Practice-based evidence: therapist as researcher, using outcome measures

Caroline Miller

Routledge
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Caroline Miller*

Dramatherapist in private practice

This article examines the nature of evidence in the arts therapies, and the benefits to clients and therapists of taking a practice-based evidence (PBE) approach to our work. PBE keeps the client at the centre of the work. It involves using assessment and outcome processes which are person-centred, and which can be designed around the client. It challenges the privileging of evidence-based practice (EBP) as providing the only standards for determining which treatments/therapies should be used with clients. It provides ways of gathering data which, cumulatively and singly, demonstrate the effectiveness of the arts therapies.

Keywords: practice-based evidence; person-centred outcome measures; alternative evidence types; therapist/researcher

Miller (2014, 223) states:

> At the heart of person-centred assessment approaches is our attempt to understand each person's lived experience and why that has brought them to therapy … As therapists we want to be able to tailor our assessments and therapy to that individual and to work with them towards the outcomes they need from the therapy. … We look at setting criteria for outcomes that match the clients' identified needs and that allow them to clearly see how they are progressing in therapy.

According to Miller (2014, 11):

> The initial assessment can establish a common agreement about the direction of therapy and help clarify approaches that would best help the client ... In order to do this work effectively, all therapists carry out some kind of assessment on which they base the subsequent treatment. For many this is an informal, seemingly intuitive process. We would like to encourage arts therapists to formalize this process and to formalize it in a person-centred way.

Evidence-based practice (EBP) and practice-based evidence (PBE)

Evidence-based practice

EBP was adapted from scientific research models to test the efficacy of medical treatments. Greenhalgh, Howick, and Maskrey (2014, 1) say the adoption of EBP

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*Email: cmillerc@xtra.co.nz

more than 20 years ago produced 'a new paradigm for teaching and practising clinical medicine' where 'tradition, anecdote, and theoretical reasoning from basic sciences would be replaced by evidence from high quality randomised controlled trials and observational studies, in combination with clinical expertise and the needs and wishes of patients'.

As currently implemented, EBP most clearly lends itself to checking the effectiveness of drug treatments for physical health problems and, to some degree, mental health problems, predominantly using randomised controlled trials (RCTs). In addition to being expensive and time-consuming to carry out, the RCT conditions are difficult to replicate in the community, as is obtaining funding for research outside of large organisations. Even in the field of medicine the utility of these approaches, with RCT results providing the best or only standard, is now being questioned. In non-drug treatments such as the arts therapies, psychotherapy, counselling, and some cultural and traditional treatments for a variety of psychological difficulties, they are clearly unsuitable and unhelpful in determining which are effective treatments.

The assumption has been that these experimental models are scientific, objective and reliable. However, Aigen (2015, cited by Chown 2016, 18) says: 'Rather than being dispassionate analysts of facts, scientists are passionate advocates for particular theories; these theoretical commitments strongly influence how facts are construed.'

Greenhalgh, Howick, and Maskrey (2014, 2) write of a crisis in evidence-based medicine in which adherence to narrow definitions of EBP has led to rule-driven, rather than patient-centred, medical practice. This is especially unhelpful with patients with complex health problems or life situations.

They further say that:

> Real evidence based medicine: Makes the ethical care of the patient its top priority; demands individualised evidence in a format that clinicians and patients can understand; is characterised by expert judgment rather than mechanical rule following; shares decisions with patients through meaningful conversations; builds on a strong clinician-patient relationship and the human aspects of care; applies these principles at community level for evidence based public health. (Greenhalgh, Howick, and Maskrey 2014, 4)

Most arts therapists would find this statement acceptable. Otera (2013) urges music therapists to separate EBP from RCTs, to find models which best suit music therapy research.

A considerable weakness of EBP is that the very stringency with which uncontrollable variables are eliminated from consideration can eliminate elements which are very important to the populations being studied. Social, cultural and geographical elements may be integral parts of high levels of wellbeing and good health for many populations. Isaacs et al. (2005) reviewed EBP and cultural competence in children's mental health, looking mostly at how well or poorly children and their families were served by health care based on EBP. They found

that most EBP research did not include members of diverse populations; and that local treatments considered by such groups to be effective had never been the subject of research. Martinez (2008) used the term community-defined evidence (CDE) to describe practices which may be generally accepted as effective within a community, but which have never been the subject of research in the EBP sense.

Practice-based evidence – what? why? and how?

Hellerstein (2008), a doctor of medicine, supports PBE as providing evidence from real-world practices which produce effective treatments.

Swisher (2010), working in cardio-pulmonary physical therapy, writes of PBE as 'the real, messy, complicated world is not controlled. Instead, real world practice is documented and measured, just as it occurs … It is the process of measurement and tracking that matters, not controlling how practice is delivered'.

Chown (2016, 21) acknowledges that 'The challenges to the arts therapies in a technical rational scientist culture, married to an aggressive neo-liberal economics that sees profit in places that were previously seen as public services, seem strong and daunting'. However, growing support for more practice-based models provides the opportunity for arts therapists to incorporate PBE into their own person-centred, arts-based approaches. We cannot ignore the realities of living and working in neoliberal environments, which include producing evidence of effective practice, but we can choose to do this by utilising PBE models which are compatible with our approaches, training and philosophies. This matches our concern for social justice and desire to widen the availability of the arts therapies for those who would find them the most compatible and accessible route to therapeutic healing.

Chown (2016, 19) writes:

> But dramatherapy works with the mind, the emotions, the imagination and how these become embodied relationally. These definitely do not work in the same way for everyone …
>
> Most evidence based practice involves eliminating uncomfortable complexities like this, attempting to understand the whole world as a set of processes to be discovered, categorised and analysed.

Music therapists have written that 'Specific, measurable, and time-bound goals do not fit easily within creative and relationship-based therapeutic practices' (Molyneux et al. 2012, cited by Rickson et al. 2016, 122).

'In New Zealand the heterogeneity in music therapy practice with children with ASD, who are in turn heterogeneous, makes quantitative research problematic because it is hard to isolate and account for all the variables' (Rickson 2016, 121).

In embracing PBE, and utilising a variety of data types, arts therapists can begin to take control of their profession by providing evidence of the effectiveness of their work. This means being organised about systematically working with our clients with assessments and outcomes and systematically recording the data gathered. We can maintain the centrality of the therapeutic relationship, and a person-centred orientation, by ensuring that our assessment and outcome processes arise from the client, the work with the client, and the client's community.

What we can usefully take from EBP is the idea of producing evidence, and consider redefinitions of what constitutes evidence. Then we can apply comparable rigour to practice-based and person-centred models, which better suit our practice.

Widening the evidence-base – what constitutes evidence?

The Missouri Foundation for Health (http://www.autismguidelines.dmh.mo.gov) offers a wider definition of what constitutes evidence-based practice, with reference to approaches to autism treatment (Missouri Foundation for Health 2012). This includes a combination of professional expertise, individual characteristics and the best available research. Gilroy (2009) devotes a chapter to the exploration of knowledge and research methodology. What is important is that data is collected in a systematic way. Crocket (2013) cites Richardson, Higgs, and Dahlgren (2004, 7) from nursing literature:

> Clinical reasoning involves making practice decisions by intentionally drawing on three sources of practice knowledge: *Propositional knowledge, which is the knowledge we get from research and theory; Professional craft knowledge, which is the knowledge we get from professional experience; Personal knowledge, which is the knowledge we get from our own experience.*

Dramatherapist Chown (2016, 21) says:

> What I find missing in evidence based practice are the same things that therapy itself struggles with – the reality of social and economic privilege, the challenge to not reduce the other to the same, the power of imagination and the difficulty in interpreting it.

Crocket (2013, 74) cites Rogers and Miller (2011):

> *a revitalisation of the term evidence-based practice so that it includes the evidence of reflexively-observed counselling experience. Such revitalisation would focus more on practice-based evidence than evidence-based practice, but accept that both can contribute towards delivering a rigorous and relevant knowledge base for counselling.*

   A paper from Substance Abuse and Mental Health Services Administration (SAMHSA) (2016, 2) says that:

> as a concept, PBE includes a broad array of data types, from qualitative data gathered through interviews, document review, non-systematic surveys, and ethnography, to descriptive statistics that describe the demographic characteristics of a target population, practitioners, and organizations using categories that are broadly accepted in social science research'.

Practice-based evidence and practice-based research

The SAMHSA document points out that PBE provides complementary information to EBP in covering areas EBP conventionally excludes. It adds that EBPs raise ethical questions relating to their lack of relevance to atypical populations (often ethnic or poor populations).

   Practice-based models take account of the therapy clients' subjective experiences, both of their current experiences and through their reporting of changes occurring throughout and at the end of therapy. Practice-based approaches can turn the evidence-based practice idea on its head, without rejecting it, bringing a post-modern view to the possibilities of evidence-based practice which allows a wider dialogue. It also comes close to the definition of evidence-based practice in its original conception. It allows for the inclusion, among approved treatments, of those which have been found effective by local communities or specific ethnic groups.

   Lieberman et al. (2010, 4–5) says that PBE practices have the flexibility to include community, cultural and social values, specific local conditions and new issues as they emerge. 'PBE offers a bottom-up, field demonstrated, effective approach that expands, enhances and enriches the growing repertoire of effective practice models'.

   Many therapists carry out academic research using post-modern research methods. Turning the evidence-based model into a practice-based model requires the kind of creativity associated with arts therapists. If data from single clients or groups were systematically collected, it could form a critical mass of evidence for the effectiveness of the arts therapies, based on actual work done with actual clients.

Person-centred

In order to provide PBE, we start by seeking the most effective treatment for our clients, and for an acceptable form of measuring outcomes to demonstrate effectiveness. Acceptable means meaningful to therapists, clients, colleagues and other relevant parties; quick and easy to use; able to be used with a client-centred focus in a way that supports and enhances the therapy process; and able to be communicated in plain language.

To support therapists and clients in seeing progress, we need to find ways to measure and monitor that progress. This starts with assessment. McNiff (2012, 66) says:

> Diagnosis … suggests a singular action whereas assessment looks at the whole range of experiences in art therapy and the resulting artworks, all of which are influenced by interactions between the people involved and the goals of the particular therapeutic setting.

From this initial assessment we can design, or choose, measures which can be readily communicated and understood. These can encourage clients regarding their progress, can help team members and others to understand what arts therapies offer, enhance the professional standing of arts therapists, and can support funding requests. They can also be used to build coherent structure into the therapeutic work.

Person-centred individually designed measures

Sales and Alves (2012, 1) say:

> Patient focussed psychotherapy research refers to the monitoring, prediction, and evaluation of patient progress in therapy. This is traditionally based on repeated standardized measurement and followed by nomothetic feedback to both therapists and patients based on those measures. Patient progress throughout therapy can also use idiographic measures, which involve using personalized instruments to elicit information that is truly specific to each patient.

Disney (2016, 12) says: 'I would argue that our creativity and empathy can make any tool fit if done alongside a client'.

The primary reason for using measures is to be able to track changes alongside the client. Therapists hold hope for clients, they hold the client's process, and they hold the client's progress. Using measures provides a clear way to share the process and progress with the client, so enhancing the feeling of hope beyond the therapists' encouraging or comforting words.

Designing individual measures fits with the creative part of the arts therapies. Such measures may be arts based, but they must be communicable to clients and to team members. They should be based on the phenomenology of that person, not just on a generic map for people with a particular disorder. While the therapist may be calling on a range of models and strategies, like attachment theory, trauma theory, or mindfulness or stress reduction, or specific arts therapies assessments, the focus is on the client's experience. It needs to continue with what is most helpful to the client and gives opening to expression and change. As we begin to hear key phrases and metaphors in the client's story we begin to see what is specific and important to this client and where and how to begin work. For example, Maria (an imaginary client) says she wants to be able to enjoy

herself again. Exploring the meaning of enjoy with Maria elicits ideas of how she might know when she begins to experience enjoyment again. It also clarifies what lack of enjoyment is like for Maria. Maria says she would praise her daughter more and be less irritable with her; play games with her daughter; meet up with friends more; notice herself laughing more; sleep better and so feel better at the beginning of each day. Exploring these further leads to Maria deciding to rate herself on these characteristics and to keep a log, which she shares with the therapist each week, with periodic rating on the chosen items. While continuing therapy is not confined to these areas, they provide further openings for therapeutic work. In addition, the therapist might offer the use of a standardised measure which can be the basis for further discussion and exploration, and arts-related work. These are then repeated at intervals to check on changes in self-rating. Both of these approaches rely on client self-report and projection, so are person-centred. Standardised measures give a further dimension in allowing comparison with other populations of similarly troubled people. Suitable measures can be found on the internet, where they come with keys for interpreting results. They do not require special training or additional cost, and many have been standardised among public health populations, so are suitable for general use. Examples of these are Kessler 10, which is a measure of psychological distress; Patient Health Questionnaire 9 (PHQ-(9), which provides some measures of depression and anxiety; Generalised Anxiety Disorder 7 (GAD 7); Psychological Outcome Profiles (PSYCHLOPS) which provides sets of questionnaires for use before, during and after therapy, for different age groups; and the Clinical Outcomes in Routine Evaluation (CORE) Outcome Measure (CORE-OM), which covers the dimensions of subjective wellbeing, problems/symptoms, life functioning and risk/harm, with pre-therapy and end of therapy versions for comparison.

These are ways to begin to collect practice-based evidence while remaining person-centred in that practice. The essential additional steps are to record the data from the assessment, and from each follow-up check, and to connect all data – psychometric, person-centred measures and narrative (from client and therapist). This is primarily for the client's benefit, but collection of such data over time can begin to form a body of evidence attesting to the efficacy of the person-centred approach and the validity of the data collected. This can be shared with the client, family members, team members and funders, or across agencies with similar clients and approaches.

Communication and language

Communication about the progress of therapy may assist clients, therapist, family members, other treatment providers (with the consent of the primary client); and may be required by funders or agencies. Communicating with a team requires straightforward language which describes the client and their behaviour in humanistic ways, and is comprehensible to everyone. But it does need to be specific.

Feeling and looking much better has a level of validity, but specific manifestations of these and what has changed for the client can be much more specific, meaningful and professional. Observation is important and so is the clarity and specificity with which those observations are reported or described. Julliard (1998) wrote: 'If art therapists can speak the common language of the outcome research movement, they are more likely to be welcomed as part of an outcomes research team. They will also be able to explain art therapy in a way that will be understood by other team members.'

Appropriate articulation may attract funding for research, to provide further evidence of the effectiveness of the arts therapies.

Crocket (2013, 32) writes about counselling: 'Unless we can articulate counselling in a way which upholds our values and speaks to the current New Right policy framework, our success in advocating for our profession and for the needs of our clients will be limited'. Manthei (2015, 62) advocates the use of standardised measures by counsellors in New Zealand, because evidence-based practice is required by funders and by the Ministry of Health; they strengthen accountability; they provide industry standards; give the opportunity for self-reflection; provide personal benefits; lead to the discovery of new knowledge and new best practices.

Alternative models for PBE and PBE research

Candy (2006, 2) defines practice-based research as 'research that takes the nature of practice as its central focus'. She says that it should be structured, answer specific questions, specify context and add to existing knowledge of the central topic. It is particularly important to document before and after. She also refers to Schon's (1983) concept of reflective practice as providing a link between action research and practice-based research. The concept of reflective practice is well known to therapists both in theory and in their use of reflective practice in their own work and within the supervision relationship.

The way forward for individual therapists and groups of therapists is to strengthen their roles as therapist-researchers in their everyday practice. This involves making clear use of recording and tracking key factors in each client's therapy. The practice can be strengthened by agencies agreeing to use common sets of measures which might also then lead to groups of agencies deciding together on common measures to use. The simplest are those listed above, which are readily available, are in wide use in public health settings in the United Kingdom, Australia and New Zealand, and are standardised with public health populations in those countries. These measures are already focussed on individual clients as they ask for subjective responses to a range of questions. To maintain the person-centred process, an individual set of measures can be readily designed around each client providing a more narrative account to support other data. This is research, and the results constitute data, but only if they are

systematically collected, recorded, amalgamated and analysed. The analysis may or may not include sophisticated statistical analysis.

As Molyneux 2012 (cited by Rickson 2016, 122) writes, 'a descriptive approach to assessment, goal-setting and review can enable therapists to take an individualised developmental approach to therapy, while still working collaboratively with families'. And 'While assessment processes do not constitute research, we would argue that descriptions, narrative, or learning stories of music therapy practice can be analysed and/or integrated with other forms of data to contribute to qualitative or mixed methods research' (Rickson et al. 2016, 123).

Doktor (2012, 333) uses a case study to demonstrate the use of dramatherapy assessment in conjunction with standardised assessment as a way of tracking progress in therapy … 'using a standardised tool can help set the baseline for progress, and how the use of dramatherapy assessment tools enable assessment of engagement with the dramatic medium and a client's ability to make use of metaphor'. This would also provide a good model for ongoing practice-based research.

Rickson (2016, 124) outlines a potential research model which pools information from a number of music therapists to develop a body of evidence carrying greater weight than information from a single music therapy client's experience. She also provides a model for mixed methods research which would be suitable for research in many disciplines, and especially in the arts therapies. Problems of small sample sizes are overcome by centrally collecting data.

Similarly, Henton (2012, 17) writes about practice-based networks (PRN) in which practice-based research (PBR) can take place. 'PRNs often involve pooling effectiveness/outcome data from local services collected using standardised measurement sets.' This allows for local, national and potentially international databases to be built, on which good practice can continue to develop and which provide meaningful evidence to be presented to funders. Dokter and Winn (2009) report on a research project they undertook, sponsored by the British Association of Dramatherapists (BADth). Their research was followed by the development of a research database now on the website of BADth. The website is regularly updated with references to research in dramatherapy using a range of methodologies.

A recent example from New Zealand illustrates some of the weaknesses of neoliberal political approaches to public health funding. In 2008 the Ministry of Health published the New Zealand Autism Spectrum Disorder Guideline, for the treatment of autism spectrum disorders (Ministry of Health 2008). The publication used evidence-based criteria, with RCTs being highly privileged in the ratings of approved treatments. The Guideline was created as a living document, which meant that periodic reviews would be carried out by a panel of experts, and the document updated. A review was carried out in 2015–2016 (Ministry of Health 2016). The review panel considered group social skills treatment for autism spectrum disorder (ASD), and considered only those treatments which had been tested through an RCT trial process and which were manualised or

standardised. In a search of international literature, the group found 10 relevant RCTs which had been carried out since 2008, and two systematic reviews. The review group considered that five of the 10 RCTs had methodological problems which ruled out their usefulness in providing an evidence base for health funding of ASD treatment. None of the trials had been carried out in New Zealand. Such trials are not likely to be carried out in New Zealand because of the small population size and the high cost. Accepting only this kind of international research means ignoring local New Zealand conditions and the significant indigenous population which has a well-articulated health model. In this instance information from the review process failed to provide useful or necessary information to assist with funding decisions.

In the case of ASD a useful protocol could include:

- a diagnosis, or agency assessment using an ASD screen;
- anxiety screen;
- definitions of social skills, and assessment in relation to these;
- measures and outcomes tailored to each specific individual with a baseline established for the focus skills;
- change monitored from baseline against agreed criteria, checked at mid-point, end point and three months later.;
- data collected locally and nationally to identify treatments in use, and to clarify which treatments are effective with which populations.

Conclusion

'PBE offers a bottom-up, field demonstrated, effective approach that expands, enhances and enriches the growing repertoire of effective practice models' (Liebermann et al. 2010, 5).

Our challenge is to each develop the role of therapist-researcher, and collect and collate data from our work with clients. Are we serious about demonstrating that arts therapies work effectively, and often enjoyably with a wide range of clients; or will we continue to lament the fact that we are not taken seriously? Why would we not want to be able to demonstrate the outcomes of therapy with our clients, their families and our colleagues of other disciplines, in clear and simple ways? Are we ready to take ownership of our therapeutic approaches, with confidence in their effectiveness, while holding true to person-centred practice?

This article offers ways to engage in person-centred practice, and in person-centred and practice-based research. Training institutions might further develop these practices by incorporating them in research and professional practice papers, which could support students and new graduates in carrying these practices forward into their work. Trainers might even become hubs of practice-based networks, which could enhance their institutions' research portfolios, as well as enhancing practice in the field.

Notes on contributor

Caroline Miller trained as a dramatherapist and psychologist. She is working in private practice in New Zealand. She has provided arts therapies services in a number of inter-disciplinary settings, including mental health services and both mainstream and special education. In 2001 she became the inaugural Co-Director of the only Masters level training programme for arts therapists in New Zealand.

References

Candy, L. 2006. "Practice Based Research: A Guide. CCS Report:2006-V1.0 November." Accessed 12 September 2016. http://www.creativityandcognition.com.

Chown, T. 2016. "What Would an Imaginal Based Evidence Based Practice Look Like?" *The Prompt*, August.

Crocket, A. 2013. "Articulating Counselling in the Context of Registration and New Right Policy." *New Zealand Journal of Counselling* 33 (2): 31–45.

Disney, N. 2016. "Evaluating Our Practice-Valuing Ourselves and Proving Our Worth." *The Prompt*, August.

Dokter, D., and L. Winn. 2009. "Evaluating Dramatherapy. EBP and PBE: A Research Project." *Dramatherapy* 31 (1, Spring): 3–9.

Doktor, D. 2012. "Combining Standardised and Individualised Approaches to Assessment with a Woman with Postnatal Depression." In *Assessment in Drama Therapy*, edited by D. R. Johnson, S. Pendzik, and S. Snow. Springfield, IL: Charles C. Thomas Publisher.

Gilroy, A. 2009. *Art Therapy, Research and Evidence-Based Practice*. Los Angeles, CA: Sage.

Greenhalgh, T., J. Howick, and N. Maskrey. 2014. "Evidence Based Medicine: A Movement in Crisis?" *BMJ* 348: g3725–g3727. doi:10.1136/bmj.g3725.

Hellerstein, D. J. 2008. "Practice-Based Evidence Rather than Evidence-Based Practice in Psychiatry." *Medscape Journal of Medicine*. Accessed 12 September 2016. www.medscape.com/viewarticle/575578.

Henton, I. 2012. "Practice-Based Research and Counselling Psychology: A Critical Review and Proposal." *Counselling Psychology Review* 27 (3): 11–28.

Isaacs, M.R., L. N. Huang, M. Hernandez, and H. Echo-Hawk 2005. *The Road to Evidence: The Intersection of Evidence-Based Practices and Cultural Competence in Children's Mental Health*. http://nrepp.samhsa.gov/Docs/Literatures/RoadtoEvidence_93006.pdf.

Julliard, K. 1998. "Outcomes Research in Health Care: Implications for Art Therapy." *Art Therapy: Journal of the American Art Therapy Association* 15 (1): 13–21. doi:10.1080/07421656.1989.10759307.

Lieberman, R., C. Zubritsky, K. Martinez, O. Massey, S. Fisher, T. Kramer, R. Koch, and C. Obrochta. 2010. *Issue Brief: Using Practice-Based Evidence to Complement Evidence-Based Practice in Children's Behavioural Health*. Atlanta, GA: ICF Macro, Outcomes Roundtable for Children and Families.

Manthei, R. 2015. "Evaluating Counselling Outcome. Why It Is Necessary? How Can It Be Done?" *New Zealand Journal of Counselling* 35 (1): 60–85.

Martinez, K. 2008. "Evidence Based Practices, Practice Based Evidence and Community Defined Evidence in Multicultural Mental Health." *NAMI Annual Convention Orlando, Florida*. Accessed 18 October 2016. racialequitytools.org/resourcefiles/Evidencebasedppt.pdf.PDFfile.

McNiff, S. 2012. "Art -Based Methods for Art Therapy Assessment." In *Assessment in Art Therapy*, edited by A. Gilroy, R. Tipple, and C. Brown. London: Routledge.

Miller, C., ed. 2014. *Assessment and Outcomes in the Arts Therapies A Person-Centred Approach*. London: Jessica Kingsley Publishers.

Ministry of Health. 2008. *New Zealand Autism Spectrum Disorder Guideline*. Wellington, NZ: Ministry of Health.

Ministry of Health. 2016. "New Zealand Autism Spectrum Disorder Guideline Supplementary Paper on Social Skills Groups for Children and Young People with ASD." http://www.health.govt.nz/system/files/documents/publications/nzasd-supplementary-paper-on-social-skills-groups-for-children-young-people-asd-mar16_0.pdf.

Missouri Foundation for Health. 2012. "Autism Spectrum Disorders: Guide to Evidence-Based Interventions Missouri Autism Guidelines Initiative A 2012 Consensus Publication." www.autismguidelines.dmh.mo.gov.

Otera, M. 2013. "Is the Movement of Evidence-Based Practice a Real Threat to Music Therapy?" *Voices: A World Forum for Music Therapy* 13 (2). doi:10.15845/voices.v13i2.

Richardson, B., J. Higgs, and M. Dahlgren. 2004. Recognising practice epistemology in the health professions. In *Developing practice knowledge for health professionals*, edited by J. Higgs, B. Richardson and M. Dahlgren, (1–14). Edinburgh, UK: Butterworth-Heinemann.

Rickson, D. J., A. Castelino, C. Molyneux, H. Ridley, and E. Upjohn-Beatson. 2016. "What Evidence? Designing a Mixed Methods Study to Investigate Music Therapy with Children Who Have Autism Spectrum Disorder (ASD), in New Zealand Contexts." *The Arts in Psychotherapy* 50: 119–125. doi:10.1016/j.aip.2016.07.002.

Rogers, N., and J. Miller. 2011. The use of evidence-based practice to inform counselling practice. In *Proceedings of the Inaugural NZAC Counsellor Education Conference*, edited by A. Crocket, Wellington.

Sales, C. M. D., and P. C. G. Alves. 2012. "Individualized Patient-Progress Systems: Why We Need to Move Towards a Personalized Evaluation of Psychological Treatments." *Canadian Psychology/Psychologie Canadienne* 53 (2): 115–121. doi:10.1037/a0028053.

SAMHSA. 2016. "Substance Abuse and Mental Health Administration." *The Practice-Based Evidence Corner*. Accessed 21 Septemebr 2016. nrepp.samhsa.gov/05e_practice.aspx.

Schon, D.A. 1983. *The Reflective Practitioner: How Professionals Think in Action*. New York: Basic Books.

Swisher, A. 2010. "Practice -Based Evidence." *Cardiopulmonary and Physical Therapy Journal* 21 (2): 4. (Editorial).