Routine Outcomes Evaluation in Psychotherapy and Counselling within a Community Setting. Research Clinic Outcomes and Reflection.

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Abstract
The research was a naturalistic, non randomised, evaluation of Transactional Analysis (TA) and Gestalt psychotherapies, Integrative Counselling Psychology and Person Centred counselling within a medium term, community based service. Routine outcome evaluation used standardised measures to assess treatment outcomes and working alliance. Adherence to the model was evaluated in clinical supervision. The outcomes showed that clients who engaged in treatment made statistically significant improvements and that Transactional Analysis and Gestalt psychotherapies, Integrative Counselling psychology and Person Centred counselling can be used effectively in treatment of anxiety and depression within a community setting. Clients had a choice about the duration of therapy and used different numbers of sessions within the framework of the service. They were also able to change a therapists. Both choices have clinical implications in terms of attrition and outcomes and require further research.

Key words: Integrative counselling psychology; Transactional Analysis (TA) psychotherapy; Gestalt psychotherapy; routine outcome evaluation, research clinic

Word count: 5529

Introduction

Counselling and psychotherapy within the UK takes place in different settings: statutory, including educational and National Health Services (NHS), private sector and voluntary agencies.
NHS is by far the largest provider of psychological therapies. The provision of services is driven by the government policies and funded by the health departments. Therapy is provided free of charge to the patients.
Voluntary agencies are not for profit or charitable agencies. They are mainly grant funded to provide a range of counselling and psychotherapy services. Therapists operate from a variety of theoretical orientations. Many are students who work free of charge and gain experience required by their training. These organisations tend to respond to the needs of the local communities and fill the gaps statutory services have been unable to meet. They usually require self referral by the clients. Therapy is offered at low cost, or free of charge and is of differing duration. Government health policies in the last ten years have impacted these services because they are primarily dependent on statutory funding.
Private sector is broadly regulated by the professional umbrella bodies. Therapists practice independently and charge for the service. Even within this sector, a number of therapists are

contracted by organisations such as Employee Assistance Schemes and private health insurers, which are guided by the national health policies.
This means that government policies impact all sectors of counselling and psychotherapy, and this influence has grown substantially over the last decade.
Recognition of prevalence of problems such as depression and anxiety in the population by the Department of Health in the (DoH, 2002) and the establishment of the stepped care model for treatment in the NHS have emphasised the importance of collecting routine outcome data in order to develop the quality of services(CSIP Choice and Access Team, 2007). This initiative within the NHS has also emphasised evidence based treatments proscribed by the NICE guidelines, primarily cognitive-behavioural therapy.
Research evidence in this climate has become essential in recognition of therapeutic approaches and treatments, more difficult to develop within the non statutory sector, which has historically provided a wider range of approaches and choices for the client. The lack of research has impacted the voluntary agencies. Moore (2006) questions whether this has led to the lack of understanding and devaluing of this sector.
The research clinic at Metanoia Institute (MCPS) has many features of a voluntary agency. It is a low cost counselling and psychotherapy service serving a multicultural, multiethnic, inner city community. However, it operates within an academic environment of a psychotherapy training institute (Metanoia Institute) and has access to research resources.
The service has become a research clinic in 2010, following an evaluation project in primary care (van Rijn, Wild, & Moran, 2011).

Aims of the research were:

- To evaluate the outcomes and the impact of humanistic and integrative psychotherapies (Transactional Analysis, Gestalt, Integrative Counselling Psychology) and Person Centred counselling in routine practice. Apart from Person Centred counselling, these humanistic and Integrative psychotherapies have had limited evaluation so far (Van Rijn, Wild, & Moran, 2012)
- To investigate differences in outcomes between clients who engaged in therapy and those that didn't

This paper will focus on the outcomes between 2010 and 2011 as well as the questions and complexities encountered during the year.

Literature

There is a wealth of research evidence for the efficacy and effectiveness of psychotherapy in general, although some approaches are more represented than others. Efficacy research, based on randomised control trials focuses on the impact of treatments on specific diagnostic categories. A research body of evidence for efficacy of cognitive behavioural therapies for depression and anxiety has lead to it becoming recognised by the clinical guidelines in the UK (NICE). The policy of Increasing Access to Psychological Therapies (IAPT) within the UK, evaluated cognitive-behavioural therapy for depression and anxiety within the NHS (D.M. Clark et al., 2009), using large scale routine outcome evaluation.

Generic counselling has also been evaluated in primary care in individual studies (Mellor-Clark, Connell, Barkham, & Cummins, 2001; W.B. Stiles, Barkham, Mellor-Clark, & Connell, 2008; W. B. Stiles, Barkham, Twigg, Mellor-Clark , & Cooper, 2006) and systematic reviews (Bower, Rowland, & Hardy, 2003; Hill, Brettle, Jenkins, & Hulme, 2008). All demonstrated its effectiveness in primary care. However, humanistic and Integrative approaches such as TA, Gestalt and Integrative psychotherapies have had very limited evaluation even though they are practiced in a variety of settings and taught in higher education. The voluntary sector practice has also had a very limited level of evaluation even though the existing research shows it to be as effective as the NHS with similar clinical presentations(Moore, 2006). This literature demonstrates a gap in research into these approaches and the practice in non health based settings.

Type of evaluation appropriate to psychotherapy also raises questions. The use of routine outcome measures in primary care, mostly using CORE 34(Barkham et al., 2001) has lead to the development of service benchmarks(Mullin, Barkham, Mothersole, Bewick, & Kinder, 2006). Despite this, evaluation in naturalistic, non randomised conditions has some methodological problems (D. M. Clark, Fairburn, & Wessely, 2008). A percentage of clients completing the measures was limited; there was no evidence of the approach therapists practiced and no evidence that it was the treatment that produced the outcomes. These questions about the internal (methodological) validity of naturalistic evaluation have to an extent been counterbalanced by the external validity of these studies (Stirman, DeRubeis, Crits-Christoph, & Brody, 2003). Clients and therapists were not chosen for research, and therapy was representative of general clinical practice. This gave credence to the generalisability of the findings and a potential to develop practice (Rao, Hendry, & Watson, 2010). However, addressing methodological issues is relevant in gaining more overall validity and (Nathan, Stuart, & Dolan, 2000) suggested the integration of the features of both methodologies in the establishment of research clinics. This approach was used at Metanoia Institute, initially in the evaluation of a brief Transactional Analysis and Integrative Counselling Psychology in primary care (van Rijn, et al., 2011) and further developed in the current project.

The Setting

The counselling and psychotherapy service where the research clinic was established has been operating since 1995. Metanoia Counselling and Psychotherapy Service (MCPS) provide a low cost, counselling and psychotherapy to the general public. Treatment can be extended to up to year, depending on the client's need and availability.

Research Aims and Methodology

The project was a naturalistic, non-randomised, evaluation of routine outcomes of Transactional Analysis and Gestalt psychotherapies, Integrative Counselling Psychology and Gestalt and Person Centred counselling. Differences between the approaches have not been evaluated due to the sample size.
Treatment was not manualised, but the adherence to the theoretical model was monitored in clinical supervision and evaluated.

Therapists

Therapists were second year students at Metanoia Institute. They were focused on starting to practice within their approach, even though some have had previous practice experience, or worked in a related field. They had regular clinical supervision at a ratio of one hour of supervision per four hours of clinical practice.
There were 67 practitioners during the year.

Clients

Clients were representative of the voluntary sector. They self referred to the service having heard about it from their GP, another voluntary agency or a word of mouth. There were 321 clients during the year. The profile of the clients for the year remained unchanged in comparison to the previous years and reflected the ethnic mix of the area.
72% of clients were female, 67% white British, 16.25% Asian and Black. 33.4% were in full time employment, which was a slight decrease to the previous year and reflected the economic conditions in the area.
Average age of clients seen was 38. The majority were between 20 and 49 (82.17%), 15.29% were over 50 and 1.27% under 20.
Clients presented to the service with a range of difficulties. Routine Outcome Measures (PHQ9,GAD7 and CORE 10 and 34) were given at the assessment and formed the additional sources of information for case formulation about depression, anxiety and general levels of distress.

Research clinic used ‘caseness’ as a measure of severity of distress, in the way used by the NHS and defined by the CORE System Ltd.

Table 1 Research Sample Caseness levels

The service also had the exclusion criteria in line with similar services and primary care settings. They were:

- Severe and enduring mental health problems such as psychotic disorders or personality disorders where these problems are (1) the primary problem or (2) may significantly interfere with treatment
- Dependent drug or alcohol users where drug or alcohol use is the primary problem or who are not stable
- Learning Difficulties

Assessors gave written information about the research to clients, answered further questions about the research and sought consent. Clients who decided not to take part, or withdraw from research during treatment continued to receive the service.

Treatment

After the initial contact, clients had an assessment session with an assessor. The assessment format has previously been developed for the service by the Head of Clinical and Research Services at Metanoia Institute(Bager-Charleson & Van Rijn, 2011), and highlighted presenting issues (such as current symptoms and functioning), developmental history and risk.
Following the assessment session clients were referred to practitioners, who offered an initial four exploratory sessions. The aim was to explore whether a working relationship could be established and a focus for therapy. If clients decided to change a therapist at this stage, they would be referred to another practitioner. Practitioners could also decide if they were unable to meet the needs of a particular client. A client would then be referred on.
The exploratory sessions aimed to offer additional safety for both the therapist and the client.
Therapists were instructed to use the outcome measures as a part of therapy, as well as for research. These conversations usually took place at the beginning of a session, when clients handed measures to therapists.

Measures

Adherence to the theoretical approaches

All sessions were audio-recorded. Clinical supervisors listened to the recordings for each client once every six sessions and assessed whether the approach matched the theoretical approach. The role of the supervisor was to both assess and support the student in developing their adherence to the model. This role was formalised by the use of adherence questionnaires.
Adherence questionnaires have been designed by the tutor teams for each theoretical approach, used in previous research and published (van Rijn, et al., 2011) The adherence to the model was evaluated using a five point scale ranging from 'No adherence' (1) to 'Full adherence' (5)

Clinical Evaluation Measures

Measures at the assessment, sixth session and at the end of therapy:

- Beck's Depression Inventory(Beck, 1996):a 21 item questionnaire measuring depression.
- CORE 34(Barkham, et al., 2001): a 34 item questionnaire focusing on categories of well being, functioning, problems/ symptoms and risk and distinguishing between clinical and non clinical populations.

Measures post each session:

- Patient Health Questionnaire,PHQ-9, (K. Kroenke, Spitzer, & Williams, 2001): a nine item questionnaire which distinguished between clinical and non clinical populations
- General Anxiety Measure, GAD -7(Spitzer, Kroenke, Williams, & Lowe, 2006): a seven item questionnaire which was initially developed for the Generalized Anxiety Disorder and found to have sensitivity for other anxiety disorders (K. Kroenke, Spitzer, Williams, Monahan, & Lowe, 2007)
- CORE 10(CORE Information Management Systems Ltd., 2007): a 10 item questionnaire focusing on categories of well being, functioning, problems/ symptoms and risk and post each session
- Working Alliance Inventory (Horvath, 1986): a 12 item questionnaire developed to measure working alliance as defined by Bordin (Bordin, 1979)

Ethical Considerations

Clients had a right to withdraw from the project at any time during treatment. Outcomes were discussed transparently between the therapists and the clients. All the data was confidential and anonymised before analysis.
Therapists chose to practice within the research clinic.
The Metanoia Institute Ethics Committee (an independent body approved by the Middlesex University) had given an ethical consent to the project.

Research Sample

The analysis was undertaken using two software packages, CORE PC, for the analysis of the CORE 34 data and SPSS, which encompassed all the data.
Table 2 shows that there were altogether 346 cases during the year, the number of cases included clients who had been reallocated within the assessment period, which is why a number of cases is higher than the overall number of clients (321).A proportion of clients were not accepted into the service. Some clients opted out of research, but continued in therapy. Outcomes were divided into three groups
Group 1 represented cases where clients engaged in therapy after the assessment period (assessment session and the four exploratory sessions).
Group 2 represented cases where clients did not engage in therapy past the assessment period. There were no adherence questionnaires, as the supervisors only completed adherence forms at session 6.
Group 3 represented cases where there were no adherence forms for the treatment. The evaluation was incomplete, and these cases were excluded from further analysis.

Table 2 Research Sample

Number of Sessions

Average number of sessions for Group 1 was 17.48 sessions. There was a difference in the length of therapy, as shown in Table 3.

Table 3. Group 1 Number of Sessions

The average number of sessions for Group 2 was 2.5 sessions. 62.8% of clients in Group 2 asked to be reallocated to another practitioner. Their average number of sessions after reallocation was 12.

Data completeness

Table 4 shows a percentage of data completeness for measures in cases for Group 1 where the clients have engaged in therapy and Group 2 where clients have ended during the assessment period.

Table 4 Data completeness

Outcomes

The tables 5 and 6 below show the descriptive statistics for each group. The measures of central tendency were close in value suggesting a few or no outliers affecting the sample. However, the standard deviations for all the measures were large in comparison to the mean. This demonstrated a wide spread of scores from the mean in the sample on all of the measures and across all the groups. It inferred that clients were entering therapy with a wide range of levels of distress, ending therapy at a wide range of levels and achieved change differently from each other. The wide spread of scores has been examined statistically using Kolmogrov-Smirnov test to establish whether the sample has a normal distribution of scores. The test shows a mixture of distributions for all the measures where pre score and post scores may be normally distributed but the difference scores are not or vice versa.

The large standard deviations suggested that the mean might not be reliably representative of all the scores in the sample. These figures also illustrated a negative skew in scores for all measures except the WAI which has a positive skew in scores, or floor and ceiling effects respectively. This can be seen by examining the Mode, the most frequent score represented in the sample. This suggested that by the end of therapy the majority of the clients were reporting less distress on the

measures producing more scores at the lower end of the scales except in the working alliance where the majority of the scores were high indicating a high level of working alliance between the clients and the practitioners.

Table 5 Descriptive Statistics Group1

Table 6 Descriptive Statistics Group 2

Improvement rates

Criteria for improvement were calculated it by the difference between scores at the start of therapy and at the end of therapy As there were clear ceiling and floor effects in the data, the percentage Improvement, No Change and Deterioration were calculated for the sample. The descriptive statistics showed that post-therapy scores were mainly low with the exception of the WAI which is high. Tables 7and 8 contain the percentage improvement scores for Groups 1 and 2.

Table 7 Improvement Rates Group 1

Table 8 Improvement Rates Group 2

The percentage improvement clearly supported the descriptive statistics. Large percentages of improvement demonstrated low scores at the end of therapy in comparison to the start of therapy. To examine this further, the data was tested to establish if these improvements rates were significant. As there was Mixture of normal and non-normal distributions in our sample a Wilcoxon Signed Ranks test has been used to examine the difference between pre and post-therapy scores. They have shown that the difference between pre and post scores for all measures was significant at $P<0.01$ for Group 1 and the direction of the difference was represented by the negative *Z* score in the table where scores were decreasing from pre to post therapy. These all have large effect sizes. Group 2 significance at $P<0.05$ was only achieved for Core 34 with a large effect size. The large number of missing cases affected the reliability of the outcomes.

Table 9 and Table 10 show the Z scores for groups 1 and 2

Table 9 Group 1, Z Scores

Table 10 Group 2, Z Scores

Which Variables Accounted for Change?

A regression was been carried out to investigate which of the variables accounted for the greatest change in clients' scores from pre to post therapy and which variable had the greatest impact on post-therapy scores. Total Attendance, Pre score (Severity), Adherence Score and WAI total score were entered stepwise into the regression. A regression could only be performed on Group 1 data as Group 2 had too many missing cases. The regression showed that Severity (Pre Scores) and WAI accounted for a significant proportion of the variation in the regression model for post scores and change scores on all measures except the Core 34 change score at $P < 0.05$ and are as follows:

- BDI-II Post - □ = .47, *t*= (142) =4.71, severity and □ = -.29, *t*= (142) =-2.96, WAI explained a significant proportion of the variance in scores, where adjusted R^2 = .252, *F* (2, 75) =13.96 which is a large effect.

- BDI-II Change -□ = .42, *t*= (142) =4.16, severity and □ = .2.16, *t*= (142) =2.16 WAI explained a significant proportion of the variance in scores, adjusted R^2 = .227, *F* (4, 77) =12.63 which is a large effect.

- PHQ-9 Post - □ = .29, *t*= (142) =3.4, severity and □ = .29, *t*= (142) =-3.43 WAI explained a significant proportion of the variance in scores, adjusted R^2 = .149, *F* (2, 115) =11.24 which is a large effect.

- PHQ-9 Change - □ = .682, *t*= (142) =10.68, severity and □ = .231, *t*= (142) =3.62 WAI explained a significant proportion of the variance in scores, adjusted R^2 = .523, *F* (2, 115) =65.1 which is a large effect.

- GAD Post - □ = .232, *t*= (142) =2.69, severity and □ = -.307, *t*= (142) =-3.56 WAI explained a significant proportion of the variance in scores, adjusted R^2 = .125, *F* (2, 116) =9.47 which is a large effect.

- GAD Change - □ = .6, *t*= (142) =8.5, severity and □ = 0.25, *t*= (142) =3.5 WAI explained a significant proportion of the variance in scores, adjusted R^2 = .423, *F* (2, 116) =44.18 which is a large effect.

- Core 34 Post - □ = .455, *t*= (142) =4.613, severity explained a significant proportion of the variance in scores, adjusted R^2 = .21, *F* (1, 85) =23.12 which is a large effect.

- Core 10 Post - □ = .29, *t*= (142) =3.48, severity and □ = -.32, *t*= (142) =-3.8 WAI explained a significant proportion of the variance in scores, adjusted R^2 = .2, *F* (2, 113) =14.9 which is a large effect.

- Core 10 Change - β = 0.52 t= (142) =6.5, severity and β = .26, t= (142) =3.28 WAI explained a significant proportion of the variance in scores, adjusted R^2 = .29, F (2, 113) =24.36 which is a large effect.

These results suggested that severity accounted for the greatest variation in client's scores. Those with the highest scores pre therapy showed the greatest difference on the outcome measures between pre and post therapy or the greatest amount of change during therapy. Some of this might have been due to the sensitivity of the measures as they could not capture change from clients with moderate or low pre therapy scores. The regression model indicated that severity and working alliance were good predictors of clients' therapy outcomes.

Discussion

Evaluation of Outcomes

The outcome measures showed that clients who engaged in therapy, achieved a very high rate of improvement of over 70% on sessional measures for depression, anxiety and general outcomes measured by CORE 10.

The project was not designed as a randomised control trial, and we cannot say that the treatment alone had caused a change in scores. Clients were not randomised, treatment was not manualised and the researches did not know about other variables in clients' lives that could have affected the outcomes.

Apart from therapy and the unknown variables, using routine outcome evaluation might also have had an impact on the effectiveness. Research suggests that providing feedback to therapists improves outcomes(Lambert et al., 2002; Miller, Duncan, Brown, Sorrel, & Chalk, 2006) and the way the outcome measures were used within the project aimed to highlight that aspect of evaluation.

Adherence to the model was high on average, as would be expected with trainee therapists who were being trained in their model and did their best to practice it. The outcomes suggested that these therapies were effective in clinical practice in this project..

High completion rates for CORE 10, GAD -7, PHQ -9, and WAI competed by over 90% of the clients, suggested that the outcomes were reliable.

Completion rates for the longer questionnaires, BDI-II and CORE 34 , although lower, were still higher than the benchmarked figure of 39% (Mullin, et al., 2006). The lower completion rates reflected unplanned endings, but the sessional evaluation showed that clients improved by then.

Length of therapy

Despite the fact that six months to a year of therapy were on offer, the length of therapy varied following the assessment period, but in itself did not have a significant impact on the outcomes. This could suggest that the optimal number of sessions for clients was individual. A collaboration between the therapist and a client about the length of therapy could be more productive than a proscribed number of sessions favoured by the majority of health settings.

Working Alliance

Clients who had a better working alliance with their therapist achieved more change, in line with previous research (Horvarth & Bedi, 2002; Horwath, Del Re, Fluckiger, & Symonds, 2011). Research clinic was structured in such a way that therapists and clients talked about the outcomes and their working alliance during therapy and addressed ruptures and misattunements. The aim was to empower clients and enhance therapy and this could have impacted the outcomes.

Challenges

Routine Outcome evaluation poses a number of challenges to researchers due to taking place within practice based settings, with complex variables dictated by practice, rather than research. These challenges limit claims about causality and effectiveness but demonstrate the realities of clinical practice.

One of the challenges within this project was that it highlighted a group who decided not to proceed with their therapists (Group 2). Due to the assessment structure at the project, Group 2 was specific to this setting. A high level of attrition is one of the clinical realities of low cost clinics and health settings but there is a paucity of research in this area.

In the few sessions they had (an average of 2.5), these clients did not achieve as much change as the Group 1. However, 62.8 % who decided to change therapists engaged well with their next therapist and had similar outcomes to the rest. This might suggest that closer matching of therapists and clients could be important in increasing levels of attendance. This would probably need to be beyond gender and ethnicity preferences , which are a common practice.

Qualitative research could give further, more in depth, insight into this process and assist therapists and organisations.

Implications for Practice and Research

The research highlighted several implications for practice and further research:

- Transactional Analysis and Gestalt psychotherapies, Integrative Counselling psychology and Person Centred counselling can be used effectively in treatment of anxiety and depression within a community setting. A Randomised Control Trial would be required to establish efficacy of these approaches.

- A choice in the length of treatment might be more effective than the 'one size fits all' approach. Further research into this area would be helpful in designing and using the psychotherapy and counselling services more effectively.

- More qualitative research is needed in the process of assessment and matching of therapists and clients,

References:

Bager-Charleson, S., & Van Rijn, B. (2011). *Understanding Assessment in Counselling and Psychotherapy*: Learning Matters.

Barkham, M., Margison, F., Leach, C., Lucock, M., J., M.-C., & Evans, C. (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*, 184-196.

Beck, A. (1996). United States of America Patent No. 0154018392.

Bordin, E. S. (1979). The Generalizability of the Psychoanalytic Concept of the Working Alliance. *Psychotherapy: Theory, Research, Practice, 16*(3), 252-260.

Bower, P., Rowland, N., & Hardy, G. (2003). The clinical effectiveness of counselling in primary care: a systematic review and meta-analysis. *Psychological Medicine, 33*(2), 203-215.

Clark, D. M., Fairburn, C. G., & Wessely, S. (2008). Psychological treatment outcomes in routine NHS services: a commentary on Stiles et al.(2007). *Psychological Medicine, 38*(5), 629-634.

Clark, D. M., Layard, R., Smithies, R., Richards, D. A., Suckling, R., & Wright, B. (2009). Improving access to psychological therapy: Initial evaluation of two demonstration sites. *Behaviour Research and Therapy, 47*, 910-920.

CORE Information Management Systems Ltd. (2007). CORE Net. from http://www.coreims-online.co.uk:

CSIP Choice and Access Team. (2007). *Comissioning a Brighter Future.Improving Access to Psychological Therapies.A Positive Practice Guide.*

DoH. (2002). *A National Service Framework for Mental Health*: London: Department of Health.

Hill, A., Brettle, A., Jenkins, P., & Hulme, C. (Eds.). (2008). *Counselling in Pimary Care:a Systematic Review of evidence*: British Assosiation for Counselling and Psychotherapy.

Horvarth, A. O., & Bedi, R. P. (2002). The Alliance. In J. C. Norcross (Ed.), *Psychotherapy Relationships That Work. Therapist Contributions and Responsiveness to Patients* (pp. 37-69): Oxfrod University Press.

Horvath, A. O. (1986). *Another Approach to Assess the Counselling Relationship:The Working Alliance*. Paper presented at the American Educational Research Association.

Horwath, A. O., Del Re, A. C., Fluckiger, C., & Symonds, D. (2011). Alliance in Individual Psychotherapy. In J. C. Norcross (Ed.), *Psychotherapy Relationships that Work. Evidence Based Responsiveness*
(pp. 25-69). Oxford: University Press.

Kroenke, K., Spitzer, R. L., Williams, J., Monahan, P. O., & Lowe, B. (2007). Anxiety Disorders in Primary Care: Prevalence, Impairment, Comorbidity, and Detection. *Annals of Internal Medicine, 146*(317-325).

Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9: Validity of a Brief Depression Severity Measure. *Journal of General and Internal Medicine, 16*, 606-613.

Lambert, M. J., Whipple, J. L., Vermeersch, D. A. D., Smart, W., Hawkins, E. J., Nielsen, S. L., et al. (2002). Enhancing Psychotherapy Outcomes via Providing Feedback on Client Progress: a Replication. *Clinical Psychology & Psychotherapy, 9*(2), 91-103.

Mellor-Clark, J., Connell, J., Barkham, M., & Cummins, P. (2001). Counselling Outcomes in Primary Health Care: a CORE System Data Profile *European Journal of Psychotherapy & Counselling 4*(1), 65-86.

Miller, S., Duncan, B., L., Brown, J., Sorrel, R., & Chalk, M. B. (2006). Using Formal Client Feedback to Improve Retention and Outcome:Making Ongoing Real -Time Assessment Feasable. *Journal of Brief Therapy, 5*(1), 5-21.

Moore, S. (2006). Voluntary sector counselling: Has inadequate research resulted in a misunderstood and underutilised resource? *Counselling and Psychotherapy Research, 6*(4), 221-226.

Mullin, T., Barkham, M., Mothersole, G., Bewick, B. M., & Kinder, A. (2006). Recovery and Improvement Benchmarks in Routine Primary Care Mental Health Settings *Counselling & Psychotherapy Research, 6*(1), 68-81.

Nathan, P. E., Stuart, S. P., & Dolan, S. L. (2000). Research on Psychotherapy Efficacy and Effectiveness: Between Scylla and Charybdis?. *Psychological Bulletin, 126*(6), 964-981.

Rao, A. S., Hendry, G., & Watson, R. (2010). The Implementation of Routine Outcome Measures in a Tier3 Psychological Therapies Service:The Process of Enhancing Data Quality and Reflections of Implementation Challenges. *Counselling & Psychotherapy Research, 10*(1), 32-38.

Spitzer, R. L., Kroenke, R., Williams, J. B., & Lowe, B. (2006). A Brief Measure for Assessing Generalized Anxiety Disorder: the GAD-7. *Archives of Internal Medicine, 166*, 1092-1097.

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.

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 the UK National Health Service Settings. *Psychological Medicine*(36), 555-566.

Stirman, S. W., DeRubeis, R. J., Crits-Christoph, P., & Brody, P. E. (2003). Are samples in randomized controlled trials of psychotherapy representative of community outpatients? A new methodology and initial findings. *Journal of Consulting and Clinical Psychology, 71*(6), 963-972.

van Rijn, B., Wild, C., & Moran, P. (2011). Evaluating the Outcomes of Transactional Analysis and Integrative Counselling Psychology within UK Primary Care Settings. *International Journal of Transacational Analysis Research, 2*(2), 34-43

Van Rijn, B., Wild, C., & Moran, P. (2012). Evaluation of Integrative Counselling Psychology and Transactional Analysis in Primary Care Health Setting. *Journal of Integrative Research,Counselling and Psychotherapy, 1*(1), 36-46.

Table 1 Research Sample Caseness levels

	Group 1 Caseness Start %				Group 2 Caseness Start %				Group 3 Caseness Start %			
	PHQ 9	GAD 7	Core 34	Core 10	PHQ 9	GAD 7	Core 34	Core 10	PHQ 9	GAD 7	Core 34	Core 10
Caseness	62.3	79	55.8	83.3	57.3	67.3	39.1	74.5	54.1	78.4	29.7	89.2
Non-Caseness	37.7	21	18.8	15.2	37.3	27.3	10.4	18.2	45.9	21.	16.2	10.
Missing			25.4	1.4	5.5	5.5	50	7.3			54.1	

Table 2 Research Sample

	Research Cases SPSS	Cases not accepted into the service	Cases Opted out	Group 1 5 sessions or more	Group 2 4 or less sessions	Group 3 7 or more sessions without adherence
No	346	16	45	138	110	37
%	100	4.6	13	40	32	10.7

Table 3. Group 1 Number of Sessions

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1-12 weeks	51	37.0	37.0	37.0
	13-24 weeks	57	41.3	41.3	78.3
	25 plus weeks	30	21.7	21.7	100.0
	Total	138	100.0	100.0	

Table 4 Data completeness

DATA COMPLETENESS %	PHQ-9	GAD-7	CORE 10	CORE 34	BDI-II	WAI
GROUP 1	99.3	99.3	97.9	74.5	62.8	95.8
GROUP 2	57.2	59.2	59.2	12.6	49.5	26.2

Table 5 Descriptive Statistics Group1

Group 1

	BDI			PHQ-9			GAD-7			Core 34			Core 10			WAI		
	Pre	Post	Diff	S1	Post	Diff	S1	Post	Diff	Pre	Post	Diff	S1	Post	Diff	S1	Post	Diff
Mean	24.44	11.56	12.43	11.08	5.89	4.91	10.57	5.75	4.86	1.7279	1.0619	.595	16.11	6.10	5.83	63.18	70.42	8.55
Median	22.0	8.50	12.0	10.0	4.5	4.0	10.0	5.0	5.0	1.740	.9300	.720	16.0	5.00	5.0	64.50	72.0	7.00
Mode	20	4	12[a]	8	0[a]	5	7	0	5	1.47	.26	.26[a]	15	0	4	67[a]	84	0
Sd	10.83	10.32	10.58	5.91	5.01	6.33	4.76	4.76	5.63	.6763	.7938	.88	7.01	5.523	6.97	12.712	13.11	12.02

a. Multiple modes exist. The smallest value is shown

Table 6 Descriptive Statistics Group 2

Group 2

	BDI			PHQ-9			GAD-7			Core 34			Core 10			WAI		
					P			P										
	Pre	Post	Diff	S1	os t	Diff	S1	os t	Diff	Pre	Pos t	Diff	S1	Post	Diff	S1	Post	Diff
Mean	23.27	22.55	7.33	9.73	7.79	1.42	9.05	8.90	.52	1.6851	1.157	.4969	14.87	13.75	1.49	55.44	63.31	3.22
Median	25.0	24.0	5.0	9.0	6.0	1.0	8.0	9.0	.00	1.850	1.120	.440	15.0	14.0	2.0	58.0	64.5	2.00
Mode	26[a]	4	0[a]	9	4[a]	0[a]	7[a]	6	0	1.97	.32[a]	.44	14[a]	19	2[a]	57	60[a]	0
Sd	10.84	14.4	7.74	5.88	5.7	4.42	5.5	5.7	5.13	.6648	.8	.6281	7.81	8.37	7.85	17.40	14.62	11.50

a. Multiple modes exist. The smallest value is shown

Table 7 Improvement Rates Group 1

%	BDI-II	PHQ-9	GAD-7	Core 34	Core 10	WAI
Improve	59.9	77.5	77.5	64.7	79.6	71.7
No Change	2.9	6.9	5.1	0.7	5.1	7.2
Deteriorate	3.6	15.9	17.4	13.2	15.3	19.6
No Data	33.6			20.6		1.4

Table 8 Improvement Rates Group 2

%	BDI-II	PHQ-9	GAD-7	Core 34	Core 10	WAI
Improve	4.6	34.6	28.4	9.2	39.4	14.8
No Change	0.9	9.3	10.1	.9	3.7	4.6
Deteriorate	0.9	16.8	22.9	4.6	17.4	9.3
No Data	93.6	39.3	38.5	85.3	39.4	71.3

Table 9 Z Scores for Group 1

Test Statistics[c]

	PostBDI1 - PreBDI	PostScore1 - PHQ9S1	PostScore2 - GAD7S1	PostCore341 - PreMeanTotal	PostScore3 - CORE10S1	PostScoreTotal - WAS1Total
Z	-7.433[a]	-7.136[a]	-7.345[a]	-6.159[a]	-9.145[a]	-5.088[b]
Asymp. Sig. (2-tailed)	.000	.000	.000	.000	.000	.000
Effect Size	-0.83	-0.64	-0.65	-0.64	-0.81	-0.58

a. Based on positive ranks.
b. Based on negative ranks.
c. Wilcoxon Signed Ranks Test

Table 10 Z Scores for Group 2

	PostBDI1 - PreBDI	PostScore1 - PHQ9S1	PostScore2 - GAD7S1	PostCore341 - PreMeanTotal	PostScore3 - CORE10S1	PostScoreTota - WAS1Total
Z	-1.428[a]	-2.702[a]	-3.364[a]	-.910[a]	-3.657[a]	-3.232
Asymp. Sig. (2-tailed)	.153	.007	.001	.363	.000	.00
Effect Size	-0.45	-0.62	-0.6	-0.24	-0.61	-0.6

a. Based on positive ranks.
b. Based on negative ranks.
c. Wilcoxon Signed Ranks Test