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Evidence Based Practice:
A Guide for Counsellors and Psychotherapists

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There has been an increasing tendency for healthcare policy makers and managers to require that all forms of therapy are supported by rigorous research evidence. This paper, which has also been distributed as an Information Sheet to all members of the British Association for Counselling and Psychotherapy (BACP), provides a practitioner-oriented introduction to evidence-based practice, with suggestions for further reading on this topic.

What is evidence based practice?

The foundation of evidence based practice is that, when we intervene in the lives of others, we should do so on the basis of the best evidence about the intervention and its likely outcome (MacDonald, 1998). Evidence based practice has been defined as the "conscientious, explicit and judicious use of current best evidence in making decisions about the care of individuals" (Sackett et al., 1996).

This represents a deliberate shift away from the "allocation of funds … based on the opinions of experts" towards reliance on "detached arguments with 'hard' evidence as to the gain to be expected from the patients" angle and the cost (Cochrane, 1972). Thus, the best possible evidence should be readily accessible to all, including those who use services and those who manage and fund them. As such, evidence based practice may yet lend itself to an egalitarian shift away from knowledge only available to, and wielded by, an elite expert few. Inevitably though, and particularly in complex interventions such as counselling and psychotherapy, what is important is the quality of the evidence as well as its dissemination and implementation.

The driving forces behind evidence based practice in the UK

Evidence based practice has been increasingly influential since the 1970s and 80s. Its

development has been partly fuelled by economic and political pressures but also by the ethical need for continual development of best practice. In a world where resources are limited and cannot entirely meet demand, to offer services to one person may, in effect, deny them for someone else. Even in private practice, clients have the right to expect that they are getting the best value for money.

Other major motivations behind the development of evidence based practice have been the rapid increase in the numbers of options available to doctors and patients, exemplified by the rapid growth of counselling provision, and a focus on the empowerment of those who use services. Inevitably, these factors have meant that there is increased demand for services to be accountable and to provide detailed information on their effectiveness.

The international **Cochrane Collaboration** (www.cochrane.co.uk) is of central importance and aims to help people make well informed decisions about health care by preparing, maintaining and ensuring access to systematic reviews of the effects of health care interventions of all kinds, including counselling and psychotherapy.

Much work on evidence based practice is global. For instance, the Cochrane Collaboration Anxiety and Neurosis Group is based in Auckland, New Zealand, technical help comes from Denmark and the co-ordinator is in London. The database itself (which is updated quarterly) is available in most district hospitals in the UK and elsewhere. All this means rapid global dissemination updated regularly. The quality of evidence remains crucial, however.

In the UK, the NHS, the largest single employer of counsellors and psychotherapists, has adopted evidence based practice as a central tenet of policy. The NHS **Centre for Reviews and Dissemination** (CRD) (www.york.ac.uk/inst/crd/) provides high quality reviews of research evidence and disseminates evidence, including helping people get research findings adopted in practice. Other important organisations include the **Centre for Health Information Quality** (CHIQ) (www.hfht.org/chiq/), the **National Institute for Clinical Excellence** (NICE) (www.nice.org.uk/) and the **Commission for Health Improvement** (CHI) (www.chi.nhs.uk/).

The **National Collaborating Centre for Mental Health** (http://www.rcpsych.ac.uk/cru/nccmh.htm) is one of six collaborating centres established by NICE and is responsible for guideline development and related audit activities in the NHS. Its work programme for 2002, for example, will focus on three areas:

Schizophrenia: it is anticipated that the completed guideline will be available in the late [northern] summer of 2002.

Depression: work on this guideline started in July 2001.

Eating disorders: work started on this guideline in late 2001.

Readers should also note that the NHS Executive produce an Evidence-based Health Care – Critical Appraisal Skills Programme including an Evidence-based Health Care workbook and CD-ROM.

The building blocks of evidence based practice

Generating the "best" evidence

The definition of evidence based practice (Sackett et al., 1996, above) takes an entirely neutral stance in relation to the types of evidence that should be considered and which should carry the most weight. However, there remains much controversy about which types of research should be considered to evaluate what can and cannot be achieved through counselling and the psychological therapies. It can be argued, for example, that some forms of research are inherently biased in favour of those therapeutic models that are most amenable to the types of data they produce. In fact, many approaches to research can contribute to the evidence base.

Randomised controlled trials (RCTs) are often accorded particular significance because of their ability to demonstrate the effect of an intervention in direct comparison with an alternative. People are randomly allocated to either an "experimental group", who will receive the intervention being tested, or to a control group who may be offered no treatment, an alternative intervention or routine care. The control group is crucial as some people will get better anyway. Indeed, any number of outside events can alter the outcomes that might be reported. Randomly allocating people to one group or the other means that each group should be as similar as possible. RCTs are rigorous and offer great opportunities for monitoring the average effects of an intervention across large numbers of people. Their strength lies in their ability (through randomisation) to offer a secure way to evaluate an intervention. They also have the significant strengths of standardisation and logical, statistical power. However, RCTs have drawbacks when used to research counselling and other psychological therapies (Rowland et al., 2000). For example, they are expensive and complex to run and very difficult for those without major funding. Furthermore, it is difficult to standardise many psychological interventions because, outside the research setting, most practitioners do not stick to a single, pure type of therapy (Parry, 2000). It is difficult to make RCTs conform to their theoretical ideal while still representing the everyday experience of practitioners.

Alternatives include **pragmatic trials** and other more **naturalistic studies** that attempt to investigate what happens in "real life". Such "practice based evidence" (Barkham & Mellor-Clark, 2000) seeks to make use of the data from normal, everyday practice, as opposed to asking what can be demonstrated under strictly controlled

(and so atypical) experimental conditions. Its weakness, of course, is that naturalistic data generally comes with all the unpredictable, complex interactions of differing influences on outcomes. Nonetheless, practice based evidence and audit also raises the possibility of the routine evaluation of clinical practice for all practitioners and is of vital importance.

Qualitative approaches have been undervalued in evidence based practice. However, there is increasing recognition given to the diversity of evidence types that should be given weight (Dixon-Woods & Fitzpatrick, 2001). Qualitative methods have a crucial role to play and their importance is stressed by the Cochrane Collaboration and proponents of evidence based practice (Dixon-Woods et al., 2001; MacDonald, 1998; NHS Centre for Reviews and Dissemination, 2001). Qualitative research allows therapy to be judged in terms of the criteria applied by clients and counsellors and is relatively accessible (McLeod, 2001). Furthermore, its rich data allows us to get a detailed appreciation of how the counselling operates and why it was effective or ineffective. It may also be more sensitive to criticisms of therapy than quantitative approaches and self-report questionnaires. McLeod (2000) suggests that when we have several hundred qualitative outcome studies we will be in a better position to judge its contribution.

Systematic reviews

No matter what method is used to generate evidence, research findings need to be synthesised into coherent, useful statements to guide both clinicians and service users. In contrast to less formal ways of reviewing research evidence, systematic reviews aim to ensure a rigorous and objective approach to evaluating and summarising research findings. Two examples in this field are reviews of brief interventions following trauma (Rose & Bisson, 1998; Rose et al., 2001) and of counselling in primary care (Rowland et al., 2001).

Systematic reviews use clear, explicit inclusion and exclusion criteria to identify all the relevant, good quality research through a rigorous and systematic search. The quality of different studies is assessed before combining them, where possible, to produce overall statements about the sum of our knowledge on the topic being reviewed.

An advantage of systematic reviews is that data from studies that are too small to provide clear findings can be pooled. Underpowered research can thus contribute to a clearer overall conclusion about outcomes. The pooling of data and its statistical analysis can be useful, but the clinical significance of findings must not be overlooked. It is important to stress that a narrative summary of qualitative data may be more

appropriate to the studies under review than a statistical analysis. Indeed, the Cochrane Collaboration guidance to reviewers deliberately emphasises the importance of qualitative methods.

Even the most rigorous reviews cannot guarantee that all biases have been excluded, such as those introduced by reliance on standardised hierarchy of evidence types, which may inherently favour some interventions over others. Consequently, quality of the review is still an important issue. We must remain critical readers (Oxman et al., 1994), and it is important that the training and professional development of practitioners includes training on critical analysis of research papers.

High quality systematic reviews can be accessed in several ways. Useful sources include the Cochrane Collaboration's database (on CD-ROM or available over the web for a subscription fee: www.cochrane.co.uk) and D.A.R.E. (Database of Abstracts of Reviews of Effectiveness – free on www.nhscrd.inst@york.ac.uk). CRD also develops and maintains the NHS Economic Evaluation Database (free on www.york.ac.uk/inst/crd).

Using the evidence: the role of practice guidelines

One of the major aims of evidence based practice is the creation of clinical practice guidelines. BACP has produced a separate information sheet on use of practice guidelines (Rowland, 2001). These are tools to help both practitioners and clients in making decisions about what will be the best course of action. They set out to offer recommendations "based on best available evidence, using a robust development process that is designed to minimise bias" including extensive independent scientific review (DoH, 2001). While such guidelines are not mandatory they are increasingly important and influential documents. Where practice differs from them, practitioners may well be called upon to explain why.

In principle, any clinical circumstance can be the subject of a guideline but most have been condition-based, such as the assessment and management of depression in primary care (AHCPR, 1993a, b, c, d). In the UK, the Department of Health has produced an evidence based clinical practice guideline on treatment choice in psychological therapies and counselling (DoH, 2001). BACP was actively involved in the development of this document and continues to be involved in many developments in evidence based practice at national and local levels.

However, all practice guidelines have their limitations. Firstly, they can only reflect evidence available at the time they are written. Those models that are under-researched will inevitably risk being under-represented. Guidelines will also become increasingly out of date as more research is completed. Thus, they have a relatively short "shelf-life"

of around two to three years. Furthermore, "they are inevitably generalisations" that can only "apply to a greater or lesser extent to individuals" (Parry, 2001, p.3). They are explicitly intended to be no more than an *aide mémoire* for practitioners (Ibid.) and not an attempt to reduce the complex interactions of counselling and psychotherapy to mere mechanistic exchanges. The proponents of evidence based practice strongly emphasise that both the freedom and responsibility of the practitioner remain unchanged (DoH, 1996; Sackett et al., 1996). Guidelines should not be used prescriptively, for example as the basis for legal proceedings or in deciding which models of counselling or psychotherapy to fund (Parry, 2000). It is vital that over-strict adherence to clinical guidelines does not lead to innovation and development being stifled (Roth & Fonagy, 1996).

Practitioner involvement

The current importance of evidence based practice means that counsellors (especially those who work within the NHS or public funded body) need to feel involved and comfortable with the concepts and practicalities.

There are many ways in which practitioners can become involved and, increasingly, it is of vital importance that they do so. Firstly, it is important that practitioners are aware of the evidence base underpinning their work and respond appropriately. This means not only keeping up with the latest research but also being a critical reader of it. At the very least, all practitioners should be able to sift the good from the bad in research.

The evidence then needs to be incorporated into practice. It is important to be open to new information, even when it means altering one's practice or taking on perhaps radically different ways of working. As a counselling or psychotherapy practitioner, this requires a degree of "research mindedness" and, sometimes, overcoming the understandable resistance we may feel if our prior views are not supported. Ethical practice requires a degree of reflective consideration of one's work and regular supervision, both of which are opportunities for building a sophisticated and individually applicable basis for developing evidence informed practice in a manner best suited to one's own context.

Other means by which practitioners can contribute to the evidence base include taking case discussion a step beyond supervision by producing case studies for publication. Many practitioners can also undertake relatively small scale studies, often through using qualitative methods that require relatively small numbers of participants to produce useful informative results. Practitioners should also routinely undertake clinical audits using appropriate measures. This not only means that they

can keep track of what their clients say and how they may change, it can also contribute to a larger body of data which can become of vital importance in itself.

Individual practitioners, or even whole services, can find it difficult to commit the time and resources that larger scale studies require. One solution to this is the development of "practice research networks" in which data are collected in consistent ways to contribute to a shared pool of information.

As a profession we also need to take some important steps forward with this. There are now Centres for Evidence Based Practice in social work, child health and nursing. It is arguable that one should now be set up within counselling. Such a centre would work at promoting training in this area and highlight (and possibly commission) research and practice needs. Such a centre would, however, require substantial funding.

Conclusion

It is important to note that, despite the central importance of the NHS in driving the evidence based practice agenda forward, the implications of evidence based practice are wider than NHS provision. The ripples of the policies and guidelines developed for use in one setting will inevitably spread as those in other settings ask whether their practice should be guided by evidence. If practice is to depart from the standard guidelines set by the most rigorous examinations of the evidence it is necessary, at least, to be able to justify such differences. Practitioners need to be closely involved in these processes. Those who ignore these concepts risk being regarded as biased by their prior beliefs rather than practising in the best interest of their clients. From the point of view of the client, such a response is clearly unacceptable (Rose, 2000). As a profession, we need to encourage understanding of the pros and cons of evidence based practice at all levels.

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Further reading

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Useful journals and databases

Bandolier

Cochrane Library. Oxford: Update Software. (Available via district hospital libraries or some academic libraries.)

D.A.R.E. (Database of Abstracts of Reviews of Effectiveness) www.nhscrd.inst@york.ac.uk

Effective Health Care and *Effectiveness Matters* bulletins

Evidence-Based Health Policy Making

Evidence-Based Mental Health

N.E.E.D. (NHS Economic Evaluation Database), www.york.ac.uk/inst/crd