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Contending with the minimum data set: Subjectivity, linearity and dividualising experiences in Improving Access to Psychological Therapies

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Contending with the Minimum Data Set: Subjectivity, linearity and dividualising experiences in Improving Access to Psychological Therapy.

The past ten years have seen a large increase in psychological interventions within the National Health Service (NHS) in England, due to the Improving Access to Psychological Therapy (IAPT) programme (Clark, 2018). This expansion was initially fueled by the Layard Report (LSE, 2006), which detailed the predicted economic advantage of extending the provision of talking therapies to those experiencing anxiety and depression. These posited economic benefits include reductions in healthcare usage, helping 75,000 people move off welfare benefits, and offering economic gains to employers through reduced sickness (Department of Health [DoH], 2012). IAPT is now a first line treatment offered to individuals presenting with mental distress, with nearly 1.4 million people referred to the service in 2015/16 (DoH 2016). People can refer themselves, and contracts to deliver IAPT services have been won by a variety of public, private and voluntary sector providers. IAPT has been particularly associated with Cognitive Behaviour Therapy (CBT). As the service has grown, however, so has the range of therapies on offer. Included in the Department of Health (2016) lists of approved 'low intensity' therapies are 'employment support', and both guided and non-guided self-help. More recognisable as psychological therapy are those classified as 'high intensity' therapies, including CBT, Interpersonal Psychotherapy, Mindfulness, and Couple's Therapy. CBT is by far the most common form of therapy administered, but it is no longer synonymous with IAPT (DoH, 2016).

Holding together this myriad of therapies and providers as a single entity called 'IAPT' can be seen to be a claim to rationalist, 'evidence-based' efficacy. The NHS England website

description of IAPT can be seen to encapsulate this focus:

> "IAPT services provide evidence based treatments for people with anxiety and depression (implementing NICE guidelines). […] IAPT services are characterized by three things:
>
> 1. Evidenced based psychological therapies: with the therapy delivered by fully trained and accredited practitioners, matched to the mental health problem and its intensity and duration designed to optimize outcomes.
> 2. Routine outcome monitoring: so that the person having therapy and the clinician offering it have up-to-date information on an individual's progress. This supports the development of a positive and shared approach to the goals of therapy and as this data is anonymized and published this promotes transparency in service performance encouraging improvement.
> 3. Regular and outcomes focused supervision so practitioners are supported to continuously improve and deliver high quality care." (NHS England, 2017).

Evidence, outcomes and monitoring are central to the service identity presented here. Process is more important than content, and outcome measures are here placed at the centre of the service. Pilgrim (2008) has commented that therapy is often presented as a technology or tool, abstracted from context, rather than as a relational practice. That tendency can be seen here, where 'therapy' 'mental health problem', and 'outcomes' are abstracted from the person experiencing distress and described in terms of a de-personalised mechanism. Also striking in this description is the focus on outcome monitoring, presented as an information sharing exercise between therapist and client. This focus is more than rhetoric; one of the defining features of

using an IAPT service is that outcome measures, in the form of the Minimum Data Set (MDS) are taken in every session. Arguably unusually, therefore, the monitoring systems used by the service at a macro level are present and visible to those using the services themselves. In this paper, we will examine the implications of this for those using the service, and how these outcome measures, built into the fabric of the service, are experienced by service users. Central to this question is an exploration of the model of distress and recovery assumed in these measures, and how this matches with the experiences of service users. It is important first, therefore, to explore the processes of measurement in IAPT in some detail.

Linearity, outcome measures and IAPT

The Department of Health (2016) guidelines outline the processes for measurement in IAPT services. Once referred to IAPT, clients are assessed in terms of 'case-ness', essentially an assessment of the severity of their problems. The Department of Health guidance recommends a primarily quantitative assessment, based on breaching threshold levels on the standardised measures used in IAPT. The two key measures are the Generalised Anxiety Disorder Assessment (GAD-7) and the Patient Health Questionnaire (PHQ-9). These are both widely used screening tools in psychological and psychiatric assessment. In IAPT, 'case-ness' is assessed as a score over 8 on the GAD7 and over 10 on PHQ. This is true for all diagnoses: a 'case' of Generalised Anxiety Disorder is operationalised as 8 on the GAD7, as is a 'case' of anxiety caused by the 'disappearance or death of a family member' (DoH, 2016).

These same measures form the core of the 'Minimum Data Set' (MDS), which is then re-administered in every IAPT session (DoH, 2016). These data are used to assess 'recovery'.

Recovery in IAPT is operationalised in terms of 'recovery', 'reliable improvement' and 'reliable recovery'. 'Recovery' is those who start at 'case-ness' and by the end of treatment their scores have fallen below the clinical level. For any change to be seen as a 'reliable improvement' this movement in scores has to be larger than the measurement error (for the measure in question, e.g. the GAD-7); for a 'reliable recovery', the change has to both move the person out of 'case-ness' and exceed the measurement error. Overall in 2015/16, the official statistics show that 46% of those who began as 'cases' moved to 'recovery' by the end of IAPT treatment (DoH, 2016).

There is a very particular model of distress being conjured through the use of these measures. Symptom intensity is taken as the only measure of distress, and a binary is drawn between those who are distressed and those who are recovered. Crucially, the movement between these two states is assumed to be uni-directional, and linear. Linearity underlies the design of IAPT; success is measured only in terms of linear movement in one direction, a reduction of symptoms. We can see that this is compelling idea, that recovery, intuitively should equal feeling less worried, less sad, and doing more in one's life. There is, however, ample evidence that complex emotional experiences, such as mental distress, and complex processes like therapeutic change, do not adhere to simple linear models (e.g., Hayes et al, 2007).

Several researchers have highlighted that far from adhering to a continuous, linear process of change, characterised by a gradual reduction of symptoms, recovery from distress is instead characterised by sudden shifts, discontinuities and fluctuations (Hayes et al, 2007; Baumeister, 1994; Nishith, Resick & Griffin, 2002). Recovery, therefore, can include periods of feeling significantly worse, as well as better. Indeed, Baumeister (1994) argues that the period preceding a major life change often includes the 'crystallization of discontent', a period of

particularly acute distress which then precipitates change. In studies with clients diagnosed with both anxiety (Heimberg & Becker, 2002) and PTSD (Nishith, Resick & Griffin, 2002) it has been found that clients experienced an intensification of symptoms before then experiencing improvement; getting 'worse' is again here a sign of positive change.

Hayes et al (2007), in mapping therapeutic change over the course of therapy for depression, also found that change was marked by discontinuity. This included a rapid improvement at the beginning, followed by a plateau; clients also experienced regular 'depression spikes' fluctuating in and out of intense periods of symptom intensification, before moving into a more settled period of feeling better. They draw on non-linear dynamics theory as a framework to bring together these findings. As Prigogine & Stengers (1984) state: "most of reality, instead of being orderly, stable, and equilibrial, is seething and bubbling with change, disorder, and process" (p. xv). Within this seeming disorder, however, non-linear dynamics maps the underlying order within complex systems, and the processes by which change is enacted between different states. Change is seen to be discontinuous, in that small changes to the parameters of a system can lead to disproportionately large changes in that system (known parochially as 'the butterfly effect'). Additionally, fluctuation, or oscillation between different states is often observed as a part of the process of change from one state to another. Within this paradigm, fluctuation and intensification of symptoms would be expected as a precursor to change, rather than slow and steady decline, as is borne out in the empirical literature (e.g. Kougiali et al, 2017; Robertson, 1995; Chamberlain & Butz, 1998).

The implications here are clear. Those who use IAPT services are being assessed using a model which potentially does not meaningfully reflect the process of change being experienced

by clients. For many services, disconnection between the process of change and the measures being used for tracking these changes could be seen as a technical or administrative problem, primarily a concern of service managers, commissioners and auditors. What brings this issue to the forefront in IAPT, however, is the presence of the MDS in every therapeutic session, as a central part of the therapeutic interaction.

Stabilising materiality and dividualising experience: Understanding the dual role of the MDS

Unpicking the role of the MDS in the therapeutic encounter also requires some theoretical tools to help theorise the MDS as a multiple actor in the experiences of IAPT service users. It is at the same time: a physical object present in the room; a tool which structures activity; and as a representation of distress and change which is then folded into the subjectivity of service users. In holding together these multiple functions, the MDS can be understood as a 'quasi-object' (Serres, 1995), defined as a material object which contains "a luminous tracer of the social bond" (1995: 87). Serres argues that such material objects cannot be separated from the social relations in which they are situated, and are: "multiple in space and mobile in time, unstable and fluctuating like a flame, relational" (1995: 90). This argument bears much similarity to Latour's (2005) argument that material objects are inherent to human interaction; that objects mediate and transform interactions. Objects, he argues, are 'non-human participants' in interaction; rather than being mere adjuncts to social life, they are part of what produces human experience:

> In addition to 'determining' and 'serving as a backdrop' for human action, things might authorise, allow, afford, encourage, permit, suggest, influence, block, render possible, forbid, and so on. (Latour, 2005: 72).

Latour here argues for an active role of objects in creating experiences, for objects to be seen as 'actants' in interaction, rather than merely the passive recipients of human meaning.

Objects then, such as the MDS questionnaire, can be seen as wholly embedded in our social, relational, meaningful interactions. This is not to argue, however that there is no difference between material and social actors and actants in interactions and experience. Serres (1995) indeed argues that the particular role material objects play is in stabilising and slowing down relationships (see also Reavey & Brown, 2009; McGrath, 2012), claiming:

> Our relationships, social bonds, would be airy as clouds were there only contracts between subjects. In fact the object, specific to the Homindae, slows down the time of our revolutions. [...] The object, for us, makes our history slow" (1995: 87).

The specific role objects are proposed to play in mediating relationships, is hence one of slowing down, of anchorage. He proposes that the very materiality of objects means that the role that they play in producing experience is can be seen as differentiated from, but at the same time wholly integrated into, inseparable from, social interaction. Material objects are here not only products of human activity, but also limitors and anchors on the range of possible actions available to people, as they engage in embodied, meaningful activity in the world. Our question here therefore becomes, what is the MDS, as an actant, doing? How does it become folded into both the therapeutic relationship and this discontinuous, complex process of distress and recovery?

In addition to this understanding of materiality, we also need to understand how the experience of repeatedly completing the same measures might become folded into subjectivity and

experiences of distress. For this issue, we turned to Deleuze's (1992) concept of the 'dvidual', outlined in his essay on control societies. Control societies are said to work by abstracting bodies and objects into data, which can then be manipulated (Shaviro, 2011). The free-floating modulatory control society aims to break down complex subjectivity into dividual parts in the form of data that can be coded. These codes are used to manage individuals, either granting or denying access to information, whereby individuals become "dividuals" (Deleuze, 1992, p. 5). Rather than being engaged with the state as an individual, a whole subject, the numerical language of control is made of codes whereby the individual becomes substituted for the code of a 'dividual' material to be controlled (Deleuze, 1992). This 'dividualising' of experience through the fragmentation of identity (Colwell, 1996), is argued by Allen and Brown (2015), to result in the implementation of strategies that dissolve the specificity of individual lives and experiences in order to defer the individuals' claims upon the state for as long as possible. The identities of the dividual become multiple and temporary and depend upon the immediate context and are used to control short-term activity (Colwell, 1996). Thus a shift from a detailed interest in individual subjectivity to a holding bay of the 'bits' of a 'dividual' is proposed whereby, within the healthcare setting, the doctor becomes concerned with the particular symptoms of the patient, rather than the overall welfare of the individual (Allen & Brown, 2015). This can be seen to reach its natural conclusion in the practices of the MDS, where the complexities of distress, recovery and therapy are reduced and captured to movement on linear scales, dividualised information fostering simplicity from complexity.

Exploring experiences of the MDS

To explore the role of the MDS, interviews with current users of an IAPT service will be examined. The positivist culture and evidence-based rhetoric currently prevalent within the field is also fed by the quantitative focus of the research currently surrounding IAPT as much research focuses on assessing the development of the service, quantitatively evaluating effectiveness and reviewing how the service is meeting centralised targets and suggestions as to how the service should be further developed (e.g. Clark, 2011; Jolley et al., 2015, DoH, 2012; Newbold, Hardy and Byng, 2013). Whilst these studies are important, lacking in the field of research surrounding IAPT is a developed account of the service users' experience (Williams, 2015). One recent study that has qualitatively explored service users' experience of accessing IAPT, suggests that therapy under IAPT constructs an experience of distress as being an individual pathology discussed within numerical representations of personal distress and focusing upon a discourse of productivity and market economy (Mackinnon & Murphy, 2016). There has also been a study investigating experiences of outcome measures in IAPT, but this had more of a focus on the 'efficacy' of such measures rather than their role in subjectivity (Fornells-Ambrojo et al, 2017). Further qualitative research specifically exploring this numerical representation of distress and of the implementation of the MDS is warranted given the significance it is afforded in the structure and evaluation of IAPT.

The structured delivery of therapy within IAPT alongside the routine use of the MDS has received criticism within the therapeutic community as it has been argued that the heavy use of measures and diagnostic tools cannot account for the subjective experience of mental distress which has been argued can only become known through service users' own reports (Middleton, 2015). Further, it has been argued that the representation of complex emotional experiences

through structured tools such as measurements, reports and diagnoses offers a 'cold' account of distress compared to the 'hot' experience of mental distress (McGrath & Reavey, 2016). These arguments draw on older critiques of quantitative measurement as applied to the complexity of psychological experience (Michell, 1999; Prior, 1998). Thus a question remains as to whether the weighting given to the MDS in defining the 'recovery' of each service user and subsequent 'effectiveness' of the IAPT service is reliably representative of service users' own understanding of their experience of their mental distress and treatment under IAPT.

The study

This was a small scale qualitative study, aimed at exploring the experiences of those accessing IAPT. Seven participants were recruited from an IAPT service in a large city in the UK in which the first author worked. Individuals who had completed one to one therapy within the service and had expressed an interest in attending further groups were contacted by the first author to be invited to take part in the study. The first author, who conducted the interviews, had no contact with the participants prior to recruitment. Six participants had completed high intensity therapy (CBT) and one participant had completed low intensity treatment (CBT-based guided self-help interventions) and was on the waiting list for high intensity treatment. The participants were made up of four females and three males, ranging in ages between 29 and 56. Six of the participants identified as white British and one as white European. Individuals who expressed an interest in taking part in the research after being contacted by the researcher were sent an invitation letter with details of the format and content of the interview, confidentiality procedures and their right to withdraw at any point to ensure they were able to give fully

informed consent to take part. They had at least 24 hours to decide whether they would like to take part in the study.

Ethical approval was granted by the host university. The NHS Research body for the trust was also contacted, who advised that the study was classified as a service evaluation project and thus it was not required to undergo NHS ethics approval. It was approved and supported by the Clinical Lead of the service.

Participants were given the option of attending the interview at the IAPT service where they had previously received therapy, or a private room at a local college. Four of the participants chose to complete the interview at the IAPT service and three at the local college. Consent forms were signed prior to the interviews commencing. Each participant took part in one interview which lasted on average for one hour. The interviews were audio-recorded. Following the interview, the recording was stored on encrypted memory stick and then transcribed.

Multi-modal semi-structured interviews were conducted. To focus the participants' accounts on the experience of being within the space of the therapy room, participants were first invited to draw their impression of the therapy room. Visual methods have been argued to be successful in generating rich, emotional and located accounts of experience (Reavey & Prosser, 2012; McGrath, 2012; Sheridan, Chamberlain & Dupuis, 2011). These drawings were seen only as prompts for the interview, and not analysed as visual artefacts themselves (see Reavey, 2012). After the interviews were completed, the participants were given the opportunity to ask questions and were again informed about confidentiality and their right to withdraw at any point. No participants withdrew throughout the process.

Analytical approach

A thematic analysis (Braun & Clarke, 2006) was performed from a process relational perspective which considers social, relational and material processes as jointly constitutive of experience (see Brown & Stenner, 2009; Brown & Reavey, 2009; McGrath, 2012). Following the completion of the interviews, the interviews were listened to and transcribed. The first author initially read and re-read the transcripts several times to become familiar with the material. This was undertaken by reading the transcripts in different orders to prevent any order bias. Codes were then identified which were relevant to the research question. Once the transcripts had been read and coded several times, themes were then identified which seemed to capture clusters of codes, connecting the codes in meaningful ways. Several of the themes initially identified were focused on the educative, responsibilising role (Harper & Speed, 2014) of CBT for the participants. This focus was then widened to consider the role of the service, as opposed to just the therapy, in participants' experiences. This shift lead to the focus on the MDS as a 'quasi-object' which embodies the positivist, outcome measuring focus of the IAPT service. Due to this interest, theoretical tools were sought which could help to theorise the role of the MDS within the therapeutic encounter. It was at this point that Latour's (2005) work on objects became important in the analysis, as well as Deleuze's (1992) concept of the 'dividual'. These complementary theoretical tools were used to structure our analysis, focusing on the activities, roles and functions of the MDS in the subjectivity and service delivery.

Unpicking the immovable object: Roles and actions of the MDS

The MDS can be understood as an 'immovable object' (Latour, 2005) within the IAPT therapeutic encounter; it is always present in the room when therapy is taking place, and must be engaged with for therapy to proceed. The ways in which the MDS functions as an actant and quasi-object were described as multiple, and hence this analysis will focus on the different functions and actions of the MDS. Three themes will be explored: the MDS as an authorizing mediator; as an alienating adversary; and as a deferring gatekeeper.

An authorising mediator: Harmonising the self with the service.

One function of the MDS which was emergent in the participants' talk was that of an authorising mediator, which acted to translate the service users' individual experiences of distress to correspond with the parameters of the service, and then reflect these representations back to the service user. For some participants, this was described as a process of harmonisation, whereby the representation of distress captured in the outcome measures became integrated into their own understanding of their distress. Jennifer, for instance, described her changing relationship with the MDS:

> Jennifer: ah fine I suppose initially I thought this is a bit weird sort of some of the I mean one
> question is like do you have sort of suicidal thoughts and I was like god no [mm] but you know
> I sort of suppose at that point at the beginning I think if anything at the beginning of all these
> things if you've never done that before it sort of feels perhaps it can kind of can feel slightly
> alienating [mm] because if you go in for example like myself it was just I felt like I was just
> going in for something very practical and [mm] then I was asked if I have suicidal thoughts
> and it felt a bit extreme [mm] but then once you sort of get into the rhythm of it you

understand the bigger picture [mm] um but generally I thought it was quite useful I mean

anything that sort of visually shows you how you're doing is no bad thing […] and um yeah I

think it was quite good to have that reflection

While Agatha described a similar evolution of her relationship with the MDS:

Agatha: ah um it felt a bit like a chore [hm mm] um first because I was being quite ah

dismissive about ah data analysis whatever but at the same time um it was both a

realisation of how I am feeling if one was to translate it in numbers or degrees or

something like that [hm mm] which was not necessarily pleasant [mm] yeah but overall I

mean you know it was no harm

Both of these examples demonstrate the ways in which the MDS functions as a mediator. Whilst

initially alienating, Jennifer describes here how the MDS as a tool harmonised her with the

"rhythm" of the IAPT service. Whilst at first Jennifer describes the questions on suicide as outside

her 'practical' agenda, over time the presence of these questions on the MDS 'translates' the

parameters of her 'agenda' to those dictated by the measures. Agatha similarly describes how at

first the MDS was separate, alien to her experience, but through repeated use of the tool became

a way to understand and represent her distress. Here we can apply Latour's idea of the technical

as a 'detour'. In these examples the development of an understanding of distress, and hopefully

recovery, is 'detoured' through the MDS as a technical object. But in being mediated through

these outcome measures, service users' understandings of distress are also translated; the

representation of distress in these outcome measures becomes part of their overall

understanding and lived experience. By the end of this process, both women describe using the

results of the MDS as a lens through which they view, monitor and understand their own distress.

Latour (1994: 32) describes translation as: "displacement, drift, invention, mediation, the creation of a link that did not exist before and that to some degree modifies two elements or agents". It is noticeable here that whilst both participants describe a translation, or shifting in their subjectivity, this is not a two-way mediation. The MDS, the outcome measures, remain fixed and thus the translation is an authoritarian one; shifting the service users' experience to align with the service. In the case of IAPT, this can be seen to mean harmonisation with the idea of distress as linear, and as a responsibility of the individual (Harper & Speed, 2014). Latour (2000: 85) suggests that objects "become mediators, at least for a while, before soon disappearing again through know-how, habituation or disuse". Thus the acting of the immovable object of the MDS may become subsumed into the therapeutic interaction such that its visible role in the construction of participants' mental distress fades into the background. This can be seen to support the 'responsibilising' (Harper & Speed, 2014) quest of IAPT; service users are here taught to incorporate the representation of their distress as a reflection to be used in fashioning a 'recovered self'.

An alienating adversary: Broken links and incomplete translations

Outlined above can perhaps be seen to be the MDS as it is supposed to function; as a technology to align service users with the wider parameters of the service. Divergent functions of the MDS however emerged throughout the participants' talk, where this translational function seemed to have broken down, be resisted or opposed.

One problem which emerged was disconnection between the experiences of the participants and the representation captured in the MDS. Suzanne, for instance, said:

Suzanne: …and <u>my</u> scores were getting <u>better</u> for whatever reason and I thought well that's not very good because I still feel rubbish a lot of the time but it's just a question of when you take them and what mood you're in [mm] and all this stuff [mm]

Here the MDS acts as a counter to Suzanne's own assessment of her affective experience; the linear picture captured through the outcome measures which is taken to represent 'getting better' does not here match her expectations of 'feeling better'. In this encounter, therefore, the MDS can be seen as having an instructional role ("feel better"). Due to the disconnection between this representation and Suzanne's experience, this instructional role is one which is then dismissed by Suzanne through minimising the validity of the measure itself ("it's just a question of when you take them"). The harmonising process between service and service user is hence interrupted and broken. Julian described a related problem:

Julian: (.) yeah so the feedback sheets because they're they seem so sort of fixed that I'm not sure how accurately they reflected either you know how I was feeling or what kind of impact the therapy was having [mm] and there is some- I mean I know I guess it might be helpful in the sense but there is there is something that feels a bit odd about kind of assigning a number to the way [mm] that you're feeling…I don't know I think it's probably better than nothing but the the feedback sheets I'm not sure that they really reflect anything [mm] I think maybe not sure if what you'll do with them the way the service works and stuff but if there was something that was more sort of qualitative then [mm] then I think that would probably be quite good

Julian here also describes a broken or blocked process of translation. Rather than incorporating the outcome measures into his understanding of distress, he instead describes a kind of broken

mirror, in which the measures do not reflect his experience in ways which can be utlised. Julian particularly draws out the disconnection between the complexity of his ongoing experience and the 'fixed' nature of the quantitative measures (McGrath & Reavey, 2016). Here we can see Deleuze's 'dvidualising' process in action, whereby messy subjectivity is translated into dividual codes, separate from the self and subjectivity. In both Julian and Suzanne's accounts we can see the limitations of the linear measures used in IAPT; the fixed linearity of the measures used do not reflect the complexity of distress and hence this disconnection blocks, or impedes the harmonisation process described above.

At some points, participants described a more antagonistic relationship with the MDS. Rather than only a failure of translation, a broken mirror, some participants described the MDS as an active adversary in the therapeutic process. Suzanne and Mary both explore how they experienced the MDS as functioning as a barrier between a deeper engagement with their mental health professionals:

Suzanne: you fill out these stupid sorry but these stupid self it's all self um it's not like a it's not a proper clinician who knows well I'm not saying that because I thought she was very good but you feel like it's not a proper clinician sitting there analy- evaluating you [hm mm] it's all self-reporting [hm mm] questionnaires which you can just make up [hm mm]

Mary: Ah (.) yeah probably because um you had a window of time and you needed to do that at the beginning um and because I didn't see or understand why I was doing it [mm] I understood why I was doing it but in relation to that session so it was a bit like yeah well

I'm kind of yeah so it did feel like a tick box exercise especially in the one to one because

it did felt like the more valuable time was with the therapist not this form [hm] so it did

become oh yeah that's the question about that yeah well what did I put last time

Here, the translational properties of the MDS are more than suspended, instead the MDS

becomes an active barrier between the service user and therapist. Both Suzanne and Mary again

indicate disconnection between their lived experiences of distress and the dvidualised version of

experience captured on the 'tick box' forms which you can 'just make up'. In addition, however,

the 'immovable object' of the MDS is described as a material barrier in the process of therapy

and treatment. The role here of the MDS in 'detouring' time and energy from therapeutic

interaction could be argued to add to the experience of therapy within IAPT as being 'arelational'

or as Pilgrim (2008: 256) puts it: "the seduction of technology diverts our attention from the

centrality of relationality". This could be problematic as it has been widely pointed out that the

quality of the therapeutic alliance, rather than the particular model or approach adopted, is a

key predictor for the success of therapy (Lambert, 2007; Bentall, 2009; Guy, Loewenthal, Thomas,

& Stephenson, 2012).

A deferring gatekeeper: Negotiating with the state

Participants also discussed the MDS as a bureaucratic tool, less specifically engaged with

understanding distress or involved in therapeutic change. As a bureaucratic tool, the MDS was

described as a way for the service, and by extension, the state, to defer and manage

responsibility. Suzanne, for example, described this function of the MDS:

Suzanne: […] it's all box ticking I guess and trying to prove that if you do go and commit

suicide that on your last form you said oh you were feeling okay so they had no idea

Here, Suzanne highlights the role of the MDS as a way for "the system" to relinquish responsibility in the event of a service user acting on suicidal ideation. Suzanne here seems to highlight a 'risk society' (Beck, 1998) element of the use of outcome measures. It has been argued that the facilitation of risk management as a quantified procedure allows the state to govern mental health difficulties from a distance (Rose, 1998). Thus the role of the MDS in facilitating risk management through "box ticking" can be seen as a part of creating new technologies of risk management and subsequently shaping the structure of the largest provision of mental healthcare in the UK. This again could be read as breaking down the complexity of working therapeutically with distress whereby the state reduces its role and responsibility (Allen & Brown, 2015), instead focusing the responsibility for recovery on the individual (Furedi, 2004, Harper & Speed, 2014). There is a paradox at work here; whilst being more present than ever within the subjectivity of distress and recovery, the state is also more absent, in contact only through the dvidualised, 'cold' (McGrath & Reavey, 2016) version of distress represented in the data set.

An additional role of the MDS, therefore, was as a gatekeeper for access to services. Achieving 'case-ness' on the MDS was necessary for continued access to services. Several participants described strategies they used to manage the dvidualised version of their subjectivity which was captured through the measures. Mary, for instance, stated that:

Mary: [...] I didn't give a completely true reflection of where I was at with my mental health state I probably exaggerated a bit [hm mm] but had I not had accessed it I probably would have been in that place eventually [hm mm] so um you know questions like are you suicidal [hm mm] I (.) I didn't say no so in order to because it's very much quantitative

with the NHS [mm] um you know I'm nearly 50 years old I've paid contributions and I and

I actually feel like I'm somebody who doesn't use the NHS [mm] I use a lot of alternatives

and I felt like you know if I had to tick boxes in order to access or get a way into getting

some Mindfulness and CBT then I would

Here Mary describes manipulating her answers in order to gain access to further services. She

cites her payment of taxes as entitling her to access public services, actively resisting the use of

the MDS to limit her claims upon the state to which she has contributed. This highlights a further

complication in the use of the MDS for the service. From the point of view of the service, one aim

is to translate the complexities, discontinuities, and 'heat' of lived individual distress into a cold,

linear, dividualised version which can be plugged into management, reporting, and used to

demonstrate the efficacy of the service. The linear simplicity of these measures also, however, is

open to being used as a tool for pulling back some responsibility and sense of service from the

state.

Contending with the MDS

In the therapeutic encounter, the MDS was described as an 'immovable object' (Latour, 2005)

which had to be negotiated by both service user and therapist. The participants described how

the MDS functioned firstly as a mediator of their distress which harmonized, or aligned, their

experiences with the parameters of the service. This has been characterized here as an

authoritarian translation, whereby the 'fixed' nature of the MDS meant that service users were

compelled to align their understanding of their distress with those of the service. Multiple blocks

to this translational process were described, with participants describing the MDS as an

alienating adversary which interfered with their understanding of their distress and/or the relationship with their therapist. When the MDS did not align with their experiences or frameworks for understanding distress, it was described as promoting alienation and disconnection. Central to non-alignment were the tendency in the MDS to characterise distress as dividualised data (Deleuze, 1992), as characterized by linear simplicity (Hayes et al, 2003). The disconnection between this dividualised, linear picture and messy subjectivity functioned as further promoting a feeling of de-subjectification (Allen & Brown, 2015). Finally, the MDS was described as playing a role of gatekeeping state responsibility. Whilst the use of the MDS in every session of therapy meant that the service was ever-present in the encounters in IAPT, these measures were also seen as a way to defer responsibility and manage risk, through the use of the partial data collected. Some participants described using this partiality to resist and reclaim some entitlement from the state through manipulation of the simplistic measures being used.

Multiple issues are illuminated here. Far from being neutral or objective, tools like the MDS are living actants within people's experiences, and the life of the service; these tools become part of how people understand and monitor their distress, as well as acting a role in therapy. It seems likely that the measures used in IAPT are not accurately reflecting the processes of distress, therapy or change (Hayes et al, 2007). This can be seen as inherently problematic for a service founded upon 'efficacy', accurate measurement and a solid evidence base. The continued expansion of IAPT in England also warrants consideration of the form of distress and recovery being promoted through the fore-fronting of such outcome measures as a cardinal feature of the service. It is shown here that the disconnect between the official model of change and people's experiences is alienating, potentially driving a wedge in the collaborative process of

therapy (Roth & Pilling, 2007).

There are some limitations to this study; it was a small scale, exploratory study which was limited in scope. In line with good reflexive practice in qualitative research (Yardley, 2008) it also worth noting that the first author had worked in IAPT as a therapist for some years at the time of data collection. This dual role as therapist and researcher was helpful in facilitating the research. It is however worth considering that the broadly critical stance the first author had developed towards many practices in IAPT through personal experience may have seeped into the data collection and analysis of the participants' accounts. This possibility was identified, acknowledged and actively counteracted ~~through~~ during the analysis, both by regularly referring back to the data to ensure that the analysis was grounded within the data itself, and by being cross-referenced by the second author, as we attempted to consider alternative readings of the data from different positions during the research. With these limitations in mind, this research nevertheless points out the need for larger and more developed fine-grained analyses of the processes and experiences woven into practices in IAPT. We would argue that a key concern for psychologists and CBT therapists is to reflect on whether the purposes of state monitoring and therapy are always opposed (Rizq, 2012), or whether more sensitive tools which can be integrated more flexibly into the everyday fabric of the service could be developed to mitigate these issues.

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