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An audit: Do the people I see 'get better'?

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"There are all these audits and measures and graphs of numbers of people using the services, but what we really need to know is do people get better"
Simon Richards, Health Authority Purchaser, 2001

This statement, made during a conference called to review community mental health services in Shropshire, made me think about my own work and whether people who see me 'get better'. Of course, a concept like 'better' (or the in vogue 'recovery') is troublesome to define, has medical connotations and may vary in meaning from person to person. On the other hand I imagine most people who have become clinical psychologists have had a general hope that the people they see would get better. As a consequence, I set out to try and audit my clinical work over the past 6 years in terms of this concept.

The People I see people who have been referred to a community mental health team that concentrates on trying to help people deemed to have 'severe and enduring mental health problems' (the definitions and realities of what this means vary - see Holmes, 2001). The estates on which many of these people live are some of the most socially deprived in Britain. The majority of people I see are (or have been) suicidal. Their past and current lives are characterised by appalling trauma. The resilience they reveal often astonishes me.

I decided to audit people who had entered into a therapeutic contract with me and who had come for at least five sessions. That is, they had identified a number of difficulties that they wanted help with and a number of hopes for the therapy, and had (according to my assessment) some degree of psychological mindedness and motivation to come. In short, I believed they might benefit from regularly meeting with me. All received individually tailored therapy, which was uni- or multi-modal, often open-ended or for at least six months duration, and which generally focussed on exploring the roots of the person's difficulties and alternative ways for them to live a more meaningful and less painful life. My page on the website for my department (www.shropsych.org) and Holmes (2001) give more detail about the kind of person/psychologist I am and the conditions within which I work.

The audit did not include people who came for less than 5 sessions: some of these people dropped out; some both of us felt I could be of little more help over and above the initial sessions we had had; some were referred elsewhere or encouraged to find help outside psychological services. Some

people appeared to significantly improve during this consultation process where as others appeared to get worse; for many I have no idea what ultimately happened to them. The audit covered a six-year period and included 55 people in total who were seen for therapy.

The Measures

Dependent variable:- getting better: This was based on my subjective judgement of whether there had been

1. no change or a worsening of the problems that initially led the person to seek help - the person had got worse/made no improvement
2. some improvement - the person had got a bit better
3. great improvement - the person had got a lot better, or recovered

Where records of evaluation had been kept, this judgement was based on (a) peoples' own evaluation of the extent to which their hopes for therapy (listed at the onset of therapy) had been fulfilled (a three point scale - 'not achieved', 'achieved to some extent', 'fully achieved'); and (b) the extent to which their problems had improved (listed at the onset and rated on a 0-10 scale, then given to them at the end of therapy and rated again).

Independent variables:- In order to explore the factors that might relate to whether people get better, nominal data on a number of factors was gathered:

~Gender

~Relationship status: single or in a couple.

~Age: Young = under 30; Not so young = over 30.

~Psychiatric Medication: People were designated to the no medication category if at the end of our contact they had either come off their medication completely or had never taken psychiatric medication. People were deemed to be on medication even if they had substantially reduced their medication.

~Experienced therapist: People were designated as seeing me as an inexperienced therapist if they saw me in the first 3 years after qualifying, and as an experienced therapist if they saw me 4-6 years after I qualified.

~Toxic environment: To some extent virtually every person I see has been living in what I would describe (and experience) as a toxic environment - environments that are often completely devoid of care or love, where there is a continual and real threat of violence in the community in which they live, there being little or no support or people they can trust, coupled to a lack of money, financial resources and decent housing. However, people were categorised as experiencing a toxic environment if they had not been able to escape from: (i) severely abusive family members (ii) severe abuse in their neighbourhood or (iii) severe abuse in their work or daytime environment. Otherwise they were categorised as living in a not so toxic environment.

An Analysis Chi-square analysis was conducted on the above variables.

Some Results Regarding gender: 11 men got worse or made no improvement, 11 got a bit better, and 3 got a lot better or recovered. 3 women got worse or made no improvement, 14 got a bit better, and 13 got a lot better or recovered. This difference was significant (Chi = 10.7, N = 55, df = 2, p<.01).

Regarding relationship status: 10 single people got worse or made no improvement, 7 got a bit better, and 5 got a lot better or recovered. 4 people in a couple got worse or made no improvement, 18 got a bit better, and 11 got a lot better or recovered. This difference was significant (Chi = 7.9, N = 55, df = 2, p<.05).

Regarding psychiatric medication: 13 people on medication got worse or made no improvement, 11 got a bit better, and 2 got a lot better or recovered. 1 person on no medication got worse or made no improvement, 14 got a bit better, and 14 got a lot better or recovered. This difference was significant (Chi = 19.6, N = 55, df = 2, p<.001).

Regarding toxicity of environment: 10 people in toxic environments got worse or made no improvement, 6 got a bit better, and 1 got a lot better or recovered. 4 people in not so toxic environments got worse or made no improvement, 19 got a bit better, and 15 got a lot better or recovered. This difference was significant (Chi = 16.1, N = 55, df = 2, p<.001) Non significant differences in the cell distributions were found for Age (chi = 1.3, N=55, df =2) and Experienced therapist (chi =1.0, N =55, df =2).

Notably, of the 14 people who got worse or made no improvement, 13 stayed on their medication, 11 were male, 10 were single and 10 were suffering in toxic environments; and 8 had all four of these factors.

Discussion One aim of the audit was to put some figures on my paradoxical beliefs that, on the one hand, especially when I'm with them, I genuinely feel that the people with whom I engage in therapy are likely to get better soon; and on the other hand, when I'm more distant from them, my skepticism about the power of therapy to lead to significant changes in people's lives and well-being, and general wariness about the claims of various schools of therapy. To some extent the results support this apparent paradox. 65% of the people who engaged in therapy got a bit better, a lot better, or recovered. However, given that only a small percentage of people referred to the CMHT, or indeed actually seen by me, ask for and experience therapy (i.e. meet me on a regular basis with a therapeutic contract of at least 5 sessions duration) it is clear that a far wider range of things than psychological therapy are needed for many people's well-being to significantly improve.

What my supervisor Joe Kiff has termed 'mid-career blues' is also reflected in the audit: If you stay in the same place long enough you get to see your ex-

clients come back into the service, and you become acutely aware of the lack of change, or slow change, that occurs for many people, and the gulf between this fact and the case studies referred to in many psychology and psychotherapy texts, the positive spin put on therapy at training courses and conferences, and the rhetoric (rather than evidence) on which well-marketed interventions are shrouded. Such 'failure' needs to be openly accepted and spoken about (Harper and Spellman, 1996).

Women benefited more from therapy with me than men. Before doing the audit I was not aware of this. It has made me think about the male-female and male-male dynamics in my therapeutic work, as well as whether therapy is the best option for many of the men that are referred for psychological therapy (see below).

My suspicion that many of the people who met with me regularly but did not get better were those who stayed on their medication was born out. As virtually 100% of the people referred to me are on medication, it has been hard for me to say to referrers that I will only engage in therapy with people who are not on medication, despite believing that such people are the ones most likely to get most benefit from psychological therapy. My thoughts return to the words of an eminent psychologist who said to me, one month after I qualified, that he had given up working in adult mental health as he had come to realise that over the previous 10 years he had been having too many conversations with haloperidol.

I am proud that, with the co-operation and help of the team's psychiatrist, I have been able to help many people reduce and rationalise their medication intake, but what stands out is that people who chose and are able to come off their medication are the ones who benefit from therapy. Of course there may be overlaps between whether someone stays on medication and many other factors. The weakness of the chi-square analysis, unlike multiple regression analysis, is that it does not reveal the nature of such overlaps. Nevertheless, it seems likely that people unable to escape from toxic environments are less likely to give up something that they feel helps modify their inner pain (or makes them feel indifferent to things, which David Healy (e.g., Healy, 1997) has said is the main effect of most psychotropic medications). One question the audit raises is whether such people (often single men in toxic environments in this audit) are best served by (what often turns out to be long-term) therapy.

Rather than readily, or even cautiously, entering into therapy contracts I have begun utilising some of the ideas of David Smail with this group of people. Clarification, solidarity and encouragement (Smail, 1999) can be provided in much more flexible ways than through psychotherapy. Power-mapping (Hagan and Smail, 1999), and connecting people with community groups, education, training and work opportunities are likely to be more

helpful than the comfort but lack of change that I have begun to associate with long-term therapy.

The vast majority of people who seek help from me have a lack of long-term, respectful, kind, thoughtful relationships in their lives, but group work and community group involvement perhaps offer more appropriate and useful ways of people attaining these, as well as offering (even if it is only slightly) more opportunities than therapy for people to access more power over their social conditions. Partly as a result of the audit, I have begun to run courses at community centres which help people find fresh ways of understanding themselves and others (including thinking about the effects of 'the impress of power', Smail, 1999), as well as doing more group and less individual work.

The people deemed most suitable for psychotherapy (e.g. Holmes, 1994; Malan, 1979) do not often come to the CMHT. In contrast to the YAVIS concept, my audit indicated that age was not a predictor of outcome, and the people who tended to get better were those in couples rather than those who were single. Of course, the measures used were fairly crude, subjective and open to bias, and many other factors might relate to outcome.
In addition, different measures would have lent a different slant to my work (for example, a simple measure of how many of these people were admitted to the psychiatric hospital (1 i.e. <2%), given the fact that the majority had a history of previous admissions or were on the borderline of being admitted on referral, would put psychological therapy in a more positive light, particularly as one of the principle aims of the CMHT is to prevent admission to hospital).

Nevertheless, this audit has helped me think about my work in a way that reading and applying the outcome research, doing service user satisfaction surveys, and consulting the results of evaluations based on standardised tests never has.

‘What is the best way of helping the actual people I meet?’ is a question I imagine we all seek to answer. Auditing our work in ways like this (a process that can also be recognised in an historical reading of the works of David Smail) can perhaps provide some insights into this issue.

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