TROUBLE IN THE VILLAGE? COUNSELLING AND CLINICAL PSYCHOLOGY IN THE NHS

JILL BRENNAN, Manchester Mental Health and Social Care Trust
HENRY HOLLANDERS, Professional Doctorate in Counselling, University of Manchester

ABSTRACT *Over the past two decades, counselling has sought to position itself within a number of different professional contexts. In recent years the growth of counselling in medical settings, most notably in primary care, has been considerable, and in many areas in the UK the presence of a counsellor in a GP surgery is now the norm rather than the exception. In many cases, counsellors are employed by psychological services and are supervised by psychologists. This is often an uneasy relationship and raises a number of issues that are highlighted in this paper.*

Key words: counselling; clinical psychology; NHS; grey literature

THE MEDICAL MODEL, PSYCHOLOGY AND COUNSELLING

The emergence of Western medicine as a profession has been described as a process of transition from a 'biographical' (Pickstone, 1994) or 'bedside' (Jewson, 1976) model of medicine to an 'analytical' (Pickstone, 1994) or 'hospital' (Jewson, 1976) model and ultimately to a laboratory/ experimental model. During the earliest stage, medicine was a theoretically and technically diverse discipline, in which the power balance between practitioner and patient was relatively equal and the approach idiosyncratic, determined by the preference and worldview of the patient. The intermediate stage is epitomized by the practitioners who established a standardized scientific medical approach within the great hospitals for the poor of Europe; here doctors became experts and patients increasingly passive and lacking in individuality. Finally, as medical researchers sought for ever more microscopic causes of disease, a model of laboratory medicine (largely independent of clinical practice), and its associated biotechnical and pharmaceutical industries came to dominate medicine.

There are striking parallels between this process of development and that of the psychological therapies. In establishing its acceptability in medical settings over the past 40 years, psychology has marketed itself as a 'scientist-practitioner' profession, echoing the claims of the analytical model of medicine in aiming to build a standardized, evidence-based body of treatments. Like medicine, clinical psychology allies itself, sometimes uncomfortably, with its

favoured twin discipline of academic/research psychology.

In contrast, counselling at present remains a disparate discipline that more closely resembles, in its approach to patients, the holistic, individually oriented and dialogic early 'biographical' model of medicine (Pickstone, 1994).

It was precisely by de-emphasizing its holistic person-centred elements that medicine became 'scientific'. It is interesting to note that objections from some quarters of the UK medical profession to the emergence of various forms of professional therapeutic counselling in the 1990s reflected concerns that their introduction into National Health Service primary care represented a return to 'magic' (Harris, 1994; Mellor-Clark, 2001). Harris' pamphlet, published by the Social Affairs Unit, suggests that: '. . . in accepting counselling the government may be turning its back on two centuries of careful and dedicated work by doctors . . . in allowing counselling into the NHS we may be deserting medicine for magic' (Harris, 1994, 24).

Harris objected to NHS funding of 'treatment of unhappiness' and asserted that some doctors would be happy to fuel the growth of counselling not because of its therapeutic value but as a convenient repository for 'heart-sink' patients: '. . . people with impossible lives whom nobody can help, the bullies, the daft, the drug-ridden, the jealous, the perplexed, the sad, the perpetually grieving, the incompetent, the nervous, the bankrupt, and those simply too horrible to live with' (Harris, 1994, 25).

However, Harris' position is by no means universal among GPs. Cocksedge (1997), for example, supports the inclusion of both counselling and clinical psychology as valid primary care interventions.

THE 'TRIBAL VILLAGE' – PSYCHOLOGICAL THERAPIES IN THE NHS

East (1995) likens the medical world to 'a tribal village society', in which 'newcomers . . . are often regarded with suspicion and hostility'. A number of professions, with unique provenance and structures for training, accreditation and regulation, overlap in their work with a similar clientele and compete for credibility (and therefore funding) within an NHS community, itself currently made up of diverse quasi-autonomous trusts (see http://www.doh.gov.uk) Counselling's recent emergence as a distinct profession, therefore, occurs in an environment that is by no means politically neutral. Awareness of systemic meanings, including the micro-political implications of the professional and theoretical orientation of researchers, necessary for an intelligent reading of the literature in any field, is particularly relevant to understanding developments in counselling in medical settings.

Feltham (1995) vividly illustrates the variety and complexity of meanings carried by the terms 'counselling' and 'counsellor' in his account of the emergence of counselling as a profession and its relationship to other social institutions.

Historically, the term 'counselling' has been applied to a wide range of activity in medical settings, where it is still used today by some health professionals to denote *advice giving, health education, befriending, emotional support,* or as a *catch-all alternative to 'psychological therapies'.*

Sometimes 'counselling' is confused with the *use of counselling skills.* For example, the NHS Review of Psychotherapy in 1996 (Roth and Fonagy, 1996) has been criticized for basing its conclu-

sions on the effectiveness of 'counselling' upon 14 studies, most of which did not include counsellors (Davidson, Curtis Jenkins and Mellor Clark, 1999)! Moreover, researchers undertaking randomized controlled trials of psychological interventions have routinely used 'counselling' to describe *an artificial control condition of 'support' against which the effects of intervention can be assessed* (see, for example, Tarrier et al., 1998). Although such studies do not directly assert the inferiority of all counselling, this common abuse of the term in the literature to denote a passive 'default' therapy condition, against which some innovative intervention has (successfully) been tested, must surely have an impact on the way 'counselling' is perceived.

Even where the term 'counselling' is applied to a purpose-specific contractual relationship between a 'client' and a 'counsellor' (BAC, 1998), details of the type of 'counselling' are all too often omitted in the literature (Hemmings, 2000; Mellor-Clark, 2001), giving the false impression that counselling is a theoretically and technically uniform activity. While counsellors will be aware that this is not the case, it is only recently that the Department of Health has acknowledged that: 'counsellors may practise within any of the therapeutic approaches . . . using psychodynamic counselling, cognitive behavioural counselling, systemic counselling and so on' (DoH, 2001).

Davies (1997) demonstrates a further complication, by applying the word 'counselling' to 'counselling psychology' rather than counselling *per se.* This is a fine but significant distinction in NHS culture, within which counselling psychologists seek to position themselves hierarchically between clinical psychologists and counsellors (cf. Milton, 1995).

At best, this semantic confusion complicates the task of intelligently reading the literature on counselling in the NHS, and, at worst, perpetuates for political purposes the myth that counsellors are underskilled practitioners of an inferior form of therapy.

Counsellors have worked in isolation in secondary medical settings over many years. Lacking a formal independent professional identity, these counsellors have always been vulnerable and hard to track (East, 1995). Referring to Breakwell's (unpublished) national survey of counselling in secondary care (undertaken for the British Association for Counselling (BAC) in 1987), East comments: 'Counselling in secondary health care is probably the most patchy and varied of all provision in medical settings. [Counsellors are often] . . . employed to work as counsellors in conjunction with a role linked to another occupational identity which may take priority when there are staff shortages or a lack of resources' (East, 1995).

The literature includes several case studies demonstrating tension between medical and non-medical models and associated political pressures upon counsellors in secondary physical health care settings (Reynolds, 1999; Vreede, 2001).

The professional interface between psychology and counselling is not a new phenomenon. Clinical psychologists, too, have long drawn caseloads from physical healthcare settings, such as stroke rehabilitation units.

However, the most telling contact between clinical psychologists and their 'village cousins', counsellors, has occurred comparatively recently. By the mid-1980s, a chronic shortage of qualified

clinical psychologists in the NHS was aggravating the problem of a growth in demand for psychological therapies that greatly exceeded supply. There was massive expansion of counselling in primary care in the late 1980s and 1990s, on the back of long waiting lists for psychology and psychotherapy (Davies, 1997; Eatock, 2000), as, freed to purchase relevant, locally delivered services, many GPs recruited practice counsellors.

Many of these counsellors were freelance workers who came from outside the relatively inflexible professional culture of psychological therapies modelled on medicine. As such, counsellors often effectively undercut higher priced centralized clinical psychology services. They brought a refreshing combination of private service provision ethos and an approach tailored to individual need, which was popular both with GPs and patients (Hemmings, 2000). In addition to reported therapeutic benefits of counselling, it seems likely that this popularity reflected its contribution to providing a more patient-friendly service in healthcare settings (Davies, 1991).

In April 2000, as NHS policy swung away from GP fundholding, towards the concept of 'managed care', practice-based funding for many primary care counsellors dried up (Foster, 2000), while (centrally funded) clinical psychology remained intact.

It is the above context that has shaped counselling's complex and, at least initially, hostile relationship with clinical psychology.

There are a number of accounts in the 'grey' literature of encounters between the professions from the early 1990s (see, for example, Brownscombe Heller, 1997; Burton et al., 1995; Shillitoe and Hall, 1997).

PSYCHOLOGISTS ON COUNSELLORS AND COUNSELLING

Initial suspicion

Clinical psychology's initial position on counselling appears typically to have been one of suspicion. Miller (1994), for example, summarizes perceived risks from the possibility of this encroachment de-skilling both clinical psychology and psychotherapy. Brunning et al. (1994) is a typical response to the encroachment of primary care counselling from a clinical psychology perspective: namely, to emphasize the more extensive nature of clinical psychology training and its scientist-practitioner approach and the risks of employing counsellors. While perhaps admirable as a rallying call to clinical psychology, the paper offers no empirical evidence for the somewhat dismissive list of characteristics attributed globally to 'primary care counsellors' in comparison to those of clinical psychologists, counselling psychologists and others (Brunning, 1994). A membership survey commissioned by the British Association for Counselling in 1993 (*prior to* a decade of expansion of postgraduate counsellor training and professional accreditation) indicates a predominately mature female graduate membership, typically with 250–500 hours of training over 2.5 years (Mountain, 1993). Brunning (1994) implies that counselling was entirely unregulated during this period. In fact, although, like psychology, counselling was not state regulated, the BAC had established both accreditation and complaints procedures by 1985. The suggestion that counsellors, unlike clinical psychologists, lack 'regular professional

appraisal' ignores counselling's fundamental commitment to reflective practice, at a time, ironically, when senior clinical psychologists were free to practise without clinical supervision.

Brunning's (1994) very choice of 'selling points' is telling. No mention is made, for example, of the relative maturity and breadth of life experience/education of counsellors – arguably highly significant therapeutic variables (cf. Gaston, Marmer, Gallagher and Thompson, 1991; Lambert and Bergin, 1994), particularly for clients addressing issues of lifestage or loss. Nor is there reference to the value of interpersonal aspects of counsellor training (cf. Davidson and Davidson, 1997). Also, for all their training, typical newly qualified clinical psychologists of the period might well have had several hundred hours less actual clinical experience than newly accredited counsellors.

THE DEMARCATION ISSUE

There was debate around caseload content of counselling and clinical psychology as a means of demarcation. In attempting to distinguish between the caseload profiles of the two groups, Kemp and Thwaites state that: 'There is general consensus regarding . . . the types of problems and clients considered suitable for counselling within a clinical psychology department . . . These problems include mild to moderate mental health problems, problems associated with life crises and relationship problems' (Kemp and Thwaites, 1998).

Burton et al. (1995) also addressed the issue of caseload, suggesting that the two professions were seeing overlapping but significantly different populations. However, their findings do not precisely reflect the 'general consensus' asserted by Kemp and Thwaites (1998), in that psychologists in their sample saw more patients with relationship problems (Burton et al., 1995). Perhaps this is a function of the influence on caseload of personalities and of the mix of clinical skills, experience and therapeutic interests available at the local level?

Burton et al.'s paper fails to address three key interrelated underlying issues, thus rendering them invisible to the naïve reader:

- The hegemony of clinical psychology in NHS psychological therapies. Clinical psychologists manage and represent the majority of full-time staff in most combined services. Counsellors tend to be part-time, 'junior' staff (cf. Shillitoe and Hall, 1997).
- The origins of notions of professional competence in the pseudo-medical paradigm of psychology. Hence, the implicit weight given to 'scientific' aspects of clinical psychology, such as psychometrics and research, in assessing clinical competence, although these have no proven bearing on therapeutic outcomes.
- The circularity created by referrers' perceptions of appropriate referral destinations in the light of the above. For example, if referrers send complex cases to psychologists on the grounds of their claims to greater competence, then comparison of caseloads will tend to reflect the above paradigmatic assumptions as much as any actual differences in competence.

Burton's summary offers some examples of psychology-oriented assumptions:

> When the symptomatic picture is complicated by longstanding relationship problems, childhood sexual abuse, habit disorders, chronic disabling anxiety or obsessional pathology, severe depression, risk of suicide, multiple psychosomatic problems, or an underlying personality disorder,

> most counsellors (with some exceptions) are not professionally equipped to deal with these more difficult patients. Five or six sessions of counselling are also likely to result in little lasting change and in some cases could do harm. Clinical psychologists continue to be required to offer longer-term treatment for more disturbed patients, to provide clinical supervision for counsellors' work, to assist GPs in developing appropriate referral guidelines, and to conduct research on treatment effectiveness. (Burton et al., 1995)

Here, for example, the possibility that counselling might be effective in more complex cases, given more than six sessions, is not considered.

In essence, then, the literature does not indicate agreement on demarcation by caseload. This may well be in part because of variation in settings and composition of teams between case studies, but also perhaps because such distinctions may be inherently questionable from a therapeutic perspective, and relate more to political positioning.

ATTEMPTS AT INTEGRATION

By the end of the decade, exclusion had largely given way to a grudging acknowledgement of the usefulness of counselling in dealing with simple, short-term cases, at the bottom of a psychology-led psychological therapies hierarchy. As the 1990s continued, however, some began to argue for the active promotion of integration, presenting their case in the clinical psychology press. Miller (1997), for example, calls for the integration of the different professions in psychological therapies services, noting that:

> Service delivery must not be a matter of professional boundaries but of appropriate matching of clients' needs and preferences with therapeutic processes and outcomes . . . Although the view is not popular among therapists, meta-analyses tend to confirm that differences in theoretical orientation and training may matter little to a successful therapeutic outcome . . . (Miller, 1997, 41)

Brownscombe Heller (1997) for example documents a decade of collaboration, driven by waiting lists and recruitment problems. While attempts at integration have not been easy, Green (1994) remains optimistic for the future of collaboration. She describes a case study involving the eventually successful integration of counsellors into a clinical psychology service in primary care, although initially '. . . clinical psychologists wanted to view the counsellors as "assisting" their work and to refer patients to them who needed "support". The counsellors wanted to be recognised as skilled therapists and equal professionals' (Green, 1994, 34).

How widespread integration is at present, and to what extent it still conceals hierarchical assumptions, is unclear. It could be argued that a profession 'arrives' when it is fully accommodated within the bureaucratic structure in which it is housed. Thus an interesting measure of the degree to which counselling is now a part of NHS psychological therapies is offered by Newman and Kellett (2000) (clinical psychologists) in a working example of the integration of psychology, psychotherapy and counselling at the level of clinical governance. On the other hand, the NHS has yet to agree a national structure of pay and conditions for counsellors!

Shillitoe and Hall (1997) (psychologist and counsellor respectively) consider clinical psychologists' objections to counselling interesting in the light of:

> the arguments that psychiatrists made [when psychology was a new profession] in an attempt to curb the development of Clinical Psychology . . . because of their limited training [psychologists] would miss underlying organic brain disease, or physical illness presenting with psychological

> symptoms . . . Psychiatrists . . . because of their comprehensive training were the natural leaders of clinical teams. (Shillitoe and Hall, 1997, 8)

In most of the above papers, gross differentials in pay, status and power between psychology and counselling remain unexamined.

Counsellors on counselling and clinical psychology

On the basis of the number of papers found on counselling in association with clinical psychology, and using the profession of the first author as an indicator, it would appear superficially that counsellors have substantially less interest in this area than clinical psychologists. This may, however, be a distorted picture, in part because of the comparative invisibility of counselling research in the mainstream literature.

The expansion of higher degree courses in counselling in UK universities over the past 20 years has encouraged developments in practitioner research among counsellors, as reflected for example in the growth in popularity of the British Association for Counselling and Psychotherapy's annual research conference and research network. However, despite high profile encouragement to practitioner researchers to publish (McLeod, 1994; McLeod, 1999), a simple comparison of the number of students who successfully complete an MA in counselling with that of published papers on counselling would suggest that the majority of masters' dissertations never appear in peer-reviewed journals. Moreover, nationwide academic search mechanisms (for example, the ASLIB index to theses) begin at PhD level. This situation is beginning to change, as doctoral programmes come on stream and the body of published counselling research accumulates, nevertheless, counselling is still in its academic infancy. Moreover, until there are more counselling PhDs and professional doctorates, counsellors are unlikely to be first authors when co-authoring with clinical psychologists (see, for example, Burton et al., 1995; Shillitoe and Hall 1997).

EXAMPLES IN THE LITERATURE

Hall (1997), writing from her experience as a counsellor working within a clinical psychology department, explores fears and hopes around counsellors and psychologists 'joining forces' across a number of primary care and hospital settings. She identifies the following fears:

- that counsellors would 'cherry pick' straightforward cases, leaving clinical psychologists with ever more complex cases;
- that counsellors might undercut/fragment existing services, threatening existing psychology jobs;
- that counselling might be second-class provision.

Among the hopes which Hall identifies as underlying the alliance between counselling and psychology in Airedale were those of:

- reducing isolation for counsellors especially in negotiating with purchasers – presenting a united front was to the benefit of both professions, in preventing fragmentation of services and deskilling of psychology;
- addressing the issue of unsupervised and isolated counsellors by providing therapeutic infrastructure for counsellors;
- sharing perspectives and ideas leading to new ways of working and avenues for research.

Writing about the same project, Shillitoe and Hall (1997) point out a number of additional issues. On a positive note, the presence of counsellors influenced the increased use of formal clinical supervision by all staff and introduced a rich variety of life experience.

However, (part-time) counsellors working in satellite settings found it harder than (full-time) psychologists at a central base to participate fully in an integrated team (Shillitoe and Hall, 1997). It may be that there are questions of age and perhaps gender here. Counsellors as a group tend to be older (Mountain, 1993) than clinical psychologists, for whom there is a well-established postgraduate training route. However, counsellors' relatively substantial and varied life-experience is acknowledged merely as a useful 'resource to draw upon' (Shillitoe and Hall, 1997) rather than as a possible source of therapeutic competence in itself.

Again, a cynic might note a number of other tacit (and as yet not evidence-based) assumptions in Shillitoe and Hall's text:

- that training, education and research equate with clinical competence;
- that counselling, as 'soft' therapy, has limited value in this environment dominated by the 'scientist practitioner';
- that psychologists are necessarily best placed and most competent to provide 'administration, support and supervision' for counsellors.

Whetton (1999) surveyed counsellors' and clinical psychologists' attitudes to working together. Although confirming mutual benefits from collaboration, she cautions that unaddressed role ambiguities may lead to counsellors becoming over-burdened with complex patients, without compensating benefits of status, pay and conditions.

THE FUTURE – KISSING COUSINS?

National Health Service mental health provision has moved on since the 1990s. The expansion of counselling is just one factor in a complex, changing situation in NHS psychological therapies, including, for example, the growth of therapeutic activity among other professions such as that of nurse-therapists specializing in cognitive behavioural therapies (Gournay, 2000), and moves to establish team-based community mental health services.

In 1997, the end of GP fundholding led to the termination of many primary care counselling contracts. (Primary care psychologists, directly employed by NHS, were less affected.) Counselling has risen to this challenge. Research has focused on an 'evidence-base' for counselling (for example, Rowland and Goss, 2000; Mellor-Clark, 2001). Counselling bodies are engaged in developing new and more rigorous professional standards (cf. http://www.bac.co.uk). Self-regulation looks likely. A core of clinically experienced NHS counsellors is growing, adapting counselling practice to local conditions and systemic demands. The UK's first professional counselling doctorates are under way.

National Health Service clinical psychology departments that recruited counsellors in the 1990s, effectively gained control of a good marketing idea (cf. Brunning, 1994). Where collaboration has occurred effectively, particularly in conjunction with psychodynamic psychotherapy, clients have enjoyed a range of therapeutic options within a single service. Clinicians have benefited, too: counsellors have learned to

be mental health professionals; psychologists have made supervision a practice norm. But this has not led to integrated specialist therapy units.

The trend of global capitalist institutions is towards bureaucratic, cost-led control, standardized practices and de-skilled labour. In parallel with the emergence of managed care in the US, the NHS has seen a variety of moves towards private finance and commercial-style management. There is clear management appeal in a much simpler NHS psychological therapies model in which relatively unskilled (and less well paid) generic mental health workers provide manualized therapies (provided by research psychologists) to the majority of those with mental health problems, with the support of prescribing professionals, primarily psychiatrists. (At present, there is still local variability in the degree to which this is implemented in the NHS. Figure 1 shows an example in which the specialist and generalist models operate contemporaneously.)

The proposed common NHS pay structure (see http://www.doh.gov.uk) under the Agenda for Change initiative, and ongoing implementation of team based mental health provision undoubtedly represent common challenges to all psychological therapists in the NHS. The question is, how will the various professions perceive their best interests and respond?

In the mid 1990s, in the face of pressures on psychological therapies from managed care, the American Psychological Association fell into inter-professional (and inter-paradigm) conflict (see for example, Beutler, 1998), triggered by an attempt by APA Division 12 (clinical psychology) to define a list of evidence-based therapies (Chambless et al., 1998). This was substantially detrimental to 'soft therapies' and arguably also to patient choice (Bohart, O'Hara and Leitner, 1998).

Although we face some similar systemic pressures (Proctor, 2002), maybe we still have an opportunity to write a different history in the UK.

The grey literature suggests that NHS patients prefer an accessible, individualized response to their psychological therapy needs (Hemmings, 2000); the clinical experience of some multidisciplinary psychological therapies teams is that such complementary working is not only feasible, but can promote best use of specialist skills (cf. Shillitoe and Hall, 1997).

Is it not in the interests of clients, clinical psychologists, counsellors and other therapists that we find a way to ensure continued public access to a broad range of therapists, with specialist training in both diagnosis-based psychological 'treatments' and more 'biographical' (Pickstone, 1984) approaches, such as counselling?

Doing so in the face of the systemic pressures outlined above would require substantial mutual understanding and co-operation between professions both at the level of clinical practice and that of research and evaluation. Finding a pragmatic common language and sustaining the necessary cross-paradigm dialogues would not be easy. More powerful professions would need to recognize that short-term pursuit of hegemonic professional interests and paradigms could exact a longer-term toll in the level of priority given to a less flexible psychological therapies 'package' by the wider mental health system.

However, it is only to the extent that we can find workable ways to co-operate among all the 'cousin' professions in the psychological therapies that we will be able to offer the best choice and most appropriate intervention to our shared clientele.

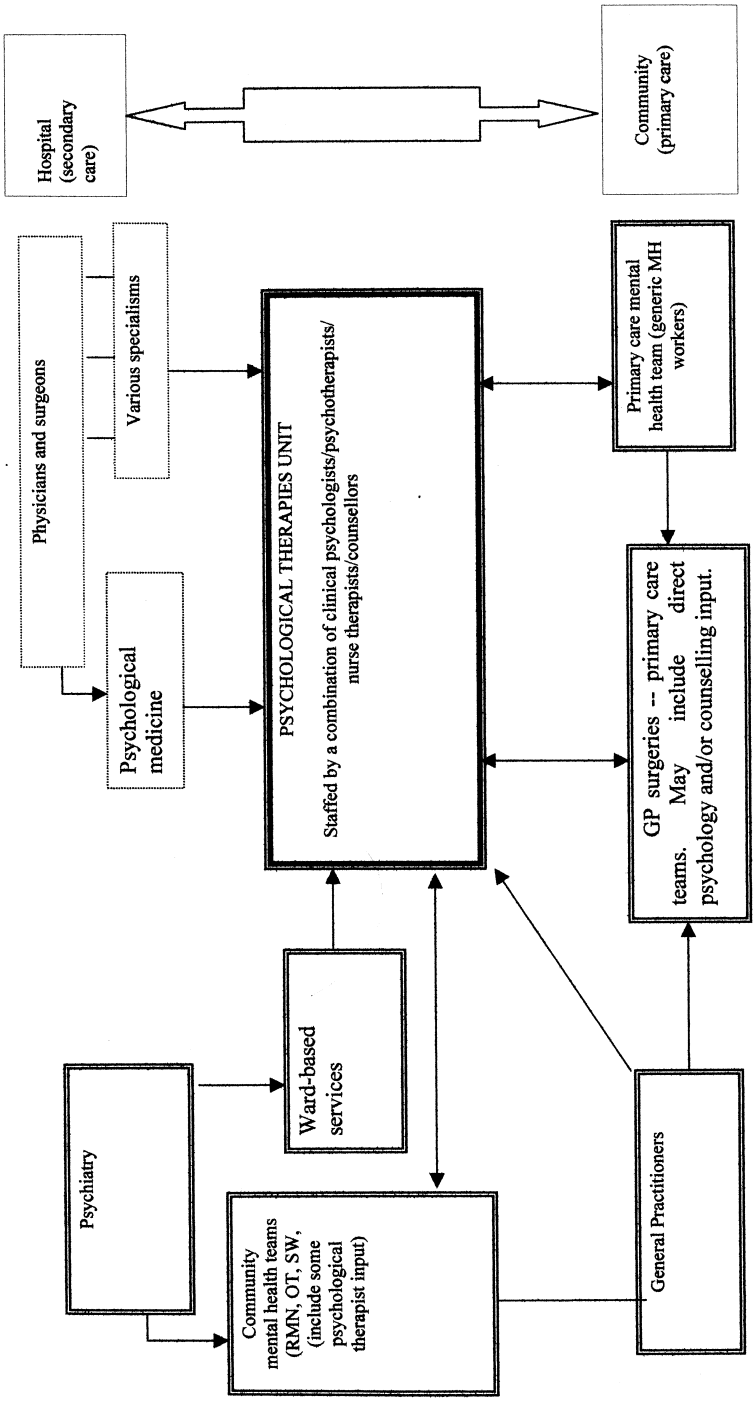

Figure 1. Example of systemic context for a psychological therapies unit.

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