An evaluation of the effectiveness of a pilot 3-session counselling model with individuals with mild and moderate psychological issues in Hong Kong

Short running title: Psychological support individuals with mild and moderate psychological issues

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Abstract

The purpose of this study was to examine the efficacy of a 3-session free-of-charge counselling model delivered by trained master-level counsellors for individuals experiencing mild or moderate psychological issues. It was hypothesised that after participating in this brief intervention, the participants' understanding of the value of counselling would be enhanced, and their levels of depression, anxiety, and stress would be reduced. One-hundred-and-five individuals aged 18 or above who scored at a mild or moderate level as assessed by the *Depression, Anxiety, Stress Scale* (DASS) and had not been diagnosed and treated for any psychiatric illness in the past year received the pilot programme. Data from the pre-intervention (T1), post-intervention (T2) and 3-month follow-up (T3) of the questionnaires was analysed using Intent-to-treat analysis. Results showed that participants exhibited reduction in the numbers of symptoms of depression, anxiety and stress, and improvement in help-seeking attitudes at the conclusion of the pilot programme. These improvements appeared to sustain for three months, and the counselling sessions seemed to have some success in removing the barriers which deter individuals from seeking professional counselling. The study is limited by its small sample size and the high dropout rates.

(192 Words)

Key words: counselling, early intervention, help-seeking behaviour, Hong Kong

Introduction

According to a meta-analysis of data from 63 countries, one in five adults (17.6%) has experienced some degree of depression, anxiety or stress (often in combination) during the last 12 months; and over the courses of their lifetimes, 29.2% of people will suffer from one or more of these conditions (Steel et al., 2014). The largest mental health epidemiological study conducted in Hong Kong reported that the weighted prevalence estimate of common mental disorders (CMD) among people aged 16-75 years for any past week was 13.3%, with the combination of anxiety and depressive disorder being the most frequent (Lam et al., 2015). Another local large scale ten-year prospective cohort study involving about 12,000 adults found that the point prevalence of probable depression increased between 2011 and 2019, rising from 1.3% in 2011-2014, to 5.3% in 2014, 6.1% in 2017 and 9.1% in 2019. On potential suicidal ideation, the point prevalence increased from 1.1 % in 2011-2014 to 3.6% in 2017 and 4.6% in 2019. These studies suggest that CMD, depressive symptoms, and suicidal ideation among adults are common and on a rise in Hong Kong (Ni et al., 2020).

Most people with mental health illness do not receive professional help (Thornicroft, 2007). Wang and colleagues (2007) found that, in 17 low-to-high-income countries, the proportion of people with mental illnesses using 12-month mental health services ranged from only 2% (Nigeria) to 18% (USA). Among individuals with CMD in Hong Kong, only 26 % had consulted mental health services in the past year; fewer than 10% had consulted general practitioners or family physicians (Lam et al., 2015). People with mental health illness do not seek help because of three major barriers: (a) knowledge-based barriers (e.g., lack of understanding about the illness and the failure/inability to recognize its symptoms); (b) structural barriers (e.g., financial cost and lack of transport); and (c) attitudinal barriers (e.g., stigma-related concerns and fears or embarrassment about revealing personal details (Thompson, Hunt, & Issakidis, 2004). Public stigma and self-stigma also contribute to non-

disclosure and poor help-seeking behaviour (Henderson, Williams, Little, & Thornicroft, 2013). Limited access to mental health services leads to under-diagnosis and under-treatment and, possibly, social isolation, which leads to a further deterioration of individual's mental health status (Zhu, Tse, Goodyear-Smith, Yuen, & Wong, 2017).

While under-utilization of mental health services is a universal phenomenon, its cause and implications may differ in varying social contexts. Specific to the Chinese culture, traditional Chinese values highlight moral excellence and self-cultivation of harmony within self, family, and society (Lam et al., 2015). People with mental health issues are generally seen as dangerous and unpredictable (Yang et al., 2007). Also, in Chinese culture, 'overthinking' has been primarily used to explain as the cause of mental illness and individuals with mental illnesses can 'rectify' the problem by 'thinking through' the issues themselves. Hence, self-help and seeking help from people within the close social circle are much more preferred by Chinese people, in preference to seeking professional help (Zhu, Tse, Tang, & Wong, 2016).

In Hong Kong, psychiatrists, clinical, and educational psychologists, and social workers are the dominant professional groups providing mental health services (Seay, 2010). Many Hong Kong residents have not experienced counselling delivered by professional counsellors and are unwilling to seek and pay for such 'talk-only' services. It is not surprising that it is uncommon for Hong Kong Chinese to seek counselling, even for non-psychiatric life issues. We, therefore, instituted a brief and cost-free counselling initiation for individuals with psychological issues and to examine its effectiveness in Hong Kong. The main objective of this study was to examine the acceptability and outcomes of a three-session brief counselling interaction, led by graduates of master-level education in counselling, both in enhancing the participants' understanding of counselling, and in reducing the level of depression, anxiety and stress. The findings of the present study are useful for the future development of empirically

based counselling programmes for people with mild or moderate depression, anxiety, or stress and, likely, a range of other psychological problems in Hong Kong.

Methods

In this pilot trial conducted between February 2015 and June 2017, we recruited and analysed data from 105 participants, aged 18 or above, who had not been diagnosed and treated for any psychiatric illness in the past year; had a score in mild or moderate level assessed by the Depression, Anxiety, Stress Scale (DASS); and had no expressed intention of harming self or others. The trial protocol that adapted some of the suggested structure and skills from the Intentional Interviewing framework (Ivey, Ivey, & Zalaquett, 2015) was initially co-developed by the research team with clinical psychology, social work, education, counselling background and the Tung Wah Group of Hospitals (TWGHs) which is the largest charitable organisation with the longest history in Hong Kong that provide medical and health, education and community services. It was then revised after a consultation with the master-level trained counsellors, who participated in the delivery of the trial in the present study. The ethical approval of the trial was obtained from the Human Research Ethics Committee for Non-clinical Faculties at the university (EA1501534). Written informed consent was mandatory for individuals to be considered for enrolment. We collected data related to serious adverse events, defined as deaths, suicide attempts, and unplanned admissions to hospital, from any cause, during the study period.

Procedures

Recruitment of participants

Multiple recruitment methods were used in the study. An advertisement of the project with its objectives and eligibility of applicants was posted on the webpage of the collaborating organization – 'Radio-i-Care' (http://www.radioicare.org), and leaflets and posters about the

trial were mailed to chosen estates, distributed to schools and medical clinics, and displayed at several monasteries managed by the collaborating organization.

People interested in this service were encouraged to contact the TWGHs through hotline/email/WhatsApp. It is very important to acknowledge the fact, that, in texts seeking participants, the terms, ‘depression’, ‘anxiety’ and ‘stress’ were not employed. Instead, applications were called from ‘distressed individuals.’ There are strong reasons for this choice of terminology. Potential applicants may, in fact, not know that they were suffering from depression, anxiety or stress. They may simply have been aware that all was not well with respect to their psychological health. Perhaps even more importantly, the research term is fully cognisant of the fact that known sufferers of depression and anxiety may be stigmatised or much more self-stigmatised among the Chinese population of Hong Kong. Potential respondents to our advertisements would almost certainly be deterred had we used the specific terms mentioned above. Again, we used the term, ‘distressed people’, as, for the purposes of this project, we did not wish to engage with those individuals, who would had been diagnosed as suffering from any form of psychological disorders. Of course, the term, ‘distressed individuals’ can apply to wide-ranging psychological conditions and even to people with issues related to physical health. To ensure that only respondents with mild or moderate depression, anxiety and stress were recruited for the research project, participants were screened one to two weeks before initial meetings with counsellors. To affect this screening, the 21-item Depression Anxiety Stress Scales (DASS) was used. DASS was administered over the phone. Successful applicants had to reach the mild range of DASS. Though respondents were rated again, face-to-face, by DASS, we adopted the phone rated DASS score as the anchor or inclusion criteria. Basic information, including the names and contact details of the applicants, was then collected by a social worker of the collaborating organisation. This was followed up by an initial screening, with respect to their eligibility to participate in the trial.

Participants

Information about 114 eligible applicants was then passed to the project coordinator of the university research team, who was also a master-level trained counsellor from the university. The project coordinator then matched participants with master-level trained counsellors. This was done within two weeks of the participants' first contact with the collaborated organization. The counsellors then initiated the first counselling session with the participants. The criteria for pairing up were based on the time schedule and availability of both the counsellors and the participants. Each participant received three, free counselling sessions within a two-month period. Each session lasted for about one hour. In addition to providing counselling sessions to the participants, counsellors were also required to submit Counsellor Progress Notes and to attend team meetings or seminars with the research team, on a bi-annual basis. During the evaluation period, 105 out of 114 eligible individuals participated in the intervention and completed the Pre-intervention questionnaire (T1) (Figure 1).

The Intervention

The framework of the trial was developed, based on the rationale that participants wanted to discuss their presenting problems (first session), discuss their here-and-now difficulties in life and enabling factors for self-improvement (second session), and finally, in the last session, discuss the termination, available community and private resources, and strategies for relapse prevention (Ivey, Ivey, & Zalaquett, 2015). The need for referral to other counselling services (for example, mindfulness practices, counselling in churches, marital counselling, or psychiatric consultation) was discussed with the clients in the last session as well. The case manager would further discuss and make necessary arrangements with the clients after the last sessions over the phone. All these three sessions were delivered within one to two months.

In general, the participating counsellors were encouraged by the research team to use the following strategies with respect to the study participants: (a) interventions, which offer emotional support, such as active listening (building empathetic relationship, empathetic responses with reflection of content/feelings/meaning, summarization); (b) interventions employing cognitive content and problem solving strategies, including psychoeducation (for example, the importance of seeking professional help, the purposes and goals of counselling, ethical concerns and confidentiality, the understanding of one's own emotions, thoughts and behaviours), behavioural assessment, activity monitoring, activity structuring and scheduling (for example, joining volunteer work, structuring daily schedules after retirement), activation of social networks (for example. attempts at new ways of communication with significant others), and problem solving (for example, identifying strengths and other coping strategies) with the participants; and (c) information and resources recommendation, such as details on available community resources (for example, contacts and addresses of paid and free long-term counselling services, workshops on mental health, Radio-i-care website/videos related to mental health).

An innovative aspect of the present intervention was to engage a peer support worker, who had been trained with basic counselling skills and had recovered from mental illness, as support people in the practice centre, with respect to handling the consent forms and questionnaires (for details on peer support worker, see references) (Chinman et al., 2014; Davidson, Bellamy, Guy, & Miller, 2012; Tse, Fung, Tsoi, Chan, & Lo, 2018). These workers also provided emotional support to the clients before and/or after the counselling session; for instance, when the peer support workers noticed the need for clients to take extra time to calm down before leaving the practice centre.

The master-level graduate counsellors

There were 75 Volunteer Counsellors (VCs) recruited from the pool of graduates of the Master of Social Sciences of Counselling programme at a local university. They graduated from the program between 2005 and 2014. Among them, 17 were male and 58 were female. Most of them were working adults, in their 30s and 40s, while a few were retirees. As well as completing the mandatory 120 supervised clinical hours during their master study(Taouk, Lovibond, & Laube, 2001) stated that they had additional volunteer experiences in counselling, 4 were counsellors in private practice, and 8 were social workers in centres or organizations providing counselling or mental health services. A 2-hour training session was conducted at the beginning of the project, to inform them about the procedures and rationale of the service. Phone discussions about the handling of difficult cases (for example, the immediate need for referral or early termination, case conceptualization and case-related reflection for the counsellors) were conducted between the project coordinator and VCs, on a needs-only basis. When the counsellors were experiencing difficulties with respect to cases, additional case supervision was arranged and carried out by the certified supervisors of The Hong Kong Professional Counselling Association (Figure 1 shows the flow of the program).

Outcomes

Primary outcomes

Attitude towards seeking professional help - Attitudes Toward Seeking Professional Psychological Help (ATSPPH): A Shortened Form (Fischer & Farina, 1995) was employed in this study. The ATSPPH-SF is a 10-item version of Fischer and Turner's 29-item scale for measuring attitudes towards seeking psychological help. Each item is a statement that is scored on a 4-point scale, ranging from 0 (strongly disagree) to 3 (strongly agree). The total score is obtained through the totalling of item scores. A high score on this scale indicates a positive attitude towards seeking professional help for psychological problems. The ATSPPH-SF has an adequate internal consistency with the current sample (αT1=.56; αT2=.59; αT3=.78).

DASS - The 21-item Depression Anxiety Stress Scales was used in the present study. The depression scale assesses dysphoria, hopelessness, devaluation of life, self-deprecation, lack of interest or involvement, anhedonia, and inertia. The anxiety scale assesses autonomic arousal, skeletal muscle effects, situational anxiety, and subjective experience of anxious effect. The stress scale is sensitive to levels of chronic, non-specific arousal. It assesses difficulty in relaxing, nervous arousal and being easily upset or agitated, irritability, over-reaction, and impatience. The DASS is a self-administered instrument with well-established psychometric properties in both clinical and community samples. It has been shown to be an effective measure in differentiating among the three states, that is, depression, anxiety, and stress (Taouk et al., 2001).

S***econdary outcomes***

Hope - The State Hope Scale used in the study was developed by Snyder and colleagues (Snyder et al., 1996). This scale has been widely used in various contexts and has been demonstrated to be largely uninfluenced by social desirability. The six items utilize an 8-point Likert scale (1 = 'false' to 8 = 'Definitely true') and instructs the respondent to answer with respect to how she/he thinks about herself/himself 'right now'.

Quality of life - The World Health Organization Quality of Life Measure, Hong Kong Chinese Abbreviated version (WHOQOL-HK) was included in this study. In this 28-item questionnaire, the service recipients would self-evaluate their own quality of life with respect to four areas: physical, psychological, social, and environmental. Again, the five domains also enjoyed high construct validity, ranging from 0.862 to 0.999 (Leung, Tay, Cheng, & Lin, 1997). Local norms of people with psychiatric problems were provided as reference.

Expectation of counselling – Expectation of counselling service was measured in T1 with a seven-item seven-point Likert scale (α=.93). The sample items are 'I am willing to share my thoughts and emotions with the counsellor' and 'I think counselling is helpful to me.' The

scale was self-constructed by the Master of Counselling Program team and used to measure the client's expectation of counselling services.

Service feedback – A 20-item seven-point service feedback form was used to measure the participants' experience of the free counselling service. The sample items are 'The counsellor respects me', and 'The counsellor facilitates me to articulate the problems I am facing.' The scale was self-constructed by the Master of Counselling Program team and used to measure the client's feedback and evaluation of counselling service. The scale was measured in T2 (α=.86).

Statistical analysis

Descriptive statistics for continuous variables were illustrated by means and standard deviations, while categorical variables were shown by numbers and percentages. The characteristics of participants, who completed the study and dropped out at T2 and T3, were compared to determine whether the dropout was a random effect. Chi-square test and Student's t test were used to compare the categorical and continuous variables, respectively.

To evaluate the intervention effect, the outcomes were compared across the three time points, using one-way Analysis of Variance (ANOVA), followed by multiple Student's t tests for paired comparisons and the Bonferroni procedure. Completers' analysis was conducted without considering the missing data. In addition to the completers' analysis, data were analysed through an intent-to-treat (ITT) analysis to address loss of follow-up data. A missing values analysis was first conducted to investigate whether data were missing. This was conducted randomly, using Little's MCAR test. Dropout participants were then evaluated through the application of the technique of multiple imputation, with 5 imputations for missing data.

Associations between attitude towards counselling services (experience of counselling services, service feedback, and attitude of seeking professional help) and psychological

outcomes (depression, anxiety, stress, hope, and quality of life) were investigated, using simple linear regression. The coefficients and 95% confidence interval were presented. The regression analyses were adjusted by age, gender, occupation, education, source of referral, and the psychological outcome(s) in previous time point(s) if any. All statistical analyses were performed by using statistical software R (R for Windows, V.3.4.3).

Results

Table 1 illustrates the characteristics of the participants allocated for the study (T1, n = 105). Women (74%) were three times more likely to participate in the study than men. Most participants were currently employed (65%) and very few were students or self-employed. Most cases were self-referrals (70%) or referred by social service centres. Over 50% of participants had received tertiary education and less than 10% had only received primary education. Seventy-one percent of participants were aged between 25 to 59 years. Table 2 shows comparisons of participant characteristics between those who completed the study (T2, n = 65; T3, n = 25) and those, who dropped out at T2 and T3. The dropout rate was 38.09% (40/105) at T2 and 76.19% (40+40)/105) at T3. There were no statistically significant characteristics for those, who dropped out at T2 and T3. In other words, the dropout patterns appeared to happen randomly.

Effects of the intervention

Table 3 shows the outcomes at the three time points and their comparisons across time points, using ITT and completers' analyses. Missing values analysis demonstrated that the data were MCAR (χ^2 Little=215.98, p=.195). ITT analysis showed that the pooled ANOVA results of the five imputed data sets were consistent with the completers' analysis. The missing data appeared to occur randomly.

When comparisons were made between T1 and T2, participants demonstrated significant improvement in terms of attitude towards both seeking professional help (p<.001)

and the alleviation of depression ($p<.01$), anxiety ($p<.05$), stress ($p<.01$). This positive effect for the latter was sustained at T3 (T1 vs. T3): depression ($p<.01$), anxiety ($p<.01$), and stress ($p<.05$). Only attitude towards seeking professional help returned to the T1 level after T3. The improvement of hope at T2 was marginally significant; this effect seemed to be sustained at T3 ($p<.05$). There was no significant improvement in relation to quality of life.

Associations between attitude towards counselling service and psychological outcomes

Table 4 shows the associations between attitude towards service and psychological outcomes. Expectation of counselling services at T1 predicted the improvement of depression ($p=.041$), hope ($p=.029$), and quality of life ($p=.0047$) at T2. Service feedback was associated with the improvement of quality of life ($p=.0142$) at T2. The attitude of seeking professional help at T1 predicted the amelioration of depression ($p=.01$) and quality of life ($p=.04$) at T2. Attitude with respect to seeking professional help at T3 was associated with the improvement of hope ($p=.0227$) at T3. There were no other significant associations.

Discussion

This pilot study aimed to examine the effectiveness of providing a brief cost-free counselling service that aims to enhance participants' attitude towards seeking professional help and their improvement on mental health status. The innovative aspects of this pilot study include its very brief nature, the involvement of professional volunteers, and the targeting of distressed individuals, who have no professional diagnosis of psychological disorders. This pilot study also aims to contribute towards the dismantling of some of the entrenched structural and attitudinal barriers in a Chinese society, which militate against individuals reaching out for professional help when afflicted with mental health problems.

In Hong Kong, counselling is not yet perceived to be a well-established and respected profession (Tse et al., 2018). Again, it is hoped that this study will play some real part in raising

the professional and social status of counselling in Hong Kong and other Chinese societies. The findings of our research project are consistent with those acknowledged by Cochrane that affirms counselling by professionals seems to have correlated with improved outcomes in the short term, and that people, who receive counselling in primary care from a trained counsellor, are likely to feel better immediately after treatment and be satisfied with the interaction (Bower, Knowles, Coventry, & Rowland, 2011).

As hypothesized, our study showed that at the end of the intervention, participants reported improvement in help-seeking attitudes and reductions in depressive, anxious, and stress symptoms and the positive changes seem to maintain when measured three months after the completion of the program. The provision of this direct experience of counselling services seems to have enhanced the participants' understanding of the nature of their illness and its impacts on their lives and the lives of others. At the same time, it may have reduced the stigma and fear of seeking professional help, thereby resolving, at least in part, the knowledge-based and attitudinal barriers of help-seeking (Sun et al., 2001; Tse et al., 2018).

Having counsellors listen empathically may provide emotional support and, consequently, also help reduce the level of emotional distress; thus, this positive experience may reinforce a positive attitude towards seeking professional help in the future (Levitt, Pomerville, & Surace, 2016; Tse et al., 2018). In a seminal work on how clients experience psychological intervention, Levitt and colleagues (2016) observed 'many studies reported that being understood and respected by the therapist led to greater self-awareness, which was found to be curative in itself' (p.819) and it may strengthen the person's willingness to seek further support. Moreover, this service for people with mild or moderate level of distress may prevent the deterioration of their mental health. They learn that they are not alone in their suffering and, just as importantly, that there is professional help, which they can access (Walpold, 2015).

Their brief encounters with professionals in this project go some way in helping them cope with any stigma, which they may face in the wider community.

This pilot is an innovative trial, which integrates university post-graduates and a non-governmental organization to better serve the mental health needs in the community setting. The graduates from master-level counselling program serve as volunteer counsellors, and peer support workers who have lived experiences of mental illness and are in advanced stage of recovery provided support in the practice centre. The participating non-governmental organization coordinated community resources for the recruitment of participants and identified the needed people, while the university oversaw the research design and program evaluation. This service model provides an integrated framework, which incorporates multiple sectors to maximise the use of community. The feasibility and effectiveness of this initial model is demonstrated in the Hong Kong Chinese context and may be examined in other contexts, especially for those societies with limited resources for mental health and low help-seeking rates for mental health problems.

We have identified some areas of improvement and direction for future research. First, the strategies adopted by the counsellors across the three sessions could be better adjusted to the need of the different psychological problems, such as stress related to work or relationship conflict. For example, individuals with grief-related issues, relatively speaking, the intervention method and case conceptualization should focus on emotional support rather than giving information on community resources. The development of a more diverse set of materials used during the session or between-session may be also necessary to accommodate the different needs and paces of learning/skill acquisition of clients. Second, other resources, such as mobile phone apps, can be utilized to further expand the understanding of counselling and to promote strategies designed to address mental health problems outside the confines of the counselling room. This additional flexibility, once the initial interventions have concluded

may be helpful in consolidating and building upon the gains, which have been made. A longer-term, follow-up qualitative study will help to verify the positive changes that correlate with the participation of our counselling services. This is an absolute priority to remove that doubt identified by Cochrane with respect to the comparative efficacy of counselling as a treatment for mental illness. Third, this model is a low-cost, highly effective programme building the link between the professionals and under-identified people in need. This new knowledge or model derived from practice should be further examined by qualitative method such as focus group interviews examining what motivated the clients to present to the service in the first place and giving them the opportunity to articulate their experience, both positive and negative, of the three-session only service.

The study is limited in that the inherent nature of the naturalistic design of the present study does not allow us to draw definite conclusion about cause-effect relationship, between the brief counselling service and the outcomes. Nevertheless, the results of this study give us confidence, that the interventions initiated in this project were beneficial to those individuals with psychological distress and very much worthy of use in the general community, outside the parameters of this investigation. The interventions initiated in the project will provide valuable experiences and insights, which will form the bases of a full-scale, randomized controlled trial. Secondly, the attrition rate of the study is high, especially in the age group, 18-39 years. This may be related to the fast life pace of Hong Kong society. People between the ages of 18 and 39 years old experience more stress in the competitive world of school or career and their mental health condition warrants more attention. Also, we suspected that because counselling is an emerging profession in Hong Kong, those who sought help initially might have a different expectation than what counselling can actually do; for instance, people may be looking for a quick fix and suggested solutions rather than self-explorations. Our ITT and MCAR analyses show that their dropouts happened at random and that, despite the high

attrition rates, provide trustworthy results. Having said that, it remains a legitimate agenda for future study to investigate the reasons why people leave the service, who are more likely to do so, and what they would suggest us to do differently.

Conclusion

The incidence of psychiatric disorders in a rapidly evolving and transforming Hong Kong is most likely to increase substantially in future years, due to the stress of city living, overcrowded housing, fierce competition in education and employment, loneliness and social and cultural alienation, not to mention the on-going social unrest since early June 2019 and the impact of the COVID-19 pandemic. At no point in this report have we suggested that counselling, alone or primarily, is the panacea for mental health conditions. Individual responses to interventions will vary markedly. What will work for one may well be ineffective or even damaging to another. What we as researchers are suggesting though is that counselling can be one of the most important means of intervention in the management of mental health issues. We have been very much encouraged by the results of our research. Hong Kong society, as a whole, needs to become more conversant with the debilitating effects of psychological disorders, to develop empathy for individuals facing the challenges, and to be supportive of government and private initiatives to increase the number and visibility of professional counsellors in needs and the mental health professionals.

Disclosure Statement.

The authors declare no conflict of interest.

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