

The human givens approach works, as therapists who use it can help to prove. Bill Andrews explains why we must – and how we can.

Doing what counts

MY NEW client is almost ready to leave and I think it has been a good session. On her arrival, I had given her a simple sheet printed with four horizontal lines 10cm long, and invited her to mark with a pen stroke, somewhere along each one, how she had felt in the past week – first, about herself, then about her relationships, then her social and work life, and, finally, her general wellbeing, with marks to the left being low and those to the right being high.



She had scored herself at about 3 in every case. An unhappy relationship was affecting her satisfaction with other areas of her life, and we addressed this during the session. Now, I give her another sheet with another four horizontal 10cm lines, on which this time she is invited to indicate how well understood and respected she felt in our session, how much we worked on what she wanted to talk about, how good a fit my approach was for her and how satisfied she feels with the session.

I ask her to be honest, as the exercise is meant to help me to help her as best I can, and we can discuss her responses afterwards. She rates each scale at about a 9, enabling me to feel confident that our work together is heading in the right direction. Through soliciting for her feedback from the beginning of therapy, I enter a partnership with her and give her a clear message that her opinions and ideas about change are very important information to me. I work in this way because, as we'll see later, research has made it crystal clear that therapists can be hopeless predictors of how good an alliance they form with their clients – and that the therapist–client alliance is one of the most important components of therapeutic success. The earlier that any challenges in the alliance can be picked up on, the greater the likelihood of better engagement with the client and corresponding reduction in drop out.

If the therapist–client alliance is so important to good therapy, then the human givens approach is clearly up there with the best, as it is all about empowering clients. Unfortunately, more attention is paid by Government to specific models and techniques, the effects of which on therapeutic success have been wildly overestimated – just one tiddly per cent of therapeutic change can be attributed to them.¹ How can such a gross misunderstanding have occurred? The answer is that we are living in the age of evidence-based medicine, and this is what now drives treatment choices and funding. The idea behind evidence-based treatment is laudable – ie ensuring that

treatments given help rather than harm and are the most effective means of achieving an end. Unfortunately, however, the process works on the assumption that there is an 'active ingredient' – a technical operation – within the treatment itself that brings about cure or amelioration of a condition, and that, if it can be identified, treatments will reliably work. This approach may be better suited to physical than to psychological medicine.

Making recommendations for best practice across the whole of healthcare is the role of the National Institute for Health and Clinical Excellence (NICE), a body that convenes working groups of relevant experts to examine the evidence of treatment efficacy in different medical specialties. This includes psychiatry, which in turn includes psychotherapy and counselling. NICE's recommendations are then graded, according to the 'quality' of the evidence (see box below). Out of all the hundreds of different psychotherapy models, the only treatment NICE consistently recommends is cognitive-behavioural therapy (CBT). It recommends it for mild, medium and severe depression, anxiety, post-traumatic stress disorder, phobias, generalised anxiety disorders, panic, obsessive-compulsive disorder and bipolar disorder, and that it should be available as an option for schizophrenia.²

RCTs can skew the picture

This would lead one to imagine that CBT is, indeed, a wonder treatment. But, in almost all cases, the NICE recommendation relies on the fact that CBT has been tested in a significant

NICE recommendations

GRADE A: based on so-called level I evidence (at least one randomised controlled trial (RCT) or meta-analysis of RCTs)

GRADE B: based on level II or III evidence (non-randomised controlled trials, non-experimental descriptive studies or extrapolations from level I evidence)

GRADE C: based on level IV evidence (expert committee reports or opinions and/or clinical experience of respected authorities)

GRADE GPP: recommended good practice based on the clinical experience of the Guideline Development Group.²

number of randomised controlled trials (RCTs) – the gold standard test used in the quest for the perfect treatment – whereas most other therapies have not. And while NICE accepts that absence of evidence is not evidence of ineffectiveness, it will rely heavily on grade A level I evidence (the RCT), if it is available. The fact that outcomes with CBT have often been found, in these trials, to be only mildly or moderately beneficial rather than stunningly so is neither here nor there, it seems.

Yet the RCT is by no means a perfect tool, as is now widely acknowledged. There are many ways to make a treatment trial look better than it is, sometimes to do with the way statistical assessments are performed and sometimes to do with the trial itself. For instance, a treatment may be compared only with 'waiting list', so any beneficial outcome is not highly meaningful. Also, in many of the CBT trials, the allegiance of the researchers to the treatment they are testing has not been taken into account. In one RCT that compared applied relaxation, CBT (which added CBT elements to applied relaxation) and a placebo (non-directive therapy, in the form of empathic listening without suggestion or advice), all of the therapists were trained in CBT in the laboratory of the researchers. It doesn't take much thought to figure out that, if trained in CBT, one will in all likelihood have an allegiance to CBT and that researchers, if choosing to explore the value of CBT, will have an allegiance to it as well. Also, all the therapists participating in the trial, as well as the researchers, were well aware that non-directive treatment was not meant to be therapeutic. The non-directive treatment did not even resemble the other treatments.³

Despite all this, the trial found that applied relaxation and CBT were roughly similar in effect. But, as it has been shown that up to 70 per cent of any observed therapeutic effect is attributable to belief in the approach by the researchers,⁴ it is no surprise that, when other investigators controlled for allegiance in the above study, even the meagre differences between treatment efficacy disappeared.⁵ And, indeed, after 12 months, it was found that the effects of applied relaxation, CBT and non-directive therapy were *all* much of a muchness.⁴

So, perhaps, it should be no surprise that research carried out in the UK on various therapeutic approaches used in routine settings tells a rather different story from the apparent CBT triumphs trumpeted in NICE guidelines. A study of the effectiveness of CBT, person-centred therapy and psychodynamic therapies in NHS settings showed that they all tended to have similar outcomes, despite theoretically different approaches.⁶ The same finding has emerged from the CORE (Clinical Outcomes in Routine Evaluation) national research database for primary care psychological therapy services in the UK – the largest UK database, so far containing data for 34,000 patients (see page 37). The data reiterate the fact that different therapeutic orientations of thera-

pists, when practised in routine clinical conditions, have little to do with therapy outcome. However, what *has* shown up is large differences between the effectiveness of different individual therapists, regardless of their orientation.⁷

And there's more. Professor Liz Bondi from Edinburgh University was commissioned to look at therapy outcomes for COSCA, the professional body for counselling and psychotherapy in Scotland. She looked at a number of different studies, and her recent report pulled no punches: "The overwhelming message from these studies is that orientation is not a significant factor in relation to effectiveness," she concluded. "This claim may appear to contradict statements made by the Department of Health about the proven effectiveness of particular approaches for particular conditions."⁸

Studies show that, on average, the treated client is better off than 80 per cent of potential clients who remain untreated.⁹ So, if the therapy 'engine' works but that has little to do with its bells and whistles, what is providing the power? We are back to the alliance.

The client–therapist alliance

Twenty years ago, the Treatment of Depression Collaborative Research Study Project, the largest comparative clinical trial ever conducted, looked at four therapeutic approaches – CBT, interpersonal therapy, antidepressants and placebo pill plus routine clinical management. The treatments were carried out in several American cities and were all delivered, under supervision, by experienced psychologists or psychiatrists, who followed the guidelines set out in treatment manuals and underwent adherence tests. Two hundred and fifty participants were randomly assigned to these four groups for 16 weeks. This landmark study, published in 1989 and considered to be one of the most methodologically sophisticated studies ever carried out, found no difference in outcome between approaches. That should be no surprise, given the evidence already cited. However, something very clear *did* emerge. Those who had formed a strong, positive alliance with their therapist by their second session were most likely to come out of their depression, while those who had not formed a good alliance were least likely to do so. The investigators were stunned by their own findings.^{10,11} (Importantly, the principal investigator, Irene Elkin, did not have an allegiance to any of the therapy approaches being researched, while all clinicians had an allegiance to the individual treatments they were carrying out – thus, in effect, controlling for the potentially contaminating effects of allegiance, as discussed above.)

The power of alliance has been found over and over again. Project MATCH was the largest study ever conducted on problem drinking. It involved over 1700 participants and looked at three different treatment approaches – CBT, the 12-step programme and motivational interviewing; again, treatment was administered at multiple sites,



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and treatment manuals and adherence tests were used. The researchers found that all of the approaches worked equally well with some of the people some of the time. But, once again, alliance predicted outcome.^{12,13} The same finding emerged from the Cannabis Youth Treatment study, published in 2004, which involved two randomised controlled trials of 600 adolescent marijuana users.¹⁴

The dodo bird verdict

With few exceptions, important studies originally designed to prove unique effects of a given therapy model have found no differences. We end up with the “dodo bird verdict” (so termed after the dodo bird in *Alice’s Adventures in Wonderland*, which decided, to Alice’s surprise, at the end of a race, that, “Everybody has won and all must have prizes”). Psychologist Dr Saul Rosenzweig first used this colourful term way back in 1936, when he observed that very different therapeutic approaches still seemed to have similar outcomes. A meta-analysis that set out to test the dodo bird verdict looked at over 250 studies conducted between 1970 and 1995 and found nothing reliably superior about any one single approach.¹⁵

In their consideration of the misguided belief that models matter, leading researchers Barry Duncan and Scott Miller of the Institute for the Study of Therapeutic Change in America wryly quote Thomas Henry Huxley’s comment about the great tragedy of science: “the slaying of a beautiful hypothesis by an ugly fact”.¹⁶ Unfortunately for us, the bigger tragedy is that, sometimes, the hypothesis refuses to die. Despite all the research findings endorsing client alliance factors, the mental health field in the UK remains dangerously enamoured of the ultimate, all-powerful silver bullet illusion: evidence-based treatment. The problem with evidence-based treatment is not only the empirically bankrupt notion that, for a particular disorder, there is a specific treatment that is best, but also its total exclusion of the client from consideration.

In evidence-based treatment, the client is equated with the problem and the treatment is viewed as if it can be isolated from the most powerful factors that contribute to change: the client’s own resources, perceptions and participation. A review of the research makes clear, however, that the client is actually the single, most potent contributor to outcome in psychotherapy – through the resources they bring into the therapy room and what influences their lives outside it.¹⁷ These factors might include persistence, willingness to change, faith, optimism, a supportive relative, being a caring parent, running a local group or belonging to a religious community – all important aspects of a client’s life outside of therapy. They also include previously demonstrated strengths and abilities.

It’s what the client brings...

After decades of outcome research, investigators Asay and Lambert¹⁸ ascribed 40 per cent of im-

provement during psychotherapy to client factors. They attributed another 30 per cent of positive outcome to the client–therapist relationship and their agreed goals and strategies for change – together accounting for 70 per cent of good outcome. A further 15 per cent was attributed to the ‘placebo effect’ of hope and expectation of positive change and the final 15 per cent was ascribed to models and techniques.

When the variance of change (the proportional contribution of the multitude of factors that potentially contribute to change) was later taken into account statistically in a meta-analysis,¹ there was a 13 per cent overall impact for therapy (not a small figure, considering the short amount of time overall that clients spend in therapy sessions) but just one per cent could be assigned to specific techniques.

There is no greater indication that the bulk of the variance of change is attributable to the client than the fact of enormous drop-out rate (47 per cent) between referral and first assessment appointments in public counselling services in both the USA and the UK. This applies irrespective of waiting times. The fact is, change happens for all sorts of reasons in people’s lives.

All this, of course, fits very well with the human givens approach to therapy. Recognition of the client and extra-therapeutic factors is at the heart of human givens training. The principle of utilisation – using whatever the client brings to therapy, be it positive resources, current or past circumstances or specific symptoms – is absolutely core. So is building an alliance through rapport building, gathering of information seen as relevant by the client, joint goal setting, accessing of the client’s internal and external resources, agreeing a strategy for bringing about change and rehearsing that change through guided visualisation – the human givens RIGGAR model which is taught in training. It goes without saying that building the hope and expectancy of change is a huge component of this approach.

While models and techniques used within a session are undeniably important, it is increasingly clear that techniques cannot be separated from the context in which they are used. They are just one means to an end, not *the* means. In the main, it is tapping into the positive resources that clients bring with them and working to build a trusting relationship with them that are crucial for good therapy. To these vital ingredients, we must add a third: the client’s theory of change.^{19,20,21} For, unless a therapist can accommodate a person’s pre-existing belief about what their problems are and how change can come about, a positive, trusting partnership is unlikely to be forged.

Earlier rather than later

But when that change happens is also a critical element in successful therapy. Forty years of data show that the bulk of change in successful therapy occurs earlier rather than later. Returns

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diminish as time in treatment lengthens. One study showed that up to 65 per cent of clients improve within seven sessions, 20–40 per cent of them within one to three sessions.²² The Project MATCH results showed that, despite long-term involvement with clients (up to 39 weeks), the bulk of change occurred in the first three months.²³ There was a similar finding in the Cannabis Youth Treatment Study.¹⁴

So the client's subjective experience of change early in the process is the best predictor of success for any particular client–therapist pairing. Further, the *client's* rating of the client–therapist alliance is the best predictor of engagement and outcome. For, as I mentioned at the start, it has been shown that therapists can be hopelessly unreliable at predicting how successfully they are getting on with their clients.²⁴ How, then, are therapists to get a more realistic idea of how they are doing, so that they can capitalise on the therapeutic benefits of alliance? This is where outcome research comes in: practice-based evidence rather than evidence-based practice.

Therapists need feedback

All the research is showing that, when therapists have feedback on how their work with their clients is going, their efficacy shoots up. One study, for instance, found that clients whose therapists had access to outcome and alliance information were less likely to drop out of treatment, less likely to deteriorate and more likely to achieve clinically significant change.²⁵ Another, which looked at client–therapist relationships at risk of a negative outcome, found that those where therapists received formal feedback were 65 per cent more likely to have a good outcome in the end than those where therapists didn't have feedback.²⁶ A third, which involved over 6000 clients, found that, when therapists used simple formal feedback scales (the Outcome Rating Scale (ORS) and the Session Rating Scale (SRS) – see page 37), the result was markedly higher retention rates and a doubling of overall positive effects.²⁰ The message seems clear: when both therapist and client know how the client rates their relationship and their work together, there is better engagement, a decrease in drop-out (a huge problem in psychotherapy, whether between referral to first appointment, between first and second appointment or somewhere further down the line between entering and ending therapy) and an increase in retention. All this turns into shorter treatment times and more reliable clinical change.

If these aren't strong enough reasons for all human givens therapists to start routinely using these simple rating scales, there's more. For, like it or not, sensible or not, evidence-based practice still holds sway and has a plum role in a current major initiative to increase availability of psychological treatments. Professor Richard Layard, the influential founder-director of the London School of Economics' Centre for Economic Performance, was invited by the Government to come up with

proposals to help counter the spiralling cost of incapacity benefits paid out for mental ill health, and he has called for 10,000 more therapists to be in post over the next seven years, delivering evidence-based psychological treatments.

In his oddly named report to Government, *Mental Health: Britain's biggest social problem?*,²⁷ Layard points out that, of incapacity benefit recipients in 2004, the biggest group comprised those with mental disorder: 38 per cent. The next largest group, with musculo-skeletal complaints, was at 20 per cent. He also noted that 16 per cent of the population at large – 19 per cent when only women are looked at – suffer from mental disorder at any one time, the vast majority of it due to anxiety and depression. Just 0.05 per cent of the population suffer from psychosis. Panic attacks account for under one per cent of incapacitating mental ill health, obsessive-compulsive disorders one per cent and phobias two per cent. The huge improvements in help available for those with the most complex mental disorders has resulted in a long wait for treatment for those with the most common disabling problems, Layard observes.

Thus, he has estimated a need for 10,000 more therapists, to be trained in 'evidence-based' therapies, such as CBT, systemic family therapy, psychosocial interventions and other dynamic therapies. He envisages 5000 of these therapists being made up of existing health professionals, such as nurses, occupational therapists, social workers or psychology graduates, and wants the number of new clinical psychologists doubled from 550 a year to 1100 a year. Over the next seven years, he wants 250 community mental health centres established across the country, either in the form of teams working together in dedicated buildings or in GP surgeries or Job Centres.

"It is not important whether services are publicly or privately supplied," he says, "provided there is good control of quality and cost ... [The private sector] avenue should be actively explored as an additional means of increasing access through commissioning."²⁷

In May this year, Secretary of State for Health Patricia Hewitt announced in a speech to the National Mental Health Partnership Conference that there are to be two demonstration sites (in Doncaster and Newham), which will be linked to a regional network of local improvement programmes and test out various models of care that can be implemented nationally. The pilots in these two very demographically different areas will receive £3.7m in funding from the Department of Health over two years.

This is all good news. The Government is recognising the enormity of problems caused by mental disorders. We need more talking therapies that work, and the problem will be if those working from the human givens approach are marginalised because of lack of evidence of our effectiveness.

Layard is an economist, so naturally he will

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CORE and ORS/SRS

The CORE System (Clinical Outcomes in Routine Evaluation) was devised 10 years ago in the UK as a means for managers and practitioners working in counselling and psychological therapy services to provide good quality information about client groups and service effectiveness. Over 300 different services across the country are contributing to its ever-growing database. The required paperwork consists of a two-sided sheet, which is given to a client to complete on starting therapy and on finishing (ie at first and final sessions). This sheet contains 34 items (such as, "I have felt overwhelmed by my problems") with tick boxes ranging from "not at all" to "most of the time", and is designed to measure the client's subjective well-being, problems, life functioning and level of risk. The therapist also completes a form at the start and end of therapy, which asks for information about waiting times, presenting problem, therapy orientation, length of therapy, etc.

It is a good system to use because it has the interest of Government; it is standardised and allows benchmarking; it is empirically validated; it allows us to talk the same language as decision makers; and it is free (as long as copyright is respected). Furthermore, early in 2007, CORENET, a paperless, internet-based system will be launched. This sophisticated system will allow collation of data from therapists anywhere on the globe where they have access to the internet.

It is also important that therapists have a measure for the outcomes of each individual session. The ORS (Outcome Rating Scale) and the SRS (Session Rating Scale), both described at the start of this article, fit the bill. They have been shown in research to be valid, reliable and feasible. Practitioners are far more likely to use these short four-item scales than longer ones.^{1,2}

In the ORS, which measures aspects of well-being, the highest score, reached by adding the total of the client's marks on the 10cm lines, is 40 (a very happy bunny). A 'cut-off' score of 25 and below differentiates those who are experiencing enough distress to be in therapy from those who are not. (The cut-off point for adolescents is 28 and children 33.)

The SRS, the measure of the client's perception of alliance with the therapist, is also scored out of

a total of 40. Scores of 9 on each line are to be expected, because clients tend to score alliance measures highly, and the therapist need only comment on the fact that the client seems broadly satisfied and invite a response. For instance, "From this SRS, it looks as though you think we are dealing with what is important to you in the right sort of way". Anything less than a total score of 36 could be indicative of a concern and is something to explore. I might say something like, "It seems as though I'm not on your wavelength here yet. Thank you for being so honest, because it means I know I need to do some things differently to help you better. Was there something I should have asked, but didn't, or could have done to make this session more valuable for you? What was lacking for you?"

Being responsive to negative feedback is a powerful alliance builder. In fact, it has been shown that, in client-therapist relationships that start off a bit negatively, the therapist's willingness to respond to client feedback is predictive of a positive outcome. The SRS provides a simple means of doing this. It takes about five minutes for a client to complete the double-sided CORE sheet and less than a minute each for the ORS and SRS.

Using the information from the CORE database, researchers have been able to show that, in the highest performing services, 68–75 per cent of patients achieve clinical and reliable change, while the national average is 50 per cent. In the lowest performing services, the figure is 27 per cent.³ We now have SRS/ORS data on 285 patients treated by 14 human givens therapists, which shows that 73 per cent of patients achieved reliable change. This already puts the human givens approach up there among the highest performing services. How much more telling this would have been if we had had CORE data to support it too. ●

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To get started or find out more, please visit the HGI Practice Research Network website at www.hgiprn.org. We are planning to carry out a time-limited study using CORENET (see box), involving a minimum of 30 therapists using the human givens approach and a minimum of 10 clients per therapist. We hope to start this project in the spring of 2007 and need as many people as possible to become involved. If you are willing to participate by submitting data, please e-mail me at info@effectivetherapy.org. You will then receive a username and password to protected pages of the network website that are devoted exclusively to HGI research.

look for evidence that has been established, and the place he will find that is in the NICE guidelines, where CBT shines out, however questionably. Although, as said, NICE itself acknowledges that absence of evidence is not evidence of ineffectiveness, 'evidence' is a real problem for most psychotherapies, which grew up within the arts and humanities. By their very nature, the arts and humanities have an aversion to number crunching. But clinical psychology has grown up in the science faculty, and science loves number crunching, as do economists. So the largely anecdotal evidence of effectiveness in most psychotherapies will not cut the mustard for an economist. We need scientifically validated evidence.

Practice-based evidence

Fortunately, there is now a clear route for achieving this, without the huge expense and complexities of trying to mount a randomised controlled trial. The National Institute for Mental Health in England (NIMHE) produced a report for the Department of Health in 2004, which actually acknowledged that particular therapy models and techniques are not the crucial ingredients for effective therapy.²⁸ "In general," it said, "brand names rarely predict outcomes and in direct comparisons most studies show a broad equivalence between therapies. While evidence-based practice can be seen as the process of disseminating the best information on 'what should be done' in a service, practice-based evidence, including audit, asks, 'has the right thing been done?' and 'has it been done right?'"

To answer these questions, the report concludes, we need service audits (how many people are seen, what the waiting times are, etc) and service monitoring and benchmarking (creating a method of looking at national averages, so that every service can see where it falls). The report recommends incorporating outcome measures into psychological services as a matter of routine, because outcome measurements are an important element of monitoring and benchmarking. The CORE system (see page 36) meets all of these requirements and has the ear of Government. (CORE is one of the tools that will be used to evaluate the pilot services in Doncaster and Newham.) The ORS forms are American and are not so well known, nor have they yet been correlated with CORE measures. However, they have been correlated with something very similar, the Outcome Questionnaire 45 (OQ45), which has 45 items compared with CORE's 34.

Glenys Parry, professor in applied psychological therapies at the University of Sheffield, advocates the development of practice research networks, where members agree to pool data relating to clinical outcomes, using the same set of measures, to enable analysis of regional or national data sets. By developing high-quality clinical databases on large clinically representative samples, practice research networks can contribute an important source of evidence on

the effectiveness of services as delivered, and encourage a research approach to the evaluation of service outcome.

'Practice research network' has become an important term because already it has come to represent the body of people gathering practice-based evidence. This is where the human givens approach can enter the equation. We have now established the HGI Practice Research Network so as actively to promote and encourage outcome-informed research into the effectiveness of the human givens approach, whatever setting it is used in. The network will be able to act as a central point for collation of this research, offer guidance to therapists and – highly important for getting us on the map – liaise with other practice research networks, nationally and internationally. It will also enable us to bring outcomes from the human givens approach to the attention of the movers and shakers, such as the Department of Health and NICE.

This is an enormously exciting opportunity. We are in the strange position where it is recognised, in a Government report, that 'brand names' don't really matter, when it comes to therapy efficacy, and yet NICE guidelines, with their leanings towards RCTs, still hold sway. But, until this anomaly is sorted out, we can take further heart from the fact that RCT-backed treatment is not always the first treatment of choice, even in NICE guidelines. For instance, in the guidelines for moderate to severe depression, the starting treatment recommended (antidepressants) is graded at B and also in the list is grade C evidence. So there is much scope for practice-based evidence to have a significant role.

I urge every therapist using the human givens approach, whether in an NHS setting or in private practice, to become a part of the HGI Practice Research Network. If, by using reliable outcome measures, we can show that what we do works, it means that we can talk the same language as the decision makers and play our part in this developing story. I believe that we should aim to be amongst the first in the UK therapy field to embrace the outcome-informed approach with every client at every session because being outcome informed is what can put us on the map. We aren't trying to prove that we are the best or even better than anyone else: we just want to show that we do what it says on the tin. As I see it now, every time a therapist sees a client and helps them transform their lives without outcome measures to help demonstrate what they have achieved and that they achieved it using the human givens approach, it is yet another golden opportunity lost for human givens. ■

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