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Evaluation of a Counselling Service for the Elderly

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Abstract

An evaluation of WellElder, a counselling service for the elderly, was conducted using four years of accumulated client information and counselling outcome data. This information was collated, analysed, and compared with the New Zealand literature and with information from other countries on counselling the elderly. Findings showed that there was considerable similarity between clients using the WellElder service and clients of all ages at other community-based services in New Zealand and abroad. In addition, outcome data demonstrated that the large majority of clients were receiving brief counselling, fewer than six sessions, and that the counselling being offered to clients was effective in meeting their needs. The implications of these findings are discussed in relation to agency policy and development.

Keywords: counselling the elderly, counselling outcome, counselling satisfaction, brief counselling

> *A wonderful service for those of us who are older, experienced, used to coping—but in need of redirection, support and an empathic boost to keep going with dignity.*—Counselling client

A brief description of WellElder

In 2007 the New Zealand government agreed to provide funding for a pilot, three-year counselling programme for people going through life changes related to ageing. The programme's overall aim was to prevent the onset of severe depression among the age group who used the service. The programme, called WellElder, was jointly funded by the Ministry of Social Development and Capital & Coast District Health Board. Additional financial support was provided by the Wellington City Council and several community organisations. The service was to be overseen by a board consisting of

people with interest and experience in elder care and counselling, including pastoral-based and private counsellors and people with strong links with Age Concern, the NZ Association of Gerontology, South East and City PHO (now Well Health), and Wesley Care. Three service options were to be offered to clients: individual counselling at the WellElder Centre, individual home-based counselling, and group-based therapy. It was expected that up to 290 people would access the programme during the three-year trial period, with each client eligible to receive up to six counselling sessions. Additional sessions could be provided depending on the results of a case review.

As it is presently organised, WellElder is a community trust providing the counselling service described above for people 55 and over living in the Capital & Coast District Health Board area, which includes Wellington City and Kapiti. This age is younger than the more usual 65 years and over that is designated as "elderly" in the literature, although a perusal of articles will quickly reveal that (a) no age limits are specified, or (b) various ages from about 50 up to 65 or older are defined as "elderly." The age of 55 was chosen by WellElder for several reasons: in recognition of the fact that Māori and Pasifika people tend to face ageing issues earlier than Pākehā; to provide services for those people with early onset of ageing-related conditions; and to provide support for caregivers who are often of a younger age.

Counselling is offered at the WellElder Centre in Newtown and in community rooms in Johnsonville and Paraparaumu, as well as in clients' homes or rest homes if client mobility is a problem. All clients are asked to contribute $10 or more per 50-minute session, but counselling is still available if clients are unable to afford this amount. Clients may self-refer or be referred by a general practitioner (GP) or other agency. To gain prior knowledge of the conditions in the home and ascertain whether there might be safety or privacy concerns, referrals are preferred for counselling in the home. WellElder also runs educational and growth groups for clients. All of WellElder's counsellors are full members of the New Zealand Association of Counsellors (NZAC) and are experienced in working with the elderly.

WellElder believes that although all people face challenges as they age, they are never too old to learn new skills, change their behaviour, grow in insight and understanding, or maintain good emotional health. Although older people are used to getting on with life themselves, it is recognised that a skilled professional can be useful at times by helping the elderly to:

- understand and move through depression;
- reduce personal anxiety and/or stress;

- make their own decisions about issues they find challenging;
- improve their relationships with others;
- develop their sense of well-being, or
- come to terms with events and decisions in their lives.

At WellElder, no issue is regarded as too big or too small to deal with: relationships, the loss of friends and family, living arrangements, memories that they live with, coping with the daily demands of life, anxiety, or depression. Whatever the elderly are facing may be brought to counselling. All discussions with counsellors are confidential, except if there is significant risk of harm to the client or someone else. However, with clients' permission, counsellors pass on their pre- and post-ORS scores (see Outcome Rating Scale, p. X) to referrers such as GPs or specialist health agencies who will continue as ongoing carers.

After four years of operation and accumulating client data, WellElder's management decided to summarise and analyse this client data as part of an evaluation of the counselling services being delivered. This decision reflects one of the original goals of the service which was to "Support research into practice-based evidence to assess/monitor the effectiveness of counselling with older people in routine practice and home settings." This evaluation was designed to:

- review and compare WellElder's client statistical data with the literature on counselling the elderly;
- assess the current functioning of WellElder's services;
- identify the strengths and weaknesses of the services being offered to WellElder's clients;
- identify areas of development and potential for future development.

Several types of evidence were collected including historical and current statements about the services offered, demographic data on all clients enrolled with WellElder, client estimates of counselling outcome, and a review of related literature on counselling the elderly.

Counselling the elderly

Published information in New Zealand on the setting up and effective operation of a community-based counselling centre for the elderly is non-existent. Information on counselling agencies in general is also scarce. The few New Zealand studies that have reported data on the utilisation of mental health services have tended to use small samples gathered over a short time period (Bridgman, 1994; Hornblow, Bushnell,

Wells, Joyce, & Oakley-Browne, 1990; Parkin, 1991; Wivell & Webb, 1995). A limitation of this data is that so little of it has been collected from the same agency and almost none of it has been collected over several consecutive years. However, more recently Manthei and Duthie (2003a, 2003b) and Manthei (2012) described in some detail the work of a community-based counselling agency in Christchurch that spanned several years. Although the data included information from clients across the age span, from younger than 20 years of age to those over 50, they were thought to be useful for general comparisons with the WellElder data in this report.

While it is accepted that counselling the elderly can be similar to counselling younger clients (Karel & Hinrichsen, 2000), there exists substantial overseas literature on counselling the elderly and therapeutically supporting their caregivers and family members, especially if social work and nursing sources are included with the psychology/therapy literature. Much of this material makes a strong case for offering specialised counselling for the elderly and provides recommendations for doing it knowledgeably and effectively (Bernstein, 1990; Ganote, 1990), including the importance of the counsellor understanding the elderly client's cultural environment and ethnic identity (Harris, 1998; McInnis-Dittrich, 2005).

There are numerous problems or conditions for which the elderly might need or seek specialised counselling. It is estimated that in the USA, half the population over the age of 65 is in need of mental health help but fewer than 20% receive it (Benek-Higgins, McReynolds, Hogan, & Savickas, 2008). Among the problems for which they might need help are depression, which is perhaps the most common, yet underdiagnosed, condition of the elderly (Hill & Brettle, 2006; Lebowitz et al., 1997); suicidal thoughts (Benek-Higgins et al., 2008; Heisel, Duberstein, Talbot, & King, 2009; Ho, 2007; Karel & Hinrichsen, 2000; Kuruvilla, Fenwick, Haque, & Vassilas, 2006; Weaver & Koenig, 1996); addiction, including alcohol, medication misuse, and illicit drug use (Briggs, Magnus, Lassiter, Patterson, & Smith, 1990; Norton, 1998); loss (of friends, status, income, identity, function) (Ganote, 1990; Jensen-Scott, 1993); change, including entering retirement (Jensen-Scott, 1993; Norton, 1998), and anxiety (Hill & Brettle, 2006).

Several writers have commented on the difficulty of correctly diagnosing the mental health problems of the elderly (Benek-Higgins et al., 2008; Karel & Hinrichsen, 2000; Lebowitz et al., 1997; Smyer, 1990). For example, depression can be especially difficult because the symptoms may be masked by the changes brought about by normal ageing and are often compounded by other physical problems or complicated

by other issues (Benek-Higgins et al., 2008; Smyer, 1990). Even a reluctance to report symptoms and/or an uncomplaining stoicism in the face of difficulties can complicate accurate diagnosis (Benek-Higgins et al., 2008; Haley, 1999; Kunkel & Williams, 1991; McInnis-Dittrich, 2005; Norton, 1998).

It has been recommended that those living with or caring for the elderly might also need emotional support and professional counselling since the role of caregiver can be challenging and can exact an emotional toll. For example, caregivers and/or family members may need help in planning for their own future as carers, or in dealing with stress and fatigue. They might also need help dealing with anger or guilt they may feel toward the elderly adult in their care (Ganote, 1990; Toseland & Smith, 1990). In recognition of these difficulties, Florsheim and Herr (1990) and Eisenberg and Carrilio (1990) have stressed the importance of working with the elderly within their family context, which is often their primary social support system.

For counsellors of the elderly to be effective, they need to be knowledgeable about developmental matters unique to the elderly. Bernstein (1990) listed a number of specialised areas of knowledge that are essential for effective counselling. In essence, counsellors need to understand how the elderly age and how they react to that ageing and to loss. This includes understanding both the normal ageing process and the common problems of ageing, such as biological loss; emotional reactions to changes in health, family, work, and social networks; and fear of change and diminished potency in key areas of life. Similar problems were identified by Norton (1998), but also included others specific to the elderly struggling with an addiction, such as the potential complications associated with taking multiple medications and dealing with the irrational beliefs that are typically related to substance abuse. The elderly also face challenges adjusting to retirement (Jensen-Scott, 1993).

To be effective, counsellors need to possess certain personal characteristics such as a liking for older people, the ability to view them positively, objectivity about their needs and desires, and an acceptance of their own ageing process (Bernstein, 1990). In addition, it may be necessary to work at a slower pace, especially when there is a need to accommodate to their clients' physical, sensory or cognitive deficits (Karel & Hinrichsen, 2000, p. 711). Counsellors may also need to be quite flexible in how they work: in terms of session length; frequency of meetings; where the counselling is conducted; in assuming a more active role than might be typical of traditional counselling relationships; and a willingness to use a variety of methods or techniques such as music, art, drama, and animals/pets (Bernstein, 1990; McInnis-Dittrich, 2005).

A working knowledge of family systems theory is helpful (Florsheim & Herr, 1990; Karel & Hinrichsen, 2000), as could assuming the role of teacher or information-giver when dealing with clients about the process of ageing and their reactions to that process (Bernstein, 1990).

Counselling the elderly is most typically delivered face-to-face in a one-to-one situation, but other methods or modalities are used, or chosen by older people: by telephone (Ko & Lim, 1996); in group settings (Thomas & Martin, 1992); using peer counsellors (Bratter & Freeman, 1990; Ho, 2007; Smith, Tobin, & Toseland, 1992; Toseland & Smith, 1990), or via clergy (Weaver & Koenig, 1996). Even the healing potential of humour related to death and dying has been noted in working with the elderly (Richman, 2006). In fact, this variety of modalities/methods is not substantially different to the ways in which traditional therapy is delivered to clients of all ages.

There is some evidence that elderly counselling clients are different in several respects from younger clients. Kunkel and Williams (1991), for example, found that a sample of 65- to 87-year-olds were more reluctant to seek counselling than were a sample of university-aged students, perhaps due to a greater sense of self-reliance and stoicism when dealing with personal problems, or wanting to avoid the stigma of being seen as needing outside help to cope with life's problems (Benek-Higgins et al., 2008). Greater stressors later in life compared to those experienced at younger ages may lead older people to become late-onset substance abusers (Norton, 1998). Compared to younger people, they may also prefer to seek help from someone other than a counsellor, such as from their doctor if they interpret their emotional symptoms as behavioural (Haley, 1999) or from their clergy with whom they might feel more comfortable (Weaver & Koenig, 1996).

The elderly have some preferences for what happens to them once they are in counselling. For example, there is some evidence that they prefer being treated in the community, that is, in a primary care setting (Gum et al., 2006). In addition, Hill and Brettle's (2006) review of research on counselling of the elderly found that those living in the community preferred individual to group counselling even though the majority of the studies they reviewed involved group treatment, perhaps for reasons of the professionals' or agencies' convenience and efficiency (Thomas & Martin, 1992). Interestingly, counselling was often said to be unavailable for the elderly in community-based health care settings. In contrast, those in residential care may prefer group counselling, but this finding needs confirmation.

Although both medication and psychotherapy have been found to be effective in

treating depression among the elderly (Karel & Hinrichsen, 2000), Gum et al. (2006) found that among a large sample of depressed elderly clients, 57% preferred counselling to medication, especially if they had previous counselling experience. Being male and suffering severe depression predicted a preference for treatment using medication. In a similar study, Kuruvilla et al. (2006) compared the attitudes of depressed elderly clients toward three treatments: antidepressants, ECT, and psychotherapy. The results showed that the elderly thought psychotherapy was just as effective as antidepressants, but with fewer side effects. ECT was viewed unfavourably.

The elderly seem to respond well to counselling (Benek-Higgins et al., 2008; Bernstein, 1990; Norton, 1998). Hill and Brettle (2006) reviewed 47 outcome studies of counselling with people over the age of 50. The studies used a variety of research designs, were conducted in a range of settings (the community, nursing homes, and hospitals), used diverse modalities, and were all rated as either excellent or good in quality. The review found that counselling older people was effective for depression and anxiety and for improving overall subjective well-being; in fact, counselling was just as effective as it has been shown to be for younger people. Age was not a factor in determining the success of interventions. This review supported the earlier findings of Bernstein (1990), who reported a body of statistical and anecdotal evidence that the elderly benefited from professional counselling. Although Heisel et al. (2009) found that evidence for counselling the elderly who were at risk of suicide was scarce, their own results suggested that a small sample of 11 clients benefited from interpersonal psychotherapy in both subjective functioning and measurable improvement in suicide ideation and signs of depression. Ko and Lim (1996) evaluated the effectiveness of telephone counselling for the elderly in Singapore. Results were positive and demonstrated that counselling by telephone could be effective for older callers with a variety of problems.

The use of peer counselling with the elderly and with caregivers has also been studied. According to a study by Toseland and Smith (1990), peer counselling with caregivers to help with the stress of caring for the elderly was as effective as professional help. Bratter and Freeman (1990) reviewed the literature on peer counselling of the elderly and found that it could be as effective as professional counselling with the elderly, and sometimes even more so. Some advantages of peer counselling, they reported, were that older people were often more willing to talk to a peer than to a professional, peer counsellors served as positive role models, and peer counsellors themselves often benefited from the relationship. Smith et al. (1992), however, found that although caregivers counselled by both professional and peer counsellors reported an

improvement in coping skills and caregiver stress, the process engaged in by professional counsellors was superior to that used by peer counsellors in a number of ways: they were perceived as warmer and more friendly; they engaged in more exploration behaviour with their clients, and, contrary to expectations, they gave more advice. Overall, it seems that according to outcome rather than process measures, peer counsellors can be just as effective as professionals with the elderly and their caregivers.

In summary, sufficient overseas evidence exists to demonstrate that counselling services for the elderly and their caregivers are needed and can be delivered effectively in a variety of ways by professionals or peer counsellors. Building on this literature, this report summarises and compares four years of data from a New Zealand agency providing professional counselling to the elderly, along with existing reports and findings.

Method

In carrying out this evaluation, the data were collected using the following procedures.

Client demographic data

As part of the standard client intake procedure at WellElder, the administrator records specific information about each new client. This data includes client gender, age, and ethnicity; referral source; reason(s) for seeking counselling; and the type and location of service provided. Client intake data were aggregated for each of the four years and the results are shown in Table 1.

Table 1. Client demographic information for the years 2008–2011

Category	2008	2009	2010	2011	Ave/yr*	Ave 2009–11*
1 Total clients for the year	64	178	173	220	159	190
2 New clients during the year	57 89%	159 89%	151 87%	167 76%	131 82%	159 84%
3 Continuing clients from previous year	— —	19 11%	33 13%	53 24%	— —	33 16%
4 Gender of new clients						
Male	16	39	31	34	30 23%	35 23%
Female	41	112	120	127	100 77%	120 77%
5 Age of new clients						
<60 years	7	12	11	15	11 8%	13 8%
60–69	16	32	41	39	32 24%	37 23%

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Category	2008	2009	2010	2011	Ave/yr*		Ave 2009–11*	
5 Age of new clients contd								
70–79	18	56	51	57	46	35%	53	33%
80–89	8	34	32	34	27	20%	33	21%
90+	3	11	5	12	8	6%	9	6%
Not known	4	6	11	5	7	5%	7	5%
6 Average age per year	71yrs	74	73	73	72.7		73	
7 Ethnic group of new clients								
Chinese	1	1	1	0	1	1%	1	1%
European/Pākehā	51	176	142	150	137	95%	156	95%
Indian	1	1	2	3	2	1%	2	1%
Māori	1	2	6	3	3	2%	4	2%
Other Asian	1	0	0	0	0	—	0	—
Other ethnicity	0	1	0	1	.5	0%	1	1%
Pacific Island	1	0	0	3	1	1%	1	1%
Unknown	0	0	0	1	0	—	0	—
					Sum =144		Sum =165	
8 Where counselling sessions were provided:								
Home visits	172	332	295	262	265	48%	296	47%
Johnsonville Community Centre	5	32	30	53	30	5%	38	6%
Rest home	17	58	68	81	56	10%	69	11%
Riddiford House	63	120	130	133	112	20%	128	20%
Kapiti Disability Centre	0	93	61	102	85	15%	85	13.5%
Hospital visit	0	0	4	8	3	.5%	4	.5%
Other	1	3	9	11	6	1%	8	1%
					Sum =557		Sum =628	
9 Currently living								
Rest home	6	15	10	8	10	6%	12	6%
With family/whānau	2	4	5	10	5	3%	6	3%
Own home	29	88	51	41	52	33%	60	32%
Rental	10	10	17	13	12	8%	13	7%
Retirement village	6	12	7	6	8	5%	8	4%
Hospital	—	—	—	1	0	0%	0	0%
Other	3	—	—	2	0	0%	1	0%
Not known	8	49	83	139	70	45%	90	47%
					Sum =157		Sum =190	

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Category	2008	2009	2010	2011	Ave/yr*		Ave 2009–11*	
10 Referral source								
Self-referred	15	23	26	35	25	19%	28	19%
Care Coordination Centre	1	5	6	10	6	5%	7	5%
Doctor	6	19	37	36	24	18%	31	21%
Hospital	2	11	14	4	8	6%	10	7%
Mental health service	1	0	0	5	2	1%	2	1%
PHO	2	12	18	23	14	11%	18	12%
Psycho-geriatric unit	1	2	2	1	2	1%	2	1%
Wellington City Mission	6	0	0	2	2	1%	1	.5%
Wesley Care	3	2	2	0	2	1%	1	.5%
Age Concern	0	1	0	1	1	1%	1	.5%
Victim Support	0	1	0	1	1	1%	1	.5%
Friend/family/other client	0	5	18	23	12	9%	15	10%
Rest home	0	2	3	6	3	2%	4	3%
MS Society	0	0	1	2	1	1%	1	.5%
Alzheimers Assn	0	0	0	2	1	1%	1	.5%
Another health provider	0	0	0	2	1	1%	1	.5%
Cancer Society	0	0	0	1	0	0%	0	0%
Not known/other	18	62	11	13	26	20%	27	216%
					Sum =131		Sum =151	
11 Reason(s) for referral for counselling (can be multiple)								*Rank*
Alcohol/drug use	3	2	0	3	8	4%	2	8
Anxiety	16	35	35	46	33	18%	39	2
Depression	22	62	49	59	48	26%	57	1
Grief and loss	7	35	28	35	26	14%	33	4=
Health reasons	7	25	26	44	25	13%	32	4=
Living situation	4	12	7	19	11	6%	13	6
Loneliness	2	11	13	7	8	4%	10	7
Relationships	11	31	35	29	27	15%	32	4=
					Sum =186		Sum =218	
12 Issues clients chose to work on in counselling								*Rank*
Abuse	—	5	5	5	—		5	11=
Alcohol/drug use	—	8	2	1	—		4	11=
Anxiety	—	49	25	34	—		36	5

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Category	2008	2009	2010	2011	Ave/yr*	Ave 2009–11*	
12 Issues clients chose contd							*Rank*
Depression	—	56	23	41	—	40	4
Grief and loss	—	61	38	45	—	48	3
Health	—	102	47	56	—	68	2
Living situation	—	23	13	19	—	18	8
Loneliness	—	42	27	17	—	29	6
Memories	—	20	9	17	—	15	9
Relationships	—	111	61	53	—	75	1
Spiritual	—	14	7	9	—	10	10
Other	—	29	22	30	—	27	7

* The 64 new clients seen in the first year of operation (2008) was considerably fewer (only 34%) than the yearly average of 190 new clients for the three years 2009–2011. Thus, yearly averages have been calculated using the figures for the last three years even though data for all four years are shown.

Counselling sessions

As clients progressed in counselling, additional information was gathered: the total number of sessions conducted; the number of clients who missed sessions; the number who booked an initial session but never attended (referred to as "no shows"); the number who postponed counselling sessions; the average number of sessions for all clients, and for males and females separately; the average length of contact with WellElder; and the number of times additional sessions beyond the standard package of six sessions were approved. This counselling information is summarised in Table 2.

Outcome Rating Scale

In this study, the Outcome Rating Scale (ORS) (Miller, Duncan, Brown, Sparks, & Chand, 2003) was used as a broad measure of counselling effectiveness. The ORS was originally developed as an ultra-brief alternative to the 45-item Outcome Questionnaire (Lambert et al., 1996). The ORS is a four-item questionnaire that has been found to be easy to explain to clients, quick to administer, and straightforward to interpret (Campbell & Hemsley, 2009; Miller et al., 2003). It has demonstrated good reliability and sufficient, though moderate, construct validity compared to lengthier scales (Campbell & Hemsley, 2009; Miller et al., 2003). Although test-retest reliability was rather low (an average of .57 over three administrations during the course of counselling), since it was to be used as a measure of change, this level was expected and thought to be acceptable. Most importantly, it reflected change in a clinical sample of

Table 2. WellElder client counselling information for the years 2008–2011

Category	2008	2009	2010	2011	Ave 2008–11*	Ave 2009–11*
1 Total sessions scheduled	300	788	745	761	649	765
2 Counselling sessions conducted	258	638	597	650	534	628
3 Missed sessions during the year	16 18	5% 2%	32 25	4% 4%	33 28	4% 4%
4 Postponed counselling sessions	26	118	113	93	88 14%	108 14%
5 Ave # of sessions for clients seen during the year						
Male	4.9	3.9	3.5	4.0	4.1	3.8
Female	4.4	4.3	4.1	3.9	4.2	4.1
6 Ave # of sessions for clients who completed counselling	5	5	4	4	4.5	4.3
7 Ave length of stay for those completing each year (in days)	113	345	84	73	154 days	167 days
8 Number of additional sessions approved as % of number conducted each year	22 9%	24 4%	44 7%	52 8%	35.5 6.6%	40 6.4%
9 Number of clients returning for a "second package of care"	0	3	12	11	6.5	8.7

* The 64 new clients seen in the first year of operation (2008) was considerably fewer (only 34%) than the yearly average of 190 new clients for the three years 2009–2011. Thus, yearly averages have been calculated using the figures for the last three years even though data for all four years are shown.

clients ($p < .00001$), and showed no significant change in a sample of non-clinical subjects ($p > .01$) (Miller et al., 2003).

Although the scale purports to assess three areas of functioning (individual, relational, and social) plus a global assessment of daily functioning, the high correlation among the four items (.96) meant that the scale could be thought of as a single global measure of client functioning. Because of this, only an overall score has been used in this analysis to measure clients' progress over the course of their counselling. Clients completed the ORS by placing a mark on a 10-cm line immediately below each item, with 0 indicating a negative state and 10 being positive. A global ORS score was generated by summing the marks made by clients on each of the four 10-cm lines

to the nearest millimetre, giving a minimum score of 0 and a maximum of 40 (Hafkenscheid, Duncan, & Miller, 2010). All WellElder clients were asked to complete the ORS at least twice: at the first session of their counselling, and again at the last session. The difference in ORS scores was calculated and tested for significance (see Table 3).

This evaluation had two limitations that may have affected the results.

1. Although an effort was made to obtain full and complete demographic and counselling effectiveness data from all clients attending WellElder across the years 2008–2011, there may be some clients whose data was not collected, or was miscategorised or misplaced. However, the number of such instances is thought to be tolerably low and should not have substantially affected the tabular data summaries or conclusions drawn from those summaries.

2. The 57 new clients seen in the first year of operation (2008) were only 36% of the yearly average of 159 new clients for the three years 2009–2011. If included in the calculation of means, this low number would have skewed some of the trends over the four-year period. Thus, to eliminate this possibility and present a more typical description of the agency's level of activity, three-year averages have been calculated (years 2009–2011). However, where available, raw data for all four years are shown in Tables 1 and 2.

Results and discussion

New clients using WellElder's services

Based on the information in Table 1, a composite picture of the typical new client can be drawn. Four out of every five new clients would be a Pākehā woman with an average age of 73 years. The typical client would most likely have been referred by a doctor or other medical service (42%) to get help with depression or anxiety, the most commonly cited referral problems.

In addition, based on the information in Table 1, the following comments seem warranted.

1. In spite of the lower number of new clients seen in the first year (57 versus an average of 159 for each of the next three years), WellElder saw 27% more clients in the first three years (367) than the 290 anticipated when it was established in 2008. This suggests that there was an unmet need for such counselling in the greater Wellington area. Interestingly, the yearly average of 159 new clients is virtually the same number (160 over four years, 2006–2009) that was seen in the 50+ age category at Petersgate

Counselling Centre in Christchurch (Manthei, 2012). This represents about three new clients per week and indicates a steady demand for this service. It is quite likely that this number could rise substantially over the next five to ten years as it did at Petersgate (Manthei, 2012), which saw a 186% increase, from an average of 56 elderly clients per year for the five years 1997–2001 to 160 for each of the years 2007–2010.

2. Significantly more females than males become new clients each year (77% vs 23%). This figure is higher than the percentage of female clients of all ages at Petersgate (63% vs 37% males) (Manthei, 2012), but closer to the 73% female clients reported by Parkin (1991) at a Presbyterian Support centre. This figure mirrors the trend in New Zealand and overseas for more women than men to use mental health services across all ages (Parslow & Jorm, 2000 [Australia]; Rhodes, Goering, To, & Ivan, 2002 [Canada]) and echoes research in New Zealand that has shown that women have demonstrably more positive attitudes toward seeking psychological counselling than men (Deane & Chamberlain, 1994; Surgenor, 1985). This gender difference also reflects the fact that there are more females than males as both sexes age, because women have a longer life expectancy than men (Statistics New Zealand, 2000). It is debatable whether WellElder could achieve a gender balance among its clients that reflects the male/female ratio in the population for each age group.

3. Ninety-five percent of clients were identified as Pākehā. The next highest ethnic user group was Māori (2%). This imbalance is striking but generally in line with other New Zealand counselling services, where Pākehā are by far the largest users (Deane, 1991 [93%]; Manthei, 2012 [83%]; Parkin, 1991 [86%]). This trend is also similar to what has been reported in the USA, where White people are typically the predominant users of mental health services (e.g., Diala et al., 2000; Doblian & Rivers, 2008).

4. Most clients were seen either in their own home (48%) or at the two WellElder centres or two other community venues (40%). For the latter group, this suggests that mobility is not a problem that prevents them from seeking help. These figures are not too dissimilar to USA data reported by Bratter and Freeman (1990) in their survey of some 80 agencies, where 33% of elderly clients were counselled in their homes and 44% were seen at an agency or senior centre, and fits with the finding of Gum et al. (2006) that the elderly prefer being treated in the community.

5. Most clients were referred to WellElder by a doctor, another medical organisation, or by a disability support organisation (43%). This figure is slightly higher than the 38% in the Petersgate summary (Manthei, 2012), but lower than the 46% reported in an earlier New Zealand study (Deane, 1991). This percentage makes sense given the greater

likelihood of people over the age of 65 needing and receiving medical support. It also suggests that similar counselling agencies should ensure that up-to-date information advertising their services is readily available at and delivered annually to all medical service providers in the area.

6. Twenty-nine percent of clients were either self-referred or referred by family or friends. This figure is lower than the 49% for Petersgate clients (Manthei, 2012) and the 50% reported by Parkin (1991), supporting the notion that older clients are more stoical (Benek-Higgins et al., 2008) and less likely to seek counselling than younger people (Kunkel & Williams, 1991). However, the proportion of WellElder clients self-referring has grown over time, an unsurprising trend for a new and successful agency. This trend also suggests that advertising in the wider community and trusted venues such as medical practices may be an important way for many clients to learn about the service.

7. The most common reason for clients being referred to WellElder was depression, followed by anxiety (ranked one and two, respectively; see Table 1, Category 11). These two reasons were followed by grief and loss, health problems, and relationships, all of equal frequency. These five concerns and their rankings are not too different from those cited in the Petersgate review (Manthei, 2012) and overseas literature that suggests that depression, anxiety, and loss of various kinds are common reasons for the elderly seeking counselling (Hill & Brettle, 2006; Norton, 1998).

8. Once engaged in counselling, many clients chose, not surprisingly, to address a broader range of issues than those for which they were originally referred or sought counselling. The two highest ranking areas of concern were relationships and health (see Table 1, Category 12). The most frequently explored relationships were with adult children (39%) and with partners (28%). Relationships with extended family (12%), neighbours (12%), and carers or health professionals (8%) were also raised. In regard to their health, clients used counselling to discuss their emotional responses to and strategies for living effectively with health issues, including chronic illness, general or declining health, sleep difficulties, the effects of a stroke, and a range of other health issues.

Another cluster of issues that were addressed by a substantial number of clients included grief and loss, depression, anxiety, and loneliness, ranked three to six, respectively. Although they appear in a slightly different rank order, the first five concerns for which clients were referred and those issues they chose to address in their counselling are the same. Other matters raised with some regularity were clients'

living situations, such as a possible or recent move to a rest home or living with family, memories with which clients wished to come to terms, and spiritual or existential issues. Relatively few clients raised abuse or their alcohol or drug use as issues of concern.

Counselling received by new clients

Based on the information in Table 2, a composite picture of the typical course of counselling for a WellElder client can be described. On average, new clients will have between four and five counselling sessions. Typically, they schedule their first three or four sessions weekly or fortnightly and then spread the last one or two over a longer interval. Once the initial counselling session has been scheduled, the client is almost certain to attend; seldom does a client miss a session or postpone one. Fewer than 7% of all clients are granted additional sessions beyond the standard number of six, suggesting that the relatively brief course of five or so sessions of counselling is sufficiently effective for the large majority of clients. The small number of "no show" clients (< 1%; not shown in Table 2) and missed sessions (4%) is notable. Even the number of postponed (but rescheduled) appointments seems modest at 14%. It seems reasonable to suggest that these figures describe a clientele that is highly motivated to engage in counselling and conscientious about keeping appointments and making good use of their counselling time. Perhaps this attitude is characteristic of the elderly, since the level of participation by WellElder clients was consistent with the high participation rates of the elderly noted in the research by Gum et al. (2006) and Kuruvilla et al. (2006).

These low rates of "lost" sessions are even more remarkable when compared with other research. For example, Manthei (2012) reported that the percentage of "no shows" and "late cancellations" at Petersgate was 24%, while another large counselling service in New Zealand has reported a "no show" rate of 15% (personal communication with the chief executive officer). WellElder's rate is also enviable in comparison with overseas studies in which dropout rates in counselling (and it needs to be pointed out that "dropout rate" in the literature is variously defined) can be as high as 47–50% (Hatchett, 2004; Hubble, Duncan & Miller, 1999; Wierzbicki & Pekarik, 1993). Several factors might contribute to the low rate: WellElder has no waiting list—clients are seen almost immediately; there are no mandated (and, therefore, possibly reluctant) clients; all appointments are confirmed in writing; and clients often comment about the warm, welcoming staff with whom they make first contact.

In addition, based on the information in Table 2, the following comments seem warranted.

1. The average number of sessions (4.3) is generally considered to be "brief counselling" and is similar to the 4.8 recorded at Petersgate Counselling Centre (Manthei, 2012). It seems that across different types of client problems, gender, and ages, counselling at community agencies can typically be expected to be five sessions or fewer. Overseas research has reported similarly low numbers of sessions for clients of all ages: for example, an average of 5.6 for Gallagher's (2010) survey of 320 American university counselling centres (this average has remained quite consistent over several years); 3.1 sessions in Lambert, Okiishi, Finch, and Johnson (1998); and 2–4 sessions in Reimer and Chatwin (2006).

2. The low number of clients who were approved for additional sessions beyond the standard six also suggests that this brief counselling experience was effective and sufficient, at least for the time being. The 6.4% for whom additional sessions were granted is considerably lower than the 20% of clients at Petersgate (Manthei, 2012) who received more than six sessions. One possible difference is the fact that there is no initial limit placed on the number of sessions at Petersgate, whereas at WellElder, where they know they are allowed up to six sessions, clients may work more efficiently during those six meetings, not realising or expecting they could apply for more. This typical brevity of counselling has implications for how counselling is conceived, structured, and delivered, and how it is promoted to WellElder's potential clients, referring agencies, and other health professionals.

Counselling effectiveness

The data related to counselling outcome is presented in Table 3. For the total number of clients (204), and for females (159) and males (45) considered separately, it is clear that the counselling they received at WellElder was effective. The mean differences in each group's pre- and post-counselling scores on the ORS were highly significant. This finding was consistent with the results of Hill and Brettle's (2006) review of counselling outcome studies, which determined that the elderly benefited from professional counselling. It is also important to note that the mean pre- and post-counselling scores of WellElder clients were remarkably similar to those of the clinical sample reported in Miller et al. (2003). This close similarity lends support to the effectiveness of WellElder's counselling programme and demonstrates that the ORS is suitable for use in New Zealand.

The higher male intake ORS score in the clinical sample reported in Miller et al. (2003) (22.3 vs 18.9 for females) was closely mirrored in the WellElder sample, with

Table 3. WellElder client Outcome Rating Scale scores

	Pre-counselling		Post-counselling		Difference		Test of significance	
	Mean	SD	Mean	SD	Mean	SD	t	P <
Total clients (n = 204)	19.7	7.4	28.2	7.3	8.6	7.2	17.0	.00001
Females (n = 159)	19.2	7.5	28.1	7.5	8.5	7.5	14.9	.00001
Males (n = 45)	21.2	6.9	28.7	6.2	7.5	5.8	8.6	.00001
Clinical sample (n = 435)*	19.6	8.7	25.7	8.7	6.1			.00001
Clinical sample Females*	18.9	8.7						
Clinical sample Males*	22.3	8.5						

* From Miller et al. (2003).

the average male pre-counselling score of 21.2 being higher than the female's average of 19.2. Although this gender difference was significant in the data of Miller et al. (2003), it was not in the WellElder data ($p < .1$). Just what this gender difference means for counsellors is not immediately obvious, but it might contribute to the explanation of the differential use of counselling by males and females. If males tend to see themselves as more healthy or in control of their lives, they would see less need to seek help from outside professional support.

When the range of individual pre- and post-counselling ORS scores was looked at, it was found that 155 clients (76%) had registered a gain of more than 3.5 on their post-counselling ORS scores (about half the standard deviation of the total clients' mean difference score; see Table 3). This rate of "improvement" following counselling is similar to that reported in the literature (see, for example, Lambert & Cattani-Thompson, 1996). In addition, when pre- and post-test ORS scores were looked at more closely, there were an additional 19 clients who had gained fewer than 3.51 points but actually had post-counselling scores higher than the group average of 28. Clearly, these 19 clients were already functioning at a relatively high level before they began their counselling and their high rate of functioning continued following counselling. Because of this, it seemed inaccurate to exclude them from those considered to have benefited. Thus, when they were added to the group of 155 who had gained at least 3.5 points, the proportion of clients who benefited from counselling was higher, at 85%.

In order to see how many clients made minimal or negative gains following counselling, all clients whose ORS scores increased by less than 3.51 were further

analysed. Again, this cut-off point was about half the standard deviation of the total clients' mean difference score. There were 49 such clients, or 24% of the total of 204. When the 19 clients who had post-counselling scores higher than the group average of 28 were removed, there were 30 clients, or 15% of the total, who made minimal or no gains in counselling. Three had a difference score of zero, and the number who actually registered a negative gain was 21 (10%). This rate is very similar to the 8% deterioration rate of community-based clients reported by Hansen, Lambert, and Forman (2002) and the 5–10% deterioration rate reported in Lambert and Ogles (2004). Overall, these findings confirm that WellElder's counselling programme was successful when compared with international findings.

Conclusions

In this study, we assessed the success of a pilot counselling programme for people aged 55 years and older who were going through life changes. First, four years of WellElder's client data were reviewed and compared with the literature on counselling the elderly and found to be similar in most respects. For example, the marked imbalances in client gender and ethnicity are the same as those reported by almost every other agency, in New Zealand and overseas. These imbalances would be difficult, if not impossible, to remediate in the short term. Although published client demographic data on the elderly collected from one agency over several consecutive years is not common in New Zealand or overseas, the present data indicate that over the first four years of WellElder's existence the type of clients it has served, their backgrounds, and their demographic characteristics have changed relatively little. Taken together, this sort of descriptive information can be used by this agency in planning future services and staffing, anticipating and controlling costs, and critiquing existing policies.

The number of new WellElder clients seen each year has exceeded the original target figure, which provides strong support for the decision to set up the pilot programme and demonstrates a clear need for a counselling service for this particular age group. It also suggests that similar services for the elderly would be well-patronised in other areas of New Zealand, particularly if they were community-based, according to Thomas and Martin (1992). Furthermore, it would be useful if other such counselling agencies collected and shared similar data from their own clientele. By this means, regional, national, and international comparisons and discrepancies among agencies could be identified and investigated. New Zealand's counselling profession has a need for this basic sort of information if it is to claim that it is fully professional and research-based.

Second, the effectiveness of the counselling provided at WellElder was assessed and demonstrated. Research on counselling effectiveness with clients spanning a wide age range has been reported previously in New Zealand (Manthei, 2005; 2007a; 2007b; 2012) and the data presented in this article supplement that information by focusing on people over the age of 55 years. It has long been thought that filling this gap in the counselling literature was an important step for the counselling profession, both to give some factual basis to the assumption that New Zealand clients behaved similarly to overseas clients, and to provide credible evidence of counselling effectiveness to the public and outside funding bodies.

The outcome measure used in this study (the ORS) is being promoted and utilised internationally as a pragmatic, ethical, and simple means of assessing counselling effectiveness (see, for example, Hafkenscheid et al., 2010, where results in the Netherlands were largely consistent with American studies). Although ORS data are now being collected in several other agencies in New Zealand, this is the first time to our knowledge that such data have been analysed and reported formally here. The scale was found to be brief and easy for clients to complete. More importantly, the fact that the outcome results were similar to the overseas data (Miller et al., 2003) helps to validate the effectiveness of the counselling being offered at WellElder. It would be useful if other New Zealand counselling agencies, whether they are working with the elderly, some other identifiable demographic group, or the general public, would contribute to and extend this line of research using the ORS.

Third, the results of this assessment highlighted some of the strengths and weaknesses of WellElder's service. For example:

- the heavy and growing use of the WellElder counselling service demonstrated that it was meeting a need for such specialised, community-based counselling;
- very few clients failed to show up for their counselling sessions—there were remarkably few "no shows" and missed sessions, suggesting both that the elderly are conscientious and that WellElder's reputation among the elderly is positive;
- counselling was typically brief and only a small number of clients (6.4%) were granted additional sessions beyond their initial allocation of six;
- WellElder's services seemed to be well accepted by the medical sector, judging by the high proportion of referrals from that source (43%);
- self-referrals have increased each year, indicating a growing acceptance of the service in the community—this increase should continue, as it did at Petersgate Counselling Centre (Manthei, 2012);

- the fact that 48% of sessions were conducted in clients' homes suggests that the service is reaching people who would not be able to access other counselling services.

The data also indicated several areas that WellElder might scrutinise more carefully. One is the marked differences in numbers of males and females and the various ethnic groups among the clients using the service. Although these differences are similar to other New Zealand services, it remains important to remove barriers to access and to identify any structural or attitudinal barriers that may inhibit some clients accessing the service. Another point to consider is that providing the counselling service at several geographically dispersed sites comes at an administrative and financial cost. The service may need to regularly re-evaluate the financial sustainability of providing accessible counselling throughout the health board area.

Fourth, the results of this assessment suggest areas for review and future development. For example, WellElder's contract with its funders specifies that, on average, clients will receive no more than six sessions. It is recognised that some clients will require additional sessions, although relatively few (about 6% per year) do receive further counselling. Thus, counsellors and their clients need to be clear from the outset that they are working within the constraints of a six-session limit. For clients who might require more than six sessions, WellElder needs to continue to ensure that there is funding available and flexibility to accommodate this possibility. In addition, based on client increases in each of the first four years of operation, and the growth of the elderly adult population in New Zealand, plans for dealing with increased client numbers need to be made.

Finally, this study has shown that, in line with overseas research, for a majority of older clients, counselling is an effective intervention for a variety of concerns and problems, including the unique issues the elderly face. We hope that other counselling agencies will begin keeping and reporting client demographic information and counselling effectiveness data so that providers and funding bodies can plan and coordinate programmes and interventions in an informed way.

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