This article was downloaded by: [The University of Manchester]

On: 18 May 2009

Access details: Access Details: [subscription number 773564139]

Publisher Routledge

Informa Ltd Registered in England and Wales Registered Number: 1072954 Registered office: Mortimer House, 37-41 Mortimer Street, London W1T 3JH, UK

Counselling and Psychotherapy Research

Publication details, including instructions for authors and subscription information:

<http://www.informaworld.com/smpp/title-content=t713734893>

A five-year evaluation of the effectiveness of person-centred counselling in routine clinical practice in primary care

Isabel Gibbard ^a; Terry Hanley ^b

^a Primary Mental Health Team, Lancashire Business Park, Leyland, UK ^b The University of Manchester, Manchester, UK

Online Publication Date: 01 December 2008

To cite this Article Gibbard, Isabel and Hanley, Terry(2008)'A five-year evaluation of the effectiveness of person-centred counselling in routine clinical practice in primary care',Counselling and Psychotherapy Research,8:4,215 — 222

To link to this Article: DOI: 10.1080/14733140802305440

URL: <http://dx.doi.org/10.1080/14733140802305440>

PLEASE SCROLL DOWN FOR ARTICLE

Full terms and conditions of use: <http://www.informaworld.com/terms-and-conditions-of-access.pdf>

This article may be used for research, teaching and private study purposes. Any substantial or systematic reproduction, re-distribution, re-selling, loan or sub-licensing, systematic supply or distribution in any form to anyone is expressly forbidden.

The publisher does not give any warranty express or implied or make any representation that the contents will be complete or accurate or up to date. The accuracy of any instructions, formulae and drug doses should be independently verified with primary sources. The publisher shall not be liable for any loss, actions, claims, proceedings, demand or costs or damages whatsoever or howsoever caused arising directly or indirectly in connection with or arising out of the use of this material.

RESEARCH ARTICLE

A five-year evaluation of the effectiveness of person-centred counselling in routine clinical practice in primary care

ISABEL GIBBARD¹ & TERRY HANLEY^{*2}

¹Primary Mental Health Team, Lancashire Business Park, Leyland, UK, and ²The University of Manchester, Manchester, UK

Abstract

Counselling is the recommended treatment for individuals with mild to moderate mental health problems of recent onset. In this evaluation of a primary care counselling service offering person-centred counselling, the Core Outcome Measure (CORE-OM) was administered at referral and at the beginning and end of therapy. A pre-post therapy effect size for 697 individuals over a 5 year period was 1.2. This compares with a waitlist (between referral and pre therapy) effect size of 0.24 for 382 individuals over a three year period. The results indicate that person-centred counselling is effective for clients with common mental health problems, such as anxiety and depression. Effectiveness is not limited to individuals with mild to moderate symptoms of recent onset, but extends to people with moderate to severe symptoms of longer duration.

Keywords: effectiveness, counselling, primary care, person-centred, CORE-OM

Introduction

Ever since Eysenck (1952) showed that two-thirds of people diagnosed with neuroses recovered without any psychological intervention, there has been a degree of scepticism regarding the effectiveness of all psychological therapy. Despite this, there has been an increase in demand for psychological therapy provided by the NHS, and much of this demand in primary care has been met by counselling (Mellor-Clark, Sims-Ellis, & Burton, 2001a).

At the end of the 1990s, the National Health Service (NHS) implemented a series of initiatives to improve the quality and efficiency of patient care (DoH, 1997). Underlying these initiatives was the principle of 'evidence-based practice', defined as 'the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients' (Sackett, Rosenberg, Gray, Hughes, & Richardson, 1996, p. 71). In addition, the principle of Clinical Governance was promoted to ensure a continuous improvement in the quality of patient care (DoH, 1997). The requirement for effective treatments was set out as a national standard in the National Service Framework for Mental Health (DoH, 1999). A hierarchy of evidence (see NICE, 2004b, p. 45), and criteria for assessing empirically supported therapies has been developed (see Roth & Fonagy, 2005, p. 50). The National Institute for Clinical Excellence was established to

assess evidence, and produce clinical practice guidelines to inform both clinical practice and commissioning decisions (e.g. NICE, 2004a,b).

In the NHS, the randomised controlled trial (RCT) and their aggregation into systematic reviews and meta-analyses are regarded as providing the best evidence for identifying effective treatments (e.g. Bower & King, 2000, p. 79). The RCT measures the efficacy of an intervention under highly controlled conditions, and is level I in the hierarchy of evidence. There is a considerable amount of level I evidence for the effectiveness of Cognitive Behavioural Therapy (CBT), and this is the recommended treatment for all primary mental health conditions. Primary care counselling in general and Person Centred Therapy (PCT) in particular is characterised by a lack of evidence for its effectiveness. This has influenced commissioning decisions and threatens the continuing funding of PCT in primary care. It also means that PCT is unlikely to benefit from the recent Increased Access to Psychological Therapy initiative (DoH, 2008, p. 9).

PCT is also called client-centred or non-directive therapy. Typically, primary care counselling is regarded as a generic term describing a broad range of interventions (NICE, 2004b, p. 155), although person-centred ideas of empathy, warmth and genuineness are influential (Roth & Fonagy, 2005, p. 13). In most primary care counselling services, counsellors utilise a variety of different approaches, and this makes it difficult to separate the evidence

*Corresponding author. E-mail: terry.hanley@manchester.ac.uk

for PCT from that of primary care counselling in general.

The aim of this evaluation was to respond to the requirement for clinical governance and to measure the outcome of therapy as part of routine clinical practice, thus employing the 'practice-based evidence' model (Barkham & Mellor-Clark, 2003). As the primary care counselling service involved in this research only offers PCT, it presented a unique opportunity to examine the effectiveness of this approach. The Clinical Outcome in Routine Evaluation measure (CORE-OM; Mellor-Clark, Connell, & Barkham, 2001b; Evans, Connell, Barkham, Marshall, & Mellor-Clark, 2003) was used to measure reliable change after therapy, and the pre-post therapy effect size was compared with a waitlist effect size from referral to pre therapy. The results were complemented by a qualitative measure of satisfaction from exit questionnaires. The relatively large sample size, the length of the evaluation, the consistency of the findings and the introduction of a waitlist comparator group makes this evaluation unusual when compared to sources in the literature.

Current evidence

The NICE guideline for anxiety concludes that there is a lack of evidence about the effectiveness of counselling for individuals with generalised anxiety disorder or panic (NICE, 2004a, p. 140). The guideline for depression concludes that there is evidence for the efficacy of counselling for depression for patients with mild to moderate depression of recent onset, but there is no evidence of its effectiveness for chronic depression (NICE, 2004b, p. 158). Neither guideline addresses the effectiveness of PCT.

Bower, Rowland and Hardy (2003) produced a meta-analysis of the clinical effectiveness of counselling in primary care. Two of the seven studies reviewed describe the counselling intervention as non-directive (Friedli, King, Lloyd, & Horder, 1997; Ward et al., 2000) and one as broadly person-centred (Harvey et al., 1998). The reviewers conclude that counselling is effective in the short term, but that the effect is modest and may not differ from other treatments routinely used in primary care. This conclusion related to primary care counselling in general, and the effectiveness of PCT specifically was not addressed. Based on the results of the study by Ward et al. (2000), which found that CBT and non-directive counselling were equally effective, Roth and Fonagy (2005, p. 123) conclude that non-directive counselling seems reasonably effective.

The existing research literature on experiential psychotherapies, including client-centred therapy, has been reviewed by Elliott, Greenberg and Lieter (2004). This is a meta-analysis of 127 studies from different countries and a variety of medical settings, of which 52 studies investigated client-centred therapy in a relatively pure form. These reviewers conclude that all experiential therapies, including

client-centred therapy, are effective, and that when different therapies are compared, all therapies are equivalent in their effectiveness.

Practice-based evidence using the CORE System (Evans et al., 2003; Mellor-Clark et al., 2001b) has been collated into the CORE National Research Database. This consists of 31,882 clients and 637 practitioners using a range and variety of different approaches, from 34 services across the UK (Mellor-Clark, 2006) and indicates that counselling is effective (Bewick, Trusler, Mullin, Grant, & Mothersole, 2006). Using a subsample of clients from the CORE National Research Database, Stiles et al. (2006) compared CBT, PCT and Psychodynamic Therapy and demonstrated that each approach was equally effective. Stiles et al. (2008) replicated this study by using a larger sample, showing an even greater approximation to equivalent outcomes. However, the lack of a control and the high rate of attrition in these studies reduces the confidence with which the improvement shown can be attributed to the therapy (Clark, Fairburn, & Wessely, 2008).

Overview of the service

The counselling service evaluated here began in 2001 when six part-time counsellors were employed as part of a Clinical Psychology Service. Counsellors were asked to offer an initial contract of 6 sessions, which could be extended for up to 12. Only counsellors whose therapeutic approach was PCT were employed as it was considered important to offer a different approach from the CBT-orientated interventions used by most other mental health professionals. The service also operated a student placement scheme, taking students training in PCT from local colleges. Over the five years of the evaluation, a total of 12 counsellors, ranging from newly qualified to British Association for Counselling and Psychotherapy (BACP) accredited with considerable experience, and 17 students have worked for the service. The primary author (IG) was both service manager and one of the practitioners.

In 2005, the counselling service was reorganised into a Primary Care Mental Health Team (PCMHT), along with Community Psychiatric Nurses (CPNs), CBT therapists and the new Primary Care Mental Health Workers. The intention was to operate a stepped care model of service delivery, in line with the NICE guidelines, where there are treatments of increasing intensity available. In this model patients are offered the lowest intensity treatment first and then 'stepped up' to more intensive treatments if necessary (Bower & Gilbody, 2005). Initially it was unclear where counselling would fit into this model, given that individuals with mild to moderate mental health problems of recent onset, who would traditionally have been referred for counselling, would receive an intervention from a Primary Care Mental Health Worker. As we already had evidence that the counselling service was effective with clients with more complex and severe problems, it was decided to

locate counselling as a high-intensity treatment. The criterion for referral was changed to limit access to clients with moderate to severe problems of longer than 12 months duration.

Methodology

Procedure

All clients were referred by their GP and assessed by a CPN. Those assessed as potentially benefiting from a short-term counselling intervention were referred to the counselling service. If medication was prescribed, this was usually offered by the GP at original referral or on the advice of a CPN after the assessment appointment. Self-help material on anxiety and depression management was also given at assessment.

The CORE System was selected to measure the outcome of therapy given its widespread use in primary care. CORE consists of four forms: the Therapy Assessment Form and End of Therapy Form are completed by the counsellor and provide contextual information. The CORE Outcome Measure (CORE-OM) is a self-report questionnaire, completed by the client, which measures overall distress. It consists of 34 items covering 4 domains of subjective well-being, problems, functioning and risk. It scores each item on a 5-point scale from 0 to 4, where the higher the score, the higher the level of distress. When administered at the beginning and end of therapy, change can be measured. The reliability and validity of the measure have been extensively tested and parameters for reliable and clinically significant change have been calculated, together with cut-off points for clinical and non-clinical populations, and severity bands (Barkham et al., 2001, 2006; Evans et al., 2002).

The CORE-OM was administered during the first and last counselling session. During the second year of the evaluation, a CORE-OM was added to the opt-in procedure at the point of referral. This enabled change during the waiting time to be calculated, and acted as a comparator group with which to compare change after therapy. Complete sets of forms were submitted when the client was discharged, and the information entered on to CORE-PC, a computer software package that collates and analyses the CORE system data, facilitating the monitoring and management of service provision.

In addition, exit questionnaires were routinely administered by post after patient discharge. Clients were asked to rate how helpful they found the therapy and how much better they felt about the problems which brought them to counselling. This information was used quantitatively as an additional measure to complement the CORE data.

Description of the sample

The sample consisted of all those individuals who were accepted for therapy in the counselling service

between April 2002 and March 2007 ($n=1098$). There was no marked difference in characteristics between those who were included and those who were excluded from the analysis. Of those who attended the service, 72% were female and 95% were white. The mean age was 40.49; 3.5% were younger than 20 years old, 19% were in the 20–29-year-old age group, 28% were 30–39, 27% were 40–49, 19% were 50–59 and 3.5% were older than 59. Thirty-eight percent were in full-time employment and 13% were in part-time employment; 14% were receiving sickness or incapacity benefit; and 11% were unemployed. Fifty-three percent lived with a partner, 29% lived alone, and 52% were caring for children.

Clients presented with multiple problems, but the most common problems overall were anxiety and stress (82%), depression (78%), interpersonal relationships (59%), low self-esteem (55.5%), bereavement and loss (46%), and trauma and abuse (25%). Eighty-one percent scored above the CORE-OM clinical cut-off (using the original clinical cut off levels of 1.19 and 1.29 for men and women, respectively; Evans et al., 2002). Anecdotally, counsellors reported that their caseload had increased in severity and complexity over the years and this is supported by the data in Table I. The average pre-therapy score increased from 1.74 in 2002–2003 to 2.03 in 2006–2007. Table I also shows how a number of indicators of severity and complexity have increased over the five years of the evaluation.

Of clients, 57% were taking anti-depressant medication. Clients waited an average of 118 days (17 weeks) to begin counselling. Table I illustrates how the waiting time increased during the first 4 years, reaching an average high of 179 days (26 weeks) in the year 2005–2006. The number of sessions used by clients increased slightly from 6.4 in the first year to 7.4 in the final year of the evaluation.

Table II shows the completeness of the data and shows how the data quality has remained high over the five years of the evaluation. Overall, 1152 individuals were assessed and 1098 clients were accepted into therapy (95%). Of those 1098 individuals accepted for therapy, 1043 (95%) completed a valid pre therapy OM (i.e. <3 missing items), 401 (37%) were excluded from the analysis as post therapy data were not available, and 697 (63%) completed a valid post therapy OM and were included in the analysis. Most of the missing data were due to clients who terminated therapy prematurely.

During the final 3 years of the evaluation, 681 individuals were accepted for therapy and 382 (56%) who completed the CORE-OM at all 3 occasions of referral, pre and post therapy, were included in the analysis. All those individuals included in the waitlist comparator group were also included in the pre-post therapy group, i.e. they moved from the waiting list to therapy. Those individuals who did not complete a CORE-OM at referral were excluded from the waitlist analysis. These were individuals who were accepted

Table I. Overall service data.

Year	Mean waiting time (days)	Mean number of sessions	Above clinical cut off (%)	Mean pre therapy score	Mean pre therapy risk score	Presenting with trauma and abuse (%)	Taking medication (%)
02-03	85.5	6.4	73.5	1.74	0.37	18	56
03-04	103.5	6.9	80	1.82	0.43	19	58
04-05	107	7.2	83	1.88	0.43	16	54
05-06	178.5	7	81	1.92	0.48	34	51
06-07	113	7.4	88	2.03	0.64	35	63
Total	118	7	81	1.92	0.48	25	57

as an urgent referral and offered an appointment without being required to opt in.

During the 5 years of the evaluation, 475 clients were assessed who scored greater than 2.0 on CORE-OM, locating them within the moderate to severe severity band (see Barkham et al., 2006). Their characteristics did not differ markedly from those of the whole service. Ninety-eight percent were accepted for therapy and 65% completed valid post therapy CORE-OMs. Seventy-six percent scored as reliably improved after therapy. The data for this group were also analysed.

Overall, 469 exit questionnaires were returned. This is 43% of those who attended the service.

Analysis of the data

As service conditions varied during the 5 years of the investigation, with changes in procedures, organisation and personnel, the data were analysed in 5 12-month periods, enabling trends and differences over time to be observed. CORE-PC calculated the mean score for each individual on each occasion the CORE-OM was administered. The difference between the pre and post therapy scores was calculated and expressed as an improvement, a deterioration or no change. In order for the change to be considered reliable, a change in scores of greater than 0.5 is necessary. Therefore in order to demonstrate reliable improvement, the post therapy score of an individual would have to be at least 0.5 less than the pre therapy score.

CORE-PC also calculated the mean score for the whole service at each occasion the CORE-OM was administered. The overall effectiveness of the whole

service was expressed as the percentage of individuals who completed valid pre and post therapy CORE-OMs who demonstrated reliable improvement. From the exit questionnaires, the number of individuals who reported that they had found counselling helpful or very helpful was calculated, together with the total number who reported that they felt better or very much better able to deal with the problems which initially brought them to counselling. This was expressed as a percentage of the total number of exit questionnaires that were returned.

In addition to calculating reliable change, the effect sizes for the waitlist and pre-post data were calculated: the effect size is way of expressing the difference between two groups, or the same group before and after an intervention. More specifically, the mean scores for the two groups in question were collated and compared using the following formula (referred to as Cohen's *d*):

$$d = \frac{\text{mean}_1 - \text{mean}_2}{\sqrt{(SD_1^2 + SD_2^2)/2}}$$

where mean_1 and SD_1 refer to the comparator condition and mean_2 and SD_2 refer to the experimental condition.

This calculation divides the difference between the mean scores for the conditions in question by the pooled standard deviation. It produces a figure which can reflect the difference between the two sets of scores, and provides an indication of the impact the experimental condition has upon the group in question. Thus, within the first condition, the referral score is compared to the pre therapy score and indicates any change in CORE-OM scores during a period of non-treatment, and the second condition compares

Table II. Completeness of the data.

Year	Clients assessed	Clients accepted for therapy	Planned ending		Valid pre therapy OM		Valid post therapy OM		Exit questionnaires	
			<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
02-03	212	203	136	67	196	96.5	129	63.5	83	41
03-04	227	214	153	71.5	204	95	141	66	89	42
04-05	217	203	151	74.4	193	95	133	65	97	47.5
05-06	230	222	146	66	212	95.5	138	62	84	39
06-07	266	256	169	66	238	93	156	61	116	45
Total	1152	1098	755	69	1043	95	697	63	469	43

Figure 1. Scatter plot – comparison between pre therapy and post therapy Core-OM scores.

the pre therapy to post therapy CORE-OM scores and therefore reflects change during a period of treatment. When examining the scores calculated, it is considered that the larger the effect size, the greater is the impact of an intervention. Opinions differ regarding the interpretation of effect sizes, but the most accepted opinion is that of Cohen (1969) where 0.2 is indicative of a small effect, 0.5 a medium ('visible to the naked eye' [p. 23]) and 0.8 a large effect size ('grossly perceptible' [p. 23]). It is these levels which are utilised when presenting the data in the following section.

Results

The comparison between pre therapy and post therapy CORE-OM scores are shown in the scatter plot in Figure 1. Those scores below the lower interrupted line on the plot reflect those individuals who demonstrated reliable improvement.

Table III shows that, overall, 67.7% of those who completed both pre and post therapy outcome measures showed a reliable improvement, 30.9% showed no change and 1.4% showed a reliable deterioration. Table III demonstrates how the effectiveness measured by CORE has varied over the five years of the evaluation, but that it has not decreased with the increase in severity and complexity of the client group, or with the change in criteria for referral which limited access to those clients who had been experiencing problems for longer than 12 months.

Of clients who returned an exit questionnaire, 90% reported that they found counselling helpful or very helpful, and 69% reported that they felt better or very much better about their problems. There were a number of clients who reported that they had found

counselling helpful or very helpful, even though they felt no better or only a little better afterwards. This may indicate that clients found aspects of the counselling beneficial, other than symptom reduction. Table III appears to indicate that effectiveness, according to the exit questionnaires, has decreased slightly over the five years of the evaluation. This may reflect the lower return rate or it may reflect an interesting difference between the client's subjective view of how they feel and the more objective view obtained from the CORE-OM.

Table IV shows a marked difference between CORE-OM scores at the beginning and end of therapy, with the 697 clients who completed both pre and post therapy CORE-OMs improving, on average, from 1.86 to 1.04. This gives an overall pre-post therapy effect size of 1.2, which is greater than the 0.8 standard cited by Cohen as a large effect and demonstrates that, overall, the therapy clients received had a large effect on their mood.

Table V shows that, on average, during the final three years of the evaluation, the 382 clients who also completed a CORE-OM at referral improved from 2.06 to 1.91 while they waited for therapy. This gives a pre-post waitlist effect size of 0.24, which is slightly larger than the 0.2 standard cited by Cohen as a small effect size. In other words, clients showed a small overall improvement during the time they waited for therapy. However, after these individuals completed therapy their average score improved to 1.05, giving a pre-post therapy effect size of 1.24. When the two groups are compared it can be seen that the effect of therapy was much greater than the effect of waiting for therapy.

Table VI shows that during the final 3 years of the evaluation, the clients in the moderate to severe

Table III. Effectiveness.

Year	Core data			Exit questionnaires			
	Reliable improvement (%)	No change (%)	Reliable deterioration (%)	Unhelpful/a little helpful (%)	Helpful/very helpful (%)	Not at all better/a little better (%)	Better/very much better (%)
02-03	66.7	32.6	0.8	10	90	25	75
03-04	63.1	31.9	5	10	90	24	76
04-05	73.5	25.8	0.8	8	92	31	69
05-06	64.5	35.5	0	12	88	32	68
06-07	70.5	29.5	0	10	90	37	63
Total	67.7	30.9	1.4	10	90	30	69

Table IV. Pre-post effect sizes for five years 2002–2007.

Year	n	Pre therapy		Post therapy		Pre-post ES
		Mean score	SD	Mean score	SD	
02–03	129	1.72	0.67	0.95	0.67	1.15
03–04	141	1.78	0.63	1.04	0.67	1.12
04–05	133	1.92	0.61	1.00	0.68	1.42
05–06	138	1.89	0.67	1.13	0.74	1.08
06–07	156	1.99	0.68	1.06	0.79	1.27
Total	697	1.86	0.66	1.04	0.71	1.20

severity band did not improve while they waited for therapy, scoring 2.43 at referral and 2.47 at pre therapy, giving a pre-post waitlist effect size of -0.09 . After these individuals completed therapy, their average score improved to 1.43 giving a pre-post therapy effect size of 1.72, a large effect size.

Discussion

The main aim of this study was to investigate the effectiveness of PCT. The results strongly suggest that PCT is an effective intervention for common primary care mental health problems. The percentage of clients who showed reliable improvement according to CORE-OM, and the percentage of clients who reported feeling better or very much better about their problems, according to the exit questionnaires, were remarkably similar (68% and 69%, respectively). Compared with the average rate of the CORE National Research Database of 73%, the effectiveness of this service appears to be below average (Mullin, Barkham, Mothersole, Bewick, & Kinder, 2006). However, this may reflect the difference in rates of completion. The CORE-OM completion rate for this service was 63%, while the average CORE-OM completion rate for the services used to calculate the benchmarks is 39% (Bewick et al., 2006).

The CORE National Research Database has not been used to calculate effect sizes and so it is not possible to make a comparison. However, the pre-post effect size of 1.2 compares to the pre-post effect size of 1.32 and 1.39 for PCT, reported by Stiles et al. (2006, 2008), and to the effect size of 0.99 calculated from the 127 studies reviewed by Elliott et al. (2004). It is larger than the moderate effect size reported by Bower et al. (2003), although a direct comparison is not possible due to the different method of calculation.

The results also indicate that PCT is not only effective for mild to moderate problems of recent onset, but also for moderate to severe problems of longer duration. There is the view that more severe and complex problems need longer-term psychotherapy. Our results show that those clients with moderate to severe problems, on average, stayed only one session longer in therapy.

Despite efforts to reduce the rate of attrition, it has remained higher than the rates in most RCTs. There are a number of possible reasons for attrition. Some clients decline to complete the forms, or there may be practical reasons such as the client being too distressed, unable to read or having to leave early. In this evaluation attrition was mainly due to those clients who terminated therapy prematurely. A client may drop out of therapy because it has been effective and attendance is no longer seen to be necessary by the client, or because of dissatisfaction with ineffective therapy, or for different reasons altogether, such as illness or moving house. As the reasons are largely unknown, the conclusions may not generalise to those clients who terminate therapy prematurely.

Failure to control for 'natural recovery' is regarded as a crucial problem in naturalistic studies such as this one, as it is known that some individuals who receive counselling would have improved in the same period of time without the counselling, particularly when clients' problems are of recent onset (Clark et al., 2008). The waitlist comparator group in this evaluation showed a small improvement during the waiting time (an average of 17 weeks), but showed a large improvement after they received counselling. This suggests that the improvement seen after therapy was not due to natural recovery, but due to the counselling they received.

Failure to control for the effects of concurrent medication is also regarded as likely to result in the overestimation of the effects of counselling (Clark

Table V. Comparison between waitlist and pre-post therapy effect sizes.

Year	n	Referral		Pre therapy		Pre-post waitlist ES	Post therapy		Pre-post therapy ES
		Mean score	SD	Mean score	SD		Mean score	SD	
04–05	112	2.05	0.59	1.88	0.61	0.29	0.94	0.64	1.51
05–06	132	2.03	0.65	1.88	0.66	0.23	1.12	0.73	1.09
06–07	138	2.12	0.68	1.97	0.66	0.22	1.09	0.79	1.21
Total	382	2.06	0.64	1.91	0.65	0.24	1.05	0.73	1.24

Table VI. Moderate to severe severity band.

n	Referral		Pre therapy		Pre-post waitlist ES	Post therapy		Pre-post therapy ES
	Mean score	SD	Mean score	SD		Mean score	SD	
196	2.43	0.51	2.47	0.36	−0.09	1.43	0.78	1.72

et al., 2008). However, with this evaluation, the prescription of medication would have taken place at referral and so medication, along with the self-help material given, is likely to have contributed to the small improvement seen during the waiting time.

Reflections

Over the five years of the evaluation there was considerable time to reflect on the value of routine outcome measurement. From a person-centred standpoint, there were reservations about using a measure that concentrates on symptom reduction rather than the client's subjective process or inner experiencing. PCT is regarded as a process of unique encounter between two people and so there were philosophical concerns about the outcome of therapy as a concept.

Methodological difficulties are known to be associated with the use of outcome measures (see McLeod, 2001), and these were experienced during the evaluation. Often counsellors would voice concerns that the CORE outcomes of a recently discharged client did not truly reflect the therapy that had taken place. However, even though it became evident that an outcome measure such as CORE-OM cannot capture the complex, subtle and personal nuances of therapeutic personality change, it can provide insights into a client's process and give an indication of what has occurred during therapy. Counsellors came to value using CORE-OM both as a therapeutic tool and as part of their personal reflective practice.

From a service standpoint, the rationale for the evaluation changed over the years. Initially it was to meet the requirement for clinical governance, but after the publication of the NICE guidelines and their emphasis on CBT, it became that of demonstrating the effectiveness of PCT to managers and commissioners at a local level, to maintain and increase funding. The PCMHT, of which the counselling service is now a part, aims to meet all the primary care mental health needs of a population and as not everyone wants, or is considered suitable for CBT, an effective alternative to CBT is vital. This evaluation has enabled PCT to become established as that alternative.

Conclusion

This evaluation provides evidence for the effectiveness of Person-Centred Therapy in routine clinical practice in primary care. It indicates that PCT is effective for common mental health problems such as anxiety and

depression. It is not limited to people with mild to moderate symptoms of recent onset, but is also effective with people with moderate to severe mental health problems of longer duration.

Acknowledgements

To Chorley and South Ribble PCT (now Central Lancashire PCT) for funding the service; to the managers, John Holland and Shaun Kenny, for their support and encouragement; to Robert Elliott for his statistical advice; to the administrative staff and to all the counsellors and clients for their hard work and commitment.

Biographical notes

Isabel Gibbard is the Lead Counsellor at Central Lancashire Primary Care Trust.

Terry Hanley is a Lecturer in Counselling at the University of Manchester and an ESRC-funded PhD student at the same institution.

References

- Barkham, M., Margison, F., Leach, C., Lucock, M., Mellor-Clark, J., Evans, C., et al. (2001). Service profiling and outcomes benchmarking using the CORE-OM: toward practice-based evidence in the psychological therapies. *Journal of Consulting and Clinical Psychology*, 69 (2), 184–196.
- Barkham, M., & Mellor-Clark, J. (2003). Bridging evidence-based practice and practice-based evidence: developing a rigorous and relevant knowledge for psychological therapies. *Clinical Psychology and Psychotherapy*, 10, 319–327.
- Barkham, M., Mellor-Clark, J., Connell, J., & Cahill, J. (2006). A core approach to practice based evidence: a brief history of the origins of the Core-OM and Core System. *Counselling and Psychotherapy Research*, 6 (1), 3–15.
- Bewick, B.M., Trusler, K., Mullin, T., Grant, S., & Mothersole, G. (2006). Routine outcome measurement completion rates of the CORE-OM in primary care psychological therapies and counselling. *Counselling and Psychotherapy Research*, 6 (1), 33–40.
- Bower, P., & King, M. (2000). Randomised controlled trials and the evaluation of psychological therapy. In N. Rowland & S. Goss (Eds.), *Evidence based counselling and psychological therapies* (pp. 79–110). London: Routledge.
- Bower, P., Rowland, N., & Hardy, R. (2003). The clinical effectiveness of counselling in primary care: a systematic review and meta-analysis. *Psychological Medicine*, 33, 203–215.
- Bower, P., & Gilbody, S. (2005). Stepped care in psychological therapies: access, effectiveness and efficiency. *The British Journal of Psychiatry*, 186, 11–17.
- Clark, D.M., Fairburn, C.G., & Wessely, S. (2008). Psychological treatment outcomes in routine NHS service: a commentary on Stiles et al. (2008). *Psychological Medicine*, 38 (5), 629–634.
- Cohen, J. (1969). *Statistical power analysis for the behavioral sciences*. New York: Academic Press.
- Department of Health. (1997). *The new NHS modern, dependable*. London: HMSO.

- Department of Health. (1999). *The national service framework for mental health*. London: HMSO.
- Department of Health. (2008). *Improving access to psychological therapies. Implementation plan: national guidelines for regional delivery*. London: HMSO.
- Elliott, R., Greenberg, L.S., & Lieter, G. (2004). Research on experiential psychotherapies. In M.J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behaviour change* (5th ed.; pp. 493–539). New York: Wiley.
- Evans, C., Connell, J., Barkham, M., Margison, F., McGrath, G., Mellor-Clark, J., et al. (2002). Towards a standardised brief outcome measure: psychometric properties and utility of the CORE-OM. *British Journal of Psychiatry*, 180, 51–60.
- Evans, C., Connell, J., Barkham, M., Marshall, C., & Mellor-Clark, J. (2003). Practice-based evidence: benchmarking NHS primary care counselling services at national and local levels. *Clinical Psychology and Psychotherapy*, 10, 374–388.
- Eysenck, H.J. (1952). The effects of psychotherapy: an evaluation. *Journal of Consulting Psychology*, 16, 319–324.
- Friedli, K., King, M., Lloyd, M., & Horder, J. (1997). Randomised controlled assessment of non-directive psychotherapy versus routine general-practitioner care. *Lancet*, 350, 1662–1665.
- Harvey, I., Nelson, S., Lyons, R., Unwin, C., Monaghan, S., & Peters, T. (1998). A randomised controlled trial and economic evaluation of counselling in primary care. *British Journal of General Practice*, 48 (428), 1043–1048.
- McLeod, J. (2001). An administratively created reality: some problems with the use of self-report questionnaire measures of adjustment in counselling/psychotherapy outcome research. *Counselling and Psychotherapy Research*, 1 (3), 215–226.
- Mellor-Clark, J. (2006). Developing CORE performance indicators for benchmarks in primary care psychological therapy and counselling services: an editorial introduction. *Counselling and Psychotherapy Research*, 6 (1), 1–2.
- Mellor-Clark, J., Connell, J., & Barkham, M. (2001b). Counselling outcomes in primary health care: a CORE system data profile. *European Journal of Psychotherapy Counselling and Health*, 4 (1), 65–86.
- Mellor-Clark, J., Sims-Ellis, S., & Burton, M. (2001a). *National survey of counsellors working in general practice: evidence for growing professionalism?* London: Royal College of General Practitioners.
- Mullin, T., Barkham, M., Mothersole, G., Bewick, B.M., & Kinder, A. (2006). Recovery and improvement benchmarks for counselling and psychological therapies in routine primary care. *Counselling and Psychotherapy Research*, 6 (1), 68–80.
- NICE. (2004a). *Clinical guidelines for the management of anxiety in adults in primary, secondary and community care*. London: NICE.
- NICE. (2004b). *Clinical guidelines for the management of depression in primary and secondary care*. London: NICE.
- Roth, T., & Fonagy, P. (2005). *What works for whom. A critical review of psychotherapy research* (2nd ed.). London: Guildford Press.
- Sackett, D., Rosenberg, W., Gray, J., Hughes, B., & Richardson, W. (1996). Evidence based medicine: what it is and what it is not. *British Medical Journal*, 312, 71–72.
- Stiles, W.B., Barkham, M., Twigg, E., Mellor-Clark, J., & Cooper, M. (2006). Effectiveness of cognitive-behavioural, person-centred and psychodynamic therapies as practised in UK National Health Service settings. *Psychological Medicine*, 36, 555–566.
- Stiles, W.B., Barkham, M., Mellor-Clark, J., & Connell, J. (2008). Effectiveness of cognitive behavioural, person centred, and psychodynamic therapies in UK primary-care routine practice: replication in a larger sample. *Psychological Medicine*, 38 (5), 677–688.
- Ward, E., King, M., Lloyd, M., Bower, P., Sibbald, B., Farrelly S., et al. (2000). Randomised controlled trial of non-directive counselling, cognitive behaviour therapy and usual general practitioner care for patients with depression 1: clinical effectiveness. *British Medical Journal*, 321, 1383–2000.