. All four groups were facilitated by at least two facilitators who used an open-ended format to generate thoughts and opinions on what each of the NCS principles meant to the participants. Discussions were audio-recorded with the permission of each focus group in order to more fully capture the comments made when planning the interview questions. All focus group participants were informed that their identities would remain confidential and that audio tapes of the sessions would be destroyed after the completion of the project.[1]

2.6.2 Consultation with NCS staff

Staff were invited (via an e-mail invitation sent to all counselling centres) to meet with researchers in the four counselling centres nearest to focus group locations. Directors of the services informed counsellors of the scheduled visits and any interested and available staff could attend. It was hoped that a mix of administrative personnel, counsellors, and directors would attend. Twelve counsellors and three administrative staff attended the scheduled meetings. The consultations were informal in nature and served a number of purposes: to provide staff with an overview of the project and what their participation in it might entail; to allow counsellors to voice any concerns they had about the project; and to help shape the content of the interviews (as the focus groups had), by operationalising the principles set out by the NCS. As some staff were not able to attend these meetings because of work commitments (such as a regular client scheduled at that time), they were provided with the opportunity to contact the research project co-ordinator (via telephone, e-mail, or letter) at any time that was convenient for them with any queries, concerns or issues they had about the project.

2.7 Drafting of interview schedule

Initial drafts of the proposed interview schedule to be used during the research process were circulated to both service users (as requested by those who attended focus groups) and NCS staff, particularly counsellors. A significant amount of feedback was received on the schedule itself, and changes were made to the schedule to make it more comprehensive and 'user' friendly.

[1] One focus group member objected to the audio-taping; thus one of the four group discussions was not taped

Following feedback from some counsellors that the project timeframe was too rushed to facilitate counsellor feedback, there was a one-month extension for counsellors to consult and provide feedback regarding the interview schedule and plan for the research process.

2.8 Piloting of the interview schedule

The interview schedule was piloted with several aims in mind, including refining the questions, checking the progression of questions and suitability for various situations, and determining the length of time the interviews might take. The Project Steering Group recommended that a pilot would best be conducted with a mix of both counsellor and previous client participants. Directors and counsellors invited individual clients to take part in a pilot interview. A total of 13 people participated in the pilot (six counsellors and seven clients). The researchers developed a set of possibly challenging client scenarios and management strategies using the interview schedule in preparation for interviews.

The pilot phase further clarified the wording and more open-ended questions were added to the schedule in order to allow more detailed information regarding specific client experiences to be incorporated.

Feedback from counsellors in particular reinforced the importance of 'checking in' with the client at regular intervals during the interview process to gauge emotional well-being and the appropriateness of continuing with the interview. Feedback from clients indicated that the interview schedule was acceptable and was not disturbing or upsetting in its content. No client distress was noted during the pilot interviews.

2.9 Final interview content and format

The content and format of the final interview schedule was based on the results of phase 1: the analysis of the focus group discussions and staff consultations, the pilot interviews and role-plays, and the comments generated from circulation of the earlier drafts. Although centred on the key principles put forward by the NCS, questions were re-arranged in a more natural progression of how participants experienced the service. The schedule progressed from how a client first heard about the service, through their perceptions on advertising or publicity, to making their first contact with the service, to the counselling process itself, and through to the termination of counselling. The finalised interview schedule was arranged into the following sections (see Appendix 3 for the complete interview schedule):

- Section A: Advertising and publicity
- Section B: The freephone service
- Section C: Making the first contact and the initial appointment
- Section D: Attending counselling
- Section E: The counselling process
- Section F: Additional supports and services
- Section G: Overall effects, completing counselling, overall satisfaction with how counselling services were meeting principles in practice
- Section H: Demographic characteristics of participants

The interview was designed to take approximately 20-30 minutes and allow the participant several opportunities to describe their experiences with the service. Interviewers were also encouraged to write comments on particularly notable aspects of the interviews following each interview. In the Results Section, some of these comments are quoted alongside the views of the participants.

2.10 Phase 2: Data collection and the interview process

2.10.1 *Randomisation process*

In order to achieve the aim of obtaining a nationally representative sample of clients attending the NCS, participants needed to be randomly selected from an overall group of clients representative of all 10 health board counselling services. Randomisation was carried out by the research team. To preserve confidentiality, each health board counselling service compiled a reference list containing

only client initials (e.g. JH) for both those in counselling and those who had completed counselling. Each set of initials was numbered by the counselling centre (to be used as a key) and this information was entered on a spreadsheet by the research team. When the research team received all ten health board lists each initial received a new "research" number. Using randomly generated numbers 900 initials were selected from both lists and each counselling service was returned a spreadsheet detailing the initials and the health board assigned number of those selected for invitation. (Appendix 4 details the selection process).

2.10.2 *Re-selection process*

At this point NCS staff in each health board had the opportunity to review those clients selected by the randomisation process for the purpose of excluding any clients deemed unsuitable to take part in the interview process. Directors or counsellors were asked to only exclude clients that they knew were non-contactable (e.g., they had no fixed address for them, and were not currently in counselling) or if it was felt that they were particularly vulnerable such that participating in the interview process might put them at greater risk. Each counselling service returned a list to the research team of those excluded and the reasons why. Replacement clients were then randomly selected to take the place of those excluded. For reasons of efficiency there was only one re-selection process for most health boards even though a certain number of the 're-selected' clients were also subsequently excluded.

2.11 Invitation process

Two different invitation processes were established for those clients currently in counselling and those no longer in counselling. These options were extensively discussed with health board and survivor group representatives to ensure maximum confidentiality and sensitivity while trying to maximise participation.

2.11.1 *Participants currently in counselling*

Ideally, a letter of invitation was given directly to each selected client from their counsellor (and signed by that person's counsellor for maximum sensitivity). The letter outlined the purpose and objectives of the study and asked the client for permission to release information (i.e. their name and address) to the researchers if they were interested in participating. In some cases the counsellor elected to mail the letter to a client, for example where pressure of time meant it would not be possible to meet the client face to face although it was felt by the Project Steering Group that the face-to-face invitation would increase participation rates. The latter option was also ideal if the client had literacy problems as the study could be explained verbally. If the client was interested in participating, they could either contact the research team directly using the research freephone number, or have their counsellor forward contact details.

2.11.2 *Participants no longer in counselling*

A letter of invitation was sent from the local Director of Counselling explaining the study and asking the former client to contact the research team directly if they were interested in taking part in the study. The letter contained the freephone contact number for the research team and a pre-paid envelope to be used if the client chose to return a consent form and contact details rather than phone the research team. This indirect method (no personal contact) was adopted as it was thought that some clients might not wish to have further contact with the NCS and/or may have been dissatisfied with the service received. Unlike those clients currently in counselling, it could not be assumed that the client's previous counsellor/therapist would be an acceptable contact person. While postal methods can produce lower participation rates (McGee et al, 2000), it was felt to be an essential cost in order to maximise sensitivity when contacting those no longer using the NCS.

2.12 Data collection process

When client consent and contact details were obtained, the researchers contacted clients to make arrangements for an interview. All clients were offered the choice of either a telephone or face-to-face interview. If a face-to-face interview was requested, the researcher suggested possible dates and

times when they would be interviewing in the client's local area. If a telephone interview was requested, a specific date and time was arranged to suit the participant.

2.12.1 *Reminder process*

International research recommends that reminders be sent to all participants who have not responded to an original research invitation in order to increase response rates. This issue was discussed in detail by the project steering group and counsellor/therapist staff in the NCS. Concern was expressed by some NCS counsellors, through the NCS Counsellor Forum, about the impact of giving reminders to clients in counselling. The Project Steering Group discussed this issue at length. Counsellor/therapist concerns were acknowledged as a legitimate concern of any intermediary who has to inform others about studies which are ongoing in parallel with service delivery. On the other hand, one reminder was seen as a standard aspect in research protocols. All clients no longer in counselling were to have received one reminder, keeping a balance between number of contacts of those currently in and not in counselling was seen as valuable and important to the outcome of the study. It was also felt that providing a client with a second chance to participate in an interview which would allow him/her to voice how they feel about services was extremely important. This opportunity was seen to have particular relevance for this client group – one seen to have been relatively hidden and ignored in society for so long. A second chance to express views was seen as uniquely appropriate. In addition the client representatives on the steering group viewed the issuing of a second invitation to clients in counselling as particularly important. In conclusion, the steering group recommended that all those invited to participate in research interviews receive a reminder in a similar format approximately two weeks after the initial introduction to the study. This reminder, as with the initial invitation, emphasised the voluntary nature of the research and its separation from the counselling contract between counsellor and client.

2.13 Procedure

Data was collected between late August and early December of 2002. A total of 19 visits were made to 14 individual locations nationwide to conduct face-to-face interviews (see Appendix 2). Clients were also given the choice to be interviewed at the RCSI offices in Dublin.

2.13.1 *Duration of interviews*

The majority of interviews took approximately 45 minutes to complete (ranging from 15 to 75 minutes). Interviews with those clients who had experienced institutional abuse typically lasted slightly longer.

2.14 Statistical analysis and data presentation

A Filemaker Pro database was used to store data. It was analysed using the Stata statistics program. The results are displayed as total number and percentage of clients. For questions involving satisfaction with service, satisfaction was rated as 0 (very dissatisfied), 1 (dissatisfied), 2 (neither satisfied or dissatisfied), 3 (satisfied) and 4 (very satisfied). In illustrating results, satisfaction questions have been collapsed from five categories to three categories, i.e. 'dissatisfied', 'neither' and 'satisfied'.

Where relevant, satisfaction ratings have been analysed by context of abuse (institutional vs non-institutional).

A regional analysis across satisfaction questions was also conducted using health board clusters defined by NCS Directors of Counselling, as individual health board participant numbers did not permit individual analysis. These clusters were selected using the following rationale:

- **Eastern region cluster** (ERHA, consisting of NAHB, SWAHB, ECAHB): This covers Dublin and surrounding areas, it is the area of largest population in the country, and forms a cohesive sector based on current service provision, in addition there is similarity in terms of how services are organised and administered.

- **South/West cluster** (SHB, SEHB, WHB, MWHB): These boards were grouped together as they have similar profiles, i.e. all have a city as part of their geographical area and also include rural populations, in addition these boards have significant numbers of clients referred because of institutional abuse.

- **North/Midlands cluster** (NEHB, NWHB, MHB): These boards were grouped together as they share a similar regional profile, i.e. they have significant rural populations as well as a number of urban centres of similar size. In addition they have a similar pattern of service use with a majority of clients reporting abuse in familial or community settings and a small percentage of clients who experienced institutional abuse.

Chapter 3

RESULTS: *Part one*

Demographic Profile of Participants

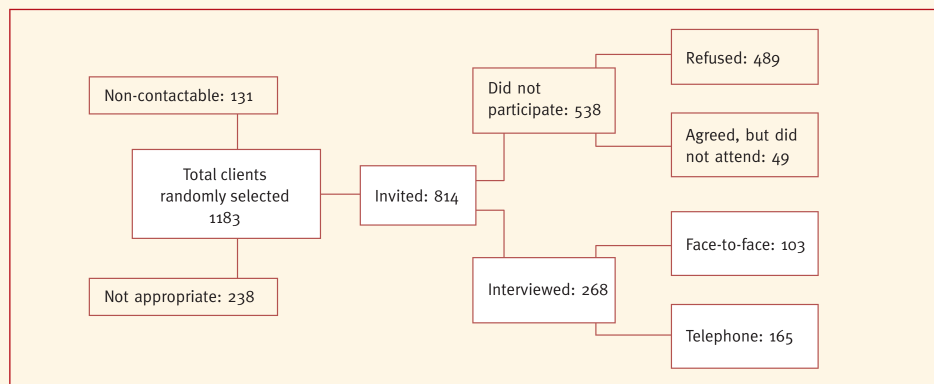
3.1 Survey response rate

A total of 1183 clients identified from lists provided by the NCS were randomly selected to take part in the interviews. Of those selected, counsellors and directors of the service determined that 369 clients were either non-contactable or that it would not be appropriate to invite them for interview. Reasons identified for not extending an invitation to interview included:

- No fixed address for the participant ("non-contactable")
- "Not appropriate":
  - Client was identified as too emotionally vulnerable to participate.
  - Issues concerning confidentiality (e.g. the client had specifically requested that the service not try to contact them via phone or mail to ensure that their family would not find out they were receiving counselling).

A total of **814** clients were therefore invited to participate. Of those invited, **268** agreed to take part and were interviewed, 44 refused and 445 did not respond to the invitation. This resulted in an overall response rate for the study of 33%.[1] While it was not possible to record why many chose not to take part in the interview process, anecdotal evidence from interviewers and counsellors suggested that for some clients, revisiting past issues may have been too painful. A small number (n=49) expressed an interest in being interviewed, but did not subsequently make themselves available. For example, some arranged an interview, but did not turn up on the day, or some sent back a consent form indicating an intent to participate, but did not make further contact with the research team. These "willing but not available" participants must be considered a subset of those who ultimately declined participation. Figure 3.1 summarises the outcomes of the selection process. Appendix 5 provides the corresponding figures for each health board counselling service and by counselling status (i.e. whether participants were currently in or not in counselling).

Figure 3.1 Invitations to take part in interview and response rate for sample



[1] For some questions, there were fewer than 268 replies. In some instances, participants chose not to answer or did not understand the question even following explanation. Some questions were not asked if the participant became distressed during interviews. The sample size (n) is shown where numbers replying are less than 268.

Of the 268 clients who chose to participate, 38% chose to be interviewed in person, while 62% were interviewed by telephone.

3.2 Demographic profile of participants

3.2.1 Gender and age of participants

Of the 268 participants interviewed, 59% were women (n=158) and 41% were men (n=110). Participants ranged in age from 19 to 74 years. Those aged 36 – 50 years comprised 41% of the sample, while those aged over 65 years were the smallest group of participants (4% of the sample) (table 3.1). The women who participated were more likely to be younger; 39% of women were aged below 35 years. All of those over age 65 were men. There was a significant age difference between participants who had experienced institutional and non-institutional abuse with institutional abuse participants being older ($p<0.001$).

Table 3.1 Age profile of participants

Age	Institutional abuse % (n)	Non-institutional abuse % (n)	Total % (n)
18-35 yrs	6 (6)	42 (69)	29 (75)
36-50 yrs	39 (36)	42 (70)	41 (106)
51-65 yrs	45 (42)	16 (26)	26 (68)
66 yrs +	10 (9)	0 (0)	4 (9)
Total	100 (93)	100 (165)	100 (258)

3.2.2 Nature of abuse experienced

In terms of the nature of abuse experienced by participants, 36% of the sample reported that they had experienced institutional abuse, while the majority (64%) experienced abuse in a non-institutional setting (table 3.2). Three participants stated that they used the NCS not because they themselves were abused, but because another family member had been abused. These three participants have been excluded from all subsequent analyses comparing those abused in an institution to those abused elsewhere. There was a difference between men and women in the type of abuse experience reported; only 18% of the women experienced institutional abuse compared to 61% of men.

Table 3.2 Profile of participants - gender and context of abuse of sample

Type of Abuse	Women % (n)	Men % (n)	Total % (n)
Institutional abuse	18 (28)	61 (66)	36 (94)
Non-institutional abuse	82 (128)	39 (42)	64 (170)
Total	100 (156)	100 (108)	100 (264)

Context of abuse is used as a major differentiating variable for many of the results described in the study. The findings indicate that current marital status differed between those who were abused in an institution and those who were abused elsewhere (table 3.3). Most notably, those abused in an institution were more likely to be separated or divorced (29%) than those abused in non-institutional settings (15%).

Table 3.3 Profile of marital status of participants by context in which abuse occurred

Marital Status	Institutional abuse % (n)	Non-institutional abuse % (n)	Total % (n)
Single	29 (27)	36 (60)	34 (87)
Married	38 (35)	49 (82)	45 (117)
Separated	24 (22)	12 (19)	16 (41)
Divorced	5 (5)	3 (5)	4 (10)
Widowed	4 (4)	0 (0)	1 (4)
Total	100 (93)	100 (166)	100 (259)

3.2.3 *Current living arrangements*

Those abused in institutions were more likely to currently reside in a city (46%) or town (39%), while those abused elsewhere more often lived in more rural locations (table 3.4).

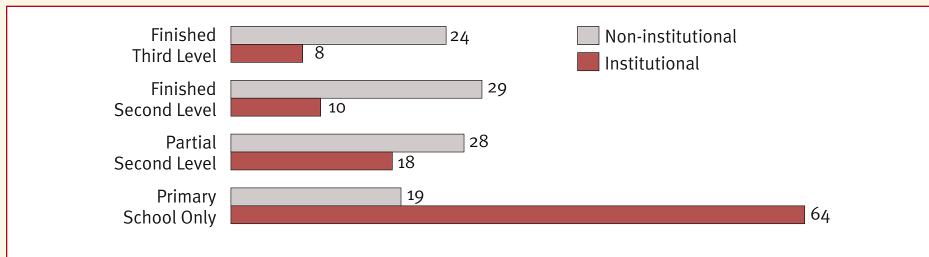
Table 3.4 Geographic location of participants

Location	Institutional abuse % (n)	Non-institutional abuse % (n)	Total % (n)
City	46 (42)	19 (32)	29 (74)
Town	39 (35)	35 (57)	36 (92)
Village	3 (3)	11 (19)	9 (22)
Rural	12 (11)	35 (57)	26 (68)
Total	100 (91)	100 (165)	100 (256)

3.2.4 *Level of educational achievement*

Participants were asked about the highest level of education they had achieved (figure 3.2). Of those abused in an institution, 64% had completed primary education only, while only 8% finished third level education. This is in stark contrast to those abused in non-institutional settings, where similar numbers completed primary education and third level (19% and 24%, respectively).

Figure 3.2 Education level of participants by context of abuse %



In order to take account of age cohort differences of those abused in institutional or other settings when considering educational achievements, sample information was organised by younger (i.e. age 50 years and younger) or older (i.e. 51 years and older) groups (table 3.5). This more detailed analysis shows that the older age profile of those in the institutional abuse group does not explain the difference in levels of education of those abused in institutional versus other settings. For example, comparing the under 50 age cohorts for both groups, it is evident that a minority of those abused in institutions completed secondary and third level education (22%) compared to 55% of the non-institutional group. Equivalent figures for over 50s are 14% vs. 32%. Thus those abused in institutions and presenting for counselling are educationally disadvantaged when compared with their age-matched non-institutional counterparts in this counselling service.

Table 3.5 Profile of education by age and context of abuse

Education	Institutional abuse % (n)		Non-institutional abuse % (n)		Total % (n)
	Age <50	Age >51	Age <50	Age >51+	Age 18–66+
Finished third level	10 (4)	6 (2)	26 (36)	12 (3)	18 (45)
Finished second level	12 (5)	8 (3)	29 (40)	20 (5)	22 (53)
Partial second level	28 (12)	6 (2)	33 (45)	12 (3)	26 (62)
Primary school only	50 (21)	80 (29)	12 (17)	56 (14)	34 (81)
Total	100 (42)	100 (36)	100 (138)	100 (25)	100 (241)

3.2.5 *Employment Status of participants*

Concerning employment, approximately half of the participants were either in paid employment or self employed (45% and 6 %, respectively). Table 3.6 provides the other categories of work status. Some differences were found between those who were abused in an institution and those abused in other settings. Those abused in an institution were more likely to be retired (16% vs. 1%) or on disability benefit (15% vs. 6%), and slightly less likely to be in paid employment (39% vs. 48%). In terms of 'early' retirement, six people of those abused in institutional care (n=94) and one participant of those abused elsewhere (n=166) reported they were retired before the age of 66

years. Those abused in non-institutional settings were more likely to be working in home duties (19% vs. 2%).

Employment Status	Institutional abuse % (n)	Non-institutional abuse % (n)	Total % (n)
Paid employment	39 (36)	48 (80)	45 (116)
Self-employed	6 (6)	6 (9)	6 (15)
Home duties	2 (2)	19 (32)	13 (34)
Disability benefit	15 (14)	6 (9)	9 (23)
Student	3 (3)	4 (7)	4 (10)
Retired	16 (15)	1 (1)	6 (16)
Unemployed	13 (12)	12 (20)	12 (32)
Other	6 (6)	4 (8)	5 (14)
Total	100 (94)	100 (166)	100 (260)

Table 3.6 Employment status of participants by context of abuse

The participants were also classified in terms of lifetime socio-economic status (figure 3.3). Differences were found between those abused in an institution and those abused in other settings. Those who were institutionally abused were less likely to be classified in the higher socio-economic groups and were more likely to be classified in the "skilled manual" and "unskilled manual" classes.

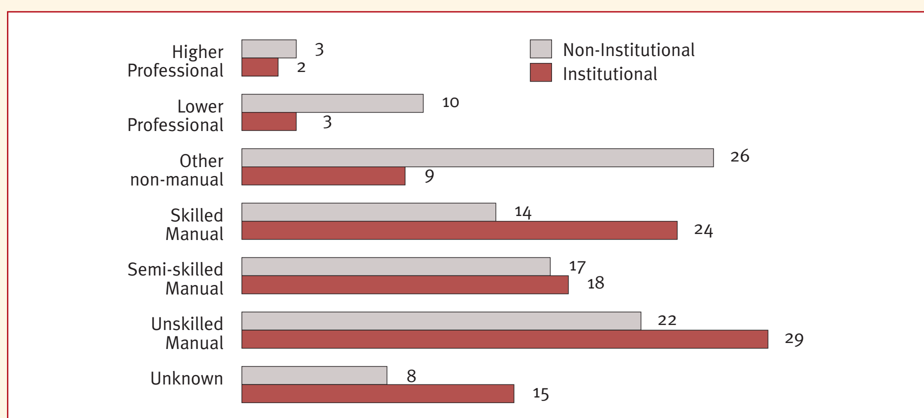


Figure 3.3 Socio-economic status of participants by context of abuse (%)

3.3 Comparison of interviewees to NCS Client Profile

The National Counselling Service 'First Report' (published 2002) provides information which can be compared with the survey participant profile (table 3.7). Comparisons reveal very similar profiles and suggest, at least in terms of broad demographic and characteristics of abuse experience, that the sample interviewed is similar to the overall population of clients using the NCS.

Characteristic	NCS Service Report (2002)	Current Study
Abuse in institutional care (%)	33	36
Gender (% men)	36	41
Age (range)	18-65	19-74
Age <36 years (%)	37	29
Age 36-50 years (%)	43	41
Age 50-65 years (%)	17	26
Age 66+ years (%)	3	3

Table 3.7 Comparison of population profiles of NCS service summary (2002 Report) and participants in this study

3.4 Profile of those were excluded from invitation lists because of 'vulnerability'

A number of clients selected for invitation were excluded as 'too vulnerable to participate' by NCS staff (n=369; 31% of all those selected for invitation). Data on all those excluded was to be noted by the NCS. A variable amount of data was received from different centres. Data was available for 304 of 369 (82%) excluded clients. Table 3.8 shows the gender profile of those who were excluded.

This gender profile broadly matches that of the study group and NCS (2002) profile, i.e. of a smaller proportion of men in the study and NCS cohort. Table 3.9 describes this group further by institutional/ non-institutional abuse. Data was available from health boards for 241 of 369 (65%) excluded clients.

Table 3.8 Gender profile of those excluded from study invitations

Women % (n)	Men % (n)	Total % (n)
55 (152)	45 (124)	100 (276)

A smaller proportion of clients from institutional care were excluded than is evident in the study and NCS (2002) profile (25% vs. 36% and 33% respectively). Differences suggest however, that gender or context of abuse did not significantly influence decisions to exclude clients from invitation.

Table 3.9 Gender and context of abuse profile of those excluded from study invitations

Type of Abuse	Women % (n)	Men % (n)	Total % (n)
Institutional abuse	5 (7)	48 (53)	25 (60)
Non-institutional abuse	95 (123)	52 (58)	75 (181)
Total	100 (130)	100 (111)	100 (241)

3.5 Profile of clients who did not respond

Of the 538 clients who did not respond to the invitation to participate, gender and/or context of abuse data was available for 482 (90%) clients. As seen in table 3.10, 64% of the 'non-responders' were women and 36% men. Concerning context of abuse, 24% of those with information available were abused in institutional care and 76% elsewhere.

Overall, evidence from those not invited, those not responding to invitations and the NCS client profile of 2002 suggest that the gender and context of abuse profile of these study participants is quite similar to all of these groups.

Table 3.10 Profile of study 'non-responders' by gender and context of abuse

Type of Abuse	Women % (n)	Men % (n)	Total % (n)
Institutional abuse	12 (36)	40 (69)	22 (105)
Non-institutional abuse	79 (245)	54 (93)	70 (338)
Missing data	9 (29)	6 (10)	8 (39)
Total	100 (310)	100 (172)	100 (482)

3.6 Counselling status of participants

Table 3.11 illustrates the percentages of participants in counselling and those no longer in counselling.

Those participants who stated that they were no longer in counselling can be further categorised into those who had completed counselling and those who discontinued. Of those participants for which this data was available (n=141), 60% were deemed to have completed counselling and 40% had discontinued counselling. Table 3.12 illustrates a breakdown of these two groups by gender and context of abuse.

Table 3.11 Counselling status by gender and context of abuse

	Institutional M % (n)) · F % (n)	Non-institutional M % (n) · F % (n)	Total
In counselling	23 (23) · 15 (15)	21 (21) · 41 (41)	100 (100)
Not in counselling	16 (43) · 7 (12)	13 (21) · 53 (85)	100 (161)

Of those who were no longer in counselling, 59% of women (n=83) had completed counselling and 41% had discontinued counselling. Similarly, two-thirds (67%) of men (n=54) were deemed to have completed counselling. Almost three-quarters (72%; n=47) of those abused in an institution had completed counselling, with 28% having discontinued counselling. Alternatively, 57% of those abused in a non-institutional context (n=90) were deemed to have completed counselling and 43% discontinued counselling. While a trend was indicated (p=0.095), there was no significant difference between the two groups in terms of completing and discontinuing counselling.

Table 3.12 Profile of clients no longer in counselling by gender and context of abuse

	Institutional M % (n) · F % (n)	Non-institutional M % (n) · F % (n)	Total
Counselling completed	33 (28) · 7 (6)	9 (8) · 51 (43)	100 (85)
Counselling discontinued	15 (8) · 10 (5)	19 (10) · 56 (29)	100 (52)
Total	26 (36) · 8 (11)	13 (18) · 53 (72)	100 (137*)

** Context of abuse data was not available for 4 participants*

3.7 Overview of sample population (completed counselling)

Data was collected from each health board area on all randomly selected clients who had completed counselling (included those excluded and re-selected, those who participated in the research and non-responders). NCS counsellors defined client status using the categories 'completed counselling' or 'discontinued counselling'. Summary results are discussed below and full tables are in Appendix 11.

3.7.1 *Completed counselling*

Of the clients who had attended and completed counselling (i.e. negotiated an ending with their counsellor), 38% were male and 62% were female. Almost one third (29%) had experienced abuse in an institutional setting, with 71% experiencing non-institutional abuse. The mean number of sessions attended by clients was 10.5 (standard deviation: 9.5) (median 8 sessions; range 1 – 72 sessions).

3.7.2 *Discontinued counselling*

Of the clients who had attended and discontinued counselling (prematurely), 40% were male. Less than a quarter (22%) had experienced institutional abuse and 78 % experienced non–institutional abuse. The mean number of sessions attended by clients who had discontinued counselling was 6.4 (SD: 6.5) (median 5 sessions; range 1 – 53 sessions).

3.7.3 *Did not attend counselling*

Clients who did not attend counselling were classified as either having been on the waiting list but never attending for initial interview ('waiting list only'), or attending for initial interview but not attending for counselling. Of those who were on the waiting list only, 35% were male and 65% were female. Most (87%) had experienced non–institutional abuse, with 13% experiencing institutional abuse. Of those clients who attended for initial interview but not regular counselling, 36% were male and 64% were female. One third (32%) had experienced institutional abuse and 68% had experienced non–institutional abuse.

Combining overall population data from the above categories, 41% of clients completed counselling (i.e. terminated the process in consultation with their counsellor). Over a quarter (26%) of clients discontinued counselling prematurely, 13% attended an initial interview but did go to the arranged counselling session and 20% made an appointment for an initial interview and subsequently did not attend.

Within this overall population data, 51% of those abused in an institutional setting who contacted the service completed counselling. Alternatively, 42% of those abused in non-institutional settings who contacted the service completed counselling. Thus a difference should be noted between this general population and the current study population, with 72% of study participants abused in an

institutional setting completing counselling and 57% of non-institutionally abused study participants completing counselling in the current study.

Results overall show the challenges for both clients and service providers in this type of service. Making contact with a counselling service for childhood abuse is likely to be a very difficult decision in a long process of acknowledging and coping with such abuse. One-third (33%) of those contacting the service did not follow through on a decision to avail of counselling. Most of those (60%) opted not to come for the first appointment they had made. Some of this reticence to engage in therapy will come from the client him- or herself while initial experiences of the counselling service may be off-putting (or indeed equally, supportive) for a vulnerable client. Once in counselling, over a third who attended (39%) discontinued prematurely. Reasons for this, from the client's perspective, are considered later in the report. These data provide some information for those trying to estimate throughput of clients when developing service plans.

Chapter 4

RESULTS: *Part two*

Participant Satisfaction with NCS principles in practice

The three most important principles of service delivery in the National Counselling Service have been identified as accessibility, high quality and client-centredness. One of the main aims of the research was to investigate the degree to which the NCS has managed to adhere to these principles in practice. The next section of the results will analyse each of these principles separately.

4a NCS: An accessible service

The NCS has operationalised accessibility to include:

- Provision of a freephone contact line in each counselling service.
- A self-referral system which enables clients to have control over access to the service, maintains client privacy and reduces barriers to the service.
- Use of local press and radio media to inform and encourage potential clients to contact the service.
- Access to the service from a range of geographical locations within each health board area.
- Choice of location promoting anonymity on behalf of the service user.

At focus group discussions that took place with survivors of childhood abuse, understanding of an accessible service was discussed at length. For the majority of participants (at focus groups) the issue of accessibility of the counselling service was very much dependant on how long an individual had to wait before receiving an appointment for ongoing counselling. The factors triggering an individual to decide to seek help at a particular time in their lives were seen as very important. These factors were mostly identified as involving crisis situations such as suicidal thoughts, feelings of not being able to cope and social isolation. For most, a great deal of emotional courage was seen as required to seek the help of the NCS. Many have to wait before seeing a counsellor. The expectation was that once they had taken the courageous step to seek help, they should be seen immediately. This belief was reflected in the 'waiting time' expectations of the survey participants.

Advertising was also identified as being very important in making the NCS accessible to people. Many suggestions were made regarding how and where the NCS should advertise (as discussed next). Accessibility was also linked to use of the freephone. Many believed that it was there to help people in crisis (similar to a helpline) and that generally when an individual was calling for the first time it would most likely be at time of crisis for them. Therefore, getting through to an answering machine or an administrative member of staff who was not appropriately trained to deal with an individual presenting in 'crisis' was an issue which created difficulty for the principle of accessibility. A wide geographic spread of service locations was also seen as crucial to providing an accessible service which could offer choice and privacy.

4a.1 Publicity and advertising

Participants were asked several questions in the section dealing with service accessibility about advertising and publicity of the service (table 4.1). When asked how they first heard about the service, the largest group of participants (21%) indicated that it was through some form of advertising (i.e., TV, radio, poster, service leaflet, or newspaper). The second largest group (18%) were informed through their GP. Another 12% learned about the service through either psychiatric services or hospital settings. Others (14%) heard through other health professionals, such as social workers, social services, counsellors or counselling services. Participants indicated they were more likely to hear about the service from friends (8%) than family members (3%). Some participants (16%) heard about the service through contact with the Commission to Inquire into Child Abuse or a solicitor.

Differences were observed in how institutionally and non-institutionally abused participants first heard about the service. For example, 27% of institutionally abused participants heard about the service through a survivor support group and 15% through the Commission or a solicitor (compared with none of the non-institutional abuse group). Compared with those who experienced institutional abuse, more participants who experienced non-institutional abuse found out about the service from a GP (25% vs. 4%), psychiatrist/hospital (15% vs. 7%) or other health professional (19% vs. 5%).

Table 4.1 First source of information about the service by context of abuse

Source	Institutional abuse % (n)	Non-institutional abuse % (n)	Total % (n)
Advertising	19 (18)	23 (38)	21 (56)
GP	4 (4)	25 (43)	18 (47)
Psychiatrist/hospital	7 (7)	15 (25)	12 (32)
Other health professional	5 (5)	19 (32)	14 (37)
Friend & Family	13 (12)	11 (18)	11 (30)
Survivor support group	27 (25)	1 (1)	10 (26)
Commission/solicitor	15 (14)	0 (0)	6 (14)
Other	10 (9)	6 (11)	8 (20)
Total	100 (94)	100 (168)	100 (262)

For those participants who indicated that they had heard through word-of-mouth (e.g. friend, support group, family member, GP), they were also specifically asked about more formal modes of advertising and publicity. When asked if they had ever seen or heard any advertising about the service, 68% said they had not, while 32% indicated that they had. Of those that had heard or seen advertising, 38% had seen it in a newspaper, and 26% had seen a service leaflet. Equal percentages of participants (20-21%) had seen or heard something about the service on the TV, radio, or on a poster.

Participants were asked to rate overall satisfaction with the information provided in the service advertisements (figure 3.4). The majority of participants who had seen or heard advertising (n=144) were satisfied with this information (77%), while 8% were dissatisfied, and 15% felt neither satisfied nor dissatisfied.

Participants were asked specifically if they recalled seeing publicity about the service following a TV shows or documentaries about abuse. While only 28% of participants recalled this type of advertising, those who experienced institutional abuse were more likely to have indicated seeing this (38% versus 23%). Of those who indicated seeing the advertising, a quarter (26%) indicated that they attempted to call the given phone number following the programme. Most of those calling said that they got through to speak to a person. When asked how they felt that call was handled, two thirds (67%) were either 'satisfied' or 'very satisfied'.

Finally, participants were asked what they felt could be done to effectively advertise the service. Almost a third (32%) mentioned either using the local papers or a poster campaign in a GP clinic or other health centre, while almost a quarter (24%) suggested more use of the radio. Much smaller percentages suggested leaflets about the service (8%) or publicity through talks given to

existing groups (less than 1%). There were numerous comments (n=107) for 'other' ways to effectively advertise the service. Some of these included advertising the service on billboards, libraries and shopping centres, more documentaries on TV, community welfare offices, schools, magazines, homeless centres, noticeboards in churches, homeless shelters, support groups, telephone books, letting others tell their experiences on TV and radio, bus stop advertisements, community centres and the internet. Others reported that to effectively advertise the service, it needed to be well explained. Using a '*catchy*' telephone number that was easy to remember was suggested.

Some participants said that it was important that the advertisement explained that the service was confidential because people may be fearful about coming forward. Another suggestion in relation to improving the current advertising was that the NCS publicise the service with organisations for people who have disabilities. In response to an open-ended question at the end of the interview, "What changes could be made to the service that could most help and encourage others who may be reluctant but interested in counselling?" several participants felt the need to re-iterate their concerns in relation to publicity and advertising. Most participants believed that an increase in advertising was necessary to encourage potential clients to engage. Many (n=154) felt that not only should advertising be increased but also that the message itself and the publicity medium were important considerations. A variety of advertising media were suggested by participants (n=42). In addition to the themes already suggested, public talks and distribution of leaflets and information to Alcoholics Anonymous, Narcotics Anonymous were proposed. Use of an actor or a survivor of abuse who utilised the counselling service was also seen to be an effective method to deliver a positive advertising campaign. Twenty-six participants specifically proposed that the NCS should endeavour to explain to the general public what counselling and the NCS involves. Fear of counselling and the perceived stigma attached to mental health services by the general public were believed to be central factors in inhibiting potential clients from seeking out help:

> *"Demystify therapy, help people understand the therapy process to alleviate fear."*

> *"People think that you're psychologically imbalanced when you attend counselling - there is a stigma attached like a mental illness."*

Some participants (n=17) felt strongly about the importance of informing other professionals about the NCS. This they felt would facilitate referrals. General practitioners, gardai, priests and teachers were identified as having a important role to play in informing and referring potential clients. Others identified specific aspects of the service which they felt should be named in any advertising campaign:

> *"Explain the service is confidential."*

> *"Explain that it is in their local area."*

> *"Tell people about the freephone."*

> *"Explain that the service is free of charge."*

> *"Explain that service specialises in child sexual abuse."*

> *"Let people know that the service is not only for the survivors of institutional abuse."*

4a.2 NCS freephone

A section of the interview focused on the freephone, its function and use by participants, and their satisfaction with it. NCS participants viewed the freephone as one of the primary features of accessibility to the service.

Participants were first asked if they knew about the freephone *before* they started counselling. A third of participants (35%; n=257) knew about the freephone before they started counselling, while most did not (65%). There were no differences between those abused in an institutional setting and those abused in another context (38% and 33%). Of those who were unaware of the freephone before counselling, half were still unaware of it at the time of the interview (i.e. 33% of the overall group). Those who were abused in institutional settings were significantly more likely to have known about the freephone at the research interview than those who were abused elsewhere (65% vs. 42%).[1]

A total of 39% of clients had heard about the freephone through their counsellor or the NCS service itself, while others heard about it through reading a service leaflet, support groups, and resource centres. Not surprisingly, those who were abused in an institution were more likely than those abused elsewhere to report that they heard about it through a support group (17% vs. 0%) while those abused elsewhere were more likely to have learned about it from a poster (9% vs. 0%) or a GP (12% vs. 0%).

From the perspective of the NCS, the role of the freephone is to be an easy-to-use administrative means of enquiry or referral to the service. It is not envisaged as, nor was it set up to be, a crisis counselling service. Although the NCS is quite clear as to the purpose and limits of the freephone, discussion of this topic in focus groups indicated that many clients of the service were either misinformed, had unmet expectations, or were not happy with the purpose of the freephone as laid out by the NCS. Thus, several questions were posed to participants about their use of, and perceived satisfaction with, the freephone. Participants were asked what they thought was/were the main purpose(s) of the freephone. Half (54%) of participants who knew about the freephone thought it was for making appointments, 31% said it was for finding out information, and 37% thought it was for talking to someone in a crisis situation.

4a.2.1 Utilisation of freephone

Participants who had heard of the freephone were also asked if they had ever used the service. Over three quarters (77%; n=167) had used the freephone. In terms of context of abuse, 79% of those abused in institutional care and 75% of those abused in a non-institution setting had used the freephone. Of those participants who had used the freephone, 125 participants were able to comment on the number of times they had used it (table 4.2). A third (37%) reported using it just once. A larger percentage (44%) used it between 2 and 5 times, while 19% reported using the freephone more than 5 times.

Table 4.2 Use of freephone service

No. of times freephone used	Participants % (n)
Once	37 (46)
2 – 5 times	44 (55)
6 – 10 times	15 (19)
>10 times	4 (5)
Total	100 (125)

When asked if they had specifically used the freephone for finding out information about the service or making an appointment, 94% who used it (n=117) indicated that they had. The majority (91%) found it easy to get through on the freephone. Most (93%) spoke directly to a staff member, as opposed to hearing a recorded message. Most (62%) indicated that they spoke to a secretary, with almost a quarter (23%) speaking to a counsellor and 14% to an administrator. Few indicated that they spoke to more than one person when making this type of call. The outcome for the majority of these calls was to set up an appointment (71%), with fewer indicating that they were put on a waiting list (14%), information was sent to them (13%), or some other outcome (12%). Most participants felt that they got the kind of response they were looking for (86%), however 8% felt that they did not, and 5% indicated that they had mixed feelings after making the call. When asked, “Overall, how satisfied are you with the freephone for getting information and/or making an appointment?” (n=123), 91% were satisfied, with 2% indicating

[1] Where interviewers discovered that the participant did not know about the freephone service, they gave the participant the freephone number and explained its purpose.

'neither satisfied or dissatisfied', and 7% 'dissatisfied' (See figure 4.1).
Although not set up for this purpose, use of the freephone during a 'crisis' was also specifically asked about during the interviews. A quarter (25%; n=130) of the participants who used the freephone at least once indicated that they used the freephone when in a crisis. Most were in counselling at the time (79%), while 12% indicated that they called in crisis before they had began counselling, and 6% after they had completed counselling. When asked how satisfied they were with the handling of this 'crisis' call to the freephone, almost a quarter (23%) were dissatisfied, with 3% feeling neither satisfied nor dissatisfied, and 74% feeling satisfied (see figure 3.4). Differences were observed across health board clusters, with less than half (45%) of participants in the North/Midlands cluster rating it as satisfied, compared with 83% and 100% satisfaction ratings from participants in the South/West cluster and Eastern region cluster respectively (see Appendix 6).

4a.3 First contact - making an appointment

The first contact participants had with the service and the process of setting up a first appointment also reflects accessibility. The majority of participants (70%; n=259) said that they 'referred themselves' to the service (i.e. made their own first appointment). The other 30% said that they were referred to the service by others (table 4.3). The majority of participants who were referred by a third party reported that their referral to the NCS was made by their psychiatrist/psychiatric services, by GPs or by support groups. There were differences in the sources of referral reported by institutional and non-institutional abuse participants. Of the 26 institutionally abused participants who were referred by others, 12 reported being referred by a support group (9 of these, i.e. one third of this group were referred by a named abuse survivor support groups). Those abused in non-institutional settings were more likely to have had a GP or psychiatric referral.

Table 4.3 Sources of service referral (other than self-referral) by context of abuse

Source	Institutional % (n)	Non-institutional % (n)	Total % (n)
Support group:			
· specific survivor group	35 (9)	0 (0)	11 (9)
· type of group not specified	11 (3)	2 (1)	5 (4)
Psychiatrist/ psychiatric staff	19 (5)	28 (15)	25 (20)
Family/ friend	12 (3)	6 (3)	8 (6)
Laffoy Commission/solicitor	15 (4)	0 (0)	5 (4)
GP/doctor	4 (1)	35 (19)	25 (20)
Rehabilitation centre	4 (1)	0 (0)	1 (1)
Social worker	0 (0)	7 (4)	5 (4)
Counsellor	0 (0)	7 (4)	5 (4)
Health board	0 (0)	6 (3)	4 (3)
Hospital/medical centre	0 (0)	6 (3)	4 (3)
Other (probation officer/teacher)	0 (0)	3 (2)	2 (2)
Total	100 (26)	100 (54)	100 (80)

4a.4 Influences on decision to seek counselling

Participants were also asked what was significant in influencing them to seek help at that particular time. Most participants (63%; n= 258) said that they themselves were most important. The next largest group of people (21%) selected categories where two factors were combined and where one factor related to their own emotional state:

> *"My wife influenced me … I knew I needed help myself also."*

> *"My marriage broke up. I was desperate. I had no one to talk to."*

Other factors included under this category were the influence of:

- Health professionals
- Media coverage of the issue of childhood abuse
- Solicitors and the Commission to Inquire into Child Abuse.

4a.4.1 *Aspects of the service which influenced decisions to seek counselling*

When participants were asked to indicate whether particular aspects of the service encouraged them to seek counselling, 87% (n=250) stated that the fact that the NCS was a free service had been encouraging. Most also indicated that the fact that it was a service which specialised in childhood abuse (85%; n=248) and that they could self-refer (83%; n=247) had encouraged them. Many participants also stated that being able to access the service in their local area (71%; n=184), through the health board (60%; n=238) and through a freephone (59%; n=174) had encouraged them to seek counselling. Three-quarters (n=81) of participants who had experienced institutional abuse stated that the fact the service was originally set-up for survivors of institutional abuse was helpful in encouraging them to seek counselling.

4a.5 Availability of information about the service

Participants were also asked if they were given any information about what the service entailed when first making contact with the NCS. While 72% of participants (n=248) said that they were given this information about the NCS, a significant portion (28%) said that they did not receive any information on first contact. This broad pattern is reflected in satisfaction ratings: 75% were satisfied with the availability of information about the service at the start of counselling while 25% were not satisfied (figure 4.1). Analysis across health board clusters showed slightly lower satisfaction in the Eastern region cluster (67%) compared with the South/West cluster (76%) and the North/Midlands cluster (80%) (see Appendix 6).

Over half of participants who said that they received information when they first made contact with the counselling centre identified the counsellor at the initial assessment as being the first source of service information. Other sources of information from the NCS were information given 'over the telephone' (29%) and leaflets given by the service (14%). Two participants had received information about the service from a talk given by NCS staff.

Figure 3.4 groups the main publicity, advertising and information questions. While satisfaction with specific aspects was high, overall satisfaction with how the service was publicised was lowest at 31%. Analysis of overall satisfaction with publicity of the service across health board clusters (Appendix 6) highlighted interesting variations, with the Eastern region cluster receiving considerably lower ratings (17% satisfied) in comparison to the South/West cluster (32%) and the North/Midlands cluster (37%).

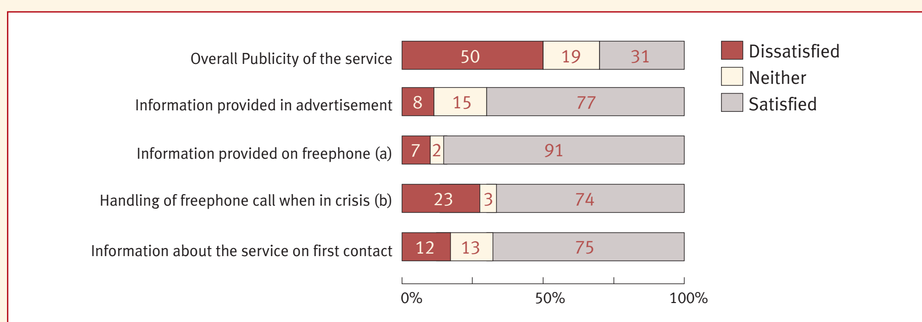


Figure 4.1 Satisfaction with accessibility: advertising and information about the service[2]

4a.6 Need for publicity

When asked about sources of dissatisfaction, a recurrent theme emerged with the majority stating that there needed to be more advertising. The most common channels advised were radio, television, newspapers and posters in GP clinics. One participant was quite angry that he had to 'reach the bottom' before he found out about his particular counselling centre. The GP was the first point of contact for a quarter of participants. Nonetheless, many participants reported GPs to be unaware of the NCS and what it has to offer:

> *"... I found if very difficult to find out about the service from anyone. I rang a few centres and they knew nothing about it. My GP never mentioned counselling to me and knew nothing."*

[2] a: percentage refers to the sub-sample who used the freephone (n=123),
b: percentage refers to the sub-sample who rang the freephone in crisis (n=35).

Some participants found out about the service through word of mouth:

> *"The service is known through word of mouth not through advertising."*

The difficulty for people having to go to someone whom they knew very well for information on the issue was seen as a possible deterrent:

> *"It's a difficult situation to ask your GP about, especially if you've known him for years."*

Of the participants who saw the service advertised, many found that the information presented was unclear or did not fully represent what the service had to offer. For instance, some thought that the service was only for clients who had experienced sexual abuse. It was not always clear that physical abuse or neglect were also addressed.

4a.7 Waiting times and waiting lists

Both the NCS and the clients who had used the service agreed that one of the hallmarks of an accessible service is a short time span between first contact and actually receiving the service. The NCS "First Report" initially set itself a goal of seeing all those abused in an institution "immediately" following their first contact. It further specified: "Any client who has been referred to the National Counselling Service in any area of the country will receive an initial appointment to meet with a counsellor within one month of their referral to the service." Participants were asked a series of questions about how long they waited to start counselling, expectations of waiting, and the experience of their initial appointment.

Seventy-five percent of participants (n=255) reported that they received an initial appointment within one month of first contact with the service. Over a quarter (27%) said that they waited one week or less before seeing someone for the first time, 18% said they waited one to two weeks, 30 % said they waited three to four weeks, and 18% waited from two to three months. Another ten participants stated they waited four to six months. Four people said that they waited longer than six months to see someone for the first time. There was no significant difference in time taken to start counselling for those who were abused in institutional care or in another context (table 4.4). Similarly, 73% of institutionally abused and 78% of non-institutionally abused waited for less than one month from first contact to initial appointment.

While the majority (73%) were satisfied with the time they had to wait, a significant minority were 'dissatisfied' (20%) or 'neither satisfied or dissatisfied' (7%) (figure 4.2)

Table 4.4 Waiting time between first contact and initial appointment by context of abuse

Waiting time	Institutional % (n)	Non-institutional % (n)	Total % (n)
< 1 week	27 (24)	28 (47)	27 (71)
1-2 weeks	24 (21)	15 (25)	18 (46)
3-4 weeks	22 (19)	35 (58)	30 (77)
2-3 months	20 (18)	17 (28)	18 (46)
4-6 months	5 (4)	3 (6)	4 (10)
>6months	0 (0)	1 (2)	1 (2)
>12 months	1 (1)	1 (1)	1 (2)
Does not know	1 (1)	0 (0)	0 (1)
Total	100 (88)	100 (167)	100 (255)

4a.7.1 *Client Perceptions of acceptable waiting times*

To understand the waiting time expectations of those entering counselling, participants who were not satisfied (27% of overall group) were asked what they thought would be an acceptable time to wait. The majority (80%) felt that when accessing the NCS for the first time, clients should not have to wait longer than one to two weeks before seeing a counsellor. Of all participants, almost a third (30%) felt that clients should not have to wait longer than one week for a first consultation. There was no significant difference between those who were abused in institutional care and elsewhere in opinions on an acceptable waiting time for the initial assessment.

4a.7.2 *Impact of waiting time before ongoing counselling*

Many NCS clients have to wait after an initial appointment until a place is available for ongoing counselling, and participants were asked if this had been the case for them. Two thirds (66%; n=251) did not have to wait and began counselling immediately following their initial appointment. One third (34%) of participants reported having to wait to start counselling after the initial assessment. Table 4.5 shows length of waiting time between initial interview and start of counselling. Significantly more of those abused in an institutional setting began ongoing counselling within one month of their initial consultation (including those who reported no wait) compared with those who experienced non-institutional abuse ($p<0.05$).

Table 4.5 Waiting time between initial interview and start of counselling by context of abuse

Waiting time	Institutional % (n)	Non-institutional % (n)	Total % (n)
No wait	67 (62)	65 (104)	66 (166)
One week	6 (5)	2 (3)	3 (8)
Two weeks	7 (6)	8 (13)	7 (19)
3-4 weeks	16 (15)	11 (17)	13 (32)
2-3 months	3 (3)	7 (11)	6 (14)
4-6 months	1 (1)	5 (8)	4 (9)
>6months	0 (0)	0 (0)	0 (0)
>12 months	0 (0)	2 (3)	1 (3)
Total	100 (92)	100 (159)	100 (251)

Participants who indicated that they had to wait after the initial assessment (n=81) were asked how satisfied they were with having to wait this 'second' waiting period. Participants were much less satisfied with having to wait after their initial appointment, with only 46% satisfied with this waiting time (figure 3.5).

When asked to elaborate, most participants reported that they felt distressed, exposed and vulnerable at the time of assessment and felt that they needed to be seen straight away:

> *"This was too long to wait. I had built up the courage to attend. It was my first time to disclose. The session left me feeling open and I had no support following this session."*

One particular client had suppressed the memories for so long that when they did surface, he felt he needed to deal with them straight away:

> *"Having to wait after the initial interview set up a whole negative context for me as I had felt no connection with the counsellor in the first session. This was reinforced when I had to wait until the next session and saw that the counsellor had to read my file and ask some of the same questions."*

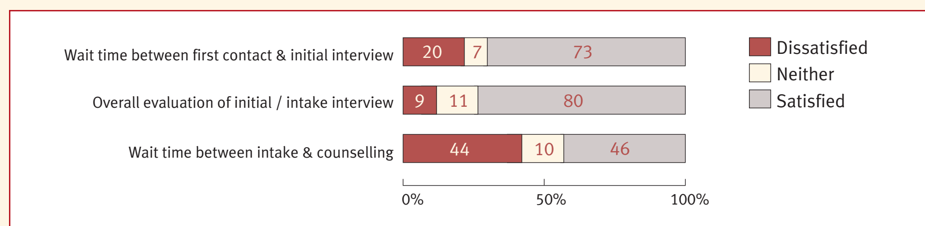
Many of those who were satisfied stated that they understood the delay as there were a lot of people on the waiting list:

> *"I was just happy I was going to be seen."*

> *"I was wondering when the counselling would start but I wasn't pushing. I was after living 40 years without it. When you read about the amount of people who were abused you have to understand the waiting list. However my psychiatrist got angry, rang the service and wrote them a letter asking them to see me immediately."*

Figure 4.2 summarises satisfaction with waiting times and the experience of the initial/intake interview. While most were satisfied, a significant minority expressed dissatisfaction with waiting times, particularly wait between intake interview and counselling.

Figure 4.2. Accessibility – evaluation of waiting times and initial/intake interview with the service



Waiting periods were often spontaneously re-addressed in the open-ended question at the end of the interview relating to changes that could be made to the service to help others. A number of suggestions were made in relation to the waiting list period and the initial session/assessment:

> *"Respond promptly. It takes courage for people to make that first call."*
>
> *"Offer support to people on the waiting list."*

Some commented specifically in relation to the assessment session, for example:

> *"I don't think that the initial assessment is a good idea as people are very vulnerable at that stage and making the move to go and see someone is huge and if they are told at that stage that they have to go on a waiting list because their problems mightn't be serious enough they mightn't come back. They should have no assessment interview. People should go straight on a list and be given a helpline while waiting."*

4a.8 Physical aspects of accessibility

Accessibility of the service also encompasses access to the location and physical aspects of the counselling centres. Participants were asked about the distance they had to travel in order to attend for counselling. Most participants reported that they were satisfied with this aspect of the service (79%; n=257). Those who were dissatisfied explained that their difficulties included having to rely on someone for a lift, other transport challenges, not having an alternative location and getting time off work. Many reported multiple challenges. One woman with three children had to find a babysitter and then explain her absence to her family. She left the service as a consequence of these multiple demands. Sometimes clients reported leaving the session feeling emotionally overwhelmed. This was seen to be even more stressful for them if they had to face a long journey home:

> *"After a heavy session when you're feeling vulnerable, all you want to do is get home so it is much easier to be closer to home."*

Others were happy with travelling to counselling centres even if they were far away, or had chosen to attend a location further away from where they lived as they felt it provided them with privacy and anonymity:

> *"I am happy with this as I don't want to go to my home town. Its 36 miles away but it doesn't bother me."*

NCS provides transport for some clients who do not have the resources to attend otherwise, and three respondents reported that their taxi fare was paid for by the counselling service. In addition, for clients who have any form of disability, counsellors will travel to a centre that is convenient for them. In total, 23 of the participants interviewed described themselves as disabled (as determined by eligibility for disability allowance). One client was receiving counselling in her home because of access problems with her wheelchair:

> *"Counselling has been provided mostly in my home. Using my house is crazy because you are not distancing yourself from the counselling process. I have had to fight tooth and nail for a wheelchair accessible room."*

Participants using private transport were less satisfied with the location of centres in terms of parking and accessibility. More than a quarter of participants (26%; n=131) were dissatisfied with the parking at their centres. Difficulties with parking caused clients unnecessary stress and in some cases made them feel vulnerable when they had to walk to their cars visibly upset after counselling. Many respondents also found that they had to park in public places which did not provide for anonymity:

> *"It was very difficult to get parking. I had to park in Tesco and walk over. It wasn't very convenient or private."*

More than a quarter of participants (28%; n=91) who used public transport to get to a centre were also dissatisfied. Public transport was often reported as very poor or non-existent. Respondents spoke of traffic delays and having to use taxis:

> *"For some periods I had to travel for a long time. One bus to the city centre and then another bus out to the counselling centre."*

One client found the public transport so poor that she mostly hitch-hiked to the sessions. Satisfaction with the location and accessibility of the service in terms of public transportation varied across health board clusters: the North/Midlands cluster received lower ratings of satisfaction (43%) than the South/West cluster (68%) or the Eastern region cluster (67%). Satisfaction levels for aspects of location and access to counselling centres are summarised in figure 4.3.

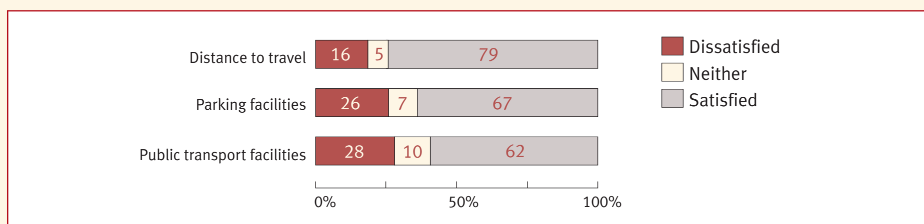


Figure 4.3 Levels of participant satisfaction with service accessibility – location of counselling centre

4b NCS: A high quality service

The NCS defines 'high quality' as one of its key principles of service. This concept is described in the following way in NCS documentation:
The NCS:

- Respects the dignity of clients.
- Offers choice to clients.
- Maintains high professional standards (among staff).
- Maintains comfortable and appropriate environments.
- Provides privacy and confidentiality.

Focus group discussion regarding the principle of high quality was extensive. Many suggestions were made regarding each of the factors which aim to operationalise the principle of high quality. However, focus group participants did not amend or redefine the principle as described by the NCS. Questions to reflect key issues regarding high quality as identified by service users were included in the interview schedule. A discussion of each of these issues, as listed below, follows.

Confidentiality

- Confidentiality
- Privacy and anonymity

Quality of service delivery

- Appearance and condition of centres
- Professionalism of office personnel

Choice

- Choice and flexibility of counselling appointments
- Availability of appointment times
- Choice of counselling service
- Choice of counsellor

Quality of counselling

- Frequency of counselling sessions
- Total duration of counselling
- Quality service and counsellor characteristics
- Level of trust in the counselling relationship
- Ability of counsellor to understand client problems
- Length of individual counselling sessions
- Counsellor knowledge and expertise
- Counsellor sensitivity
- Ability of counsellor to listen

4b.1 Confidentiality

Several aspects of the service were identified as representing a high quality service, with the major issues concerning client confidentiality. The NCS has a clearly agreed policy in relation to confidentiality, and general practice is to inform participants about the limits of confidentiality at their first appointment.

Prior to asking questions about confidentiality, interviewers first reviewed the limits of client confidentiality and asked participants if they had been informed of them by their counsellor. Most participants (84%; n=252) said that the limits of confidentiality had been explained to them, that they made sense (95%) and that they were acceptable (94%). Some however, reported that the limits of confidentiality had not been mentioned to them at the start and this caused some confusion:

> *"I was told it was confidential and that's all. Nothing more. I wasn't happy. Later on in the sessions I wasn't sure what was going to happen. It should have been explained at the start."*

Some participants were overwhelmed by being informed of the limits and did not feel able to agree to the limits of confidentiality straight away:

> *"I was given no choice in this. If I wanted help I had to sign the form about this. It was very difficult. I wasn't ready. I needed more time to come to terms with what had happened to me. This was my first time to disclose."*

One participant had an understandable lack of trust for institutions so it was difficult for him to accept the limits. Overall, however, when asked how satisfied they were that the service respected their rights to confidentiality, satisfaction was very high (94%; n=243) (see figure 4.4).

When asked if a complaints procedure had been explained to them, almost half (43%; n=245) of participants reported it had not, 22% were unsure and 35% said that it had been explained.

4b.2 Privacy and anonymity

Along with confidentiality, many participants were concerned with issues of privacy and anonymity. Because these issues were brought up in the context of the entrance and exits to centres by focus groups participants, the interview included a question about this issue. The majority of participants (65%; n=246) said that the entrance/exit to the counselling centre helped provide for privacy. However, over one third of participants (35%) said that it did not help provide for privacy. When these participants were asked to explain their response, the main reasons given for their perception of lack of privacy were that the centre was located in a public place such as a hospital, shopping centre, GP clinic, health board office and on a main street location. Many participants reported that they were very uncomfortable entering the counselling centre:

> *"The counselling centre is on a main street. You have to ring the bell and wait for someone to answer the door. I am afraid that someone I know might see me standing there."*

> *"Definitely not [satisfied] - there is only one door and it brings you into the doctor's surgery, and the secretaries and the people in the waiting room can see you from downstairs. There is no privacy."*

Mixed views were expressed regarding the appropriateness of having a sign stating that it was a counselling centre. Of those who were satisfied that the centre provided privacy, some stated that having it located in a public place was good for privacy as they could have been going there for any reason:

> *'There are different things in the same building so it allows for privacy."*

> *"'It is part of a hospital; no one would know I am coming here for counselling."*

Participants were also asked if there were any aspects of the counselling centre which made it difficult to attend. A substantial minority of participants (19%; n=243) indicated that there were aspect(s) which made it difficult to attend, including privacy, distance and the lack of flexibility in scheduling appointments. A concern expressed by some clients was that they already knew members of staff at the centre.

4b.3 Appearance and condition of centres

Another aspect identified as consistent with a high quality service was the appearance and physical conditions of counselling centres. Most participants (86%; n=252) were satisfied with the appearance of the counselling centre they attended, with 11% dissatisfied and 3% neither satisfied nor dissatisfied. The main areas of dissatisfaction concerned comfort, size and privacy. Some counselling centres were reported as old, noisy or located in inappropriate places such as a hospital or GP clinic:

> *"It is stuck in a hospital with people who are there for other reasons. It is stuck down in the basement. This is not a nurturing environment whereby you get a feeling that someone cares when you walk in."*

> *"There is lino on the floors. You have to wait in a hall with other people who are waiting for other services. Then you're brought out to a Portacabin with windows all along and people constantly traipsing past throughout the session."*

Others found their counselling centre to be clean, comfortable and modern:

> *"It's a very modern centre; it's done up inside and its warm and inviting."*

Participants felt that the some centres did not allow for real privacy for structural reasons. They reported being conscious that they could be overheard:

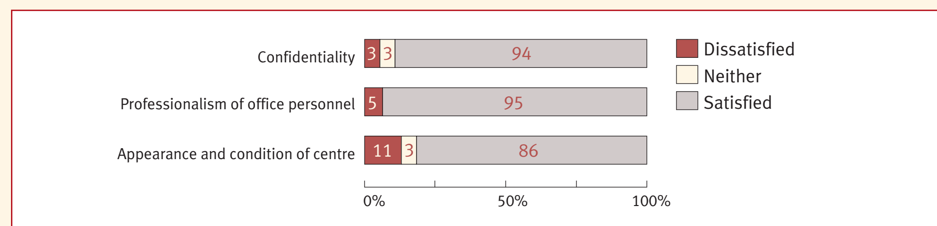
> *"Walls are paper thin - sometimes in the session one part of me wanted to release emotional pain and cry out but one part of me couldn't let go knowing people might hear me."*

When asked in an open-ended question at the end of the interview for suggestions on how to improve the service, some participants included suggestions about the physical aspects of the centres, including making the reception area bigger and making the entrance and exit more private.

4b.4 Professionalism of office personnel

Having a high quality service was defined to include not only the building, but the staff employed there and their level of professionalism. Thus, participants were asked how satisfied they were overall with the office personnel (e.g. receptionists, administrators), both on the telephone and in person. Ten percent of participants said that there were no administrative/office personnel attached to the particular centre they attended and thus the question was not applicable. Of the remainder, the majority (95%, n=222) were satisfied with the office personnel. Figure 3.7 summarises the main questions regarding satisfaction with these different aspects of the service.

Figure 4.4 Satisfaction with quality of the service



4b.5 Choice and flexibility concerning counselling appointments

Both the NCS and focus group participants identified choice and flexibility as important aspects of a high quality service. These two concepts were discussed several times in relation to:

- Structuring of counselling sessions
- Availability of appointment times
- Frequency of sessions, duration of a single session
- Total duration of their counselling experience.

4b.5.1 Availability of appointment times

The majority (85%; n=247) of participants were satisfied with the availability of appointment times to fit their schedules. There was no significant difference in satisfaction between those who were abused in institutional care and those abused in another context. Those participants who were not satisfied were asked to elaborate on their answers. Most who commented were dissatisfied with the flexibility of the counselling service in relation to appointment times. For example, it was difficult for those working to take time off during working hours as many did not want to explain the reason to their employer:

"Difficulties with getting time off work and having to explain why I need the time off and then returning to work following the session if I am upset."

Similarly, one client found the available schedule difficult for her in terms of confidentiality as she had not told her husband about the abuse. One specific suggestion to improve satisfaction was to have counsellors working in shifts so that they could accommodate a high proportion of clients who are working during the day:

"It's a nine-to-five service. This is not providing the service clients need, everyone wants a late system. The counsellor should work shifts like 3-10pm."

Some participants reported not having a regular, consistent appointment time, which would have brought a sense of order to the world for some.

4b.5.2 Frequency of counselling sessions

When participants were asked the typical frequency of their sessions, over half (57%; n=245) indicated that they were seen once per week. A further 22% were seen once fortnightly, and 6% once a month. A minority (15%) had other arrangements, for instance, an appointment structure that began as one session per week, changed to once a fortnight and then once a month as time in counselling progressed. One third (33%) of participants said that they did not choose the frequency of sessions. The majority of participants (90%; n=245) were satisfied with the frequency of their sessions, while 8% were dissatisfied and a further 2% neither satisfied nor dissatisfied. Participants who had discontinued counselling were significantly less satisfied with the frequency of sessions than those who had completed counselling ($p<0.05$) (Appendix 8).

4b.5.3 Length of individual counselling sessions

Because many focus group members expressed dissatisfaction with the length of counselling sessions, this issue was included in the interview. Most participants (76%; n=246) were satisfied with the length of their individual counselling sessions, with 15% dissatisfied and a further 9% neither satisfied nor dissatisfied. Those participants who had discontinued counselling were significantly less satisfied with the length of individual counselling sessions than participants who had completed counselling ($p<0.01$) (Appendix 8).

When asked to elaborate on reasons for dissatisfaction with length of counselling session, almost all participants said that they felt the session 'wound up' too quickly. Some clients reported their sessions were shortened to less than the usual one hour. Participants saw this as being a result of decisions made by the counsellor / service:

"The session is cut short because someone else is waiting to be seen."

However, sometimes this difficulty was seen as being caused by something outside the control of the centre, such as transport or travelling distance.

For some participants 'clock watching' on the part of the counsellor was experienced as disconcerting and uncomfortable:

"At the start of counselling one hour is not sufficient. I was conscious of clock watching which makes you feel anxious."

Dissatisfied participants reported that they would like some choice in the duration of the session. Conversely, for some participants who were very satisfied with the length of their session, there did not seem to be a fixed length of time for the counselling session:

"It ran over a bit sometimes. I never had the feeling you had to go … mainly two hour sessions."

"[The counsellor] does extend the time if need be. I don't feel under any pressure to leave. Time is never a matter of concern."

Participants who were not satisfied were asked to say how much time should be allocated per session given that the counselling service needs to schedule appointments for a specific length of time. Almost half (44%) of participants said that a session should be allocated up to 90 minutes. Equal numbers of participants suggested 60 minutes per session (22%) or more than 90 minutes per session (22%).

4b.5.4 Total duration of counselling

Those participants who had finished/completed counselling were asked how satisfied they were with the total length of time they spent in counselling from beginning to end. While over half of the participants (60%; n=145) reported satisfaction with the duration of time spent in counselling, a substantial number were dissatisfied (27%) or neither satisfied nor dissatisfied (13%). Those participants who had discontinued counselling were significantly less satisfied with the total length of time spent in counselling than those who had completed counselling ($p<0.001$) (Appendix 8).

Participants also rated their satisfaction with how their counselling ended, with 61% (n=143) reporting that they were satisfied. Of those participants who were not satisfied, 36% stated that they themselves had made the decision to end counselling, 16% said the counsellor had made the decision to end counselling, and 29% indicated it was a joint decision. A number of these participants felt that they had left the counselling service with issues and difficulties unresolved.

Both participants who were satisfied and those who were dissatisfied with how the counselling ended explained why it ended. In some cases, participants themselves were not able to continue to attend due to personal, family or work commitments (e.g. marriage difficulties or job opportunities). In others, the counsellor suggested they should finish up:

"I wasn't ready to finish. I felt her caseload was too full and that's why she finished. I told her I didn't feel ready."

"My counsellor was leaving and I could not face dealing with another person. I couldn't make the last session and I have not heard from them since."

Some participants felt that the counselling and/or the counsellor was not helping, that they weren't 'getting anything' from the counselling or that their issues remained unresolved. A satisfied participant reported:

" Although it was a mutual decision [to finish sessions], I would have liked more counselling, I have been twice since I left."

Other participants said that they were unable to cope with the emotional pain which they experienced during counselling:

"I ended it after attending two to three sessions as it was making me too upset."

"You would need time out to do counselling…you can't function properly while attending – can't hold on to a job."

For some participants, counselling sessions were ended as a referral to another health professional was deemed a more suitable service.

Figure 4.5 summarises the main satisfaction questions concerning the structure of counselling sessions for comparison purposes.

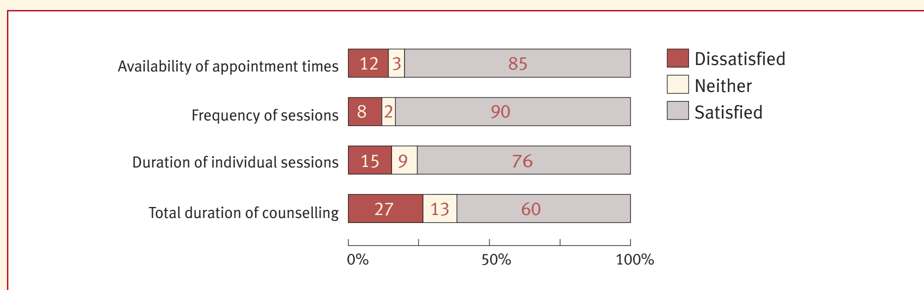


Figure 4.5 Satisfaction with aspects of frequency and duration of counselling sessions

4b.6 Choice of counselling service

Choice as a component of a high quality service also arose in the context of flexibility of the service, particularly in accommodating those who had difficulty with counselling centre location. If a participant expressed dissatisfaction with any aspect of the service relating to location and accessibility, they were asked 'Had you a choice of attending another service?'. Over one third of participants (38%; n=171) did not know or had never asked. One third (34%) said that they did not have a choice of attending another service and 29% stated that they did have an alternative option. When those who responded 'no' were asked if they knew why not, the main reasons were that they were not given information about the availability of an alternative service location, or that the alternative location was too far away.

4b.7 Choice of counsellor

Choice of counsellor was also seen as being a component of a flexible, high quality service. Participants were asked if they had ever wanted to change to another counsellor. While most (84%; n=241) did not, a significant minority (16%) indicated that they did feel this need at some point. If a participant indicated that they had considered changing counsellor, they were asked if they had tried to change to a different counsellor. Very few (16%; n=44) of those wanting to change reported trying to change counsellors. When asked why not, clients reported a number of reasons. Some said that they were concerned about hurting the counsellor's feelings, letting him/her down or annoying him/her. Some acknowledged their own difficulty in changing:

> *"I was afraid of having to start over and explain everything to another counsellor."*

One client who left because she was dissatisfied reported that she was not made aware that she could change to another counsellor and that no one checked with her to find out why she left counselling. Of those who indicated that they did try to change counsellors, only half were successful in changing to another counsellor:

> *"I just wanted someone who I could have an evening session with but that wasn't possible."*

> *"He was the only one available in my area."*

One respondent reported that her counsellor 'just gave up' and did not try to work further with her when she wanted to change. Another mentioned that the NCS paid for them to see a private counsellor:

> *'I had a problem with the service – not the specific counsellor – she was working within the service rules/regulations. [Name of service] pay for me to see a private counsellor."*

4b.8 Counsellor characteristics

Counsellor characteristics that made participants feel they were receiving a quality service were seen as a very important aspect of a high quality service. The NCS discusses these issues in terms of professionalism and training. Focus group participants felt they could identify a 'high quality' counsellor in terms of:

- Their sensitivity.
- Ability to listen and understand.

- Their knowledge of the relevant issues.
- The level of trust that could be developed.
- Their approach to counselling.

4b.8.1 Counsellor sensitivity

The high level of satisfaction (92%; n=246) with counsellor sensitivity towards important issues in the participant's life was striking. Some stated that they experienced great relief and healing from talking about their abuse experience and being listened to by a counsellor:

> *'The counsellor is helping me to heal as well as listening to me."*
>
> *"I'm at the stage where I can tell her what's bothering me today. Initially it was difficult to link the past with the present."*

When participants reported that they were not satisfied (8%), the main reasons concerned two relatively contrasting issues: a lack of feedback from, or inadequate relationship with counsellor on the one hand, and an over-engagement in details of the participant's story on the other hand. While the majority of participants reported being satisfied with the counselling process, the 'lack of feedback' theme emerged quite strongly as a source of dissatisfaction across all questions relating to the counselling process.

Being listened to by the counsellor was not always seen as adequate. Some participants did not experience the process of being listened to as healing. Many had a strong desire to engage in a fuller interaction with the counsellor. They felt that a deeper level of verbal engagement should also involve direction or guidance being given by the counsellor. The experience of 'just being listened to' often felt repetitive for some of the participants who were dissatisfied and was cited by some as a factor in terminating the counselling process:

> *"She very rarely gave me feedback … I needed reassurance for a few sessions to help me feel comfortable enough to talk, this didn't happen."*
>
> *'There was no direction from the counsellor - as if she were not fully there."*
>
> *"If she had knowledge she would have had a strategic plan of where we were going next and how we would get there. She didn't seem to know, she should have been able to put what I was saying together and give some sort of direction."*

Regarding having a 'connection' with the counsellor, one participant felt the counsellor was 'too clinical' and felt uncomfortable with this approach. Some participants sensed vulnerability in their counsellor, particularly in relation to their disclosure of the details of their abuse experience. While some participants experienced this positively, others expressed dissatisfaction. One participant, for instance, felt that the counsellor was too vulnerable and at times felt her to be on the verge of tears. However, another participant who rated counsellor sensitivity as 'satisfied' viewed this same reaction very differently. He felt that it was normal that the counsellor seemed shocked when he disclosed details of his childhood abuse. To him, this meant that the counsellor was "only human":

> *"I could tell by her facial expression that she wasn't used to hearing about what I had experienced – I don't mind as I could appreciate the human side to her".*

4b.8.2 Counsellor knowledge and expertise

Most (84%; n=241) felt satisfied with their counsellor's knowledge and expertise in working in this area:

> *"This girl was born to do this job, I have nothing but the height of respect for her."*
> *"I wanted more direction at the start, I did not know what to do. I know now that this is not right, I had to find my own answers."*

"I was frustrated with my counsellor. I can see now that I was expecting her to participate in my symptoms. Now I am clear and see that she was being professional and glad she stayed back."

"Anything he said was good and made sense … he had a lot of practical experience. I feel it is important to know where people are coming from. If he was too much of an academic with unrealistic ideas I wouldn't have been happy with him. I think counsellors should actually go down and look at these institutions to see what it was like for us."

Dissatisfied participants again spoke about a lack of feedback, feeling in this case that this was a sign of lack of counsellor knowledge or expertise. They also described concerns about qualifications, feeling that counsellors were too young and had an academic, but not a real understanding of the issues, i.e. 'textbook' knowledge.

For some older participants, meeting a counsellor who was a lot younger than themselves was described as a somewhat disconcerting experience. However most felt that the overall skill and warmth of the counsellor was more important. The gender of the counsellor sometimes elicited this same response. For some there was a sense of unease with regard to disclosure of sexual and physical abuse details to a counsellor of the opposite sex. However, neither age nor gender was ever described as the sole factor in participant's decisions to terminate counselling. Given a choice, some older clients said they would like a more mature counsellor - someone who had a life experience in terms of years that in some way might match their own:

"I am sure of her knowledge and I know her qualifications but it's not really enough. If I had a choice I'd like it if the counsellor had more life experience, that I'm talking to someone older who had been through abuse."

Apart from qualifications and maturity, the lack of personal experience of abuse was sometimes perceived by participants as limiting a counsellor's insight and understanding of the participant's past childhood experiences. Some participants felt that only by experiencing childhood abuse oneself could one fully understand and relate to another person who had experienced childhood abuse. A participant who had a very positive overall experience of the counsellor noted:

"I found her great but I wasn't really sure of her experience. At the start I sensed she was uncomfortable with some issues I was bringing up … maybe you have to experience something (abuse) to really know."

4b.8.3 Trust in the counselling relationship

The number of participants who described the relationship with their counsellor as trusting was extremely high (93%; n=239). As one participant stated:

"I could speak to her about anything."

Trust in the counselling process was described as an element of the relationship which grew over time:

"The relationship got more trusting as the sessions went on."

Acknowledgement by participants that those who have experienced childhood abuse find it extremely difficult to trust further strengthens this positive result:

"It's very hard to trust when you come from an institution."

"To begin with, I wouldn't trust anybody and it would take a long time for my trust to be gained."

Barriers to trust

While the majority of participants said that the counselling relationship was of a trusting nature, some themes emerged that explained lack of trust or breaches of trust. One important theme was that of self-blame. This occurred where trust was perceived to be lacking or absent in the relationship and when the participant blamed him- or herself:

> *'This could have to do with me also. I was very mixed up at the time, it could have been my fault, perhaps I wasn't open to the experience".*

Lack of feedback or interaction by counsellors was also a barrier to trust:

> *"I did make an effort and it left me feeling vulnerable because she didn't know what to do with that information".*

On occasion, participants noted that they were still working on building a trusting relationship in the counselling sessions.

Trusting the service

While not specifically addressed in this section, some participants spoke of trust as not just being about the counselling relationship. It was also seen as relevant to the overall service. Both in individual interviews and during the focus groups, it was suggested that the fact the NCS was a service provided by the health boards may have a negative impact on the overall trust relationship between the client and the service. This was particularly true for some survivors of institutional abuse who identified the State as being responsible for their childhood abuse. Because of this, they found it difficult to reconcile (or accept) that this same body (the health board) was to be the sole provider of counselling to help deal with their childhood abuse. As one very angry participant put it:

> *"It's about the providers of the counselling …I want no part of the Irish system of counselling. It's State supported counselling and I refuse to take it."*

An independent (non-health board) counsellor would have been preferable for some survivors of childhood abuse. Since many of the survivors of institutional abuse planned to attend the Commission to Inquire into Child Abuse, for some participants it did not seem 'right' that State-employed or health board-employed counsellors provide this service:

> *'There is a lack of choice in connection with the very things you had grown up to despise and hate."*

While this need was addressed in some instances where a health board would fund a qualified 'external' counsellor for the specific participant, it was not clear that this was the case in all health boards or that all survivors of institutional abuse were aware that this choice existed in their region. Trust also emerged as an issue with some participants in the context of their current family life. For example, some younger women with children felt an underlying anxiety and sometimes an acute fear of social workers (particularly if they had been placed in residential care or an industrial school themselves). Because the counselling service is a health board service, some found themselves being somewhat cautious about what they said to their counsellor. This was because they perceived a possibility that there might be child protection implications to their discussions, for example if the participant was drinking, depressed or 'not coping'.

4b.8.4 Counsellor's ability to listen

The vast majority of respondents (95%; n=248) were satisfied with the counsellor's ability to listen to them. Some participants simply stated *"incredible"* and *"the best"* when asked to rate their counsellor's ability to listen. Reasons for dissatisfaction in a minority again related to an absence of

fuller interaction or engagement with the counsellor. Some reported a lack of interest by the counsellors and others commented on listening as a skill.

4b.8.5 Counsellor ability to understand the client's problems

Participants' ratings of satisfaction with the ability of the counsellor to understand their problems was also high (85%; n=244), with 9% dissatisfied and 6% neither satisfied nor dissatisfied. Feeling understood was seen as very important to the therapeutic relationship:

> *"There is a bond between us and we click now. She has feelings as well and I am sticking with her."*

Engaging with a counsellor who the client perceived to be a 'real' person was important. Getting feedback was also an indication to the client that the counsellor understood them:

> *"I got great feedback from both counsellors."*

> *"She shed light on a lot of things."*

Helping the participant reframe some of their negative life experiences and thus reducing or eliminating feelings of self-blame was also identified as beneficial by participants. Other participants who were very satisfied with the counsellor's understanding of their issues and problems explained their response by stating that the counsellor was very skilled at dealing with these issues:

> *"The counsellor was very focused and not fazed at all by things."*

A strong sense of participant isolation in terms of experiencing life so differently and painfully to others who were not abused as children was clear from comments. Participants who were not satisfied with their counsellor's ability to understand their problems again described some recurring themes. These included a lack of feedback from the counsellor, feeling that the counsellor's knowledge was 'textbook' rather than a real understanding of the issues and finally that the counsellor was 'too young' and therefore lacking in life experience:

> *"I'm not sure that she understands; she listens, I would like it to be more interactive; I feel like I just come in and talk."*

> *"She has book knowledge. She applies theory. I need to meet someone real – a real person – who has travelled the journey."*

4b.8.6 Overview of client satisfaction with counsellor

Figure 4.6 summarises the levels of satisfaction with the counsellor factors identified as being a part of a high quality service.

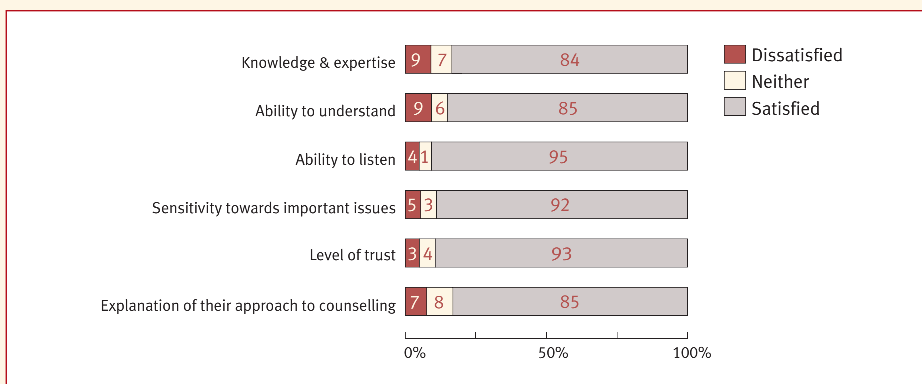


Figure 4.6 Satisfaction levels with counsellor factors as part of a quality service

Comparison of satisfaction ratings from those in counselling and those no longer in counselling highlighted significant differences between the two groups. Those participants who were not in counselling were significantly less satisfied with the sensitivity of the counsellor ($p<0.05$), the knowledge and expertise of the counsellor ($p<0.05$), their relationship with the counsellor ($p<0.05$), and the ability of the counsellor to understand their problems ($p<0.01$) (Appendix 7).

Those participants who were no longer in counselling were further broken down into those who had completed and those who had discontinued counselling. Significant differences between these two groups were again noted in some ratings of satisfaction with counsellor characteristics. Participants who had discontinued counselling were significantly less satisfied with knowledge and expertise of the counsellor ($p<0.05$), relationship with the counsellor ($p<0.05$) and the ability of the counsellor to understand their problems ($p<0.05$), than those who had completed counselling (Appendix 8).

4c NCS: A client-centred service

The NCS states that it endeavours to ensure that the counselling service is client centred by:

- Promoting the autonomy of the individual client.
- Taking a holistic view of the client.
- Being sensitive to the therapeutic needs of the client.

Focus group participants were asked for their definition of the concept of 'client-centred'. An area of primary importance to participants in this discussion concerned the provision of additional support for clients, such as out-of-hours emergency care, a crisis helpline and support while waiting for counselling. From the perspective of focus group participants, taking a 'holistic' approach towards working with clients involved having a broad scope of possible services on offer. These services/issues are not always dealt with by the counselling relationship and/or service but nevertheless were seen by some participants as necessary prerequisites for providing a 'client centred' service.

4c.1 Client needs while on the waiting list

If participants indicated that they felt the need for support while on the waiting list, they were asked to select what type of support they thought would have been the most useful from a list generated from focus groups discussions.

Having access to a crisis help-line was selected as the most useful support (42%; n=80), while general telephone contact was seen as the next most useful support (26%). Access to a trained volunteer was selected by 10%, while group-type supports were fairly equally endorsed by the remainder of participants (figure 3.10).

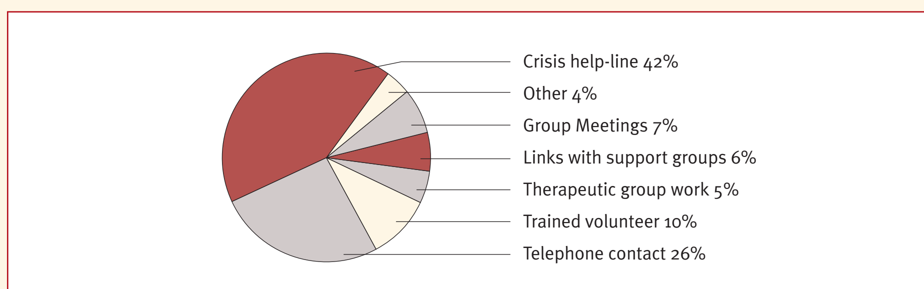


Figure 4.7 Types of support required while on waiting list (n=80)

4c.2 Client needs while in counselling

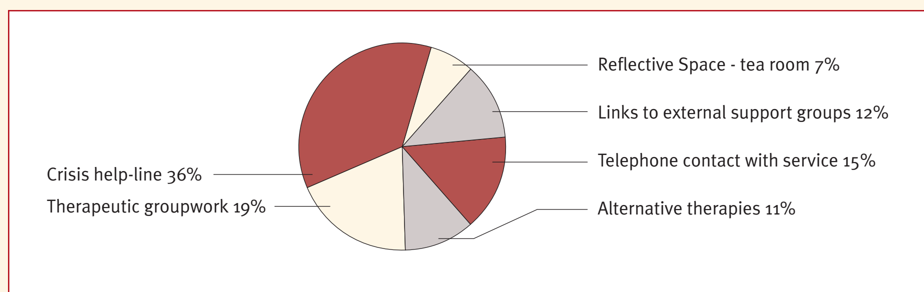
Focus group participants often commented on the need for additional support even after starting counselling. Many felt they had needs between sessions that were not addressed. Thus, questions were asked of participants in order to better understand what these needs were and how they might best be addressed. Participants were first asked if they were offered any additional supports outside of counselling sessions. A quarter of participants (25%; n=242) indicated that they had been offered additional support. Many participants (45%; n=234) indicated that they felt the need for some additional support while attending counselling. If they indicated such a need, a list of possible supports (suggested during focus groups) was read out to the participant, and they were asked to choose which single item would provide the most useful support to them. The most frequently selected additional support was access to a crisis helpline (36%), followed by therapeutic groupwork (19%), telephone contact with the service (15%), links to external support groups (12%), alternative therapies (11%), and lastly reflective space (7%) (Figure 4.8).

Participants were asked to rate their satisfaction with the amount of support available to them between individual counselling sessions. Only half of participants were satisfied (52%; n=234), with one quarter (25%) dissatisfied and 23% neither satisfied or dissatisfied.

4c.3 Client needs related to therapy issues

Focus group discussions also revealed that many participants felt there were some issues that they

Figure 4.8
Types of support wanted between or immediately after individual counselling sessions

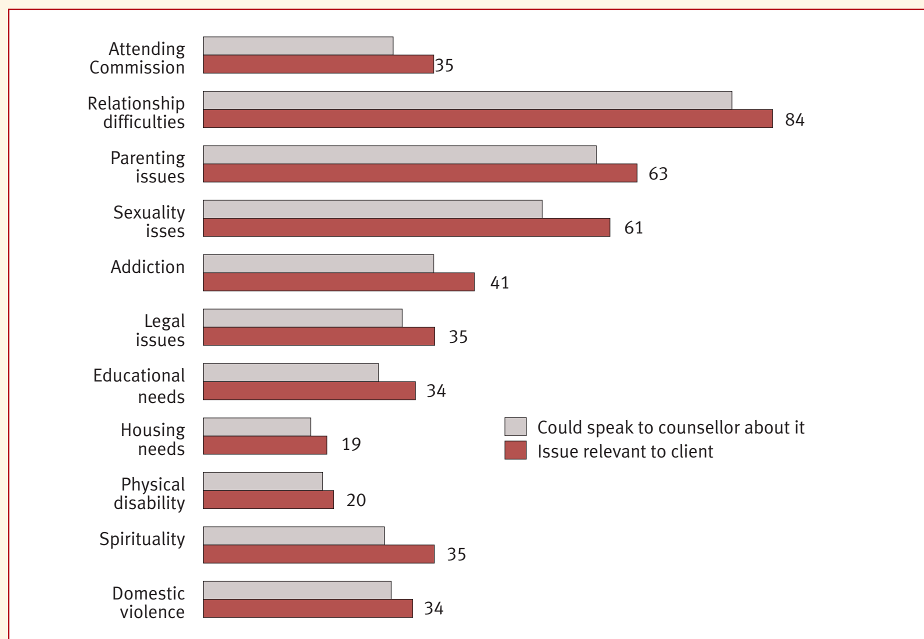


wanted or needed to discuss with their counsellor, but were not able to discuss with them, for whatever reason. In order to explore this issue, participants were read a list of issues that might arise for those who have experienced childhood abuse. They were first asked if this was an issue that was applicable to them, and if so, whether they felt they could speak to their counsellor about it.[5]

Figure 4.9 depicts the percentage of participants who felt that a particular issue was relevant to them, and of those, the percentage who felt that they could speak to their counsellor about that issue. As illustrated, the issues seen as most relevant by participants were: relationship difficulties (84%), parenting issues (62%), sexuality (61%), addiction (41%), attending the Commission to Inquire into Child Abuse (35%), spirituality or religious needs (35%), legal issues (35%), educational needs or reading difficulties (34%), physical disabilities (20%) and housing needs (19%).

Most participants felt that they could speak about these issues to their counsellor. Of interest, however, is the number of participants who felt that they could not discuss a particular issue with their counsellor, for whatever reason. When examining this list of issues in terms of the topics which clients perceived to be less 'open for discussion', a different order emerges. Those topics which participants identified as relevant and felt least able to discuss were: sexuality (25%), the Commission (24%), spirituality/religious needs (21%), legal issues (19%), educational needs (18%), domestic violence (16%), addiction (15%), physical disability (15%), housing (13%), parenting (10%) and relationship difficulties (9%).

Figure 4.9
Evaluation of client-centredness. Issues identified as relevant to clients and ability to discuss them with counsellor %



4c.4 Client need for referral to other services

It was recognised that the NCS may not be able to provide all the services required, and that referral to another service may be more appropriate in some cases. Participants were asked if they

[5] Participants were also told that they could simply state that they preferred not to answer as these questions were seen as some of the most personal in the entire interview.

had needed to be referred to a specific service (from a list of services read out to them). If they had felt that they needed to be referred to a service, they were then asked if they had actually been referred to that service by their counsellor. The total numbers of participants who indicated that they needed a referral to other services were quite small (from 12% to 7%). The largest number had felt the need for referral to another health professional (12%), followed by referral to a social worker, social welfare, or a housing agency. While few participants reported needing referrals, the percentages of those who were actually referred on were also low. Half (50%; n=28) of those who felt they needed a referral to another health professional were actually referred, while one third (35%; n=17) of those who needed a referral to social welfare or a housing agency were referred on. Over half (57%; n=28) of those who had identified the need for a referral to a social worker had actually been referred.

4c.5 Additional needs

Focus group participants suggested various other services that they felt should be provided by the NCS. Although most centres in the NCS did not have such services, the level of interest in these "additional" services should be evaluated as it was deemed important by the client focus groups. So as to not raise expectations that these services were available, or even about to 'come on line' in the near future, this section of questions was prefaced by a statement that most if not all NCS centres did not provide these services.

Participants were asked to indicate their interest in availing of a wide range of additional services (from a list generated from focus group discussions). Figure 4.10 illustrates the percentages of those who indicated interest in each service. Only participants who had not already been offered a service were asked if they would like to avail of a particular service.

While therapeutic group work is available in a number of boards across the country, access to therapeutic group work was highlighted by a number of participants.

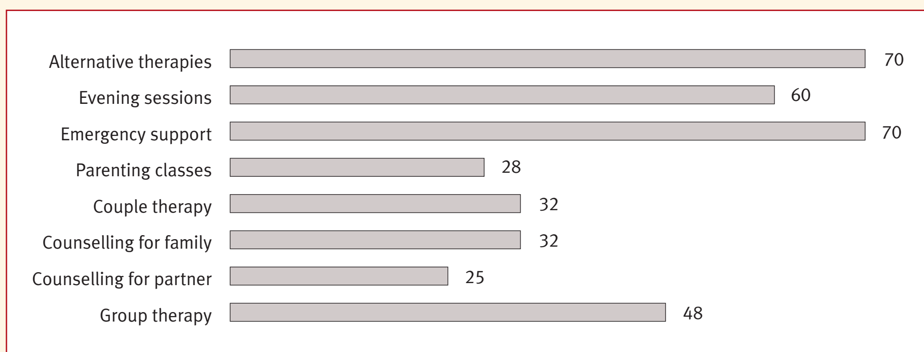


Figure 4.10 Participant interest in referral to additional services from the NCS

In an open-ended question at the end of the interview, participants spontaneously commented on other needs or issues that if provided, may help and encourage others to attend counselling. Suggestions included providing a creche or childminding facilities, providing transport for people who live in rural areas or who cannot afford to travel and providing 'a room where survivors of institutional abuse could come together'.

4c.6 Promoting client autonomy

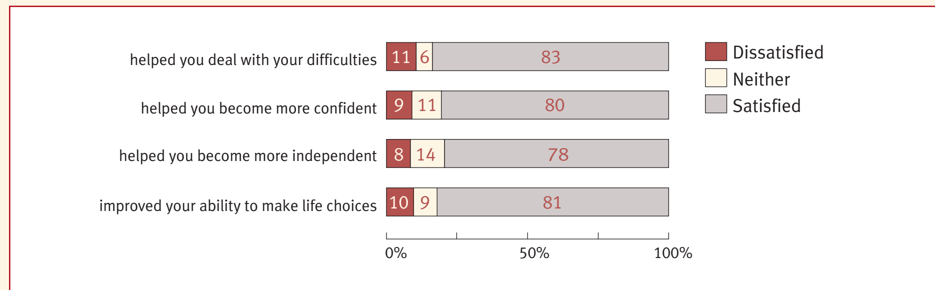
The importance of promoting autonomy is viewed by the NCS as an essential aspect of a client-centred service. Thus, a series of questions were asked of participants to help determine if they felt the service promoted their autonomy and independence. It is important to note that while these questions focus on the overall effects of counselling as perceived by the client, they are not an independent measure of the therapeutic outcome for the client.

Both participants who were still in counselling and those who had finished counselling were asked these questions. If a participant had just begun the counselling process or had left counselling prematurely they could choose to answer any of the above questions as 'too soon to rate'.

Participants were asked to reflect on their experience of the NCS and how it affected them overall. The first question in this section asked if counselling had helped them deal with the difficulties that made them seek counselling in the first place. The majority of participants (83%; n=224) were satisfied that it had, while 6% were 'neither dissatisfied or satisfied' and 11% were 'dissatisfied'.

Slightly fewer participants were satisfied (80%; n=213) that counselling helped increase their confidence. More than three quarters (78%; n=216) reported that counselling had helped them become a more independent person. Those who were abused in an institution were less satisfied that counselling had helped increase their sense of independence (71% vs. 82%). Lastly, 81% of participants felt that counselling had improved their ability to make life choices.

Figure 4.11 Satisfaction with promoting client autonomy



Significant differences in satisfaction between those participants who were currently in counselling and those who were no longer in counselling were observed: those participants who were no longer in counselling were significantly less satisfied that counselling had helped address their original difficulties ($p<0.001$), that counselling had increase their confidence ($p<0.01$), that counselling had helped them become a more independent person ($p<0.05$), and that counselling had improved their ability to make life choices ($p<0.01$) (Appendix 7).

In summary, across questions about autonomy, approximately a fifth of participants were not satisfied with the outcomes of counselling, while between 78% and 83% perceived positive outcomes from counselling in relation to these issues (figure 4.11).

4c.7 Emerging themes

The themes emerging from open-ended questions are summarised to give an overall sense of how participants perceived the effects of counselling. While researchers did not uniformly seek out explanations when a client indicated they were 'satisfied' with services (as the focus was more on highlighting areas to address in future quality initiatives), some participants did volunteer a spontaneous response to explain their choice of rating:

> *"I think they helped me to live with someone and share my life. Talking through really did help."*

> *"It was early days when I left, but I did feel better about things afterward – it shed some light."*

From the comments made by participants who had indicated that they were neither satisfied nor dissatisfied, dissatisfied and very dissatisfied the following themes emerged.

4c.7.1 *Pain - Inability to cope*

For some participants, entering into a counselling relationship which involved exploration of their childhood abuse resulted in acute emotional pain and a sense of not being able to cope with this type of exploration/ uncovering work:

> *"No – it made me more upset and I went back on the drink afterwards."*

"I was overwhelmed by the feelings associated with abuse, I couldn't cope with it. I felt worse than before I went for counselling."

For many of these participants, the feelings and memories surrounding their abuse experience were "boxed off" for so long as a coping mechanism that talking about what had happened was a traumatic experience:

" The service did not have the support available that I needed. I was traumatised by the experience. I had survived by staying out of feelings up to that."

4c.7.2 Unresolved issues

This theme was identified as a result of participants explaining that the same issues that led them to seek counselling remain unresolved. Participants usually cited the reason for a 'neither satisfied nor dissatisfied', 'dissatisfied' or 'very dissatisfied' response as being due to the unresolved nature of their issues/problems. When the individual responses coded as 'unresolved issues' (n=52) were assessed, a number of themes emerged.

Participants said that the reason their problems were unresolved was because they left counselling too soon. Early departure from counselling was influenced by a wide variety of reasons. These influencing factors range from the limits of confidentiality, availability of appointment times, duration of counselling sessions offered, trust/relationship with the counsellor and premature termination of counselling.
Some participants who were still in counselling explained that any 'improvements' or benefits in relation to these questions were still ongoing and therefore their issues were 'unresolved':

"I am still not motivated to do the things that I know that I should be doing. This is not a reflection on my counsellor, I just need more time."

" It's a slow process, something big might happen later on."

4c.7.3 Difficulties in entering into the process of counselling

Some participants explained that they found it quite difficult to engage fully in the counselling process and therefore were not satisfied with the overall effects of counselling:

" I'm glad I talked about it but on the whole I don't feel any different. I wasn't totally honest with the counsellor."

" I think it's my fault because I find it difficult to enter the process. I find it difficult to share experiences."

4c.7.4 Client characteristics and their impact on the experience of counselling

Some participants identified confidence and independence as pre-existing attributes or characteristics, which they either did or did not possess before entering the counselling process:

"I have always had confidence. The service didn't help me with that."

"I feel I was independent in the first instance - I'm a high achiever, it's about justifying my existence and it helps build my self esteem."

Confidence was sometimes described as a fluctuating characteristic which was somewhat dependant on being in counselling:

"My confidence increases when I see my counsellor and have had a session but because of the long gap in between sessions I find my confidence plummets again."

4c.7.5 *Counsellor-client relationship*

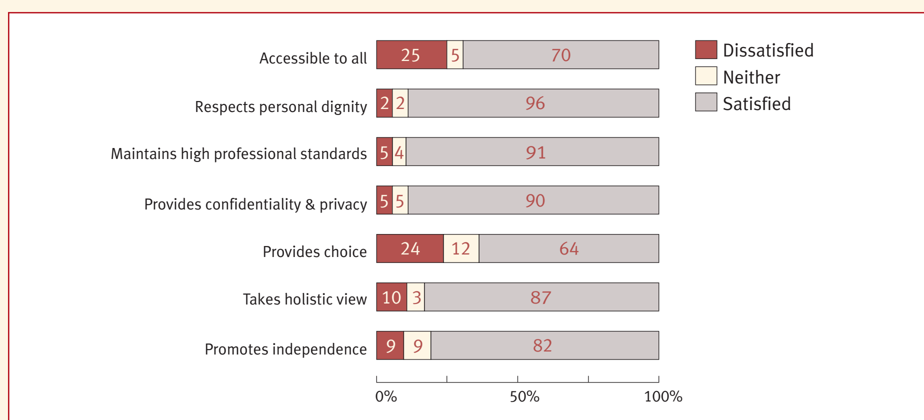
Some participants cited the counsellor–client relationship as a reason for not experiencing any overall the beneficial effects of counselling. Many different individual factors were reported. These ranged from differences in the client-counsellor agenda or lack of feedback from the counsellor, to a personality clash between client and counsellor.

4c.8 Ratings across all NCS quality principles

A series of brief statements that summarised the principles put forth by the NCS were rated by participants (figure 4.12). Participants were most likely to agree that the service respected the dignity of its clients (96%; n=247) and that the service maintained high professional standards (91%; n=241). Other principles that were seen to be met by a high number of participants were confidentiality and privacy (90%; n=242), taking a holistic view (87%; n=245) and promoting independence (82%; n=240). Participants were more likely to disagree that the service met the principles of accessibility (25% disagreed), and choice (24% disagreed).

Participants were asked to give an overall rating for the NCS on a five-point scale ranging from 'Very good' to 'Very poor', and 89% of participants indicated that the service provided by the NCS was either very good (63%; n=249) or good (26%). A small minority said that it was very poor/ poor (6%) or neither good nor poor (5%).

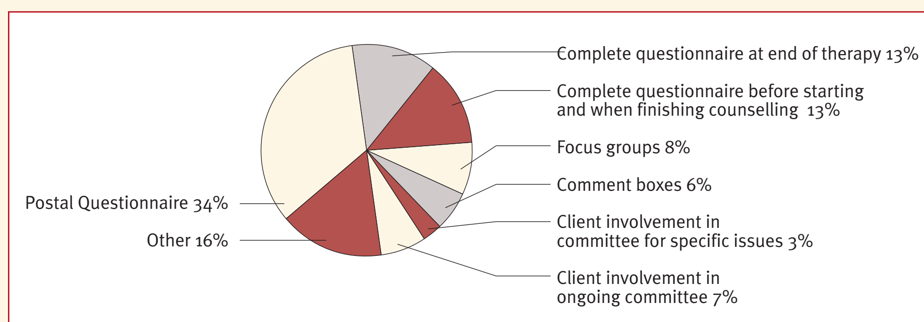
Figure 4.12 Summary of client evaluations of the NCS performance on their stated principles regarding a quality service



4c.9 Client involvement in future service evaluation efforts

Little is known about client interest in and preferences for participation in service evaluation. Participants were asked to specify their preference for future service evaluation out of a number of options (figure 4.13).

Figure 4.13 Client preferences for future service evaluation



One third of participants (34%) said that given the choice in any future NCS evaluation, they would they would prefer to give feedback/evaluate the service using a postal questionnaire. The remainder of participants indicated different preferences for giving feedback to the NCS. Some said that they would prefer to 'fill out a questionnaire' at the end of their counselling (13%) and a

further 13% said that they would prefer to fill out a questionnaire both before counselling started and then when it finished. Small numbers of participants indicated a preference for the other options listed: client involvement on a committee set up for a specific issue (3%), client involvement on a regular and ongoing committee (6%), comment boxes (6%), with 8% indicating a preference for focus groups which provide feedback. A small number chose to verbalise their own ideas for giving feedback regarding the service. The majority of these contributions involved the client expressing a preference for a study similar to this consultation being repeated or for a telephone interview. These findings must be taken in conjunction with the caution that a majority of those invited to take part in this study declined to do so. Engaging clients in feedback activities is a challenge to be addressed in future evaluations.

Chapter 5

DISCUSSION AND CONCLUSION

The discussion comprises a consideration of both the findings from the research interviews and the overall process of conducting research in this context.

5.1 The study process

Given the sensitive nature of the subject of this report, the potential vulnerability of the NCS client population, and the fact that the NCS is the first nationally co-ordinated health board service, this first consultation exercise provided an important learning experience from a number of perspectives. The study process involved a number of methodological challenges, mostly incurred in order to protect the welfare of individual clients and to take account of the ethical considerations of the project as outlined from earlier. An additional issue which became apparent during the research process related to the potential conflict of research and therapeutic roles which was illustrated in relation to concerns expressed by some counsellors regarding issuing an invitation to clients to participate in the study. This decision posed difficulties for some counsellors who felt that it could compromise their relationship with clients. This problem was not anticipated. From the NCS perspective, client consultation has always been part of the remit of the service. Previous experience by the research team with medical and nursing staff informing patients of research projects and providing invitations had not raised such difficulties. It was hoped that invitation letters with a freephone contact would make clear the independence of the counsellors from the study. In addition, the client representatives on the steering group did not perceive there to be a conflict and felt an invitation from a counsellor was appropriate. This issue highlights the need for all concerned to work to agree what is necessary and desirable to achieve the goal of offering clients a possibility to comment on services they use as well as highlighting the issue of how research can be integrated into ongoing therapeutic practice. Greater consultation is advised for future projects. Another challenge for the study process was the differences in information systems held by each health board and the need to protect client confidentiality which impacts on how records are held. This made the random selection of clients representing institutional/non-institutional and ongoing/completed clients more difficult to achieve. In some boards, the lists had to be created/completed in order to conduct the study. This considerably extended the workload of individual administrators and the recruitment period for the study.

5.2 Survey response rate

The response rate for the study (33%) was disappointing. However, it compares well to the response rate for 'Survey 3' of the Northern Ireland Report (Park, 2002) where views and experiences of service users of counselling services were sought. In the Northern Ireland Report, researchers and professionals also had concerns regarding the invitation process. There it was decided that the most suitable method of contacting clients /service users was to ask the counsellors to distribute the questionnaires. Advertisements were also placed in local newspapers inviting clients of counselling services to participate. Thirty-seven questionnaires were given to members of the public as a result of these advertisements. Even though the actual survey response rate is not explicitly stated, it was possible to calculate a response rate of 17% using the figures provided. Response rates for similar studies vary depending on the method of invitation, i.e. postal

or face-to-face and the nature of the questionnaire used. For example, Gaston & Sabourin (1992), in their study of client satisfaction and social desirability, elicited a 65% response rate. Again the questionnaires were distributed through therapists. Baronet and Gerber (1997) used telephone calls to contact clients of a community crisis centre and, conducting the interview by telephone, achieved a high response rate (92%). Moore and Kenning (1996) used a combination of telephone invitation and postal questionnaire in their study 'Assessing Client Satisfaction in a Psychology Training Clinic' and achieved a 62% response rate. Hemmings (1997), in his study on counselling in primary practice, achieved a response rate of 82% and 53% (two stages of the research). He reported that in relation to the counselling satisfaction questionnaire, 96 participants out of a potential 188, completed the questionnaire yielding a 51% response rate. Lebow (1983) indicates that an average of 55% of clients in mental health facilities respond to surveys when participation is solicited. Appendix 5 shows the wide variation in response rates within the various health boards of the NCS illustrating the possibility of a number of variables impacting on a response rate. Insofar as could be determined, there were no differences between those participating and non-responders. The demographic profile of the study sample was very similar to the NCS population as described in the 'First Report' (NCS, 2002) across a number of important variables. Further analysis of the non-responders of those randomly selected and invited and those excluded showed no significant differences in demographic profile. While these comparisons provide some reassurance, it is very likely that non-responders are more vulnerable than those willing to participate. Low response rates are common in groups dealing with sensitive issues. This pattern was also found in other Irish studies: e.g. a study of those abused as children by clergy (ongoing study, Health Services Research Centre); a study of those infected by hepatitis C from state provided blood products (25% for those who were contacted by letter with 61% for those who could be telephoned following an introductory letter) (McGee et al, 2000); and a study of those who had experienced miscarriage (49% response) (Jackman et al., 1993). While the response rate for the study was low, the sample obtained represents an important achievement in consultation with a very vulnerable group of service users. User satisfaction surveys are now very common but closer examination shows that potentially vulnerable groups or sensitive issues, e.g. clients attending mental health services or counselling services, are seldom surveyed. The information available thus provides the first national survey of feedback from clients to a counselling service in Ireland.

5.3 Results within the context of consumer satisfaction research

Over the past decade, patient satisfaction surveys have become an important and useful component of health service evaluations in Ireland as elsewhere. However, the majority of client satisfaction research with counselling services/mental health services concerns studies conducted in the United States. Much of this research is limited in terms of its comparability to this study due to the specificity of the particular counselling/mental health service involved here. Given the limited research in the area of mental health/counselling service client evaluations, it is difficult to draw comparisons or establish an acceptable satisfaction rating. Lebow (1983) reviewed early studies concerning satisfaction with mental health treatment and found that 83% of participants reported satisfaction with services with 10% of clients reporting dissatisfaction. Reynolds et al. (1990) found similar results with the satisfaction ratings of clients with severe mental and emotional disorders. Hemmings (1997) in a U.K. study used the 'Counselling Satisfaction Questionnaire' to assess client satisfaction as part of a broader study on counselling in primary care and found that: (a) the majority (82%) of participants felt that counselling had helped them, (b) 80% of participants felt that they had been understood by their counsellor, (c) 83% felt that they had been given enough time to talk and d) three quarters of participants felt that it was easy to talk to their counsellor. As noted earlier, the SAVI Study (2002) assessed satisfaction with counselling for those who had attended for sexual abuse in Ireland. The vast majority (93%) were satisfied with their experience of counselling.

While researchers in the field of client satisfaction with counselling and outpatient mental health services have advised the use of standardised and tested measurement tools (Attkinson & Greenfield 1984), the aims of this particular study were not adequately addressed by any one available satisfaction questionnaire. Therefore, it was decided to devise a unique interview

schedule, which would address the relevant issues and service principles of the NCS. The high satisfaction ratings with the principles of the NCS need to be viewed in the context of generally high ratings for client/patient satisfaction surveys (Lebow 1983a, 1983b; Larson et al., 1979). Previous research studies with other health service users in Ireland have also typically found at least 80% satisfaction with services, e.g. hepatitis C service users (McGee et al., 2000), general hospital inpatients (Mc Carthy et al., 1999), homeless men and women (Feeney et al., 2000; Smith et al., 2001) and hospital outpatients (Doyle et al., 2002). Pelletier (1985) recommends that in order to balance out the predominantly high satisfaction levels reported in surveys of various health settings, neutral responses can be regarded as possibly negative and therefore positive ratings below 75% regarded as a cause for concern. It was also the case for this survey that further exploration of 'neither satisfied nor dissatisfied' responses tended to illuminate 'negative/dissatisfied' feelings. Combining Pelletier's (1985) recommendations and the level of 80% as the level which most other Irish health and related services have been rated for satisfaction, aspects of the overall NCS can be considered in terms of achieving high or low satisfaction by considering an 80% threshold. The pattern of findings is outlined in table 5.1.

Table 5.1 Summary of satisfaction ratings across dimensions

Specific aspects of service with ≤80% satisfaction rating	Specific aspects of service with >80% satisfaction rating
Service access	
Information (advertisement) (77%) Publicity (31%) Crisis call (74%) Information (service) (75%) Waiting (first seen) (73%) Parking (67%) Distance/Location (79%) Public transport (62%)	Information (freephone) (91%) Initial interview/Intake session (80%)
Quality standards	
Length of session (76%) Duration of counselling (60%)	Appearance of centre (86%) Office personnel (95%) Availability of appointment (85%) Frequency of sessions (90%) Confidentiality (94%) Counselling explanation (86%) Counsellor sensitivity (92%) Counsellor knowledge (84%) Relationship with counsellor (93%) Counsellor ability to understand (95%)
Client-centred service	
Independence (78%)	Helped address difficulties (83%) Confidence (80%) Choices (81%)

[* An 80% threshold is somewhat arbitrary. Depending on one's perspective, this means that 4 in 5 clients are satisfied or, conversely, that 1 in 5 is not. All services should have an aim to increase user satisfaction. Hence, in a continuous quality improvement system, 80% satisfaction on a specific dimension means 'well-done – a lot achieved' and, for the future, 'more to do' in this area of service delivery.]

One of the challenges of evaluating satisfaction with counselling services is the relative lack of exposure of most individuals in Ireland to counselling services. As the NCS is the first national counselling service in this country, the study participants may for the most part lack an awareness of possible alternatives to the service as offered, i.e. lack of knowledge and experience of what constitutes a 'good' counselling service. It is unlikely for instance, that clients have information concerning the appropriate or usual duration of counselling.

Nonetheless, there is evidence that clients can discriminate between different components, which may enhance or detract from their overall satisfaction with a particular service. In a study of consumer satisfaction with institutional and community care, Corrigan (1990) found that patients in both settings discriminated between four different dimensions of care: characteristics of staff, treatment services, the physical environment and activities that foster autonomy. There is also evidence that clients are willing to provide varied feedback on their service experiences. Gaston (1992) showed that psychotherapy client satisfaction was not influenced by social desirability demands of the interview setting. Gaston also found that client and therapist gender, therapy modality and duration of treatment did not change the association between satisfaction and social desirability. This suggests the findings from this study can be viewed with some confidence. While satisfaction surveys are an important component of service evaluation, they in themselves are not a measure of therapeutic outcome. However, Boot et al. (1997) note, in relation to client satisfaction:

> *" 'Satisfaction' may be related to process rather than outcome, but in counselling, process and outcome are likely to be inextricably entwined."*

5.4 Key findings of the survey

5.4.1 Aspects of the service relating to access

Satisfaction ratings with specific aspects of accessibility were generally high: freephone service (91% satisfied), initial interview (80%), location of the centres in terms of the distance travelled (79%), public transportation (62%) and parking (67%). Satisfaction with waiting to be seen by the service for the first time was 73%. However, only 46% of those who had to wait after the intake interview were satisfied with this additional waiting period. Overall satisfaction with how the service was publicised was lowest at 31%.

5.4.2 Aspects of the service relating to quality standards

Exceptionally high satisfaction ratings were given to most aspects representing a high quality service. For example, participant ratings for aspects of the counselling relationship such as sensitivity was 92% and ability to listen was 95%. Professionalism of office personnel also achieved a remarkably high rating (95%).

The main themes explaining the minority of non-satisfied participants were: lack of feedback/interaction during the counselling session and participant perception that professionals who have not experienced abuse themselves lack an understanding of the life experiences of those who have been abused as children, i.e. they had'textbook knowledge'. Satisfaction with duration of counselling (for those who had completed counselling/ 'dropped out') yielded the lowest satisfaction rating in this section of the study (60% were satisfied).

5.4.3 Aspects of the service relating to a 'client centred' service

Participants were asked to select, from a prepared list, what type of support they thought would have been the most useful while on the waiting list. Having access to a crisis helpline was selected as the most useful support (42%), while general telephone contact to the service was seen as the next most useful support (26%). Many (45%) indicated that they felt the need for some additional support while attending counselling with half of these (25% of the overall group) indicating that they had been offered additional support. If in need of support, the most frequently selected additional support was a crisis helpline, followed by therapeutic groupwork, telephone contact with the service, links to external support groups, alternative therapies, and 'reflective space'.

5.4.4 Participant ratings of the overall principles of the service

Participants were most likely to agree that the service respected the dignity of its clients (96%) and that the service maintained high professional standards (91%). Other principles that were seen to be met by a high number of participants were: confidentiality and privacy (90%), taking a holistic view (87%) and promoting independence (82%). Participants were more likely to disagree that the service met the principles of accessibility (25% disagreed) and choice (24% disagreed).

5.5 Principle: An accessible service

The key aspects of this principle are outlined under separate headings. There was a lot of variability in satisfaction with aspects of this service dimension.

5.5.1 Advertising/publicity for the service

Publicity, including advertising, elicited the highest level of commentary from participants. This was especially notable in the open-ended questions. This issue received the lowest satisfaction rating in the survey. Making the general public aware of the existence of the service was seen as particularly important by participants. It was felt that serious consideration should be given to how, where and when the NCS is advertised. Fear of counselling services and the possible stigma attached to seeking help with emotional/psychological difficulties were identified by participants as barriers to accessing the NCS. Thus participants felt that much could be achieved through appropriate, widespread and consistent advertising. Finding out about the service was very difficult for some participants. The element of chance or luck involved in discovering the service, or the frustrating experience of finding out about the NCS after many efforts to find an appropriate service was described. Making the general public more aware of the existence of this national service was seen as an important step in reducing these difficulties. Researchers also noted that when explaining the study to participants there was sometimes a lack of awareness of the 'national' aspect of the service. Referring to the 'National Counselling Service' sometimes elicited a confused response from participants as the service tended to be more easily recognised when the regional title of the service or local centre name was used. An important consideration in pursuing any publicity/advertising campaign by the NCS is the impact it might have in prompting requests for counselling from members of the public. As stated in the introduction to this report, careful attention needs to be given to advertising to ensure that it is targeted at those who may need to avail of services and takes account of the capacity of the service to respond to the potential demand that might follow an advertising campaign.

5.5.2 The NCS freephone service

Many participants endorsed the freephone as a useful and satisfactory method of accessing and contacting the NCS. A high satisfaction rating was reported in terms of using the freephone as a method of making appointments and finding out information about the service. However, a substantial number of participants did not know about the freephone. Even for those in counselling, a third still did not know this that facility existed. Some participants believed that they could use the freephone number as a method of contacting the service in times of crisis. The NCS however, is very clear that responding to crisis calls is not the purpose of the freephone service. If the NCS plans to maintain this approach, it is important that the role of the freephone is made clear to clients. One challenge to this is the fact that many people (over 70%) indicated that they were either very or extremely distressed when they first contacted the service to make an appointment. Given that potential clients to the service will contact the service in a state of distress, the response they receive from a freephone service has important ramifications. While the consequences for the individual caller are clearly of concern, there is also the issue of support for staff in an administrative (telephone answering) role. An overall system of managing these calls for the benefit of callers and frontline administrative staff is needed. This might involve, for instance, training in basic listening skills and a debriefing system or the opportunity to pass particularly distressing calls onto an available counsellor. It should be noted that most (74%) of the individuals who reported using the freephone while in crisis were satisfied with the call (as were 91% of overall freephone users). Clearly, administrative staff provide a high quality freephone service. Feedback to researchers indicates that centres already undertake training activities and that a national training protocol is in place. The expertise of those already conducting this training should be used to ensure that all staff who work in this administrative role have the training and support they need to provide this important 'first contact' with clients.

5.5.3 NCS waiting times/initial interview

The NCS are committed to seeing clients as promptly as is possible. The goal of seeing all those abused in an institutional context "immediately" following their first contact was initially set by the service. The NCS 'First Report' further states: *"Any client who has been referred to the National*

Counselling Service in any area of the country will receive an initial appointment to meet with a counsellor within one month of their referral to the service". Those who have experienced abuse within an institution as a child are to be offered priority appointments (a commitment given by the government when the service was established for this group). Availability of resources will influence the extent to which the target waiting times are met. The Northern Ireland report on counselling (Park, 2002) and the Heather Report provide some comparative data on waiting times for those accessing counselling services. For example, the Northern Ireland report surveyed 136 counselling organisations and 133 clients of counselling services. Participants were asked about waiting lists and waiting times. Key findings of the counselling organisations survey were that the majority of organisations and individual counsellors (42%) had waiting times of less than one month while 12% of the organisations surveyed had waiting times of at least six months. It was also reported that 70% of organisations prioritised their waiting lists based on an assessment interview with the client. The number of people on the waiting lists of surveyed counselling organisations ranged from less than 5 to 100+. Only 9% of organisations reported having over 100 people on their waiting list. The findings of the survey on service user experiences were that 32% of service users saw their counsellor within one week of the initial meeting while 8% of participants indicated that they had to wait for more than six months to see a counsellor. The Heather Report also addressed the issue of waiting lists and times. Individual organisations were asked about their current waiting lists. Some factors such as staffing numbers and availability of premises were cited as influencing the length of waiting time to access services. At the time of the study in 1999, four services providing counselling to the survivors of sexual abuse gave the following information regarding their waiting times and waiting lists:

- Aisling Centre: waiting time 4-5 weeks
- Derry Well Woman Centre waiting time 11 months
- Nexus (Derry): waiting time for assessment 4-5 weeks with counselling provided 2-3 months thereafter.
- Nexus (Enniskillen): waiting time for assessment 2-3 months with counselling provided approximately 2 years later.

Clearly these waiting times, and those of the NCS, illustrate a situation of increasing service demand. Individual survivors expressed concerns regarding waiting times:

> *"I felt frustrated. I wanted to get better but I was on the waiting list for a long time – doing nothing with my time." (The Heather Report, 1999)*

The results of this NCS study showed that a number of participants were dissatisfied with the time they had to wait for counselling. Dissatisfaction ratings were higher for clients who had to wait after the initial consultation to commence counselling. Reasons for dissatisfaction with waiting times were explored in the Results Section. Primarily, participants felt that their (sometimes extreme) emotional vulnerability, at the point of first contacting the service and the fact that 'crisis' situations usually precipitated a first contact with the NCS, were strong reasons to drastically reduce, if not eliminate, the waiting list. Counselling for many was seen as a 'life saving' experience, not a choice or an elective option to 'book' for some future date, but a last hope for someone in 'dire' need. Results indicated that the initial interview/intake interview was an extremely important component of the counselling service on a number of levels:

- An opportunity to disclose the childhood abuse experience (often for the first time) and therefore to feel believed and listened to
- An opportunity to obtain crucial information regarding the service - to explore and clarify service expectations (if different for the service user and service provider and if not negotiated here it may cause future difficulties)
- An opportunity to explore confidentiality and its limits.

5.5.4 *Increasing demand for counselling*

In 2000, when the service was established, the invitation to avail of counselling was extended beyond those abused in institutional care to any adult in Ireland who had experienced any form of childhood abuse (i.e. neglect and emotional, physical and sexual abuse). Prevalence figures for the experience of childhood abuse in Ireland were not available to service planners and service providers at that time. In 2002, the SAVI Study (McGee et al, 2002) published prevalence figures on the experience of childhood sexual abuse in Ireland. This study indicated that at least one in every six Irish adults had experienced some form of sexual abuse involving physical contact[6] during their childhood (others forms of abuse were not assessed). While it is known that not everyone who experiences childhood abuse will choose or need counselling, it is clear that a substantial number of individuals will as adults be eligible to access the NCS. In SAVI, although the overall percentage of the population reporting using counselling services for sexual abuse was small (12%), there was a pattern of increased use by younger participants in the study. For instance over 20% of both men and women aged 18-30 attended counselling. For those aged 60-79, counselling rates were 12% for women and 3% for men abused as children. This suggests that demand for counselling is likely to increase with younger generations who have experienced abuse being more willing to come forward. Publicity about services such as the NCS and the wider acceptability of both counselling and disclosure of childhood abuse means that demand will increase. The evidence from the NCS suggests this as the demands on its service are increasing. In 2002 more than 2,000 people were referred to the NCS. This represents a 12% increase on referral figures for 2001. In order to ensure that the service remains of a high quality, the issue of waiting times will need to be addressed as a priority, this is a significant challenge given that current resources in the service are being utilised to full capacity. The resource issue is not primarily about services for those abused in institutional care. Rather, the special circumstances which resulted in a government commitment to State-funded counselling services for those abused in institutional settings highlights the lack of commitment to counselling services more generally in Ireland. There is a similar case with hepatitis C where those who were inadvertently infected with hepatitis C through State provided blood products have had a government commitment to funded and readily accessible counselling services. Both examples suggest that existing service provision has not been sufficient to meet the needs of these groups. Since over two thirds of those using the NCS are individuals who have experienced abuse in contexts other than institutions, the NCS has in effect become a national service for childhood abuse and neglect rather than a specialist service for those from institutional settings. Waiting lists will grow as the service is publicised more and becomes known through users and health and social service professionals throughout the country.

5.5.5 *Physical accessibility*

Distance to travel, parking facilities and transport to and from the service have the potential to cause a certain degree of difficulty and discomfort for some clients. In relation to some aspects such as distance to travel, mixed views were reported by participants. Some had a preference for travelling a distance to their service as this afforded a certain amount of privacy and anonymity while for others having to travel posed many practical problems and potential barriers to accessing the service on a weekly basis. The over-riding message from these findings is the importance of choice of location to suit particular client needs. One theme which emerged in relation to transport difficulties was the challenge of returning to one's car in a public area or using public transport when distressed. The value of a quiet room (not a waiting area) where clients could regain their composure and prepare themselves for the journey home following counselling was raised by some participants.

5.6 Principle: A high quality service

Overall, participants identified a high level of satisfaction with the national counselling service in relation to quality aspects of service.

5.6.1 *NCS as a confidential service*

Overall satisfaction with confidentiality of client details (at 94%) was extremely high. Confidentiality seems to be taken very much as a 'given' by service users. This parallels findings in other Irish counselling studies, e.g. the review of hepatitis C service users showed that 93% were

[6] SAVI figures show 21% of girls and 16% of boys aged <17 years have experienced some form of sexual abuse involving physical contact

satisfied with the confidentiality of counselling services (McGee et al, 2000) and 95% of those using counselling services in SAVI were satisfied with confidentiality. This is a very reassuring finding for the NCS given some individuals' concerns about the lack of independence of health boards from the systems of investigation of institutional abuse and the particularly sensitive nature of the work undertaken in counselling adults who have experienced childhood abuse.

5.6.2 *Client awareness of the NCS complaint procedure*

While the percentage of study participants who said that they did not hear about the NCS complaints procedure was high (42 %), there may actually be a higher level of awareness of a complaints procedure among its clients than some other health services. For example, a recent Eastern Regional Health Authority document entitled, "*People Matter - a Report on the Experiences & Expectations of People of the Health Services*" (2002), reported that among people who had used their health service in the last 12 months, only 5% had said they had been made aware of complaints procedures. However, whatever the comparison, the results illustrate that much work needs to be done in terms of raising awareness of such an important issue as the complaints procedure in the NCS. This is particularly important because of the limited range of alternative options in counselling services in Ireland (both in the public and private sector because of a shortage of trained professionals). The role of an advocate to facilitate client complaints procedures, particularly within vulnerable client groups, may be a useful one. This concept is frequently used by voluntary and statutory health services in the UK and lessons could be learned for the Irish context.

5.6.3 *Appearance and condition of centres*

Each region has developed a service to meet unique regional needs. Thus all services are not identical in structure. This in itself is not a problem. However, some differences in service provision are not conducive to the provision of a high quality service and thus make for an inequitable service. These differences concern a number of issues - unsuitable locations for counselling (i.e. hotel rooms, portacabins and rooms in shopping centres); frequency with which participants could see their counsellor; and lack of wheelchair accessible rooms, parking facilities and comfortable waiting rooms. Thus there is a lack of standardisation of basic facilities and of basic choices in relation to the frequency of service provision across centres.

5.6.4 *Counsellor factors*

Participants expressed the highest ratings of satisfaction in relation to their counsellor and the counselling process. Across five key factors: sensitivity, knowledge and expertise, ability to understand, ability to listen, sensitivity and trust, participants strongly endorsed a positive and satisfied view of their counsellor and the counselling relationship. Given research evidence on the primacy of the therapeutic relationship and the working alliance of counsellor and client (rather than the therapeutic modality) in effecting positive changes for the client (Hubble, Duncan & Miller, 1999), this is a very significant positive finding for the NCS. Where participants noted that they were not satisfied, a recurrent theme regarding a lack of interaction/feedback from the counsellor emerged. While it was noted by a minority, when noted it was a point which caused great frustration and dissatisfaction. A desire for deeper exploration of issues and needing to feel more than 'just listened to' was expressed. While it is not clear if participants were advised of a particular approach to counselling, or of the role of feedback and silence, it is clear that participant expectations were not met regarding the level of interaction they anticipated in some counselling situations. McLeod's (1990) review of literature concerning clients' experiences of therapy also corroborates other studies that suggest that clients want more 'advice' and recommendations from therapy than they receive from their therapist. This review also highlighted key areas of dissatisfaction as identified by clients or aspects of the experience which may hinder the counselling process. These 'hindering' factors included: (a) the client's own inclination to maintain silence and avoid talking about certain issues, (b) an inability to make a connection with the therapist and (c) the client's perceptions that their therapist used incorrect interventions or interpreted things in a way that were inconsistent with the client's true feelings. In this NCS study, a typical comment from participants who were extremely satisfied with the counselling relationship were those comments indicating that meeting someone who seemed 'real' or 'non-academic' or

someone who showed either a true understanding or an effort to truly understand their experience helped strengthen the therapeutic relationship and contributed to the participant's sense of healing.

5.7 Principle: A client-centred service

From the onset, operationalising the principle of a client-centred service posed difficulties in terms of ascertaining client understanding of the concept and 'marrying' the client perspective with the counsellor perspective. The explanation of the principle as set out in the project tender was used as the cornerstone for discussion in focus groups with service users. Client-centredness was for the most part equated with the provision of a holistic service. Additional support /emergency support at times of crisis and referrals or information regarding other services and agencies were identified as being of importance to participants. As discussed earlier, the need for a service such as a telephone help-line was identified as one useful 'tool' in providing such additional support to vulnerable participants. The NCS Model of Service clearly envisages:

> *'A one-stop service for clients which will provide linkages to other services as necessary, referral to other specialists and practical assistance such as transport and family support.'*

This service principle does not purport to provide all services to NCS clients but rather places an emphasis on the role of referral and working links with other organisations. As outlined in the introduction to this report, the NCS has stated its commitment to 'linking in' with other services and groups for survivors of childhood abuse (NCS, *First Report*, 2002). Service users at focus group consultations endorsed this service characteristic. However, there appeared to be a shortfall in terms of the provision of such a service. In parallel, some counsellor feedback indicated that counsellors and a counselling service 'cannot be all things to all people'. Some elements of facilitating the requirements of a one-stop service may be seen as outside the scope of the counsellor role. For example, while counsellors do, in consultation with clients, make referrals to other agencies such as social work and mental health services there are other key areas of client need which may not fall within the remit of the counsellor role. Some of these issues were outlined in the Fife Report for survivors of childhood abuse and by the focus group participants in this study. These may range from referrals to or information regarding social welfare services, financial advice, legal issues, to the arrangement of practical issues concerning transport and the provision of support 'out-of hours'. A solution to this important question may be found in the Fife Report (2001) and the NCS 'First Report' (2002). They both note that collaboration between counselling professionals and other services, including the establishment of working linkages are of central importance to the development of services for the survivors of childhood abuse. A co-ordinated effort to achieve these linkages is needed for each counselling service. Health services in the UK and in the voluntary sector are increasingly incorporating an advocate role into their service provision. Assessing the need for a 'befriending service' also has the potential to address client needs for additional support which are not necessarily part of the counsellor role.

5.8 Conclusion

There was agreement from the majority of participants in this study that the NCS is meeting its service principles in pratcice. As with the study conducted by Corrigan (1990), service users of the NCS seem to have discriminated across different aspects of the service. This is very useful service feedback as it allows the organisation, in a continuous quality improvement system, to focus attention on those aspects of the service resulting in the most dissatisfaction. It is also important to remember that difficulties with one aspect of a service have the potential to negate the value of other satisfying aspects. For example, the client who experiences difficulties with transport to the NCS but has a very positive and fulfilling counselling relationship with his or her counsellor, may have to leave the service early or with unresolved issues if transport continues to be a challenge. The study found that 26% of participants who had completed counselling were dissatisfied with the overall duration of their counselling. For many, this was because they had left the service 'too soon' due to matters not directly concerning the counselling relationship. A service is needed which offers a forum to verbalise dissatisfaction or other reasons for leaving before termination of counselling occurs. In other words, a form of 'exit interview' may help ensure that termination is the preferred choice for that client at that time (with counsellor compatibility, client distress,

practicalities of getting to counselling and other barriers to remaining in counselling being addressed). This exit interview may also be a forum to indicate that where current barriers to service uptake are resolved in the future (whether they are pragmatic, e.g. work demands or personal, e.g. the issue is now too distressing to handle), the client would be welcomed back into counselling.

5.8.1 Summary

Across three core principles as set out by the NCS when it was established, the study identified that participants reported high levels of satisfaction with the service. The results clearly show that from the perspective of service users, considerable success has been achieved in translating these principles into practice. This has been achieved within a system of limited resources, where there has been a vacuum in terms of statutory service provision of this type of counselling service up to the year 2000 and in a context where the service was established as a result of public campaigning by a group who felt wronged, unacknowledged and unsupported because of their institutional abuse and subsequent lack official recognition and retribution. Thus, the NCS started with the requirement to demonstrate government follow-through on public commitments to deliver high quality services to a particularly vulnerable and sensitive group. The results of this study provide evidence that many of the commitments made to ensure a high quality, accessible and client-centred service have been met. The time and effort of all those involved in this study: service administrators, counsellors and (particularly) clients, will have been well spent if this achievement is acknowledged and if evidence on areas for further improvement is incorporated into a quality improvement system for coming years.

Chapter 6

RECOMMENDATIONS

Understanding the dynamic and evolving nature of the NCS is important when considering this report's recommendations. As outlined in the introduction of this report and in the NCS's own *First Report* (2002), many new policies and initiatives have been developed and implemented as the service has evolved over the past three years. This service evaluation is a 'snapshot' of a service at a specific time. Clients currently in counselling and clients who had left/finished counselling were interviewed. (It was felt inappropriate to interview clients at the very vulnerable time of first contact with the service). Therefore some of the participants may not have experienced or benefited from these new service developments/policies. Equally, developing difficulties with the services may not be evident for clients who have been using the service for some time. For example, there is a concern that waiting times to start counselling have lengthened in the last six months. Thus access may be more difficult for those now trying to avail of services. Conversely, services such as groupwork have become more widely available while service facilities (offices, locations etc) are also more widely available than at the start of the NCS. Finally, it also needs to be acknowledged that the service provider's perception of the service being offered may in some instances differ to that of the service user's perception and experience. Both are important with an onus to try and understand if there are discrepancies between perceptions from the two perspectives. Thus from one perspective a recommendation may highlight a deficiency in the current service while from the other, there may be a sense that this recommendation is already enacted, whatever the perspective, these considerations of perspective need to be taken account of when reading the recommendations of this report.

Principle: An accessible service

6.1 Advertising and publicity

As stated in the introduction to this report, careful attention needs to be given to advertising to ensure that it is targeted at those who may need to avail of services and takes account of the capacity of the service to respond to the potential demand that might follow an advertising campaign. However, the importance of service advertising as seen by study participants must also be acknowledged. There is a 'Catch-22' scenario here. Advertising will increase the numbers likely to present for counselling and will, with currently available staffing, result in increased waiting times. Difficulties with this situation, in the medium term may be resolved through public and/or professional pressure on government to make more resources available. In the longer term, the service thus becomes available to a larger cohort of those who could benefit but at the cost of raising expectations and waiting for those who respond to advertising. The other option is not to advertise or to do so cautiously in order not to exacerbate the already growing waiting list. This has the short-term advantage of a more manageable list but the long-term disadvantage of being an unlikely target for service expansion. The solution is beyond the scope of this report. However, the data available from here and from the NCS First Report (2002) illustrate the extent to which this service has become a national service for all those abused in childhood. This point needs to be

clearly articulated in resource deliberations with government funding agencies. Staffing comparisons from elsewhere would be informative in these discussions.

Participants saw advertising and publicity as serving two tasks: one was to make potential users aware of the service and the other to reduce stigma through increasing the acceptability of the service and creating a greater understanding of counselling. Thus, a greater focus on the nature and level of advertising is needed. There is also a need to establish an awareness of the NCS as a national service with regional offices. While addressing the stigma associated with child abuse and use of counselling services cannot be the sole responsibility of the NCS, it is recommended that as the NCS have an important role as frontline service providers, they should work in conjunction other agencies towards achieving this task.

Recommendation 1: Providing an accessible service

1.1: That the NCS develops its advertising and publicity profile to increase awareness of its counselling service for those who have experienced abuse as children.

1.2: That NCS advertising campaigns are scheduled at coordinated and nationally agreed intervals.

1.3: That any advertising campaign involving the NCS will endeavour to reduce the stigma associated with counselling service use and a history of child abuse.

1.4: That any advertising campaign involving the NCS will consider the various means of advertising its services, i.e. through public and health professional routes.

6.2 Waiting times

Since over 70% of participants indicated that they were very or extremely distressed when they first made contact with the NCS, with some reporting additional dissatisfaction and distress if they had to wait again after the intake interview before commencing counselling, it is recommended that every effort be made to alleviate the distress caused by waiting. As outlined in the introduction of this report, the NCS has established a working group to develop policies and strategies to minimise waiting times and distress associated with such waiting times for clients. It is also recognised by the NCS that the therapeutic needs of people who have experienced childhood abuse generally require longer terms/durations of therapy. Many of the clients who attend the service, particularly those who have experienced abuse in institutions, have complex problems with significant levels of difficulty. Many clients would be seen by international guidelines to require more than a year of weekly sessions in counselling. The NCS *First Report* (2002) identifies a significant number of clients (approximately 15%) who require 2 years or more of counselling/therapy. There is a concern, that when services become overstretched, cases wll be processed more rapidly than is advisable. However, in counselling, limiting the number of sessions available, either explicitly or implicitly, is not recommended as a method of dealing with waiting lists for issues as complex as child abuse. The clients right to the optimum amount of time in counselling is formally recognised across health boards. Brief time-limited therapy should not be utilised unless expressed as being preferable by the client and counsellor. The tension between waiting lists and counselling sessions provided should be resolved by focussing on increasing resources rather than reducing the level of appropriate services available to clients. Average numbers of sessions needed can be combined with staffing capacity (number of counselling sessions provided annually) and change in client numbers annually to predict staff needs in the coming year. To do this equivalently and easily across boards on an ongoing basis, an agreed, complete and up-to–date information systems (which includes data on current status, i.e. from awaiting intake interview to no longer in counselling) is needed. Each health board has in conjunction with survivor groups developed an information system to compile this information and protect client confidentiality.

Recommendation 2: Providing a timely service

2.1: That the NCS puts in place ways to manage the access process for potential clients to minimise distress. If required (i.e. if the client is deemed to be very distressed), the immediate needs of the client should be assessed and appropriate intervention offered when a client first discloses childhood abuse to the service. This assistance is to support the client until such time as counselling can begin.

2.2: That the NCS reviews the current access process with particular emphasis on the initial interview and subsequent waiting time to commence counselling.

2.3: That the NCS provides the optimum number of counselling sessions for positive outcomes as agreed between counsellor and client, rather than as determined by resource constraints.

2.4: That the NCS co-ordinates evidence within and across health boards annually to predict staffing levels needed; this is to be used as a basis for requesting resources to enable timely delivery of services.

6.3 Freephone service

The freephone service was used by a substantial number of participants to access the service for the first time. While not established as a crisis helpline, many people accessing counselling for the first time or when in counselling, use the number in a time of crisis. For many, it is an act of courage and a personal challenge to seek out counselling. Given these factors, the management of that first call is an extremely important issue. Appropriate training and support is necessary to deal with the first-time caller or the distressed client. As accessing a trained counsellor by freephone is not usual, providing administrative staff with basic training to handle these calls is important. This training should be established in consultation with administrative staff and with due acknowledgement of the high level of satisfaction with their services as noted by study participants.

In parallel to the freephone service for appointments, this report highlighted a desire on the part of survivors of both institutional and non-institutional abuse for the establishment of a telephone helpline. It was identified as the support preference of those waiting for counselling and for those who were attending counselling but felt the need for some additional support. While staffing a new national helpline, especially a 24-hour service, would be a considerable task, participants noted that times of crisis do not fall within the 9-5 day working schedule. There are a number of voluntary helplines in existence at the present time. However, they were seen by some as not entirely suitable to address the needs of the NCS client group. In particular, some survivors of institutional abuse felt that as the nature of their abuse was not always sexual abuse, certain voluntary helplines would not be suitable. A helpline where telephone counsellors would have a greater understanding of their experience within residential institutions and of their current needs as a group was seen as a more beneficial option. This option has already been recommended in the NCS First Report (2002). It has been advised that such a service should be particularly noted to people on the waiting list. The possibility of working in conjunction with an existing adult helpline, e.g. investing in a collaborative training programme regarding the needs of the survivors of childhood abuse (particularly those abused in institutional care), should be investigated. In line with discussions with the survivors groups, a subgroup of the NCS has been working on the provision of a helpline in order to meet client needs outside of the therapy setting and out-of-hours.

Recommendation 3: Providing an easily-contactable service for distressed clients

3.1: That NCS management, in consultation with administrative staff, review current levels of training to establish if adequate and appropriate training and support is provided to staff to respond appropriately to distressed callers and first-time callers to the freephone service.

3.2: That the NCS specifies a timeframe for establishing a national telephone helpline, as recommended in its First Report (NCS,2002).

6.4 Availability of appointment times

The majority of participants were satisfied with the availability of appointment times. Some participants reported that the counsellor did hold the counselling session as late as possible in the evening (if the need arose). The NCS currently provides an out-of-hours service across the country at various locations where resources permit, (all boards are reported as providing a level of out-of-hours provision on a case-by-case basis). A number of services have a dedicated out of hours service. However, a significant minority of participants experienced difficulty in relation to this issue. For some participants the 9-5 appointment time structure was not suitable. Furthermore, 60% of all participants indicated that they were interested in the availability of counselling appointments outside the 9-5 o' clock time structure.

Recommendation 4: Providing an out-of-hours service where necessary

4.1: That the NCS assesses the need for provision of counselling sessions outside the 9-5 o'clock working day schedule to facilitate those clients who have work or family commitments during this period. Where available, an out-of-hours service should be made known to clients.

6.5 Access and quality

While the actual counselling relationship is of primary importance, certain physical and environmental factors enhance and complement the therapeutic process for the client. The majority of participants reported that they were satisfied with the appearance and condition of the counselling centre. However, qualitative data from a small number of participants pointed to infrastructural components of service delivery which fell short of suitably high quality premises. Of particular concern was that three physically disabled study participants (from different health board regions) had not been able to access their local counselling centres. Two of these participants had to have counselling at their home while efforts were being made by the counselling centre to secure a suitable alternative counselling location.

Recommendation 5: Providing services in an accessible and acceptable environment

5.1: That the NCS reviews current premises to ensure that counselling centres are accessible for clients with disabilities. Account should be taken of various types of disability including hearing and visual impairments.

5.2: That the NCS reviews premises on an ongoing basis to ensure that each counselling location is physically conducive to the counselling process in terms of seating, sound proofing and other such physical conditions

Principle: a high quality service

6.6 Choice of service

Client choice within the NCS is important. Choice relates both to location and to counsellor. Initial meetings with counsellors have an important role to play in terms of identifying client expectations, concerns and beliefs regarding what counselling is and what the NCS can offer. The service, through it's staff, needs to foster a climate of open dialogue regarding problems/ difficulties with the counselling process and service issues experienced by the client group. As the client may not always be able to directly address these issues (e.g. counsellor incompatibility) with the attending counsellor there is a need to have an identified intermediary within the service. The nature of choices available to clients within the NCS should be clearly communicated at intake interview stage, e.g. choice of therapist gender, therapeutic modality, frequency and time of sessions and counselling centres available within the region. This process may be assisted by the provision of service information leaflets. Given that not all clients can utilise written information, efforts to communicate such service information to clients using alternative methods needs to be considered. If a client experiences difficulties with a particular aspect of the counselling service, every effort should be made to communicate the existence of alternatives and provide choices to avoid termination of counselling. The main reason(s) for terminating counselling should be noted

for each client. Those terminating because they are unable or unwilling to continue should be sent a suitable exit questionnaire and the opportunity to discuss this, with an intermediary where appropriate, to ascertain if all efforts have been made to ensure a positive outcome for the client concerned.

As over 42% of study participants had not heard about health board complaint procedures, there is a need to communicate about health board complaints procedures to this client group. The possibility of developing a role for a client advocate to deal with service queries or complaints should be considered.

Recommendation 6: Providing choice of service to clients

6.1: That the NCS endeavours, through clarification of the options and service choices available to clients, to maximise choice for those wishing to avail of its services.

6.2: That the NCS ensures each client receives both written and verbal information regarding the service complaints procedure. This should be an integrated part of the introductory sessions, and related written materials for clients.

6.7 Client feedback on service issues:

When participants were asked what they thought would be the most suitable and acceptable method of eliciting their views regarding the NCS, the majority indicated a preference for postal questionnaires. A key learning point of this study for the NCS was the necessity to establish a client's willingness to be contacted or asked to participate in any future research projects at the onset of the counselling contract. The manner in which the client may be contacted to participate in any such research must also be established. As this was the first national consultation project with service users, it must be viewed as a very valuable learning experience for all concerned.

Recommendation 7: Providing clients with an opportunity to participate in service evaluation and quality improvement activities

7.1: That the NCS solicits client feedback for service quality improvement purposes in a structured and co-ordinated manner at regular intervals and then integrates recommendations into practice as a matter of course.

6.8 Counselling factors and the counselling process

Very high levels of satisfaction were noted with these aspects of the service. Lack of feedback to clients was noted as the main source of difficulty for those who were not satisfied. The results of this study should be provided to counselling staff. In a comprehensive feedback system, the views of counsellors on service quality and opportunities for continuous quality improvement should also be taken into account.

Recommendation 8: Providing staff with an opportunity to participate in service evaluation and quality improvement activities

8.1: That the results of the study, including the very high levels of satisfaction with the counselling process, be communicated to NCS staff.

8.2: That the NCS outlines mechanisms to consult with staff on how best to advance its quality agenda.

Principle: A client-centred service

6.9 Links with other services

Study results highlighted the importance of links with others agencies and services for clients. A commitment to 'models of sharing' both among health boards and with external services, is outlined in the *First Report* (2002). However, regional differences in the availability of resources,

counsellors' therapeutic background (and perspectives or their role as service referral agents), and access to social work and other relevant services may influence the extent of these links and the referral systems they can offer to clients. Clients need to know what links can be made, if needed, and to feel able to discuss their need of such services where necessary.

Recommendation 9: Providing clients with assistance needed in contacting services other than counselling

9.1: That the NCS explores, in consultation with survivor support groups, those mechanisms of service delivery which aim to meet client needs for additional support.

9.2: That the NCS further develops and disseminates information to staff on a regional and national basis regarding links and working collaborations with other relevant sectors, e.g. addiction, mental health and childcare.

9.3: That the NCS, as outlined in the First Report (NCS, 2002), disseminates information to clients regarding the nature, method and limits of referral to other agencies.

9.4: That the NCS investigates the potential need and role of advocate and of 'befriending' and 'volunteer mentoring' positions within the service

9.5. That the NCS, in consultation with other agencies and groups who provide services for survivors of childhood abuse, makes available a directory of services and support groups nationally and regionally.

6.10 Group therapy

Many study participants (48%) expressed their desire to avail of group work. Many felt that this type of therapy would have the potential to help the healing process. The NCS is committed to the development of therapeutic group work and sees the value of this approach. Therapeutic group work is currently offered in 5 of the 10 health boards and is being developed across other boards. The group work currently provided includes therapeutic groups at the pre-counselling stage to support clients who are waiting, group work in association with ongoing counselling and group work as a progression from individual therapy. A working group dedicated to the issue of group therapy provision across the country has been established.

Recommendation 10: Providing clients with the opportunity to attend group therapy

10.1:That the NCS assesses service demands for/interest in group therapy, plan and develop provision on this basis.

6.11 Study findings and actions

This study has been an important national consultation exercise with NCS clients. Results of the study, in summary form, should be displayed in counselling centres as a further exercise in obtaining and providing service feedback to promote the quality service concept. Decisions concerning actions to take based on deliberations between NCS staff (including management, counsellors and administrative staff) and client representatives, should also be displayed.

Recommendation 11: Providing opportunities for service providers and users to consider and advise on the findings of service evaluations

11.1:That the NCS consults with relevant constituencies and agree what actions to take based on the findings of the present study.

11.2:That key results of the study and subsequent actions committed to by the NCS be provided in summary form as a public notice to inform staff and clients in counselling centres.

Recommendation 12: Providing opportunities for future research

12.1: That the process of consultation for future research be as inclusive as possible and take account of representing all relevant parties.

12.2: That the NCS, in consultation with survivor groups and staff, identifies areas for future research. Specific areas of importance as highlighted by this report include counselling outcomes for those abused within institutions as children compared to those abused in another context.

Chapter 7

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Appendix 1

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Appendix 2

Focus Group and Interview locations

Focus group locations

- Cork
- Dublin
- Sligo
- Athlone

Attendance numbers for service users: 41

Attendance numbers for NCS staff: 15

Two RCSI facilitators per group

Interview locations

1. Dublin
2. Cork
3. Sligo
4. Castlebar
5. Limerick
6. Longford
7. Navan
8. Cavan
9. Donegal
10. Letterkenny
11. Carraig on Shannon
12. Clonmel
13. Waterford
14. Galway

Appendix 3

NCS Consultation Project - Interview Schedule

Introduction

I'd like to start by thanking you for agreeing to be interviewed today. As you may know, you are one of approximately 300 people who have been randomly selected to take part in the evaluation. I won't be asking you about why exactly you went to the service. The questions that I will ask will be about the service itself. The purpose of these interviews are to help the NCS know what's working well with the service and what things they could improve or change. The interview will take about 30 minutes and the information gathered will be used to assess satisfaction with the National Counselling Service to date and to ensure that this service is effective and responsive to user needs.

All the information that you provide will be kept strictly confidential by the research team. Your counsellor and the NCS will not have access to your specific responses. The results will be presented in the form of percentages. Please let me know if you are uncomfortable with any of the questions I ask, and we will just skip over them. In other words, you do not have to answer any questions that you do not want to answer. You may also decide to end the interview at any time.

I'd just like to take a few minutes to go through a consent form with you.(interviewer read through consent form and ask for interviewee's signature). Do you have any questions you would like to ask me?

A1 I know very little about you except that you used the service at some point.
Could I just ask you before we start:
Are you still in counselling with the NCS? Yes ☐ No ☐

Section A - Advertising & Publicity

I'd like to start by asking you a bit about how you first heard about the service and it's publicity.

A2 Can you remember how you first found out about the service?
Was it *(Read out: tick one box only)*

- Radio ☐
- TV ☐
- Newspaper ☐
- GP ☐
- Poster ☐ » 2a Where was it? ________________
- Service leaflet ☐ » 2b Where was it? ________________
- Other ☐ » 2c (explain) ________________
- Friend ☐
- Support group ☐
- Family member ☐

A3 Have you ever seen or heard any advertising about the service? Yes ☐ No ☐
(if no go to A6)

A4 What kind of advertising was it? *(READ OUT, Tick all that apply)*

- 4a Radio ☐
- 4b TV ☐
- 4c Newspaper ☐
- 4d Poster ☐ » 4f Where was it?______________
- 4e Service leaflet ☐ » 4g Where was it? ______________

3

A5 How satisfied were you with information provided in the advertisement of service?

Very Satisfied ☐ Satisfied ☐ Neither satisfied nor dissatisfied ☐
Dissatisfied ☐ Very dissatisfied ☐

A6 Did you ever see this service advertised after a TV show/ documentary or a film about abuse?

Yes ☐ No ☐ *(if no go to A10)*

A7 Did you try to call that number following the program/show? Yes ☐ No ☐

A8 Did you get to speak to someone? Yes ☐ No ☐

A9 How was that call handled?

Very Satisfactorily ☐ Satisfactorily ☐ Neither satisfactorily nor unsatisfactorily ☐
Unsatisfactorily ☐ Very unsatisfactorily ☐

A10 What if anything could be done to effectively advertise the service?
(DO NOT READ OUT, tick all that the client /mentions)

10a leaflets ☐ 10e outreach talks ☐
10b nationwide tv ☐ 10f poster campaign in GP clinics /health centres ☐
10c radio ☐ 10g nothing, already effective ☐
10d local papers ☐ 10h other ☐ » 10i (explain) ____________________

A11 Overall how satisfied are you with the publicity of the service?

Very Satisfied ☐ Satisfied ☐ Neither satisfied nor dissatisfied ☐
Dissatisfied ☐ Very dissatisfied ☐

11a Why was that? ____

Section B- The Freephone

I will move on now to talk about the freephone service provided by the National Counselling Service:

B1 Each service has a freephone number. Did you know about the freephone service before you started counselling?

Yes ☐ *(if yes then go to B3)* No ☐

B2 Are you aware of it now? Yes ☐ *(if yes then go to B3)* No ☐

Tell the person that there is a freephone set up; that the purpose of it is primarily so that people can call and set up an appointment with a counsellor, or change appointment times. Say that it isn't used as a crisis line, because often the secretary will not be able to put the caller in touch with a counsellor immediately. Tell them the phone number 1.800.xxxxx. *(go to section C)*

B3 Where did you find out about the freephone ? *(Read out, tick only one)*

Friend	☐	Newspaper	☐
Support group	☐	Poster	☐
Radio	☐	Counsellor / NCS	☐
TV	☐	Family member	☐
GP	☐		
other	☐ (explain)______________________		

B4 What did you think the main purpose of it was?
(Read out, Tick as many as client mentions)

4a Making an appointment ☐
4b Finding out information ☐
4c Talking to someone if in crisis ☐
4d Other ☐ (explain)______________________

B5 Have you ever used the freephone service? Yes ☐ No ☐ *(if no then go to section C)*

B6 Approximately how many times have you used the freephone? ___________

B7 Have you used the freephone service for finding out information about the service or making an appointment? Yes ☐ No ☐ *(if no then go to B15)*

B8 Was it: (*Tick all that apply)*

Before you were in counselling ☐ While you were in counselling ☐
After having completed counselling ☐

B9 Did you find it easy to get through to someone? Yes ☐ No ☐

B10 Did you get to speak to someone? Yes ☐ No ☐ *(if no then go to B14)*

B11 Who did you speak to? *(Read out)*

Secretary ☐ Counsellor ☐

Administrator ☐ Director ☐ Unknown ☐

Other ☐ (explain) ______________________________

B12 What was the outcome of that phonecall? *(Read out, tick all that apply)*

12a Made an appointment ☐

12b Had information sent to me ☐

12c Put on waiting list ☐

12d Other ☐ (explain) ______________________

B13 Did you get the kind of response you were looking for from the freephone?

Yes ☐ No ☐ Mixed feelings ☐ Not sure what I wanted ☐

B14 Overall, how satisfied are you with the freephone for getting information and or making an appointment?

Very Satisfied ☐ Satisfied ☐ Neither satisfied nor dissatisfied ☐

Dissatisfied ☐ Very dissatisfied ☐

B15 Did you ever use the number when you felt like you were in crisis? Yes ☐ No ☐ *(if no then go to section C)*

B16 Was it: *(Tick all that apply)*

16a Before you were in counselling ☐ 16b While you were in counselling ☐

16c After you completed counselling ☐

B17 Overall, how satisfied are you with the way that the call(s) was(were) handled when you made a crisis call?

Very Satisfied ☐ Satisfied ☐ Neither satisfied nor dissatisfied ☐

Dissatisfied ☐ Very dissatisfied ☐

17a Why was that?

____

3

Section C- Making the first contact & Appointment

Now, I'd like to ask you a few questions about your first appointment. *(Do not read out if client has already explained, Say "You already mentioned that . . . Is that right?)*

C1 Did you make your own appointment or did someone make it on your behalf?

Self-referral ☐

Referred by someone else ☐ By whom: ________________

C2 When you first made contact with your counselling center, did they give you any information on what their service is/does?

Yes ☐ No ☐

C3 In what way was this information given? *(Read out, tick all that apply)*

3a A talk given to a group ☐ 3b Over the Freephone ☐

3c Over the phone ☐ 3d Leaflet ☐

3e Other ☐ 3f (Explain) ______________________________

C4 Overall, how satisfied were you with the availability of information about the service at the start of counselling?

Very Satisfied ☐ Satisfied ☐ Neither satisfied nor dissatisfied ☐

Dissatisfied ☐ Very dissatisfied ☐

C5 Do you remember approximately what month and year it was that you made your first appointment?

___________ Month ____________ Year

C6 How upset/ distressed were you feeling at that time?

Extremely Distressed ☐ Very Distressed ☐ Somewhat Distressed ☐ Only a little Distressed ☐ Not at all Distressed ☐

C7 What was the most important thing that made you decide to seek help at that particular time? (*Read out, tick only one)*

Support Group ☐ GP ☐

Family ☐ Friends ☐

Myself ☐ *('I decided I needed to')*

Other ☐ Explain ____

3

C8 Did you experience abuse in an institution such as a foster home or children's home or did you experience abuse in another context? *(if person hesitates, say it is helpful to know this information because the NCS tries to prioritise those who have experienced instit. abuse).*

Institutional ☐ Non-institutional ☐ Prefers not to answer ☐

Neither: Attended because family member was abused ☐

C9 Could you estimate how long you were waiting between making the first contact/call and seeing someone for the first time?

days _________ weeks __________ months _________

C10 Overall how satisfied were you with that waiting time?

Very Satisfied ☐ Satisfied ☐ Neither satisfied nor dissatisfied ☐

Dissatisfied ☐ Very dissatisfied ☐

C11 How long do you think would be an acceptable time to wait?

days _________ weeks __________ months _________

C12 When you did get to first meet with a counsellor, how satisfied were you with that session? *(prompt: They sometimes call this an initial or intake interview)*

Very Satisfied ☐ Satisfied ☐ Neither satisfied nor dissatisfied ☐

Dissatisfied ☐ Very dissatisfied ☐

C13 Why was that? ____

____

C14 Sometimes clients have to wait after the intake interview/ initial meeting and the start of counselling, Was that true for you?

Yes ☐ No ☐

14a Could you estimate how long you were waiting between the initial/intake interview and the start of counselling?

days _________ weeks __________ months _________

C15 Overall how satisfied were you with the waiting time between the intake interview/ initial meeting and the start of counselling?

Very Satisfied ☐ Satisfied ☐ Neither satisfied nor dissatisfied ☐

Dissatisfied ☐ Very dissatisfied ☐

C16 Can you say a bit about why?

____

____

C17 How long do you think would be an acceptable time to wait?

days _________ weeks __________ months _________

C18 Was the person that you saw at the intake interview/ initial meeting the same person who became your counsellor?

Yes ☐ No ☐

C19 Was that something you chose? Yes ☐ No ☐

C20 Was this okay for you? Yes ☐ No ☐

20a Why?______________________________________

(*Note to interviewer: If person was waiting to be seen 2 weeks or more, continue with box below, otherwise SKIP to Sect D)*

You mentioned you were waiting to be seen. I'd like to ask you some more questions about that. I'd just like to first say, so that there is no confusion, that generally counselling centres do not provide support to people while waiting.

C21 Were you offered any support while on the waiting list? Yes ☐ No ☐

C22 Did you feel the need for some type of support while on the waiting list?
Yes ☐ No ☐

C23 In your opinion which do you think would be the most useful support while waiting?
(tick one only)

Group meetings (with other people on the waiting list) ☐
Links with support groups (external to the NCS) ☐
Therapeutic groupwork (therapy in group with others
who have similar issues) ☐
Trained volunteer- someone who has used the NCS ☐
Telephone contact from the service ☐
Crisis help-line ☐
Any other ideas ☐
Explain: ______________________________________

3

Section D- Attending Counselling

Now I would like to ask you about some practical aspects of attending counselling.

D1 About how many miles (one way) from the facility do you live?

0-5 ☐ 6-10 ☐ 11-15 ☐ 16-20 ☐ 20+ ☐

Overall, how satisfied are/were you with the location and accessibility of the service in terms of:

D2 Distance?

Very Satisfied ☐ Satisfied ☐ Neither satisfied nor dissatisfied ☐
Dissatisfied ☐ Very dissatisfied ☐

2a Why was that? ______________________________

D3 Parking ? N/A ☐

Very Satisfied ☐ Satisfied ☐ Neither satisfied nor dissatisfied ☐
Dissatisfied ☐ Very dissatisfied ☐

3a Why was that? ______________________________

D4 Public transportation? N/A ☐

Very Satisfied ☐ Satisfied ☐ Neither satisfied nor dissatisfied ☐
Dissatisfied ☐ Very dissatisfied ☐

4a Why was that? ______________________________

D5 Overall how satisfied were you with the appearance and physical conditions of the centre?

Very Satisfied ☐ Satisfied ☐ Neither satisfied nor dissatisfied ☐
Dissatisfied ☐ Very dissatisfied ☐

5a Why was that? ______________________________

D6 Did the entrance/exit to the counselling centre help provide for privacy /anonymity?

Yes ☐ No ☐

6a Why was that? ______________________________

D7 Was there any aspect of your local counselling centre which made it difficult for you to attend?

Yes ☐ No ☐

D8 Do you mind telling me what that difficulty was? ______________________________

(Note to interviewer: If person was dissatisfied with ANY of the above, continue with box below, otherwise SKIP to D11)

D9 Had you a choice of attending another service?

Yes ☐ No ☐ I don't know/ I never asked ☐

D10 Do you know why not? ____

D11 Overall how satisfied are/were you with the office personnel (receptionists, administrators) on the telephone or in person?

Very Satisfied ☐ Satisfied ☐ Neither satisfied nor dissatisfied ☐
Dissatisfied ☐ Very dissatisfied ☐

11a Why was that? *(Do not read out options, but tick if mentioned)*

Answering machine ☐ Inappropriate response ☐ Engaged tone ☐
Other ☐ *(explain)*

____

Thinking back to when you first began counselling,

D12 Overall, how satisfied were you with the availability of appointment times that fit your schedule?

Very Satisfied ☐ Satisfied ☐ Neither satisfied nor dissatisfied ☐
Dissatisfied ☐ Very dissatisfied ☐

12a Why was that? ____

D13 What was/ is the frequency of your sessions typically:

Once a week ☐
Once every fortnight ☐
Once a month ☐
Other ☐ *(explain)* ______________________________

D14 Did you choose this frequency of sessions? Yes ☐ No ☐

D15 Overall how satisfied are/were you with the frequency of your sessions?

Very Satisfied ☐ Satisfied ☐ Neither satisfied nor dissatisfied ☐
Dissatisfied ☐ Very dissatisfied ☐

3

D16 Overall how satisfied are/were you with the length of your individual counselling sessions?

Very Satisfied ☐ Satisfied ☐ Neither satisfied nor dissatisfied ☐
Dissatisfied ☐ Very dissatisfied ☐

D17 Why? *(Do not read out options, but tick all mentioned)*

17a Felt pressured to tell everything straight away ☐

17b The session wound up too quickly ☐

17c Other ☐ *(Explain)* ____________________

D18 How much time do you think would be appropriate, given the fact that they do need to schedule for a specific length of time? ____________ (minutes)

Confidentiality is a very important part of counselling and is only breached for the most serious of reasons which are:

- A serious concern about a potential risk to you
- A serious concern about a potential risk to another person
- A serious concern about a potential risk of abuse to children

D19 Were you told about the limits of confidentiality? Yes ☐ No ☐

D20 Did they make sense to you? Yes ☐ No ☐

D21 Were/are these limits acceptable to you? Yes ☐ No ☐

D21a Why is that? ____________________

D22 Overall how satisfied were you with the service respecting your right to confidentiality?

Very Satisfied ☐ Satisfied ☐ Neither satisfied nor dissatisfied ☐
Dissatisfied ☐ Very dissatisfied ☐

D23 Why is that?____________________

D24 Was a complaints procedure explained to you? Yes ☐ No ☐ Unsure ☐

Section E- The Counselling Process

Now I'd like to ask you about your counselling sessions / process:

E1 Did your counsellor give you an explanation of their approach to counselling?
Yes ☐ No ☐ Unsure ☐

E2 Overall how satisfied were you with the explanations of their approach to counselling?

Very Satisfied ☐ Satisfied ☐ Neither satisfied nor dissatisfied ☐
Dissatisfied ☐ Very dissatisfied ☐

E3 How satisfied were you with the fact that it wasn't explained?

Very Satisfied ☐ Satisfied ☐ Neither satisfied nor dissatisfied ☐
Dissatisfied ☐ Very dissatisfied ☐ Dissatisfied

E4 Overall how satisfied are/were you with the sensitivity of the counsellor towards the important issues in your life?

Very Satisfied ☐ Satisfied ☐ Neither ☐ Dissatisfied ☐
Too soon to Rate ☐ Very dissatisfied ☐

Why is that? ______________________________

E5 Overall how satisfied are/were you with the knowledge and expertise that your counsellor has in working in this area?

Very Satisfied ☐ Satisfied ☐ Neither ☐ Dissatisfied ☐
Too soon to Rate ☐ Very dissatisfied ☐

Why is that? ______________________________

E6 How would you describe the relationship that you have with your counsellor?

Very Trusting ☐ Trusting ☐ Neither ☐ Untrusting ☐
Very Untrusting ☐ Too soon to rate ☐

Why is that? ______________________________

E7 Overall how satisfied are/were you with the ability of your counsellor to listen to you ?

Very Satisfied ☐ Satisfied ☐ Neither satisfied nor dissatisfied ☐
Dissatisfied ☐ Very dissatisfied ☐

Why? *(Do not read out options, but tick all mentioned)*
7a Note-taking off-putting ☐ 7b Clock-watching by the counsellor ☐
7c Counsellor has/had insufficient knowledge of abuse, particularly institutional ☐
7d Other ☐ *(explain)* ______________________________

E8 Overall how satisfied are/were you with the ability of your counsellor to understand your problems?

Very Satisfied ☐ Satisfied ☐ Neither satisfied nor dissatisfied ☐
Dissatisfied ☐ Very dissatisfied ☐

8a Why was that? ______________________________

When a person has experienced abuse in childhood, they sometimes find that there are other related issues that they would like to speak to their counsellor about, but find it

3

difficult to do so. It might also be that the counsellor does not seem willing, or gives the impression that counselling is not the place to discuss these issues.

I'm going to read a list of some of these issues. I wonder if you would let me know if any of these were an issue for you and if you felt you could speak to your counsellor about it.

Again just to say that if you are uncomfortable with any of the questions, just let me know and we can skip over them.

		Applicable		Could speak to Counsellor		Prefer not to answer
		Yes	No	Yes	No	
E9	Relationship difficulties	☐	☐	☐	☐	☐
E10	Parenting issues	☐	☐	☐	☐	☐
E11	Sexuality/sexual needs	☐	☐	☐	☐	☐
E12	Addiction	☐	☐	☐	☐	☐
E13	Legal issues	☐	☐	☐	☐	☐
E14	Educational needs/ reading difficulties	☐	☐	☐	☐	☐
E15	Housing needs	☐	☐	☐	☐	☐
E16	Physical Disability	☐	☐	☐	☐	☐
E17	Spirituality/Religious needs	☐	☐	☐	☐	☐
E18	Domestic violence	☐	☐	☐	☐	☐
E19	Commission	☐	☐	☐	☐	☐
E20	Other	☐ *(explain)* ________________				

E20 Did you ever want to change to another counsellor? Yes ☐ No ☐

E21 If you were not happy with your counsellor, did you try to change to a different counsellor? Yes ☐ No ☐ N/A (I was happy enough with them) ☐

21a Why not? ______________________________

21b Did you get to see someone else? Yes ☐ No ☐

21c Why not? ______________________________

[Note: If they indicated that they were seen for institutional abuse, ask the questions in box below, otherwise SKIP to Sect. F]

You mentioned that you sought counselling for institutional abuse. Is that right?

E22 Do you mind me asking, have you or do you intend to go to the commission?

Yes ☐ No ☐ *(If hesitating, say* "The only reason I am asking is so I can ask:*)*

E23 How would you evaluate the support you were given when preparing to attend the commission, during the commission, and afterwards? (by your counsellor/the other health board staff)

Very Satisfied ☐ Satisfied ☐ Neither satisfied nor dissatisfied ☐

Dissatisfied ☐ Very dissatisfied ☐

Section F-Additional Supports & Services

Now I would like to ask you about some other aspects of the service that are not typically provided by a counselling service. For example, out of hours counselling or additional support for clients between sessions.

F1 Some people find that even when they start counselling they need a range of additional support between sessions. Were you offered any additional support outside of the sessions while attending counselling? (i.e.between and after individual counselling sessions) Yes ☐ No ☐

F2 Did you feel the need for some additional support while attending counselling sessions?

Yes ☐ No ☐

F3 What single thing would provide the most useful support to you between/after individual counselling sessions? *(Read out, tick only one)*

Reflective space/coffee/tea room ☐ Alternative therapies ☐

Links to external support groups ☐ Therapeutic groupwork set up by the NCS ☐

Telephone contact with service ☐ Crisis helpline ☐

Other ☐ *(explain)* ____________________

F4 Overall how satisfied were you with the support available to you between individual counselling sessions?

Very Satisfied ☐ Satisfied ☐ Neither satisfied nor dissatisfied ☐

Dissatisfied ☐ Very dissatisfied ☐

Sometimes people need a referral to other services. I'm going to read out a list and I would like to check if you needed a referral to any of the following.

F5

Did you need a referral to:	No	Yes	Referred?	Not referred?
5a Health professional	☐	☐	☐	☐
5b Housing agency	☐	☐	☐	☐
5c Social worker	☐	☐	☐	☐
5d Social welfare	☐	☐	☐	☐

5e Other ☐ *(explain)* ____________________

F7 Overall how satisfied are/were you with the availability of information on how to get the most out of other relevant services?

Very Satisfied ☐ Satisfied ☐ Neither satisfied nor dissatisfied ☐

Dissatisfied ☐ Very dissatisfied ☐

3

As previously stated, many of the Counselling centres do not offer all of the services I am about to read.

F8 Have you been offered or would you personally avail of any of the following services?:

		Was offered:		Availed of:		Wasn't offered, but would avail of:	
		Yes	No	Yes	No	Yes	No
8a	Group therapy *(therapy in group with others who have similar issues)*	☐	☐	☐	☐	☐	☐
8b	Counselling for your family *(children etc.)*	☐	☐	☐	☐	☐	☐
8c	Counselling for your partner	☐	☐	☐	☐	☐	☐
8d	Couple therapy	☐	☐	☐	☐	☐	☐
8e	Parenting skills classes	☐	☐	☐	☐	☐	☐
8f	Evening counselling session *(outside 9-5)*	☐	☐	☐	☐	☐	☐
8g	After hour/emergency support	☐	☐	☐	☐	☐	☐
8h	Alternative therapies *(e.g. aromatherapy, reiki..)*	☐	☐	☐	☐	☐	☐
8i	Other *(specify)*	☐ ________________					

F9 Was there any other facility or service that the NCS could offer to you to assist you in availing of counselling*?* Yes ☐ No ☐

(Read out options)

9a supervised playroom ☐ 9b Travel expenses ☐

other ☐ *(explain)* ________________

Section G -Overall Effects, Completing Counselling, Principles

Now I would like you to think about your whole experience of the NCS and I will ask a few questions about how it has affected you overall.

(For people who have only had a few sessions: If you feel you cannot rate these next items, please say 'too soon to tell')

G1 Overall how satisfied are you that your experience of counselling has helped you deal with the difficulties that made you seek counselling in the first place?

Very Satisfied ☐ Satisfied ☐ Neither satisfied nor dissatisfied ☐
Dissatisfied ☐ Very dissatisfied ☐

1a *(explain)* ________________

3

G2 Overall how satisfied are you that your experience of counselling has helped you become a more confident person?

Very Satisfied ☐ Satisfied ☐ Neither satisfied nor dissatisfied ☐
Dissatisfied ☐ Very dissatisfied ☐

2a Explain ____________________

G3 Overall how satisfied are you that your experience of counselling has helped you become a more independent person?

Very Satisfied ☐ Satisfied ☐ Neither satisfied nor dissatisfied ☐
Dissatisfied ☐ Very dissatisfied ☐

2a Explain ____________________

G4 How satisfied are you that your experience of counselling has improved/ is improving your ability to make choices about the direction you want your life to take?

Very Satisfied ☐ Satisfied ☐ Neither satisfied nor dissatisfied ☐
Dissatisfied ☐ Very dissatisfied ☐

3a Explain ____________________

[Note: The next section boxed below is to be asked only of those who have COMPLETED counselling. Otherwise SKIP to G9]

G5 Overall how satisfied were you with the total length of time you spent in counselling?

Very Satisfied ☐ Satisfied ☐ Neither satisfied nor dissatisfied ☐
Dissatisfied ☐ Very dissatisfied ☐

G6 Could you estimate the month and year counselling ended? Month ______ Year _______

G7 Overall how satisfied are you with how your counselling ended ?

Very Satisfied ☐ Satisfied ☐ Neither satisfied nor dissatisfied ☐
Dissatisfied ☐ Very dissatisfied ☐

G8 How was it decided to end the counselling?

You ☐ Your counsellor ☐ Both ☐

Other ☐ *(explain)* ____________________

G9 Did you get information about how to go about getting counselling in the future? (e.g whether you could come back to counselling after the sessions/course have finished?)
Yes ☐ No ☐

3

G10 Which aspects of the service were particularly helpful in encouraging you to seek counselling? *(Read out, tick yes or no for each one)*

	Yes	No, not helpful
10a That it specializes in childhood abuse	☐	☐
10b That it is a free service	☐	☐
10c That you can self refer	☐	☐
10d That it was available through the health board	☐	☐
(Only read out next option if institutionally abused)		
10e That it was originally set up for the survivors of institutional abuse	☐	☐
10f Freephone	☐	☐
10g Accessible in my area	☐	☐

10h Anything else you think was helpful? ___________________________

G11 What changes could be made to the service that could most help and encourage others who may be reluctant but interested in attending counselling?
(explain) ___________________________

G12 Are there any aspects of the service I have not already mentioned that you feel could be changed for the better? Yes ☐ No ☐

What? ___________________________

____

I'm going to read out a series of statements about the NCS and I would like to you indicate whether you agree of disagree with the statements I'm making.

G13 It is a service which is accessible to all potential clients

Strongly Agree ☐ Agree ☐ Neither agree nor disagree ☐
Disagree ☐ Strongly Disagree ☐

Explain: ___________________________

G14 It is:-a service that respects the dignity of its clients

Strongly Agree ☐ Agree ☐ Neither agree nor disagree ☐
Disagree ☐ Strongly Disagree ☐
Explain: ___________________________

G15 It is a service that maintains high professional standards among its staff

Strongly Agree ☐ Agree ☐ Neither agree nor disagree ☐
Disagree ☐ Strongly Disagree ☐

Explain: ___________________________

G16 It is a service that provides confidentiality and privacy

Strongly Agree ☐ Agree ☐ Neither agree nor disagree ☐
Disagree ☐ Strongly Disagree ☐

Explain: ____________________

G17 It is a service that provides choice to clients (e.g. choice of counsellor gender, location etc)

Strongly Agree ☐ Agree ☐ Neither agree nor disagree ☐
Disagree ☐ Strongly Disagree ☐

Explain: ____________________

G18 It is a service which sensitively addresses all aspects of the client's life (takes a holistic view)

Strongly Agree ☐ Agree ☐ Neither agree nor disagree ☐
Disagree ☐ Strongly Disagree ☐

Explain: ____________________

G19 It is a service which promotes the independence of the individual client (e.g. not dependent on the service)

Strongly Agree ☐ Agree ☐ Neither agree nor disagree ☐
Disagree ☐ Strongly Disagree ☐

Explain: ____________________

G20 Overall, how would you rate the National Counselling Service?

Very good ☐ Good ☐ Neither good nor poor ☐
Poor ☐ Very poor ☐

Future Evaluation?
After this survey is completed, the National Counselling Service would like to have regular feedback from clients.

G21 What do you think would be the best way to do that?
(Read out) In your opinion which do you think would be the best way of hearing those views? *(tick one only)* I will read out a short list. Stop me at any time and I can go back over something if you need me to.

Questionnaires posted out to the client? ☐
Questionnaires filled out at the end of therapy? ☐
Questionnaires that were filled out before therapy was started, and then again afterwards? ☐
Comment boxes (available at the centre for whenever a client wants to make a suggestion)? ☐
Focus groups? ☐

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Client involvement in special committees set up for a specific issue? ☐
Client involvement as a representative on an ongoing committee? ☐
Other ideas? ☐

Section H - Demographics

Before we finish up, I would like to ask you a few more questions that will help us be able to describe the people who participated in the study. *(If they hesitate on any question, say* 'These questions are only so we will be able to tell if the NCS is serving everyone equally — both young and old, those who live in a rural area versus a city, those with more education and those with less et cetera...)

H1 What is your age? _______ Years

H2 What is your present marital status?
Married or cohabiting ☐1 Separated ☐2 Divorced ☐3 Widowed ☐4 Single ☐5?

H3 Could I ask you now if you live in: A city ☐1 A town ☐2 A village ☐3 or rural area ☐4?

H4 Which of the following best describes the highest level of education you have completed yourself?
Primary ☐1
Up to Group, Junior Certificate or equivalent ☐2
Leaving Certificate or equivalent ☐3
Finished third level – university/regional college or equivalent ☐4

H5 How would you best describe your current status regarding work?
In paid employment ☐1
Self employed in your own business or farm ☐2
Home duties/Housewife etc. ☐3
Retired ☐4
Student ☐5
Other (please specify)________________________________ ☐6

H6 What was/is your occupation in your most recent job or business? *[Interviewer: Please check as fully as possible the type of work done to classify socio-economic status: e.g. If farmer, record the acreage, if manager or supervisor record the numbers supervised. If relevant, record the rank or grade – e.g. rank in army or Gardaí, grade in civil service.]*

H7 *[Int: Ask only if they have a partner:]* What was/is the occupation of your spouse or partner in his/her most recent job or business? *[Int: same details as above.]*

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Thank you again for your most valuable input to this study.

[Interviewer to fill out section below after the interview is completed]

Time Interview Finished_______________ Duration of Interview_______minutes

Did you have to refer respondent to external/NCS counsellor? Yes ☐
*Specify*____

Please rate how you think this interview went:

Very smoothly	☐	Smoothly	☐	Neither	☐
Difficult	☐	Very difficult	☐		

If difficult, why?____

Appendix 4

Selection Process

Procedure for contacting those who have completed counselling

- Each counselling centre sends their client list (initials only) to RCSI on Excel spreadsheet
- RCSI selects clients randomly selected from these lists
- RCSI waits for H.B. Ethical approval if not already granted
- RCSI sends list of initials to administrative staff
- Counselling team checks names for suitability of postal invitation and indicates outcome on Excel spreadsheet
- Administrative staff returns Excel spreadsheet to RCSI
- If client is suitable, Director signs letter of invitation and sends letters to clients
- RCSI will review spreadsheet, and randomly select other clients to replace clients who were not suitable
- Clients reply directly to RCSI (by SAE or freephone)
  OR Two weeks after posting, RCSI sends list of those who have not replied to invitation to administrative staff with reminder letters
- RCSI sets up the interview with each individual client who agrees to participate
- Administrator sends reminders to those who have not had contact with RCSI *

* *Note: Clients will only receive one reminder letter. Clients who indicated on their consent form (or through telephone contact) that they did not want to participate will not be sent a reminder letter.*

Appendix 4

Selection Process

Procedure for contacting those who are currently in counselling

- Each counselling centre sends their client list (initials only) to RCSI on Excel spreadsheet
- RCSI selects clients randomly selected from these lists
- RCSI waits for H.B. Ethical approval if not already granted
- RCSI sends list of initials to administrative staff
- Client's counsellor checks names for suitability of invitation
- If client is suitable, client's counsellor signs letter of invitation and explains the study to their client

Clients can reply through their counsellor or directly to RCSI (by freephone)

- Counsellors indicate on Excel spreadsheet outcomes for their clients (e.g. invited v. not invited; agreed to participate v. declined invitation; whether the client will contact RCSI or RCSI should phone them)
- For clients who agree to participate, RCSI sets up the interview with each individual
- RCSI will review spreadsheet, and randomly select other clients to replace clients who were not suitable or declined to participate

* *For clients who agreed to participate, and indicated that they would contact RCSI directly but have not done so, RCSI will send list to administrator who will pass to counsellors so that they can remind clients verbally. Clients will only be reminded once.*

Appendix 5

Participant response rates by health board & counselling status breakdown

Health board response rates

Health Board	Total Selected	Invited	Refused	Interviewed	Response Rate %
South Western Area	43	32	13	19	59
East Coast Area	49	38	22	16	42
Northern Area	94	77	53	24	31
Midlands	165	113	82	31	27
Mid-Western	107	68	57	11	16
North Eastern	150	135	94	36	27
North Western	127	82	51	31	38
South Eastern	125	70	49	21	30
Southern	120	89	44	45	51
Western	203	107	73	34	32
Total	1183	811	538	268	33

Health board response rates by those in counselling and completed counselling

Health Board	In Counselling				Completed Counselling			
	Invited	Refused	Interviewed	Response Rate %	Invited	Refused	Interviewed	Response Rate %
South Western Area	13	4	9	69	19	9	10	53
East Coast Area	15	5	10	67	23	17	6	26
Northern Area	29	23	6	21	48	30	18	38
Midlands	33	19	14	42	80	63	17	21
Mid-Western	35	29	6	17	33	28	5	15
North Eastern	32	16	16	50	103	78	20	19
North Western	32	21	11	34	50	30	20	40
South Eastern	33	21	12	36	37	28	9	24
Southern	34	15	19	56	55	29	26	47
Western	36	25	11	31	71	48	23	32
Total	292	178	114	39	519	360	154	30

Appendix 6

Participant satisfaction across health board regional clusters

Participant satisfaction with aspects of accessibility

"Overall how satisfied were you with…"	Satisfied %(n)	Neither %(n)	Dissatisfied %(n)
… information provided in the advertisement?			
Total	77 (111)	15 (21)	8 (12)
ERHA (NAHB, SWAHB, ECAHB)	70 (16)	26 (6)	4 (1)
SHB, SEHB, WHB, MWHB	78 (51)	12 (8)	10 (6)
NEHB, NWHB, MHB	79 (44)	12 (7)	9 (5)
… the publicity of the service?			
Total	31 (78)	19 (48)	50 (129)
ERHA (NAHB, SWAHB, ECAHB)	17 (10)	21 (12)	62 (36)
SHB, SEHB, WHB, MWHB	32 (33)	19 (19)	49 (50)
NEHB, NWHB, MHB	37 (35)	18 (17)	45 (43)
… the freephone for getting information and making appointments?			
Total	91 (112)	2 (2)	7 (9)
ERHA (NAHB, SWAHB, ECAHB)	91 (18)	4 (1)	4 (1)
SHB, SEHB, WHB, MWHB	89 (47)	2 (1)	0 (0)
NEHB, NWHB, MHB	93 (44)	0 (0)	2 (1)
… the freephone when calling in crisis?			
Total	74 (26)	3 (1)	23 (8)
ERHA (NAHB, SWAHB, ECAHB)	100 (6)	0 (0)	0 (0)
SHB, SEHB, WHB, MWHB	83 (15)	0 (0)	17 (3)
NEHB, NWHB, MHB	45 (5)	9 (1)	46 (5)

Participant satisfaction with aspects of accessibility (cont.)

"Overall how satisfied were you with..."	Satisfied %(n)	Neither %(n)	Dissatisfied %(n)
... availability of information about the service at the start of counselling?			
Total	75 (186)	13 (31)	12 (30)
ERHA (NAHB, SWAHB, ECAHB)	67 (38)	9 (5)	24 (14)
SHB, SEHB, WHB, MWHB	76 (77)	15 (15)	9 (9)
NEHB, NWHB, MHB	80 (71)	12 (11)	8 (7)
... waiting time between first contact and seeing someone for the first time?			
Total	73 (180)	7 (18)	20 (50)
ERHA (NAHB, SWAHB, ECAHB)	64 (36)	10 (6)	26 (14)
SHB, SEHB, WHB, MWHB	71 (73)	9 (9)	20 (21)
NEHB, NWHB, MHB	79 (71)	4 (3)	17 (15)
... the initial/intake interview?			
Total	80 (203)	11 (28)	9 (24)
ERHA (NAHB, SWAHB, ECAHB)	74 (43)	16 (9)	10 (6)
SHB, SEHB, WHB, MWHB	81 (86)	10 (11)	9 (9)
NEHB, NWHB, MHB	81 (74)	9 (8)	10 (9)
... waiting time between initial interview and the start of counselling?			
Total	46 (37)	10 (8)	44 (36)
ERHA (NAHB, SWAHB, ECAHB)	41 (11)	11 (3)	48 (13)
SHB, SEHB, WHB, MWHB	50 (16)	9 (3)	41 (13)
NEHB, NWHB, MHB	45 (10)	10 (2)	45 (10)

Appendix 6

Participant satisfaction across health board regional clusters

Participant satisfaction with aspects of accessibility (cont.)

"Overall how satisfied were you with..."	Satisfied %(n)	Neither %(n)	Dissatisfied %(n)
... location and accessibility of the service in terms of the distance ?			
Total	79 (203)	5 (14)	16 (40)
ERHA (NAHB, SWAHB, ECAHB)	80 (47)	3 (2)	17 (10)
SHB, SEHB, WHB, MWHB	84 (89)	6 (6)	10 (11)
NEHB, NWHB, MHB	73 (67)	7 (6)	20 (19)
... location and accessibility of the service in terms of the parking facilities ?			
Total	67 (88)	7 (9)	26 (34)
ERHA (NAHB, SWAHB, ECAHB)	73 (16)	4 (1)	23 (5)
SHB, SEHB, WHB, MWHB	62 (29)	6 (3)	32 (15)
NEHB, NWHB, MHB	70 (43)	8 (5)	22 (14)
... location and accessibility of the service in terms of public transport ?			
Total	62 (56)	10 (9)	28 (26)
ERHA (NAHB, SWAHB, ECAHB)	67 (20)	6 (2)	27 (8)
SHB, SEHB, WHB, MWHB	68 (26)	11 (4)	21 (8)
NEHB, NWHB, MHB	43 (10)	13 (3)	44 (10)

Appendix 6

Participant satisfaction across health board regional clusters

Participant satisfaction with aspects of a high quality service

"Overall how satisfied were you with..."	Satisfied %(n)	Neither %(n)	Dissatisfied %(n)
... the appearance and physical conditions of the centre?			
Total	86 (216)	3 (9)	11 (27)
ERHA (NAHB, SWAHB, ECAHB)	85 (49)	0 (0)	15 (9)
SHB, SEHB, WHB, MWHB	87 (91)	2 (2)	11 (12)
NEHB, NWHB, MHB	85 (76)	8 (7)	7 (6)
... professionalism of the office staff/personnel?			
Total	95 (211)	0 (0)	5 (11)
ERHA (NAHB, SWAHB, ECAHB)	92 (46)	0 (0)	8 (4)
SHB, SEHB, WHB, MWHB	96 (90)	0 (0)	4 (4)
NEHB, NWHB, MHB	96 (75)	0 (0)	4 (3)
... the service respecting your right to confidentiality ?			
Total	94 (229)	3 (7)	3 (7)
ERHA (NAHB, SWAHB, ECAHB)	95 (52)	3 (2)	2 (1)
SHB, SEHB, WHB, MWHB	94 (94)	3 (3)	3 (3)
NEHB, NWHB, MHB	95 (83)	2 (2)	3 (3)

Appendix 6

Participant satisfaction across health board regional clusters

Participant satisfaction with aspects of a high quality service (cont.)

"Overall how satisfied were you with…"	Satisfied %(n)	Neither %(n)	Dissatisfied %(n)
… explanation of their approach to counselling?			
Total	86 (148)	8 (13)	6 (11)
ERHA (NAHB, SWAHB, ECAHB)	81 (30)	8 (3)	11 (4)
SHB, SEHB, WHB, MWHB	91 (71)	6 (5)	3 (2)
NEHB, NWHB, MHB	82 (47)	9 (5)	9 (5)
… sensitivity of the counsellor towards the important issues in your life?			
Total	92 (227)	3 (6)	5 (13)
ERHA (NAHB, SWAHB, ECAHB)	92 (51)	0 (0)	8 (4)
SHB, SEHB, WHB, MWHB	96 (99)	2 (2)	2 (2)
NEHB, NWHB, MHB	88 (77)	4 (4)	8 (7)
… knowledge and expertise your counsellor has of working in this area?			
Total	84 (202)	7 (18)	9 (21)
ERHA (NAHB, SWAHB, ECAHB)	85 (46)	6 (3)	9 (5)
SHB, SEHB, WHB, MWHB	85 (88)	10 (10)	5 (5)
NEHB, NWHB, MHB	81 (68)	6 (5)	13 (11)
… relationship that you have with you counsellor?			
Total	93 (223)	4 (8)	3 (8)
ERHA (NAHB, SWAHB, ECAHB)	91 (49)	4 (2)	5 (3)
SHB, SEHB, WHB, MWHB	94 (95)	3 (3)	3 (3)
NEHB, NWHB, MHB	94 (79)	4 (3)	2 (2)

Participant satisfaction with aspects of a high quality service (cont.)

"Overall how satisfied were you with…"	Satisfied %(n)	Neither %(n)	Dissatisfied %(n)
… ability of counsellor to listen to you?			
Total	95 (237)	1 (2)	4 (9)
ERHA (NAHB, SWAHB, ECAHB)	89 (50)	2 (1)	9 (5)
SHB, SEHB, WHB, MWHB	99 (103)	1 (1)	0 (0)
NEHB, NWHB, MHB	95 (84)	0 (0)	5 (4)
… ability of counsellor to understand your problems?			
Total	85 (207)	6 (15)	9 (22)
ERHA (NAHB, SWAHB, ECAHB)	84 (47)	7 (4)	9 (5)
SHB,	85 (88)	8 (8)	7 (7)
NEHB	85 (72)	3 (3)	12 (10)

Appendix 6

Participant satisfaction across health board regional clusters

Participant satisfaction with aspects of a client centred service.

"Overall how satisfied were you with..."	Satisfied %(n)	Neither %(n)	Dissatisfied %(n)
... support given when preparing to attend the commission?			
Total	72 (47)	11 (7)	17 (11)
ERHA (NAHB, SWAHB, ECAHB)	87 (13)	13 (2)	0 (0)
SHB, SEHB, WHB, MWHB	69 (27)	8 (3)	23 (9)
NEHB, NWHB, MHB	64 (7)	18 (2)	18 (2)
... support available to you in between individual counselling sessions?			
Total	52 (122)	23 (54)	25 (58)
ERHA (NAHB, SWAHB, ECAHB)	51 (26)	20 (10)	29 (15)
SHB, SEHB, WHB, MWHB	50 (49)	24 (24)	26 (25)
NEHB, NWHB, MHB	55 (47)	24 (20)	21 (18)
... information on how to get the most out of other relevant services?			
Total	36 (43)	36 (43)	28 (34)
ERHA (NAHB, SWAHB, ECAHB)	26 (7)	44 (12)	30 (8)
SHB, SEHB, WHB, MWHB	32 (17)	33 (18)	35 (19)
NEHB, NWHB, MHB	49 (19)	33 (13)	18 (7)

Appendix 6

Participant satisfaction across health board regional clusters

Participant satisfaction with aspects of a client centred service (Overall effects)

"Overall how satisfied were you that..."	Satisfied %(n)	Neither %(n)	Dissatisfied %(n)
...your experience of counselling has helped you to deal with the difficulties that made you seek counselling in the first place?			
Total	83 (186)	6 (13)	11 (25)
ERHA (NAHB, SWAHB, ECAHB)	77 (42)	7 (4)	16 (9)
SHB, SEHB, WHB, MWHB	85 (82)	7 (7)	8 (8)
NEHB, NWHB, MHB	86 (62)	3 (2)	11 (8)
... your experience of counselling has helped you become a more confident person?			
Total	80 (170)	11 (24)	9 (19)
ERHA (NAHB, SWAHB, ECAHB)	82 (40)	6 (3)	12 (6)
SHB, SEHB, WHB, MWHB	82 (76)	11 (10)	7 (7)
NEHB, NWHB, MHB	76 (54)	16 (11)	8 (6)
... your experience of counselling has helped you become a more independent person?			
Total	78 (168)	14 (31)	8 (17)
ERHA (NAHB, SWAHB, ECAHB)	75 (39)	15 (8)	10 (5)
SHB, SEHB, WHB, MWHB	79 (71)	15 (14)	6 (5)
NEHB, NWHB, MHB	78 (58)	12 (9)	10 (7)
... your experience of counselling has improved your ability to make choices about the direction you want your life to take?			
Total	81 (174)	9 (19)	10 (23)
ERHA (NAHB, SWAHB, ECAHB)	76 (39)	8 (4)	16 (8)
SHB, SEHB, WHB, MWHB	81 (73)	10 (9)	9 (8)
NEHB, NWHB, MHB	83 (62)	8 (6)	9 (7)

Appendix 6

Participant satisfaction across health board regional clusters

Service Principles

"It is a service …"	Agree %(n)	Neither %(n)	Disagree %(n)
…which is accessible to all clients?			
Total	70 (173)	5 (12)	25 (63)
ERHA (NAHB, SWAHB, ECAHB)	62 (35)	5 (3)	33 (19)
SHB, SEHB, WHB, MWHB	75 (79)	3 (3)	22 (23)
NEHB, NWHB, MHB	69 (59)	7 (6)	24 (21)
… that respects the dignity of its clients?			
Total	96 (236)	2 (5)	2 (6)
ERHA (NAHB, SWAHB, ECAHB)	93 (53)	2 (1)	5 (3)
SHB, SEHB, WHB, MWHB	99 (103)	0 (0)	1 (1)
NEHB, NWHB, MHB	93 (80)	5 (4)	2 (2)
… that maintains high professional standards among its staff?			
Total	91 (219)	4 (10)	5 (12)
ERHA (NAHB, SWAHB, ECAHB)	87 (48)	4 (2)	9 (5)
SHB, SEHB, WHB, MWHB	94 (95)	3 (3)	3 (3)
NEHB, NWHB, MHB	89 (76)	6 (5)	5 (4)
… which provides confidentiality and privacy?			
Total	90 (219)	5 (12)	5 (11)
ERHA (NAHB, SWAHB, ECAHB)	91 (49)	5 (3)	4 (2)
SHB, SEHB, WHB, MWHB	90 (94)	5 (5)	5 (5)
NEHB, NWHB, MHB	90 (76)	5 (4)	5 (4)

Service Principles (cont.)

"It is a service ..."	Agree %(n)	Neither %(n)	Disagree %(n)
... which provides choice to clients?			
Total	64 (155)	12 (30)	24 (59)
ERHA (NAHB, SWAHB, ECAHB)	56 (32)	18 (10)	26 (15)
SHB, SEHB, WHB, MWHB	68 (70)	11 (11)	21 (22)
NEHB, NWHB, MHB	63 (53)	11 (9)	26 (22)
... which sensitively addresses all aspects of the client's life?			
Total	87 (213)	3 (7)	10 (25)
ERHA (NAHB, SWAHB, ECAHB)	82 (47)	2 (1)	16 (9)
SHB, SEHB, WHB, MWHB	89 (90)	1 (1)	10 (10)
NEHB, NWHB, MHB	87 (76)	6 (5)	7 (6)
... which promotes the independence of the individual client?			
Total	82 (197)	9 (22)	9 (21)
ERHA (NAHB, SWAHB, ECAHB)	72 (39)	13 (7)	15 (8)
SHB, SEHB, WHB, MWHB	82 (82)	11 (11)	7 (7)
NEHB, NWHB, MHB	88 (76)	5 (4)	7 (6)

Appendix 7

Profile of satisfaction for those in counselling and not in counselling

Participant satisfaction with aspects of accessibility

Satisfaction with...	N	In counselling			Not in counselling			Statistical difference
		Dissatisfied	Neither	Satisfied	Dissatisfied	Neither	Satisfied	
		%	%	%	%	%	%	
Information (advertisement)	143	11	11	78	6	17	77	0.36 (NS)
Publicity	254	60	16	24	44	21	35	0.061 (trend)
Information (freephone)	122	7	3	90	8	0	92	0.32 (NS)
Crisis call	35	28	0	72	18	6	76	0.48 (NS)
Information (service)	246	14	11	75	10	14	76	0.57 (NS)
Waiting (first seen)	247	20	8	72	20	7	73	0.88 (NS)
Intake session	254	10	8	82	8	13	79	0.45 (NS)
Distance	256	14	3	83	17	7	76	0.27 (NS)
Parking	130	26	10	64	26	4	70	0.38 (NS)
Public transport	91	23	10	67	31	10	59	0.73 (NS)

Participant satisfaction with aspects of a high quality service

Satisfaction with...	N	In counselling			Not in counselling			Statistical difference
		Dissatisfied	Neither	Satisfied	Dissatisfied	Neither	Satisfied	
		%	%	%	%	%	%	
Appearance of centre	251	9	3	88	12	4	84	0.72 (NS)
Office personnel	245	1	11	88	7	9	84	0.12 (NS)
Avail of appointment	246	10	4	86	13	3	84	0.69 (NS)
Frequency of sessions	244	9	1	90	7	3	90	0.41 (NS)
Length of session	245	13	7	80	16	10	74	0.59 (NS)

Appendix 7

Profile of satisfaction for those in counselling and not in counselling

Participant satisfaction with aspects of a high quality service (cont)

Satisfaction with...	N	In counselling			Not in counselling			Statistical difference
		Dissatisfied	Neither	Satisfied	Dissatisfied	Neither	Satisfied	
		%	%	%	%	%	%	
Confidentiality	242	4	2	94	2	4	94	0.55 (NS)
Sensitivity	245	1	2	97	8	3	89	0.04 (*)
Counsellor knowledge	240	3	9	88	13	6	81	0.029 (*)
Relationship with counsellor	247	1	2	97	5	0	95	0.045 (*)
Cllr ability to understand	243	3	4	93	13	8	79	0.009 (**)

Participant satisfaction with aspects of a client centred service

Satisfaction with...	N	In counselling			Not in counselling			Statistical difference
		Dissatisfied	Neither	Satisfied	Dissatisfied	Neither	Satisfied	
		%	%	%	%	%	%	
Helped address difficulties	223	2	3	95	17	7	76	0.001 (***)
Confidence	212	2	8	90	13	13	74	0.008 (**)
Independence	215	2	13	85	11	16	73	0.041 (*)
Choices	215	4	5	91	14	12	74	0.005 (**)

NS: non-significant difference
** $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$*
(statistically significant difference; smaller fractions=greater differences – thus < 0.001 is a greater difference than $p < 0.05$)

Appendix 8

Profile of satisfaction for those who have completed counselling compared with those who have discontinued counselling

Participant satisfaction with aspects of accessibility

Satisfaction with...	N	Completed counselling			Discontinued counselling			Statistical difference
		Dissatisfied	Neither	Satisfied	Dissatisfied	Neither	Satisfied	
		%	%	%	%	%	%	
Information (advertisement)	76	10	17	73	11	20	69	0.91 (NS)
Publicity	132	53	11	36	44	15	41	0.64 (NS)
Information (freephone)	55	8	0	92	11	0	89	0.79 (NS)
Crisis call	17	22	0	78	25	12	63	0.53 (NS)
Information/ service	126	11	14	75	15	13	72	0.81 (NS)
Intake session	129	8	10	82	13	19	68	0.20 (NS)
Waiting Time (first)	127	21	6	73	24	0	76	0.18(NS)
Distance	130	15	4	81	20	4	76	0.70 (NS)
Parking	62	23	6	71	22	4	74	0.93 (NS)
Public transport	43	39	3	58	8	17	75	0.07 (trend)

Participant satisfaction with aspects of a high quality service

Satisfaction with...	N	Completed counselling			Discontinued counselling			Statistical difference
		Dissatisfied	Neither	Satisfied	Dissatisfied	Neither	Satisfied	
		%	%	%	%	%	%	
Appearance of centre	127	6	3	91	18	4	78	0.10 (NS)
Office personnel	124	9	10	81	5	9	86	0.71 (NS)
Avail of appointment	123	10	0	90	14	9	77	0.01 (*)
Frequency of sessions	121	4	2	94	19	5	76	0.015 (*)
Length of session	123	10	9	81	32	14	54	0.004 (**)

Appendix 8

Profile of satisfaction for those who have completed counselling compared with those who have discontinued counselling

Participant satisfaction with aspects of a high quality service (cont)

Satisfaction with...	N	Completed counselling			Discontinued counselling			Statistical difference
		Dissatisfied	Neither	Satisfied	Dissatisfied	Neither	Satisfied	
		%	%	%	%	%	%	
Confidentiality	120	1	1	98	5	5	90	0.29 (NS)
Sensitivity	122	6	1	93	14	7	79	0.06 (trend)
Counsellor knowledge	119	8	6	86	24	7	69	0.046 (*)
Relationship with counsellor	124	2	0	98	14	0	86	0.016 (*)
Cllr ability to understand	121	6	6	88	23	9	68	0.018 (*)
Time spent in counselling	109	20	6	74	40	22	38	0.001 (***)
...ending	108	19	13	68	38	8	54	0.08 (trend)

Participant satisfaction with aspects of a client centred service

Satisfaction with...	N	Completed counselling			Discontinued counselling			Statistical difference
		Dissatisfied	Neither	Satisfied	Dissatisfied	Neither	Satisfied	
		%	%	%	%	%	%	
Helped address difficulties	113	17	5	78	26	5	69	0.53 (NS)
Confidence	108	13	11	76	15	18	67	0.59 (NS)
Independence	113	12	13	75	13	26	61	0.21 (NS)
Ability to make choices	107	15	8	77	20	11	69	0.69 (NS)

NS: non-significant difference
** $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$*
(statistically significant difference; smaller fractions=greater differences – thus $p < 0.001$ is a greater difference than $p < 0.05$)

Appendix 9

Participant ratings across all satisfaction questions

Participant satisfaction ratings

"Overall how satisfied were you with..."	Satisfied %(n)	Neither %(n)	Dissatisfied %(n)
... information provided in the advertisement?	77 (111)	15 (21)	8 (12)
... the publicity of the service?	31 (78)	19 (48)	50 (129)
... the freephone for getting information and making appointments?	91 (112)	2 (2)	7 (9)
... the freephone when calling in crisis?	74 (26)	3 (1)	23 (8)
...availability of information about the service at the start of counselling?	75 (186)	13 (31)	12 (30)
... waiting time between first contact and seeing someone for the first time?	73 (180)	7 (18)	20 (50)
... the initial/intake interview?	80 (203)	11 (28)	9 (24)
... waiting time between initial interview and the start of counselling?	46 (37)	10 (8)	44 (36)
...location and accessibility of the service in terms of the distance ?	79 (203)	5 (14)	16 (40)
...location and accessibility of the service in terms of the parking facilities ?	67 (88)	7 (9)	26 (34)
...location and accessibility of the service in terms of public transport ?	62 (56)	10 (9)	28 (26)
...the appearance and physical conditions of the centre?	86 (216)	3 (9)	11 (27)
...professionalism of the office staff/personnel?	95 (211)	0 (0)	5 (11)
...the service respecting your right to confidentiality ?	94 (229)	3 (7)	3 (7)
...explanation of their approach to counselling?	86 (148)	8 (13)	6 (11)
...sensitivity of the counsellor towards the important issues in your life?	92 (227)	3 (6)	5 (13)
...knowledge and expertise your counsellor has of working in this area?	84 (202)	7 (18)	9 (21)
...relationship that you have with you counsellor?	93 (223)	4 (8)	3 (8)
...ability of counsellor to listen to you?	95 (237)	1 (2)	4 (9)

Appendix 9

Participant ratings across all satisfaction questions

Participant satisfaction ratings (cont.)

"Overall how satisfied were you with…"	Satisfied %(n)	Neither %(n)	Dissatisfied %(n)
…ability of counsellor to understand your problems?	85 (207)	6 (15)	9 (22)
… support given when preparing to attend the commission?	72 (47)	11 (7)	17 (11)
… support available to you in between individual counselling session?	52 (122)	23 (54)	25 (58)
… information on how to get the most out of other relevant services?	36 (43)	36 (43)	28 (34)
…your experience of counselling has helped you to deal with the difficulties that made you seek counselling in the first place?	83 (186)	6 (13)	11 (25)
…your experience of counselling has helped you become a more confident person?	80 (170)	11 (24)	9 (19)
…your experience of counselling has helped you become a more independent person?	78 (168)	14 (31)	8 (17)
…your experience of counselling has improved your ability to make choices about the direction you want your life to take?	81 (174)	9 (19)	10 (23)

Participant satisfaction ratings (cont)

"It is a service …"	Agree %(n)	Neither %(n)	Disagree %(n)
… which is accessible to all clients?	70 (173)	5 (12)	25 (63)
…that respects the dignity of its clients?	96 (236)	2 (5)	2 (6)
…that maintains high professional standards among its staff?	91 (219)	4 (10)	5 (12)
…provides confidentiality and privacy?	90 (219)	5 (12)	5 (11)
… provides choice to clients?	64 (155)	12 (30)	24 (59)
…which sensitively addresses all aspects of the client's life?	87 (213)	3 (7)	10 (25)
…which promotes the independence of the individual client?	82 (197)	9 (22)	9 (21)

Appendix 10

Letters of Invitation

SAMPLE

Health Board Logo/Letter head

Date:

Dear ___________,

I am writing to tell you about a survey of people using the National Counselling Service. The National Counselling Service has asked the Health Services Research Centre at the Royal College of Surgeons in Ireland to carry out an evaluation of the service with people who have attended counselling. Over 300 people have been invited at random to take part in the evaluation. The information gathered will be used to assess satisfaction with the National Counselling Service to date so as to ensure that this service is effective and of the highest possible quality for clients.

We invite you to be interviewed. The interview will take approximately 30-40 minutes. The issues you will be asked about will include:

- How accessible the service is? (e.g. how easy or difficult is it to get the service?)
- How satisfactory the service is/was for you? (e.g. is the service of help for your particular needs?)
- How the service could be improved?

You will not have to answer any personal issues relating to your background.

Taking part would be voluntary and strictly confidential. The survey will not record names and locations. No identifying information will be recorded; it will be anonymous. All you have to do is think about it and I will phone you within the next two weeks (or talk to you when I see you next) to see if you have any questions and/or are interested in taking part in this evaluation. However if you would prefer you can contact the researchers directly by phoning them on the freephone at 1800 XXXXXX.

The interview will be held somewhere convenient to you and the research team will try their best to suit you on the time and date of interview. If you have to travel, the researchers can provide 32 Euro towards travel and inconvenience. If it would be more convenient for you, it could be arranged that you are interviewed by one of the researchers over the telephone.

We would value your views in order to provide a high quality service to clients now and in the future. Thank you for considering the request.

Sincerely,

SAMPLE

Health Board Logo/Letter Head

Date:

Dear ____________,

I am writing to tell you about a survey of people using the National Counselling Service. The National Counselling Service has asked the Health Services Research Centre at the Royal College of Surgeons in Ireland to carry out an evaluation of the service with people who have attended counselling. Over 300 people have been invited at random to take part in the evaluation. The information gathered will be used to assess satisfaction with the National Counselling Service to date and to ensure that this service is effective and of the highest possible quality for clients.

We invite you to be interviewed for the study. The interview will take approximately 30-40 minutes. The issues you will be asked about will include:

- How accessible the service was? (e.g. how easy or difficult was it to get the service?)
- How satisfactory the service is/was for you? (e.g. was the service of help for your particular needs?)
- How the service could be improved?

You will not have to answer any personal issues relating to your childhood.

Taking part would be voluntary and strictly confidential. The survey will not record names and locations. No individual responses will be passed to the National Counselling Service. Only the researchers will know who took part. We hope that you will consider taking part as it is very important and useful to hear the views of those who have finished or left the service early.

The interview will be held somewhere convenient for you and the research team will try their best to suit you on the time and date of interview. If you have to travel, the researchers can provide 32 Euro towards travel and inconvenience. If it would be more convenient for you, it could be arranged that you are interviewed by one of the researchers over the telephone.

Please let the research team know directly if you are interested in taking part or if you have questions before you make a decision. You can contact them by returning the enclosed form using the stamped addressed envelope provided or by phoning them on the free-phone number at 1800 XXXXXX

Sincerely,

____

Director of Service
[ ] Board

Appendix 10

Letters of Invitation

SAMPLE

Rminder Letter
Date:

Dear ____________,

We recently sent a letter on behalf of the Royal College of Surgeons in Ireland inviting you to participate in an important evaluation of the National Counselling Service. You may have already returned the consent form to the research team indicating your preference in terms of participation. If this is the case we thank you for your response and apologise for this reminder.

If however, you have not responded there is still time to participate and I would encourage you to make contact with the research team to set up a confidential interview. You can contact them on Freephone No 1800 XXXXXX. You can rest assured that your specific information will not be used outside of the research team and will only be used for the purposes of this study.

This is your chance to say what you think about the service. Whatever your experience, the interviewers would like to hear from you. Your views are especially valuable and will help inform planning of high quality services for clients in the coming years.

The interview could be conducted over the telephone on a day and time that is suitable to you.

Interviews will conclude by the 15th of November 2002. As we will not be writing to you again, we would like to take this opportunity to thank you for taking the time to consider this request.

Yours sincerely

____

Appendix 11

Overview of sample population (completed counselling)

The following tables are based on all randomly selected clients who had completed counselling (including those excluded and re-selected, those who participated in the research and non-responders). NCS counsellors defined client status as 'completed counselling' or 'discontinued counselling'. Data was not available for one health board, and another board provided data on some clients.

Number attending and completing counselling per health board by gender and context of abuse

Health Board	No. of sessions	No. of clients	Mean no. of sessions	Median no. of sessions	Gender		Context of abuse	
					Male	Female	Institutional	Other
ECAHB*								
SWAHB	304	17	17.8	12	5	11	5	11
NAHB *	291	16	18.2	12	3	3	1	2
SHB	265	33	8.0	6	19	14	19	4
NEHB	256	33	8.3	6	7	26	3	28
NWHB	300	31	9.7	8	5	26	0	31
MWHB	299	26	11.5	8	16	10	15	11
MHB	222	27	8.2	8	7	14	1	20
SEHB	491	52	9.4	6	24	28	22	30
WHB	723	64	11.5	10	22	42	13	50
TOTAL	3151	299	10.5	8	108	174	79	197

[incomplete sample]*

Appendix 11

Overview of sample population (completed counselling)

Numbers attending and discontinuing counselling (prematurely) per health board by gender and context of abuse

Health Board	No. of sessions	No. of clients	Mean no. of sessions	Median no. of sessions	Gender		Context of abuse	
					Male	Female	Institutional	Other
ECAHB*								
SWAHB	141	7	23.5	14	3	4	2	5
NAHB *	11	4	2.8	3	*1	*	*	*1
SHB	125	26	4.8	4	11	15	14	12
NEHB	113	18	6.3	5	9	9	2	16
NWHB	168	20	8.4	5	6	14	0	20
MWHB	143	18	7.9	7	7	11	6	12
MHB	279	49	5.7	4	15	28	3	38
SEHB	40	7	5.7	6	3	4	1	6
WHB	217	44	4.9	4	19	25	12	32
TOTAL	1237	193	6.4	5	74	110	40	142

[incomplete sample]*

Number of persons who did not attend initial interview and those who attended an initial interview but not counselling by gender and context of abuse

	Did not attend initial interview					Did not attend counselling				
	No. of clients	Gender		Context		No. of clients	Gender		Context	
		M	F	I	O		M	F	I	O
ECAHB*										
SWAHB	0	0	0	0	0	4	1	3	2	2
NAHB *										
SHB	1	0	1	1	0	16	12	4	11	4
NEHB	52	17	35	4	47	9	3	6	1	8
NWHB	19	7	12	0	2	9	3	6	0	9
MWHB	2	1	1	1	1	5	1	4	2	3
MHB	30	6	19	*1	*1	20	*3	*10	2	10
SEHB	7	2	5	*1	*	11	3	8	3	8
WHB	33	15	18	4	29	24	7	17	3	8
TOTAL	144	48	91	12	80	98	33	58	24	52

[Incomplete sample; M: Male, F: Female; I: Institutional abuse, O: Other abuse]*

Appendix 12

Participant Quotes

This appendix includes a selection of randomly selected quotes which are grouped according to areas explored in the study. They are listed with the participants gender, age and context in which abuse was experienced. They do not equally represent, the gender, age, context of abuse or satisfaction ratings of the study participants, but offer a picture of participants' views.

Advertising

> *"I never knew about the service until my friend told me. I never saw any form of advertising about the service."* [Female, non-institutional abuse, 59 yrs]

Initial interview

> *"I was. very nervous – I felt a few things had been brought to the surface. When I went out onto the street things were swimming around in my head, it was very difficult to cope with."* [Male, institutional abuse, 62 yrs]

> *"You should not have to prove that you are worthy for priority counselling."* [Female, non-institutional abuse, 43 yrs]

Physical aspects of accessibility

> "*The difficulty is around the time it takes me to travel there - one hour there and one hour back."* [Female, non-institutional abuse, 24 yrs]

> *"They need to broaden it more into the community, difficult to attend because of transport difficulties.*" [Male, non-institutional abuse, 44 yrs]

> *"If my husband wasn't available I would have to miss counselling. This presents a difficulty in that I couldn't ask anyone else for a lift as they would know where I was going."* [Female, non-institutional abuse, 56 yrs]

> *"Sometimes I feel upset coming out and want to go straight into the car, not down a dark street in the winter, it feels unsafe."* [Female, non-institutional abuse, 35 yrs]

> *"Make the buildings more wheelchair accessible."* [Female, non-institutional abuse, 36 yrs]

> *"The bus only came twice daily."* [Female, non-institutional abuse, 59 yrs]

Confidentiality, Privacy and anonymity

> *"I felt a bit pressured to give stuff away. Have to think before I talk in case I say anything that might mean the counsellor reporting."* [Female, non-institutional abuse, 31yrs]

"It is in a shopping centre where lots of people are coming in and out. There was a sign up but I don't know how they could resolve this as people like to see the sign so they can find out about it." [Male, non-institutional abuse, 48yrs]

"Having to meet a receptionist and letting her know why I was here, that I was here to see a counsellor. This is someone who is not involved in counselling and now she knows why I am here." [Male, non-institutional abuse, 42 yrs]

"Some of the staff knew me and it made it very difficult for me initially." [Male, non-institutional abuse, 28]

"Every counsellor should have their own private office and not share a waiting room. People stood around outside the centre smoking. This made it uncomfortable walking in." [Male, institutional abuse, 44yrs]

"Have somebody meet the clients coming in for the first session if they have to go through a public area to get to the counselling room/centre" [Male, non-institutional abuse, 45yrs]

"It's on the main street and people could see me go in and out. It was like they knew what had happened to me." [Female, non-institutional abuse, 42yrs]

"The waiting room might be full...reception area is very public. It is possible that you might meet someone you know." [Female, non-institutional abuse, 54yrs]

"It was out of the way down by the river and in the mornings there is nobody around." [Male, institutional abuse, 40yrs]

"People know it is a counselling centre. They would know where I was going and I feel very ashamed about what happened to me"

Availability of appointment times

"There were only certain days that the counsellor was available so I was limited to what days I could attend." [Male, non-institutional abuse, 42yrs]

"I would have liked a regular day and time. The days and times chopped and changed." [Male, institutional abuse, 48yrs]

Length of individual counselling sessions

"The sessions were thirty minutes and I felt there was some clock watching. It [length of session] *should be up to the client for the first few sessions"*

[Female, non-institutional abuse, 36yrs]
"I travel twenty five miles to my counselling centre. The taxi might be late picking me up. This means that my session might only be for 50 minutes".
[Male, institutional abuse, 56yrs]

"You should never run out a time on these things – it takes a while to settle down. You can't give a set time - it should vary from session to session."
[Male, institutional abuse, 44 yrs]

"The client should be given the choice of choosing how long the session lasts. The service needs to be more friendly and open." [Female, institutional abuse, 43 yrs]

"I would see the counsellor clock watching. I wish there had been a clock for me to see so that I could monitor the time. I also wish I could leave earlier if I don't want to stay for an hour." [Female, non-institutional abuse, 44yrs]

"I can cut the sessions short myself if needs be." [Male, institutional abuse, 57 yrs]

"The counsellor holds me on for up to two hours if I'm upset."
[Female, non-institutional, 35yrs]

Total duration of counselling

"I would have liked to continue but another family crisis got in the way"
[Female, non-institutional abuse, 46yrs]

"My counsellor was leaving the service. She had told me in advance that she would be leaving and could only offer me a limited number of sessions. I took this because nothing else was on offer. When she left, the service could not offer me one-on-one counselling. They offered me group therapy, which took place on the other side of town at night-time. This was not suitable for me" [Female, institutional abuse, 53yrs]

"I had so much going on at the time, my marriage was in difficulty … I felt it was better to take a break. I couldn't concentrate" [Male, non-institutional abuse, 49yrs]

"I didn't feel ready to leave but the counsellor said I was [ready] and he is the expert. I took his word". [Female, non-institutional abuse, 59yrs]

"I didn't want to end it but had no option. A job came up and there was no appointment time to suit me. Even though the counsellor offered me a 5 p.m. time, I couldn't make it" [Male, institutional abuse, 27yrs]

"I was better off out there as I wasn't helped at all by this counsellor."
[Female, non-institutional abuse, 54yrs]

Appendix 12

Participant Quotes

"Counselling had to end for the meantime because I am now attending an addiction counsellor. I see my counsellor in the NCS about once a month for a support session." [Male, institutional abuse, 42yrs]

"The counsellor explained that I would need to go through the psychiatric services." [Male, non-institutional abuse, 31yrs]

"My job and life became hectic. I had one more session to attend but I never got to it. I will ring back to say thanks … I would have liked four to five more sessions." [Male, institutional abuse, 57yrs]

"It was difficult as the old feelings kept coming back" [Male, institutional abuse, 32 yrs]

"I did not want to go over old ground – too painful and I had been in counselling for years." [prior to the NCS]) [Male, non-institutional abuse, 45yrs]

" It helped me to deal with the issues but six weeks in counselling is not long enough." [Male, institutional abuse, 57yrs]

"The time is too short. I am trying to get back into the service but my counsellor is booked up." [Male, institutional abuse, 59yrs]

Counsellor characteristics

" She wanted to know how I felt and let me talk."[Male, institutional abuse, 56yrs]

"We hit it off form the beginning –we clicked." [Female, non-institutional abuse, 36yrs]

"She was very considerate."[Male, institutional abuse, 55yrs]

"Genuine person."[Female, institutional abuse, 45yrs]

"I need the counsellor to be one-on-one, not just sit back and listen … analyse me after the session." [Male, institutional abuse, 44 yrs]

"She gave me good advice." [Female, institutional abuse, 52]

"When I first met her I thought she was too young, I asked myself what does she know about life – what you read in a book ?… theory and practice are two different things, there are times when I feel I am not getting through to her." [Female, non-institutional abuse, 45yrs]

Appendix 12

Participant Quotes

"No-one would [understand] unless they had been through it themselves". [Female, non-institutional abuse, 19yrs]

"She was a lot younger than me and I wasn't sure how she could really understand my problems". [Female, non-institutional, 44]

Choice of counselling service

"This is all that I was offered."[Male, institutional abuse, 56yrs]

"The other centres are too far away... other choices are not suitable." [Male, institutional abuse, 44yrs]

"This was the nearest one." [Female, non-institutional abuse, 59yrs]

"I didn't know where to go for another service." [Female, non-institutional abuse, 36yrs]

Choice of counsellor

"I just wanted someone who I could have an evening session with but that wasn't possible." [Female, non-institutional, 50]

"He was the only one available in my area." [Female, non-institutional, 42]

"She just gave up she never understood that I needed answers, exploring issues." [Female, non-institutional, 43]

Trust in the counselling relationship

"I didn't build up a rapport with the counsellor – she didn't make me feel like I could trust her. I just froze and said to myself, I haven't a hope of talking to you". [Female, non-institutional, 22]

Barriers to trust

"If she had responded more I might have been able to trust her." [Female, non-institutional abuse, 44yrs]

Trusting the service

"Divorce the service from the health board, there are negative associations in peoples' minds relating to the health board. The service should be separate".

[Male, institutional abuse, 42yrs]

Impact of the experience of counselling

" She was able to unlock doors." [Male, institutional abuse, 63yrs]

"It made me more tolerant, to talk without blowing a gasket."
[Male, institutional abuse, 70yrs]

"There are times when I feel that it does help me to feel more confident, other times I feel that it is a complete waste of time". [Male, institutional abuse, 56yrs]

"..definitely, it has given me the strength to choose what I want."
[Male, institutional abuse, 55yrs]

"....it helped me to live with someone and share my life, talking it through really did help." [Female, non-institutional abuse, 50yrs]

" Its an absolutely brilliant service, it turned my life around. I'm more confident now, I now know what I'm a worthwhile person. My counsellor challenged me, made me think about things differently and was very understanding."
[Female, non-institutional abuse, 33yrs]

Appendix 13

Survivor Support Groups

Survivor Support Groups: *Contact Details*

National Office for Victims of Abuse (NOVA)
Manager: Kevin Brady
19 Upper Ormonde Quay
Dublin 7
Freephone: 1800 25 25 24
Tel: 01 8728482

Right of Place
Unit n4, Crawford Commercial Park
Freephone: 1800 200 709
Fax: (021 4975740
E-mail: upton.stp
Web Site: www.Right Of Place.com

Aislinn Centre
Christine Buckley
Ormonde House, Ormonde Quay
Dublin 7
Tel: 01-8725771

Justice and Healing for Institutionally Abused (JHFIA)
Victor Hackett
Dublin
Tel: 01-867-1006

Le Cheile Eile
North East Support group
for Survivors of Institutional Abuse
Chair Person: John Caulders
C/o Rian Counselling
Town Hall Street
Cavan
Tel:

Right of Peace/Clonmel Group
Michael O Brien
Co Tipperary
Tel: 052 80880(w), 087 645 4298

SOCA UK
Mick Waters
18 King Edward Rd, Hillfields
Coventry, CV1 5BT
Tel: 0044 2476 551952

Organisation for the Recovery from Institutional Abuse
Jo Baker
Co Meath
01 825 2353

Alliance
Tom Hayes
Co. Armagh
Tel: 04838 871 708
Fax: 04838 871 676

Irish SOCA
John Kelly
Dublin
Tel: 01 455 0413, 087 247 5591

Irish Deaf Society
30 Blessington St, Dublin 4
Contact: Sinead Braiden,
Tel: 01 8601878, Email: ids@indigo.ie

Appendix 14

Contact Details

National Counselling Service

for Adults who Experienced Abuse in Childhood

Contact Details

Theresa Flacke.
Director of Counselling,
Woodquay Centre Counselling Service,
Western Health Board,
7 Daly's Lane,
Woodquay,
Galway.
FREEPHONE 1 800 234 114
Ph. No. 091-561336/8
Fax No. 091-561174
Woodquay.counselling@whb.ie

Ms. Noreen Harrington,
Director of Counselling,
Mid-Western Health Board,
Adult Counselling Service,
106, O'Connell Street,
Limerick.
FREEPHONE 1 800 234 115
Ph. 061-411900
Fax. 061-411566
josullivan@mwhb.ie

Dr. Philip Moore,
Director of Counselling,
Harbour Counselling Service,
Southern Health Board,
Penrose Wharf,
Penrose Quay,
Cork.
FREEPHONE 1 800 234 116
Ph. 021-4861360 (Niamh)
Fax. 021-4861368
harbour@shb.ie

Ms. Fiona Ward,
Director of Counselling,
Rian Counselling Service,
North Eastern Health Board,
34 Brews Hill,
Navan,
Co. Meath.
FREEPHONE 1 800 234 117
Ph. (046) 67010
Fax. (046) 67016
rian@nehb.ie

Mr. Gerard O'Neill,
Director of Counselling,
Comhar Counselling Service
South Eastern Health Board,
49-50 O'Connell Street,
Waterford
FREEPHONE 1 800 234 118
Ph. No. 051-852122
Fax No. 051-852129
lenihanm@sehb.ie

Mr. Tom McGrath,
Director of Counselling,
North West Regional Counselling Service,
North Western Health Board,
1 St. Eunan's Court,
Letterkenny, Co. Donegal
68 John St Sligo.
FREEPHONE 1 800 234 119
Ph. 074-672501
Fax 074-67252
Fidelma.conboy@nwhb.ie

Appendix 14

Contact Details

Ms. Isolde Blau,
Director of Counselling,
Laragh Counselling Service,
Northern Area Health Board,
1 Prospect House
Prospect Road
Glasnevin
Dublin 9 FREEPHONE 1 800 234 110
Fax. No. 01-8334243
Isolde.blau@nahb.ie

Director of Counselling,
ALBA Counselling Service
South Western Area Health Board,
2, McElwain Terrace,
Newbridge,
Co. Kildare.
FREEPHONE 1 800 234 112
Ph. No. 045-448176/7
Fax: 045-448179
albacounselling@erha.ie

Ms. Rachel Mooney,
Director of Counselling,
AVOCA Counselling Service
East Coast Area Health Board,
Baggot Street Hospital,
Baggot Street,
Dublin, 2.
FREEPHONE 1 800 234 111
Fax: 01-6681750
Avoca.counselling@erha.ie

Mr. Jonathan Egan,
Director of Counselling,
The Arches Adult Counselling Service,
Midland Health Board,
21 Church Street,
Tullamore, Co. Offaly.
FREEPHONE 1 800 234 113
Ph. 0506-27141
Fax 0506-27617
Thearches.counselling@mhb.ie

The National Counselling Service provides counselling to adults who experienced abuse in childhood and is available in each health board area.

Any adult wishing to avail of counselling should phone the counselling service in their local area to make an appointment.

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