

Combining Evidence Based Practice & Practice Based Evidence in CAMHS : some tentative thoughts for practitioners and commissioners

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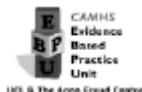
And members of the CORC committee and research group, and many others..

They may not all necessarily agree with what follows but they have particularly helped shape it

The gap from research based evidence to practice



From DCSF guide to the evidence for Targeted Mental health in schools 2007



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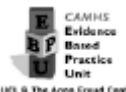
The limitations of practice based evidence

The advantages of practice-based evidence :

- it has emerged from a practical, naturalistic setting
- it can be applied to a wide range of approaches or interventions
- it can provide rich insights
- it can be context-specific.

However,

- it cannot demonstrate that outcomes are a direct result of a specific intervention
- it is subject to possible bias
- it may not be representative
- it may not be reported or written down in a way that others can scrutinise or understand how conclusions have been reached.



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The limitations of research based evidence

- All research is provisional
- All research raises as many questions as it answers
- All research is difficult to interpret and to draw clear conclusions from
- Qualitative research may be vital to elaborate experience, suggest narratives for understanding phenomena and generate hypotheses but it can't be taken to prove anything
- Quantitative research may be able to show hard findings but can rarely (never?) give clear answers to complex questions .

And yet, despite all the challenges, it is still worth attempting to encourage an evidence-based approach, since the alternative is to continue to develop practice based only on assumption and belief

Possible way forward for the practitioner:

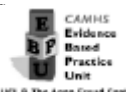
When first working with a particular child/family consider the following in this order:

- Trial based research based evidence
- Evidence related to the particular context/culture of child
- Practice based evidence
- Anecdote

and , most crucially, what the child and family want

Controversial thought

- Is it appropriate to ask for informed consent if offering something without trial based evidence ?



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Key components of good practice?

- May be dangers in stopping too soon and going on too long (average of 10 sessions - but clearly may be big differences either side)
- Good to have clear goals for each session
- Time limited/goals based treatments tend to do better than open ended (though should include the possibility that may do more than originally planned)
- Build in reflection and review- how would you know if things were not going well?



How to be a “supershrink”: emerging work from Miller and Duncan

Prepared to try new things, check up and to seek out feedback

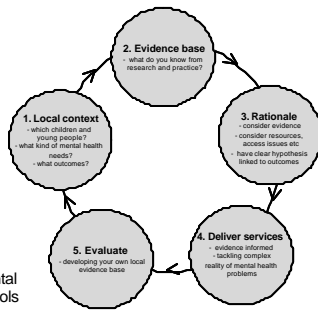
Deliberate practice may be key

Miller and Duncan eg

<http://www.talkingcure.com/uploadedFiles/networkerSlides.pdf>



Possible way forward for the commissioner:



From DCSF guide to the evidence for Targeted Mental health in schools 2007



Indicators of a good service?

Reflection

- What means of outcome evaluation is in place – how is this used by staff eg is this included in supervision discussions
- Are there examples of where the service has changed as a result of learning from a) the research literature and/or b) experience eg from an audit

Outcomes

- How does the services' outcomes compare with those from other areas (NB What would count as a similar area for comparison)

Procedures

- If you asked a part timer would they know a) the key protocols b) how decisions are made

Interagency working

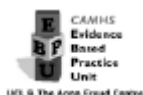
- How are links across agencies- if you investigated some children and families with interagency input would you find coherent join up



Interpreting outcome data

- Use the information to set hypotheses..
- On basis of hypotheses develop focused questions for investigation- the more focussed questions the better
- Look for specifics

NB bear in mind potential paradoxes in data eg satisfaction of those trainees on best training schemes were sometimes worse than those in worst because high expectations only partially met (evidence from RCPsych training programme evaluation)...



Starting to hypothesise about differences in outcome for Service A than for national average

Hypothesis 1: measure not right for this population
Check: compare context of use with context in which measure validated/suggested for use

Hypothesis 2: data entry or analysis errors
Check: audit of data entry/spot checks and re-run analyses

Hypothesis 3: Problems being worked with are different
Check: compare case mix

Hypothesis 4: cultural differences among those completing the questionnaires

Check: compare relevant cultural factors (NB an issue to identify which these are)

Hypothesis 5: Differences in type of service or difference in what offered

Check; compare service key activities,



Determining if negative outcomes mean it is a poor service- looking for triangulating evidence

A) poor service:

High DNAs, high complaints and adverse incidents, low ratings of satisfaction alongside poor outcomes on problem improvement, evidence of poor practice in other ways e.g. only one sort of treatment on offer, treatments not match NICE guidance , no assessments undertaken, no goals set

B) good service

Case mix particularly hard to work with or particularly unlikely to show positive change eg autism, positive satisfaction ratings alongside poor problem improvement ratings, low DNAs, appropriate range of treatments for population, goals set, assessments undertaken

