

WHAT HAPPENED NEXT? :
LONG-TERM OUTCOMES *from* LONG-TERM THERAPY.

A study of client outcomes from the Women's Counselling and Therapy Service.

Leeds, 2010



ACKNOWLEDGEMENTS

In the production of this report the Women's Counselling and Therapy Service (WCTS) would like to express it's thanks to:

The clients who provided the data
Leeds Partnership Foundation Trust
Kathryn Chatburn

WCTS is currently funded by Leeds City Council Adult Social Care to provide individual and group therapy for up to two years to adult women with moderate to severe, long-standing, mental health difficulties.

Women's Counselling and Therapy Service (WCTS): CORE-OM Data and Follow up Analysis

Introduction

The Women's Counselling and Therapy Service was set up in 1984 for women who would not otherwise have access to longer term therapy. This was either because they were on low income and so could not afford private therapy, or because through stigma, isolation or trauma they were unable to access NHS psychological or psychotherapy services. WCTS was created as a stand-alone voluntary sector charity working with adult women, 18 and over, who have enduring, moderate to severe mental health difficulties.

In 1984 a women-only enterprise was a radical departure from the usual ways of delivering services to women. But by 2002 The Department of Health's document 'Women's Mental Health: Into The Mainstream' stated that.... 'Gender is a key issue that influences an individual's experience of the world and therefore gender issues should be incorporated into research, service planning, delivery and evaluation.' Furthermore it said: 'Reasons for women-only developments include:

- The expressed preferences of women to ensure choice is available
- Specific gender, cultural or religious needs
- The generation of a safe environment which has particular relevance for specific groups of women, such as those with experience of male violence and abuse, those with sexually disinhibited behaviour, older women or lesbian women'.

It demonstrates the extent to which our work and the work of many others had changed the thinking.

The women who come to WCTS have multiple obstacles blocking their path to an ordinary, good-enough life; our data shows a recent worsening of this profile.

Clients' incidence of traumatic/abusive experience is consistently shown to be three times higher than that benchmarked nationally for therapy services by CORE (clinical outcomes in routine evaluation) IMS.

In addition, our clients on incapacity benefit rose by 12% in 09-10 (to 30%) with a further 12% unemployed. Clients with dependent children rose 6% (to 36%) and those living alone - that is not with another adult - rose by 9% (to 42%). Clients taking medication for their psychological difficulties rose by 11% (to 63%).

WCTS collects data measuring all clients' mental health. This happens at assessment, at the first therapy session and at the final therapy session. We have had this data audited by CORE IMS each year since 04-05, showing in most years that 60% of women have a statistically significant recovery by the end of therapy.

This report represents a significant extension of that audit. We wanted to see whether the benefits recorded at the end of the client's therapy stayed with her. What happens in women's ordinary lives once the therapy relationship is over and without the dedicated weekly space to think about what's going on? Do we make any difference? If so, what?

The goal here has been to provide evidence more systematically of what clients have been telling us all along – that therapy can 'turn my life around.'

We have approached this as simply as possible. In 2006 a researcher on our management committee devised a follow-up questionnaire. We put her questionnaire together with a further CORE outcome measure and are now able to present two consecutive years' worth of data from clients. We will continue to collect this data annually, allowing us to observe patterns and changes over time.

The data has been collected from clients with a range of therapeutic experiences. Some received a group therapy; some individual and a few both. Therapeutic approaches included psychoanalytic psychotherapy, psychodynamic and humanistic psychotherapy, person-centred and integrative counselling. Clients' therapy contracts ranged from six sessions up to two years.

Recently in some arenas of public sector commissioning of therapy the value of a plurality of therapy approaches has been diminished. This data makes a case for the value of variety. It shows that neither clients nor therapists opt unnecessarily for longer-term work. And it demonstrates that a women only voluntary sector service can provide excellent outcomes for clients.

We recognise the limitations of this information. Clients have self-selected and numbers are small. But in a climate of economic stringency it is possible for us to collect and analyse this data consistently and make good use of what it tells us.

WCTS gratefully acknowledges that the data analysis which follows has been provided through Leeds Partnership Foundation Trust by assistant psychologist Kathryn Chatburn.

Aims

The Clinical Outcomes in Routine Evaluation Outcome Measure (CORE-OM) is designed to measure global distress and to be used as an initial screening tool and an outcome measure. It contains 34 items, of which the mean can be used as an indicator of global distress. The 34 items can also be broken down into the following dimensions; wellbeing, problems/symptoms, functioning and risk. The mean item scores can be used separately when distinction between the dimensions is required.

The aims of this evaluation were:

- To determine the overall level of change in clinical outcomes, assessed by the CORE-OM, of clients treated by WCTS.
- To compare the outcomes found by the CORE-OM with clients' perceived changes in various areas of the clients' lives assessed using the self report questionnaire developed by WCTS.

Method

Clients who completed therapy at WCTS between 1st April 2006 and 31st March 2008 were given the CORE-OM before therapy and after therapy as part of their routine clinical care. In order to provide further information about the effectiveness of therapy, all clients were approached after therapy to ask if they would be happy to complete a follow-up CORE-OM and a feedback questionnaire to provide information on perceived changes in their personal and professional life and on contact with medical and mental health services since the end of their therapy. This follow-up information was collected at two time points: October 2008 and October 2009. In October 2008, 31% of clients (i.e. 25 out of 79 clients) agreed to provide further information and returned the additional measures, and in October 2009 20% did so (i.e. 19 out of 94 clients).

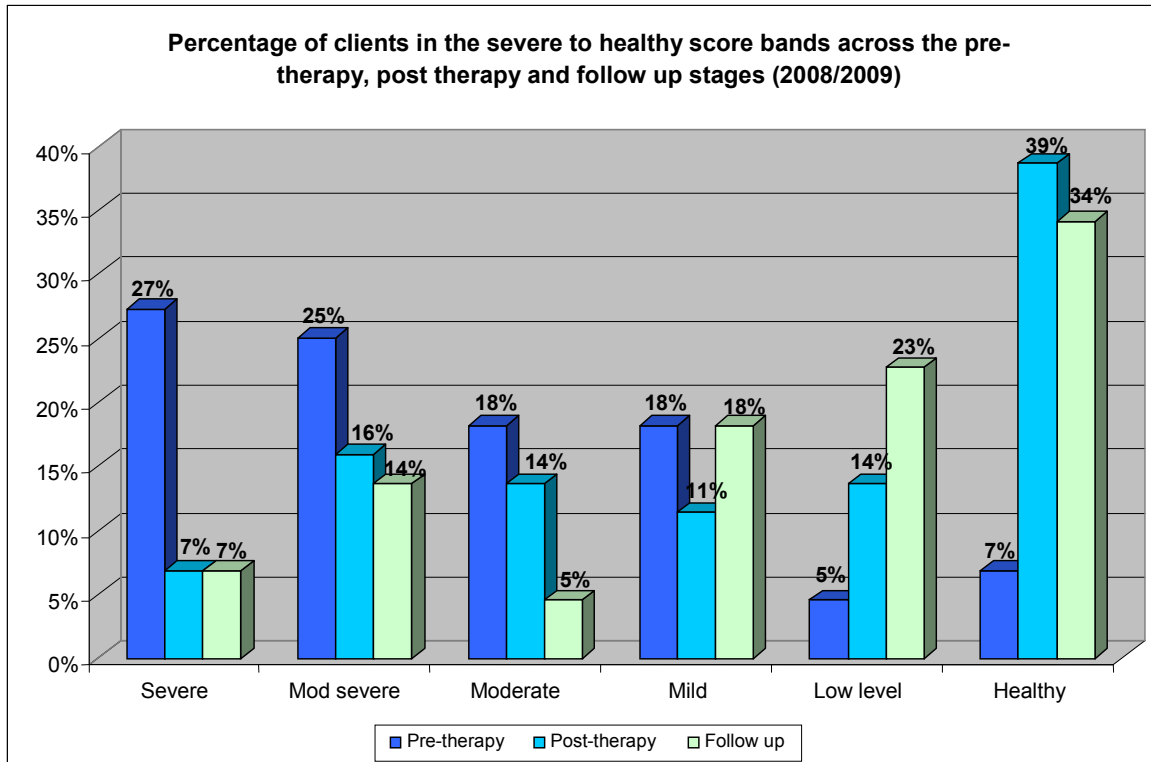
The information from these two groups is analysed separately in the remainder of the report. The first group (Group 1) finished their therapy between 1st April 2006 and 31st March 2007, and consisted of 25 women with a mean age of 40 years (range = 26 to 61 years). The second group (Group 2) ended their therapy between 1st April 2007 and 31st March 2008, and consisted of 19 clients with a mean age of 37 years (range = 26 to 58 years).

Results

The scores of the CORE-OM can be interpreted in two ways. The first, by adding the scores for each item to obtain a number between 0 and 136, and the second by dividing the total by 34 so that the average score lies between 0 and 4.0.

Score 'Bands'

The scores of the CORE-OM can be interpreted as bands to indicate the level of global distress experienced by the client. The bands used correspond reasonably well with similar terminology used in describing scores for measures such as the Beck Depression Inventory (BDI). The bands are 5 points wide, with the exception of the 2 lowest bands, so 'a statistically reliable change will commonly mean that a patient has moved up or down one band (CORE Partnership, 2007). In the case of this research, the bands were divided according to the mean score for each item.



The table below shows the boundaries for each band:

Severe	over 2.5
Mod severe	2.0 to <2.5
Moderate	1.5 to <2.0
Mild	1.0 to <1.5
Low level	0.6 to <1.0
Healthy	0 to <0.6

Graph 1: This graph indicates the percentages of clients in each category (severe to healthy) and their score bands in each stage of measurement (pre therapy to follow up).

The graph illustrates the changes in the percentages of clients in each band of distress from pre-therapy to their follow up.

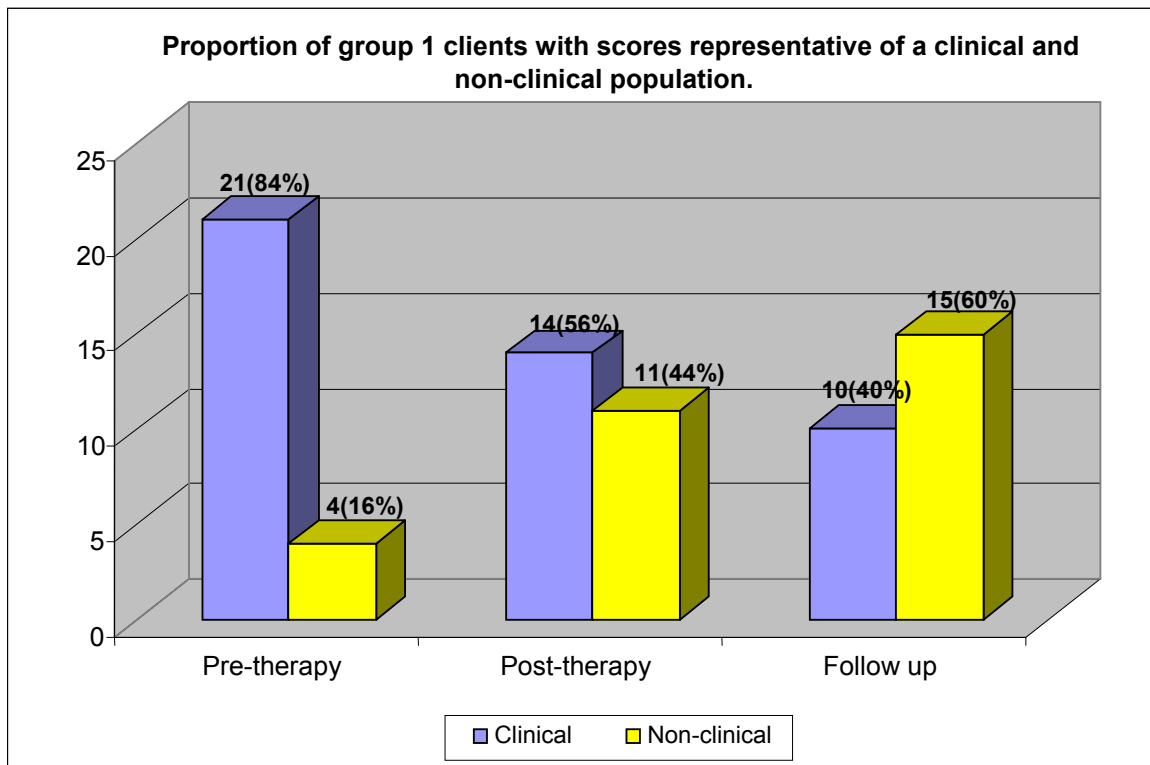
up. The results reveal that numbers of clients producing scores in the 'Severe', 'Moderately Severe' and 'Moderate' bands

decreased from pre-therapy to follow-up. At the pre-therapy stage 53% of the clients were banded in the 'severe' and 'moderately severe' categories, dropping to 23% at end of therapy and 21% at follow-up. At the beginning of therapy, 12% of clients scored below the cut off (i.e. in the 'low level' and 'healthy' range), but this rose to 53% post-therapy and 57% at the follow-up.

Clinical and Non-Clinical Populations

In order to measure psychological distress, scores are measured against normative data published by the Core System Group for non-clinical populations, allowing clinically significant change to be determined. The data gathered by CORE for the clinical and non-clinical populations was generated using representative populations. The norms for the non-clinical population was gathered from two different universities and a sample of convenience e.g. therapists and researchers etc (n=1106). In addition to this the norms for the clinical population were gathered from a sample of clients receiving or waiting for a variety of psychological interventions in a wide variety of settings throughout Britain (n=890).

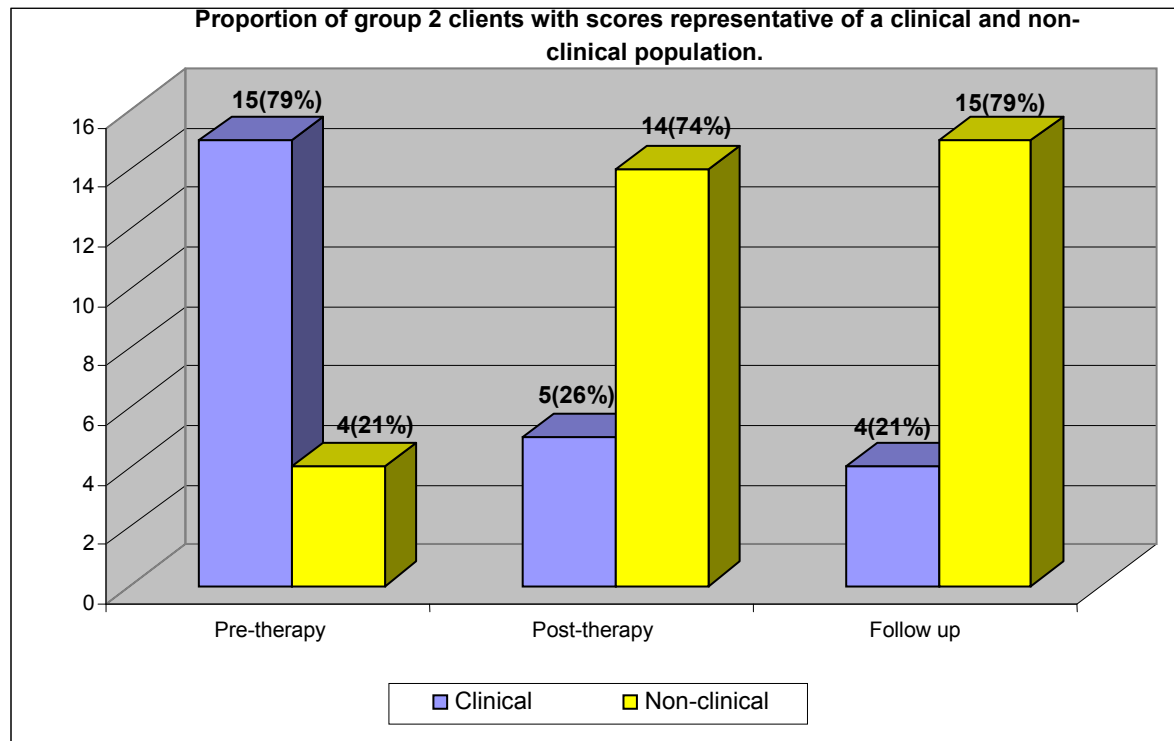
The scores generated by the clients in this study were placed into the clinical and non-clinical populations and were compared at the pre-therapy, post therapy and follow up stages to identify any clinically significant changes throughout the course of their treatment. Jacobson and Revenstorf (1988) stated that clinically significant change is 'sufficient improvement to have moved the client to a score more representative of the general population than a clinical population'.



Graph 2: The graph to the left shows the number of clients from Group 1* (n=25) who have scores that are consistent with the clinical and non-clinical population at the pre-therapy, post therapy and follow up stages.

* Group 1: Finished their therapy between 1st April 2006 and 31st March 2007, and consisted of 25 women with a mean age of 40 years (range = 26 to 61 years).

Graph 3: The graph below shows the number of clients from Group 2† (n=19) who have scores that are consistent with the clinical and non-clinical population at the pre-therapy, post therapy and follow up stages.

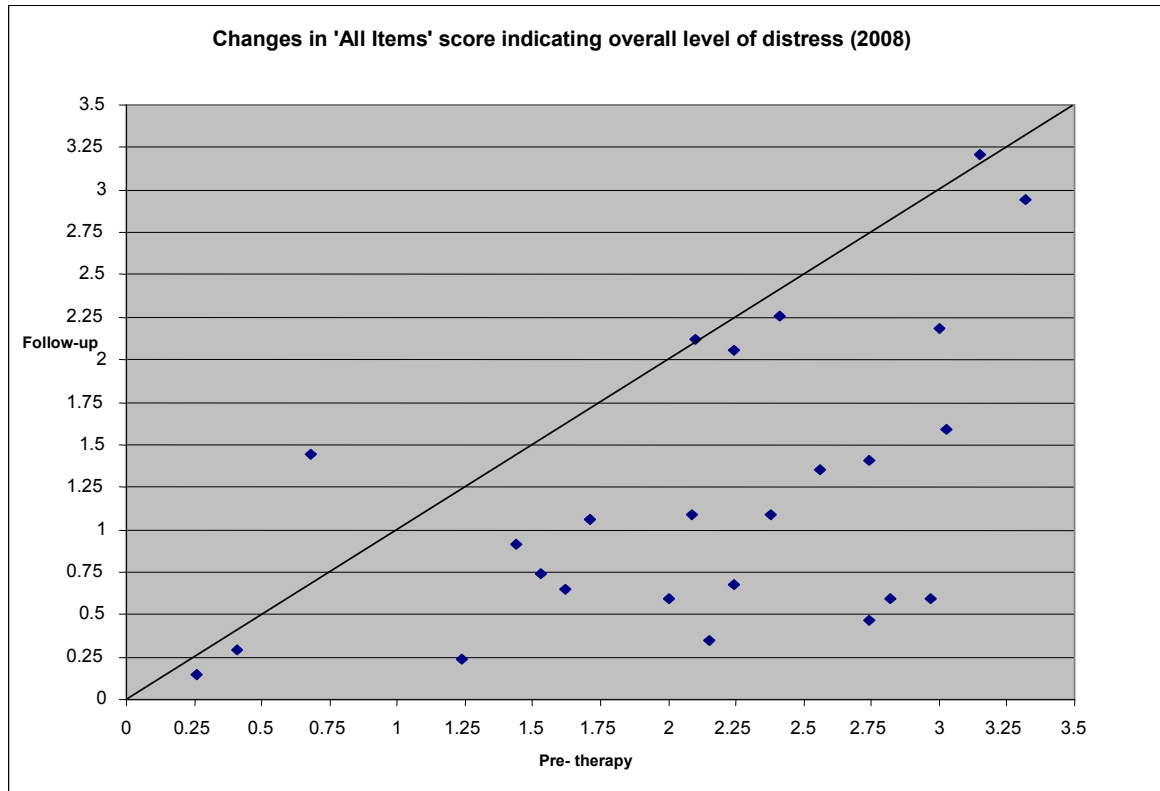


Both of the graphs highlight the decrease in the level of distress for many of the clients. In Group 1 the proportion of clients in the non clinical range grew from 16% at the pre-therapy stage to 60% at follow up. In Group 2, the proportion in the non clinical population increased from 21% pre therapy to 79% post therapy. Overall the results indicate the number of clients in the clinical population decreased from 82% (pre-therapy) to 32% (post therapy). At the follow up stage 68% of clients achieved scores that were consistent with those of a non-clinical population.

† Group 2 ended their therapy between 1st April 2007 and 31st March 2008, and consisted of 19 clients with a with mean age of 37 years (range = 26 to 58 years)

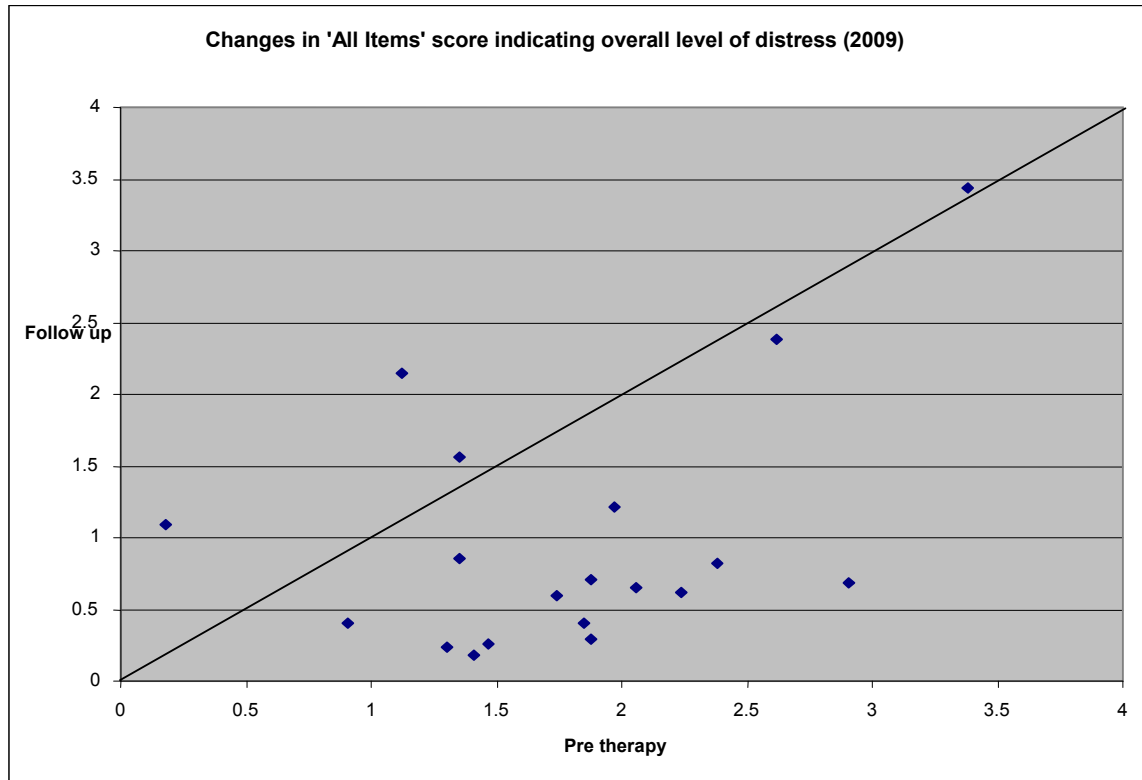
The graphs below show, in more detail the number of clients in each Group. The 'All items' score from the pre-therapy and follow up stages are plotted for each individual client and display the proportion of clients that showed improvements in their scores and those whose scores indicated they became worse following treatment.

Graph 4: Changes in CORE-OM 'All item' Scores for Group 1



The points below the bisecting line illustrate the clients whose scores had improved at the follow up point of the study. In Group 1, 22 (88%) of the 25 clients showed improvement in their scores. The remaining 3 (12%) clients in this Group generated scores at the follow up stage that indicated greater global distress than they experienced before their therapy began.

Graph 5: Changes in CORE-OM 'All item' Scores for Group 2



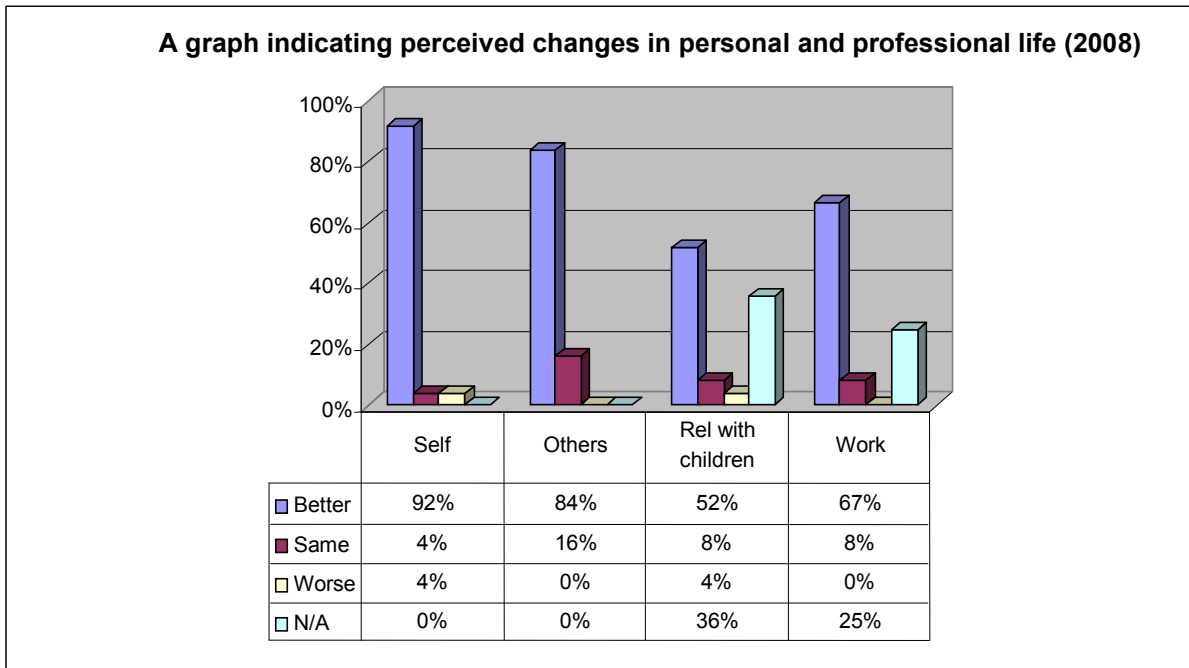
In Group 2, 15 (79%) of the 19 clients showed improvement in their scores. The remaining 4 (21%) clients in this Group generated scores at the follow up stage that indicated greater global distress than they experienced before their therapy began.

Perceived changes

Besides completing the follow up CORE-OM the participating clients also completed a questionnaire developed by WCTS. This addressed perceived changes in various areas of the clients' lives.

The graph below indicates the perceived changes of Group 1 clients at the follow up stage. These perceived changes include how the clients felt about themselves, how they felt about other people, what differences they saw in their relationship with their children and the changes they noticed at work.

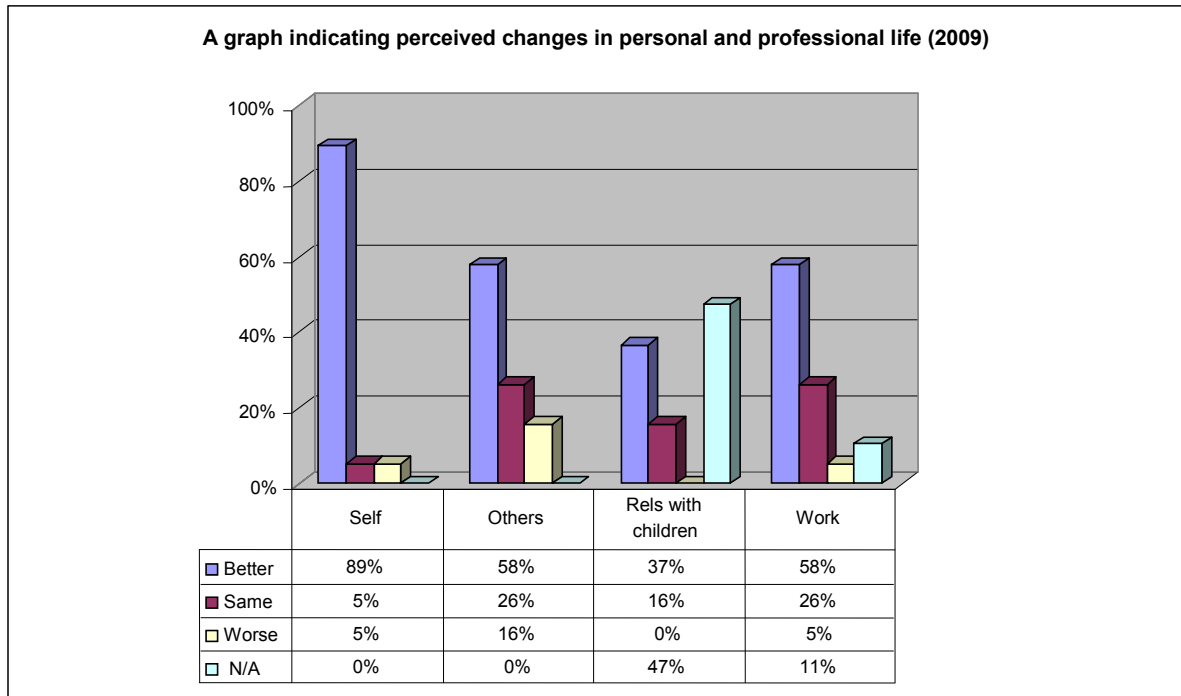
Graph 6: Perceptions of Change for Group 1



In each of the categories, the majority of clients in Group 1 believed there was an improvement. With only 4% of clients believing that they felt worse about themselves and that their relationship with their children had got worse.

The graph below indicated the same categories of perceived changes for the clients in Group 2 of the study.

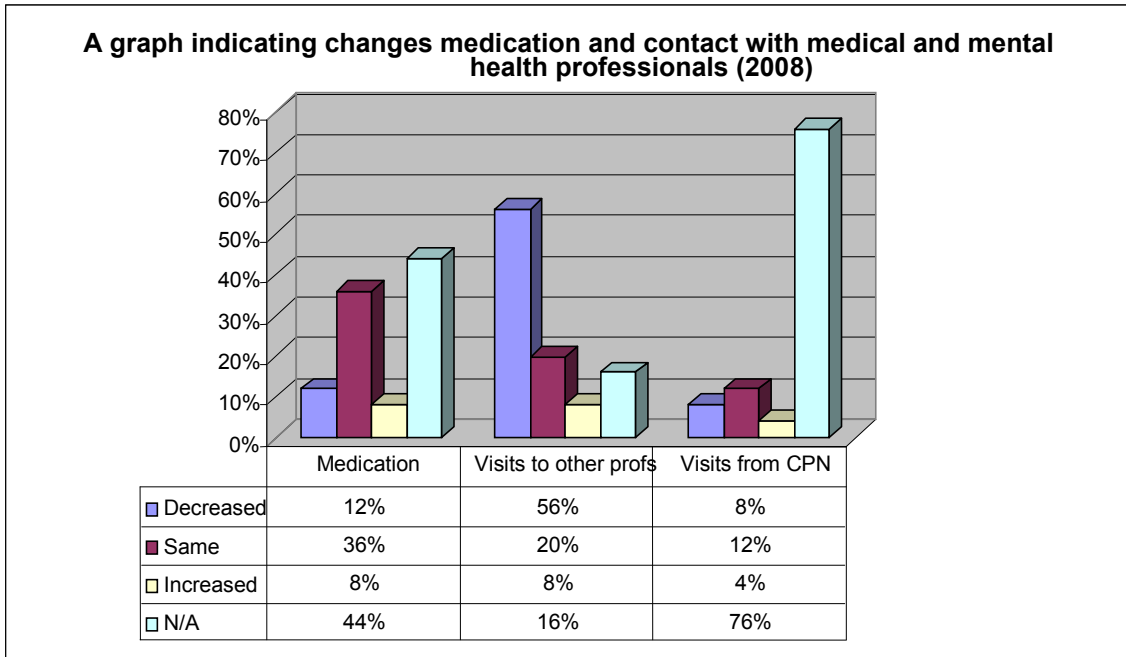
Graph 7: Perceptions of Change for Group 2



Again, in each of the categories, the majority of clients believed there had been an improvement in the various aspects of their lives. However, the improvements were not as great as those in Group 1. When rating how they felt about other people, only 58% stated they felt better whereas 16% stated they felt worse.

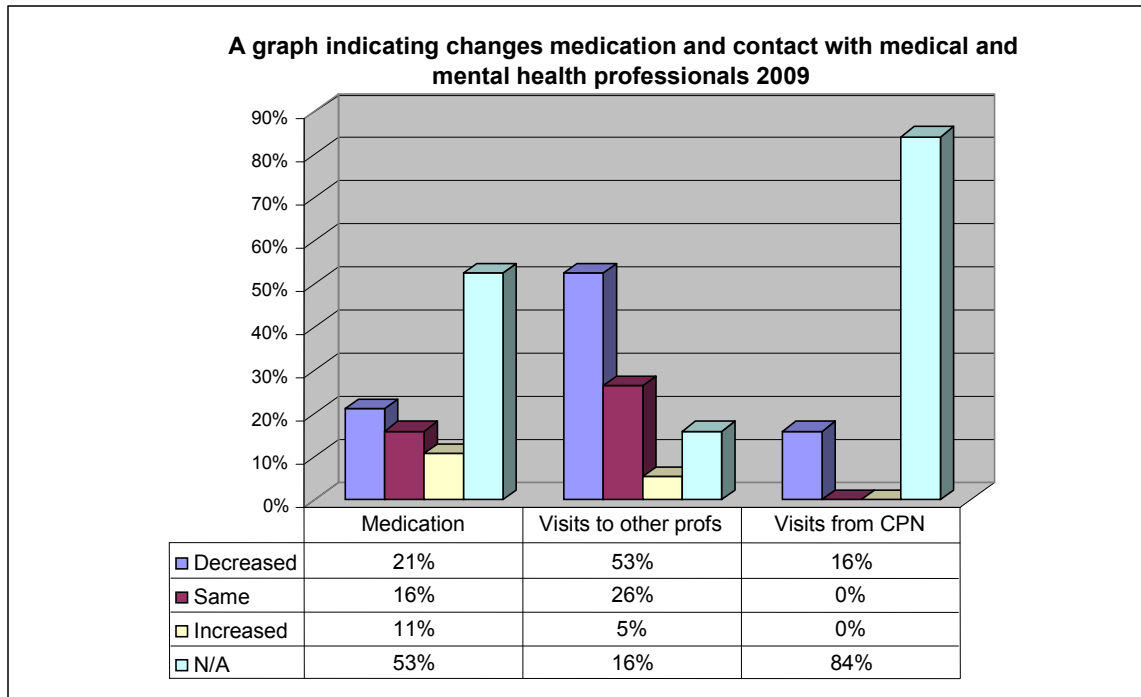
The graph below reveals the results of the second part of the questionnaire relating to perceived changes. These changes include, changes to medication since before therapy began, changes in the amount of visits to/from other professionals and changes in the number of visits from the client's Community Psychiatric Nurse (CPN).

Graph 8: Changes in Medication and Contact with Professionals for Group 1



The graph indicates that these categories are not applicable in a large proportion of the cases. Greater numbers of the clients reported no change in these areas in comparison to the first part of the questionnaire. However visits from other professionals had decreased in 56% of cases.

Graph 9: Changes in Medication and Contact with Professionals for Group 2

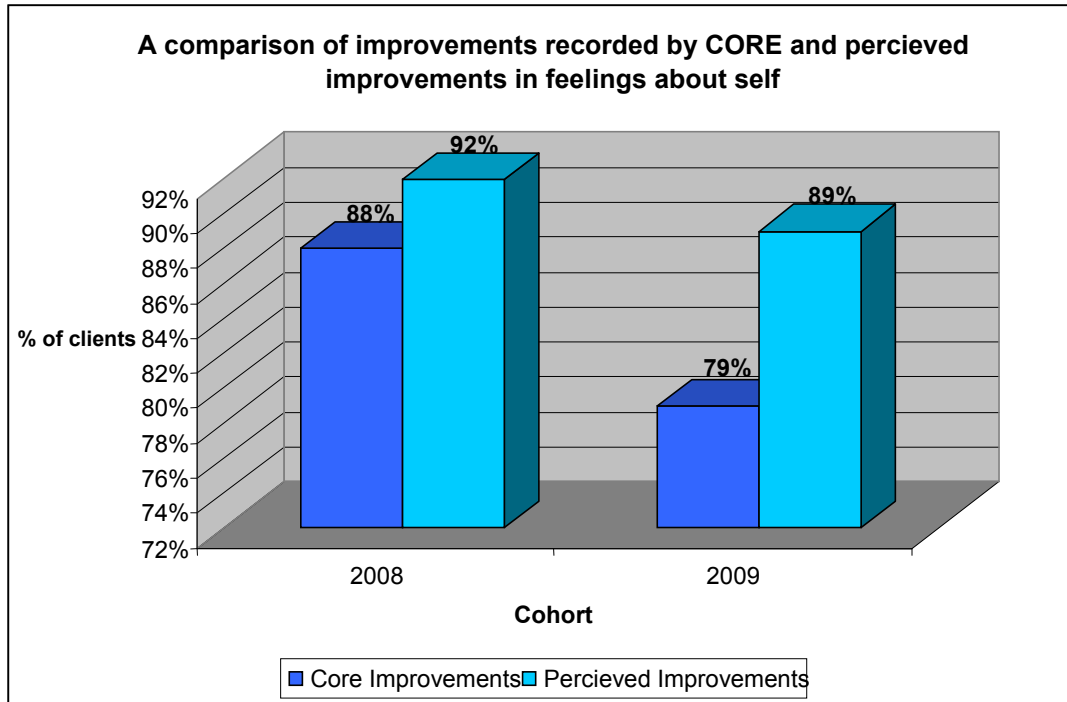


In Group 2 there were also a large percentage of clients for whom the categories were not applicable. However, visits from other professionals had decreased in 53% of cases and for the 16% of people who received visits from a CPN, the frequency of their visits did decrease.

Comparing results from the CORE-OM to clients perceived changes

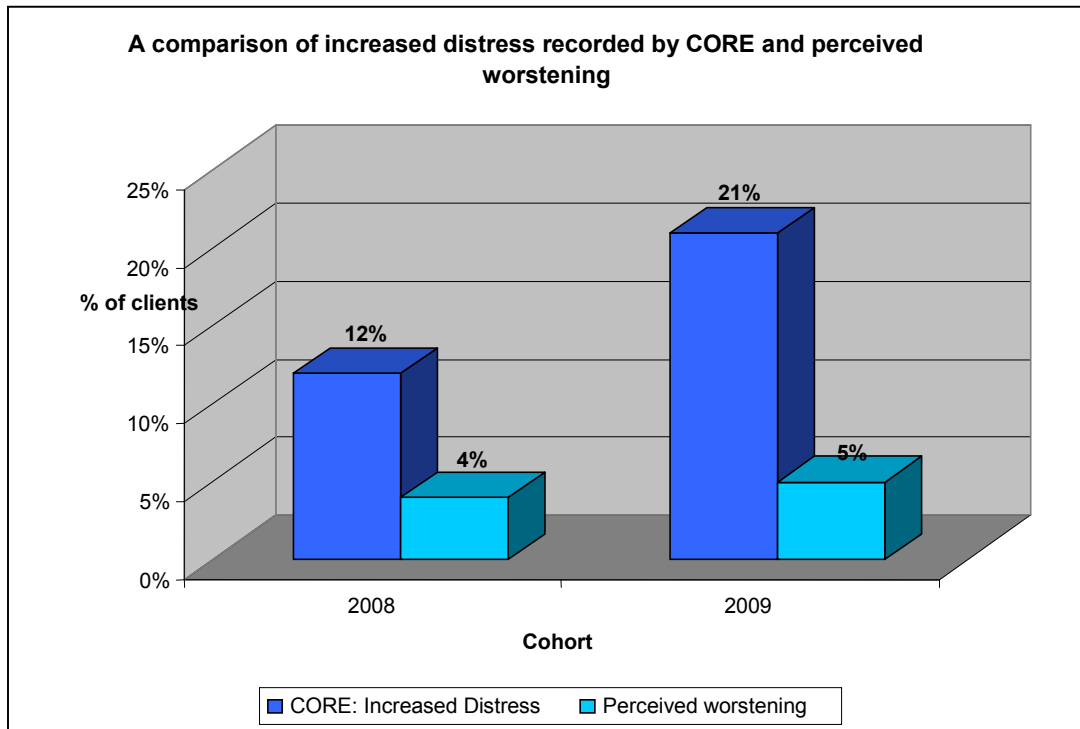
The 'All Items' score of the CORE-OM includes each client's rating of their wellbeing, problems/symptoms, functioning and risk. The following graph shows a comparison between improvements identified highlighted using the CORE-OM and improvements identified via the first question on the questionnaire which looked at the Groups' perceived changes in how they felt about themselves following therapy.

Graph 10: Concordance between Improvement Measures for Groups 1 and 2



The graph indicates the 2008 cohort showed an increased number of improvements that were recorded by the CORE-OM and an increased number of perceived improvements.

Graph 11: Concordance between Decline in Measures for Groups 1 and 2



Discussion of the results

The aim of this evaluation was to investigate changes in the level of distress experiences by two groups of clients following intervention by WCTS using the two measures previously described.

The mean scores for the core areas were used to analyse the CORE-OM data. Initially this was converted into bands (severe, moderately severe, moderate, mild, low level and healthy) as this commonly used format for clinicians mirrored the presentation of results for other assessments such as the Beck Depression Inventory (BDI) (Graph 1).

The pre-therapy results showed 53% of the clients were in the 'severe' and 'moderately severe' categories which changed to 23% post therapy and then 21% at the follow up stage. The follow up stage also revealed that 57% of the clients scored in the 'low level' and 'healthy' range. Interestingly, the 'mild' score band remained constant with 18% of clients fitting this score band at the pre-therapy and follow up stages.

In a paper by the CORE Partnership (2007) a potential reason for this is identified. It states that clients in the 'Mild' range are less likely to achieve improvement than those clients in the moderate to severe ranges but virtually all are expected to recover as they are only just above the cut off point. Similarly, the paper goes on to explain that for a 'healthy' client (with a mean score of <0.6) the chances of improvement are insignificant and that they are unable to recover as they are already below the cut off score and in the healthy range.

For the clients in the 'low level' banding (between 0.6 and 1.0), the CORE Partnership (2007) highlight that there is only around a one-third chance that they will improve and again they are unable to recover as they are below the cut off score.

As an alternative to splitting the clients' scores into bands, the CORE-OM scores were categorised according to the clinical and non-clinical norms provided by CORE. The pre-therapy results show that 82% of the clients produced scores that were consistent with those of a clinical population which reduced to 32% at the post therapy stage.

It is clear from graphs 4 and 5 that the majority of the clients involved in the study showed a decrease in their CORE-OM score indicating a decrease in their level of global distress. Interestingly, when these scores were compared with the findings of the follow up questionnaire, the number of women who perceived improvements in feelings about themselves was higher than the improvements picked up by the CORE-OM form.

The link between these two results is a tentative one as the results of an in-depth clinical outcome measure is being compared to the answer to one question and a more comprehensive comparison between the clients' perceived improvements and the results of the CORE-OM should be carried out.

CORE-OM covers various core aspects of a person's distress and would continue to pick up problems and symptoms. However, following therapy; the woman may feel better equipped to deal with these problems and therefore may feel better in herself and more able to cope. Similarly, there was evidence that some clients showed a greater level of distress at the follow up stage than the pre-therapy stage. This could be due to the client becoming more aware of her emotions following therapy. She may then find it hard to deal with experiences from her past, discussed during therapy, from which she may have previously dissociated.

Conclusion

The findings indicate that the 48% of clients in Group 1 and 68% of clients in Group 2 achieved 'reliable and significant change' on the CORE-OM. This compares favourably with published studies that demonstrate a 40% rate of reliable and significant change in non-selected clinical populations (e.g. Paley, Cahill, Barkham, Shapiro, Jones, Patrick and Reid, 2008).

The data used to generate the present findings only represent a sample of clients from WCTS (i.e. 31% of the first year group and 20% of the second group). In future it may be worthwhile considering asking all clients to complete follow-up outcome measures in addition to the pre- and post- therapy measures to ensure that the present results are representative.

References

Core Partnership (2007). Is initial overall CORE-OM score an indicator of likely outcome? CORE Partnership Occasional Paper, No.1. CORE IMS: Rugby.

Paley, G., Cahill, J., Barkham, M., Shapiro, D., Jones, J., Patrick, S. & Reid, E. (2008). Psychology and psychotherapy: Theory, research and practice. 81 (2) 157-175.