Getting the most from the MDS

Richard Davis, Snr. Lecturer Counselling/Psychotherapy

uclan
University of Central Lancashire

1. Getting the most from . . .

Remember MDS's function

- to put patients at the centre of the therapy
- Deliver outcomes appropriate to need.
- Improve clinical practice and service quality – managers need it for planning, evaluation and service improvement.
- Enhance clinical governance.

(IAPT Data Handbook (2011) http://www.iapt.nhs.uk/silo/files/the-iapt-data-handbook.pdf).

(Without which may not have led to . . ..)

Some good news for person centred approach – CFD recovery rates viz: CBT.

Recovery rates for CBT and counselling for depressive episodes are comparable (41.3% and 41.1% respectively). Outcomes for CBT were slightly better than counselling in the case of mixed anxiety and depression (40.1% and 36.0% respectively) and a higher recovery rate was found for family loss in those accessing counselling as opposed to CBT (43.6% and 22.2% respectively).

	Counselling (no CBT)	CBT (no Counselling)
Mixed Anxiety and depression	36.0%	40.1%
Depressive Episode	41.1%	41.3%
Family Loss	43.6%	22.2%

Glover et al, 2010, Table 38, p.102)

Ensures Equality and Equity of Access

Equality Act 2010

Services are legally required to recognise the diverse needs of individuals in the community

Must collect and analyse information of the different experiences of individuals

Collect information by age, ethnicity, faith, gender, diagnosis and sexuality

Links between physical and mental health

Used for health needs assessments

Big Picture ambivalence?

Traditionally, data collection rare in person centred mental health contexts, incl. training?

Substantial resistance from practitioners (MDS viewed as part of the 'medicalization' of human distress / a 'blunt instrument').

Seen as fitting one clinical model only?

Time consuming?

Interferes with patient therapist relationship?

But did Carl Rogers do this?

Record therapy sessions?

Argued that psychotherapy can be done by ‘lay’ (non-medically qualified) people?

Commit to the on-going educating of therapists

Research therapy?

Developing new methodologies?

Apply research to practice?

Sanders, P. (2008). The Radical Roots of counselling: Opposition to medical metaphors and the manufacture of distress. Conference Presentation

Would Rogers be opposed to Big Picture issues such as . .

Patients, often distressed, having a right to know that therapies are safe and effective.

Inequity of service across the UK so evaluation is required to set appropriate levels of provision as part of the HNS framework.

Evidence that if therapies are inappropriate it can lead to psychological deterioration.

Psychotherapy in the HNS represents a significant public investment; it is unethical to waste this funding with ineffective treatments.

Psychotherapy is still marginal in statutory agencies - research is important in establishing it as a bona fide treatment of choice.
(Parry 2000)

Empathy for MDS? Weaknesses?

'Client factors' (complex and non-complex) are not factored in - but substantive amounts of research points to its significance in outcome e.g motivation, ability to form a meaningful working alliance, social cultural/ contexts, fragile process, etc. (Beutler 2010)

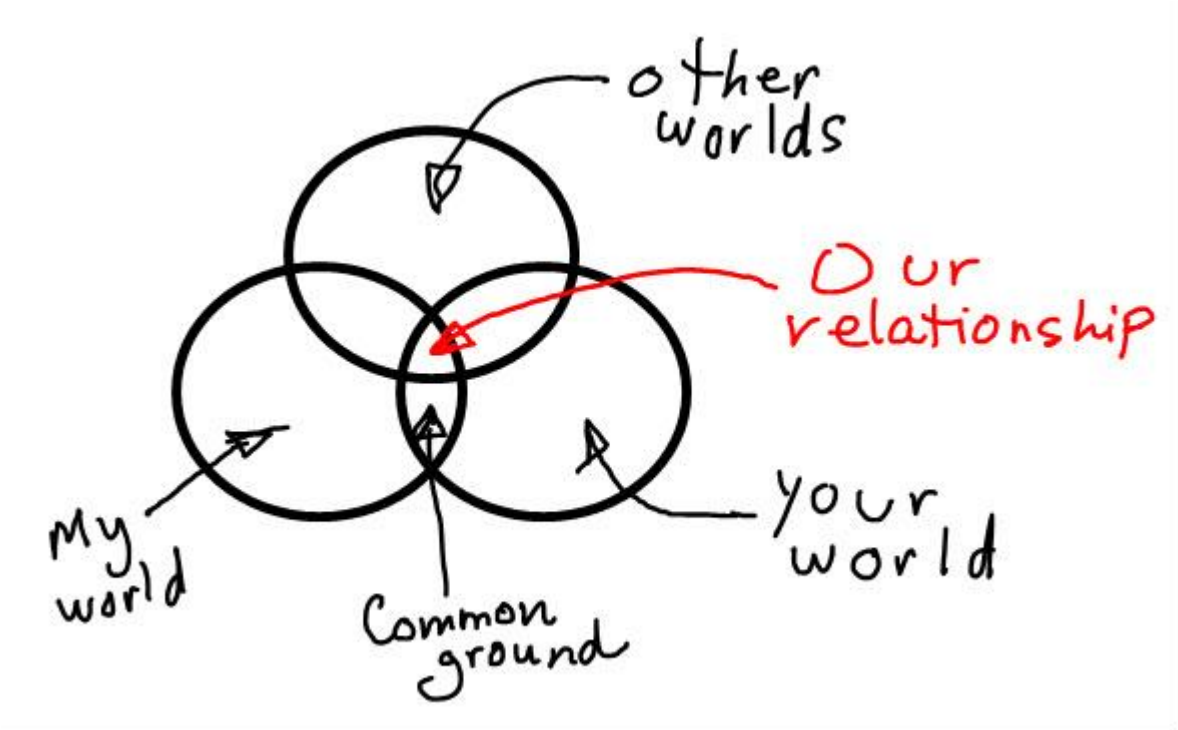
No focus on relationship factors (Cooper 2009)

Empirically grounded therapist personality factors are a factor in outcome. MDS does not factor in that a patient's experience of empathy from one therapist will/can be different to another's.

No accounting for 'extra-therapeutic' effects.

2. **Getting the most from MDS:**

the little picture



Functions of Data Collection

The ‘little picture’ function of the MDS is to make it a tool for the therapeutic relationship.

Actively work more collaboratively than initial training may have taught you with patients at the outset and throughout the therapeutic period so MDS becomes NB to clients.

Agree with patients the best approach for their difficulties
(e.g if slow progress: use MDS items PHQ-9 and GAD7 as a focus)

Review continuing appropriateness of chosen intervention (e.g. talk through how shame can prevent us feeling ok and self accepting).

Identify therapy targets. (How will you & I know when you are ok?)

Manage the therapy process (physical discomfort is manageable in a therapeutic relationship. (The IAPT Data Handbook 2011)

Patient-reported Outcome Measures (PROMS)

Effective communication with patients
(e.g rationale for ‘process guiding’)

Client involvement in decision making

Case Supervision

Effective inter-professional communication

(The IAPT Data Handbook 2011)

Communication & Involvement

1. **Assessment: Bonding and awareness** e.g: Use MDS for early clarity of therapeutic alliance / insight factors (e.g can the client go ‘inward’?).

2. At review

e.g. use MDS to establish progress or hindering factors.

1. Normalising: ‘anxiety can ‘spike’ in emotionally focused therapy; or establish a therapeutic focus (denied emotion / internal self critic, embodied sensations, etc).

Communication & involvement

2. Identify ‘Stuck Process’ – e.g: PHQ9. Q.8

‘Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual’

(Possibly) work on the ‘embodied self’ – ‘the body remembers!’

Encouraging inwardness to the body = ‘process directions’ = use of ‘focussing’ & the empathic naming of embodied responses.

May evoke painful/distressing memories = ‘Unfolding work’

Communication & Involvement

Gad 7: Q.2: ‘Not being able to stop or control worrying’

Communicate why this may be happening!

That maladaptive emotion and conflictual self aspects (configs. of self) keep ruminatory negative cognitions in place resulting in ‘depressive’ visceral sensations and ‘stuck’ maladaptive emotion.

(Possibly) Gently negotiate ‘Process Guiding’.

Empathise with maladaptive emotions as a life coping strategy = seek to validate and promote ‘primary adaptive emotion’.
(Hill, A., & Sanders, P. (2014)

Communication & Involvment

E.G '. . . . hopeless/ dejected / sad . . . . and a part of you was angry.'

Empathise with and facilitate a full dialogue with all split 'self aspects' & with negative introjects.

Ideal/Ought self aspects (Harsh Critic) + 'Weak me' experiencer.

How one self aspect constantly suppresses another.

Pathogenic worry: self interruptions? (fear/dread is 'weak' and 'criticised') = empathy/focus & support the non-interruption of the internally supressed other. (Hill, A., & Sanders, P. (2014)

Case Supervision

Can it be used for Case Supervision? Team supervision?

Effective inter-professional communication

Client involvement in decision making

Acknowledge gains.

Or when to end . . . .

Or if more time is required . . . . .

or available . .

Patient Feedback

'It made you realise if you were having a good week or a bad week. What you had managed to do or how I was actually feeling'

'I seemed to improve every time we filled that in, so that was encouraging as well'

'It was like a goal to try to bring it down'

Simpson, A., et al. (2008). *Mental Health in Family Medicine. 5, 95-104*

Positive Clinician Feedback

I liked it, [the PHQ9] *I liked to use it every session. I didn't find it difficult at all. And clients, even if they hadn't the piece of paper with them at certain times, it was ok….*

I liked the simplicity of the PHQ9, it was quite simple, compared with [another widely used measure] *and that was really, really good.'*

Richards et al (2006)

Managers: Give your counsellors time if the MDS informs you of this need.

‘Counselling for depression is a manualised form of psychological therapy as recommended by NICE (NICE, 2009) for the treatment of depression. It is based on a person-centred, experiential model and is particularly appropriate for people with persistent sub-threshold depressive symptoms or mild to moderate depression. Clinical trials have shown this type of counselling to be effective when 6 - 10 sessions are offered. However, it is recognised that in more complex cases which show benefit in the initial sessions, further improvement may be observed with additional sessions up to the maximum number suggested for other NICE recommended therapies such as CBT, that is, 20 sessions’.
Retrieved from http://www.bacp.co.uk/learning/Counsellingfordepression

‘Typically people with mild to moderate depression might receive between six and 10- sessions over eight to 12 weeks. In cases of serious depression, up to 20 sessions of counselling are recommended’.
Retrieved from http://www.iapt.nhs.uk/workforce/high-intensity/counselling-for-depression/

Conclusion

To identify what is helpful in therapy is an ethical requirement. MDS goes some way.

Cooper (2008) identifies that 90% of therapists consider that they are in the highest 25% of effective practitioners. He asks the question: on the basis of what evidence? MDS goes some way.

Therapists who integrate all aspects of the therapeutic alliance factors into their work are more likely to have increased effectiveness than those that do not. (Beutler 2010).

Is MDS a therapeutic alliance factor worth looking after and promoting?

References

Beutler, L, E. (2010). *What if common factors were not common* ? UKCP Inaugural Research Lecture.

Cooper, M. (2009). *Essential Research Findings in Counselling and Psychotherapy: The Facts are Friendly*'. London: Sage.

Glover, G., Webb, M., Evison, F. (2010) *Improving Access to Psychological Therapies: A review of the progress made by sites in the first rollout year.* North East Public Health Observatory.

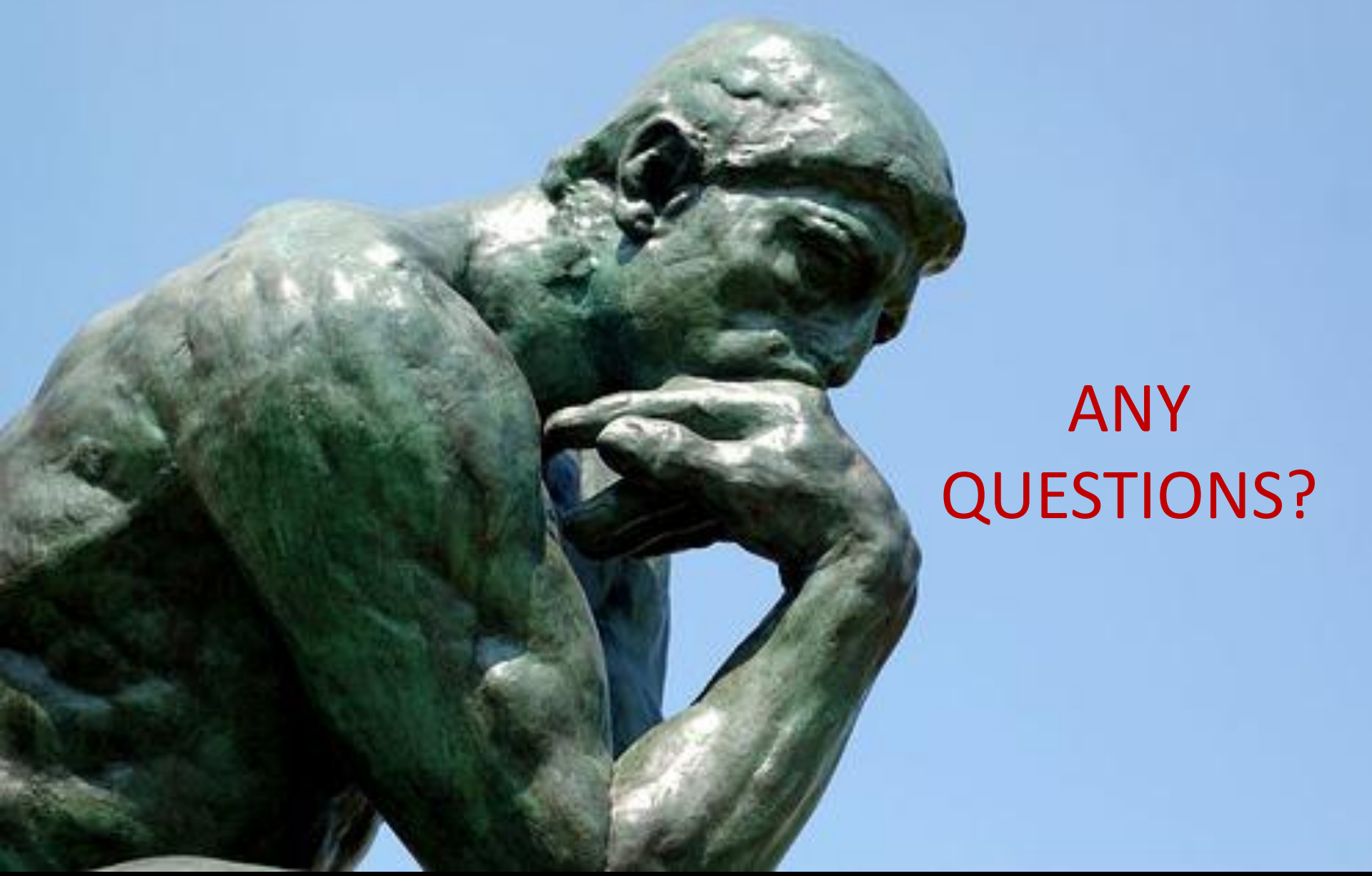
Parry, G. (2000). *Evidence-Based Psychotherapy – An Overview*'. In (Eds. Rowland, N. and Goss, S). *Evidence-based therapies Counselling and Psychological Therapies.* London: Routledge.

IAPT Data Handbook (2011). http://www.iapt.nhs.uk/silo/files/the-iapt-data-handbook.pdf.

Sanders, P., & Hill, A. (2014). *Counselling for Depression*. London: Sage.

Simpson, A., Richards, D., & Gask, L.., & Hennessy, S., & Escott, D. (2008). Patients' experiences of receiving collaborative care for the treatment of depression in the UK: a qualitative investigation. *Mental Health in Family Medicine*, 5, 95-104.

Richards, D.A., Barkham, M., & Bower, P., & Gask, L.., & Gilbody, S., & Lovell, K., & Rogers, A., & Torgerson, D., & Escott, D., & Fletcher, J., & Hennessy, S., & Kendal, S., & Lankshear, L., & Richardson, R., & Simpson, A. (2006). *A Trial Platform of Enhanced Care for Depression in Primary Care: Final Report.* York, University of York. (available from the MRC).



INNOVATIVE THINKING
FOR THE REAL WORLD

uclan
University of Central Lancashire