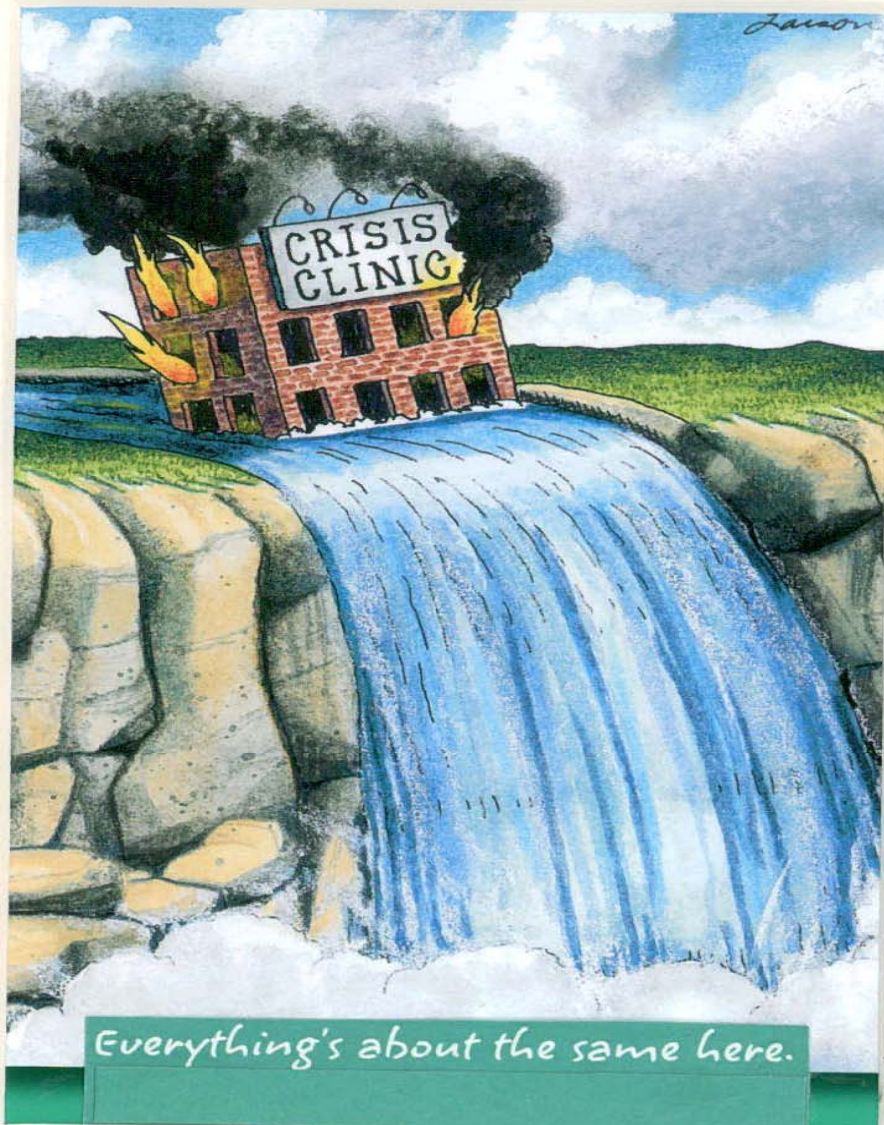


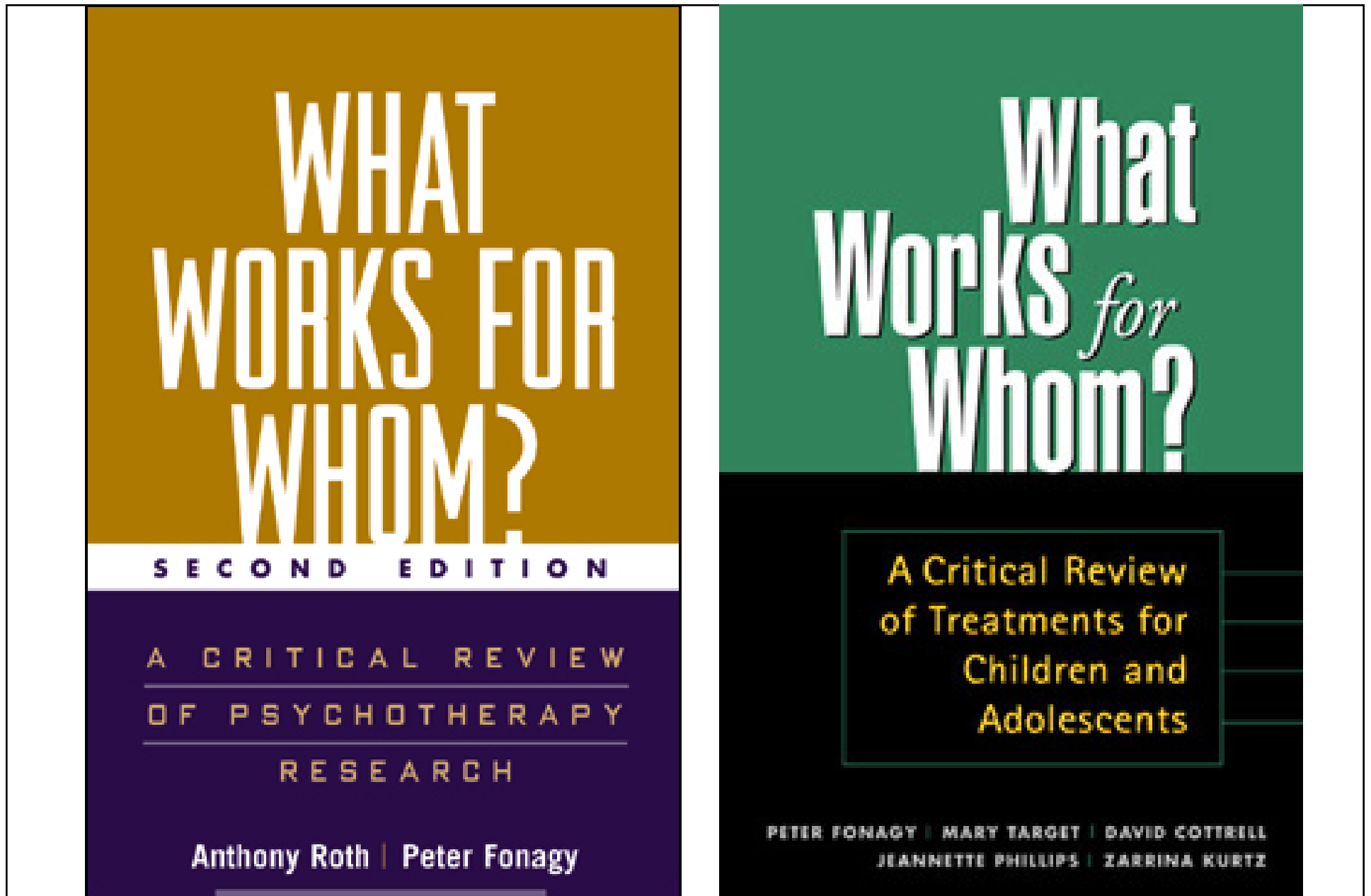
# Some challenges in establishing evidence based practice in CAMHS

Peter Fonagy

University College London &  
The Anna Freud Centre

[P.Fonagy@UCL.AC.UK](mailto:P.Fonagy@UCL.AC.UK)





Two books that perhaps claim more than they can deliver

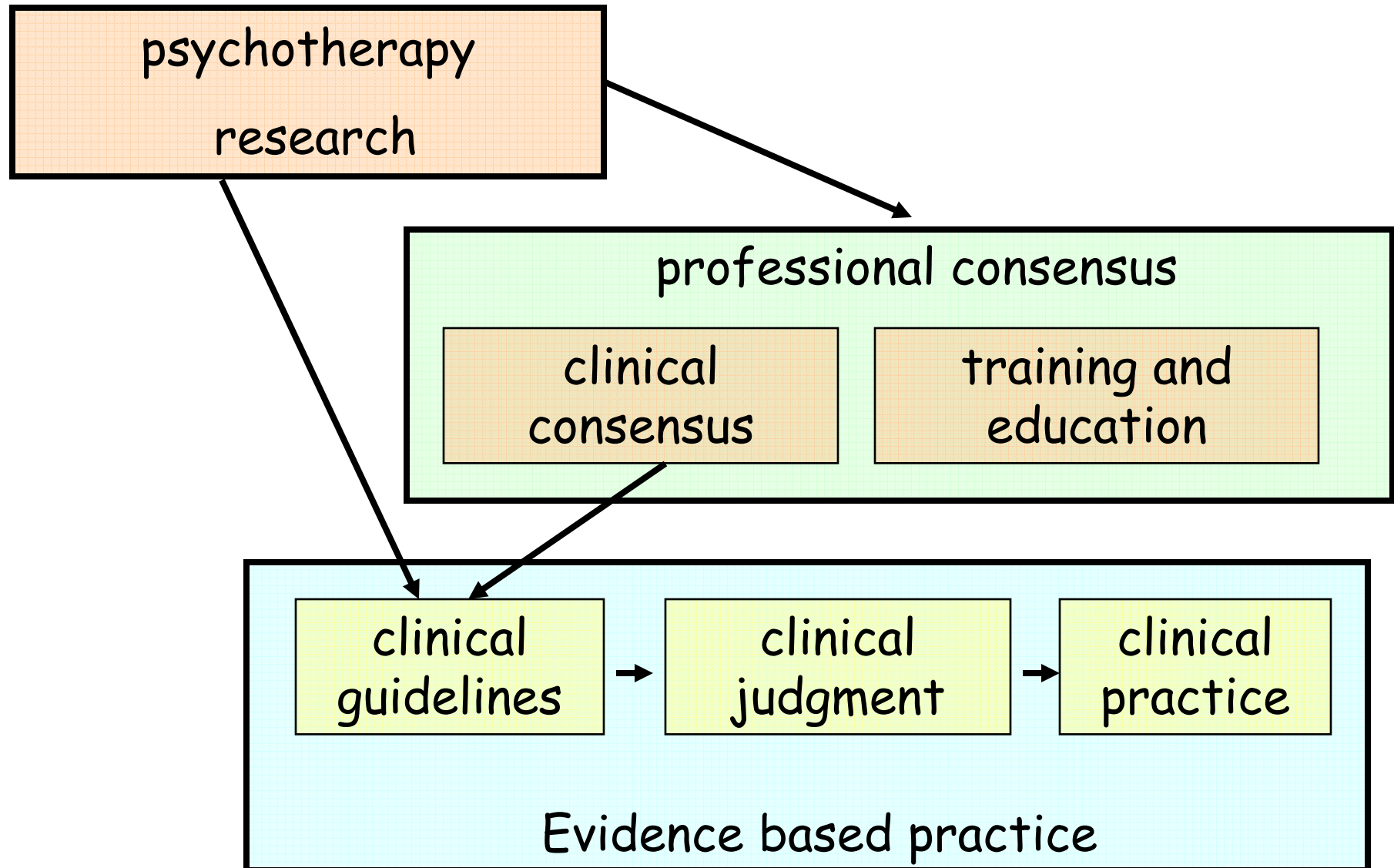


## The progress associated with evidence based practice

---

- Move away from “*do this, do that*” practice to “why to do this or that”
- The intent is to increase certainty at the expense of intuition and unsystematic clinical experience by strengthening the grip on cause-effect relationships
- The main tool is the ‘hierarchy of evidence’ based essentially on the methodological character of studies rather than on their quality
- ‘While evidence-based approaches can improve *de rigueur* medical practice, “evidence-based” should not be understood to be synonymous with “best practice” in all relevant respects’ (Goldenberg, 2006, Soc. Sci. & Med.)

# Roth, Fonagy and Parry model of EBP



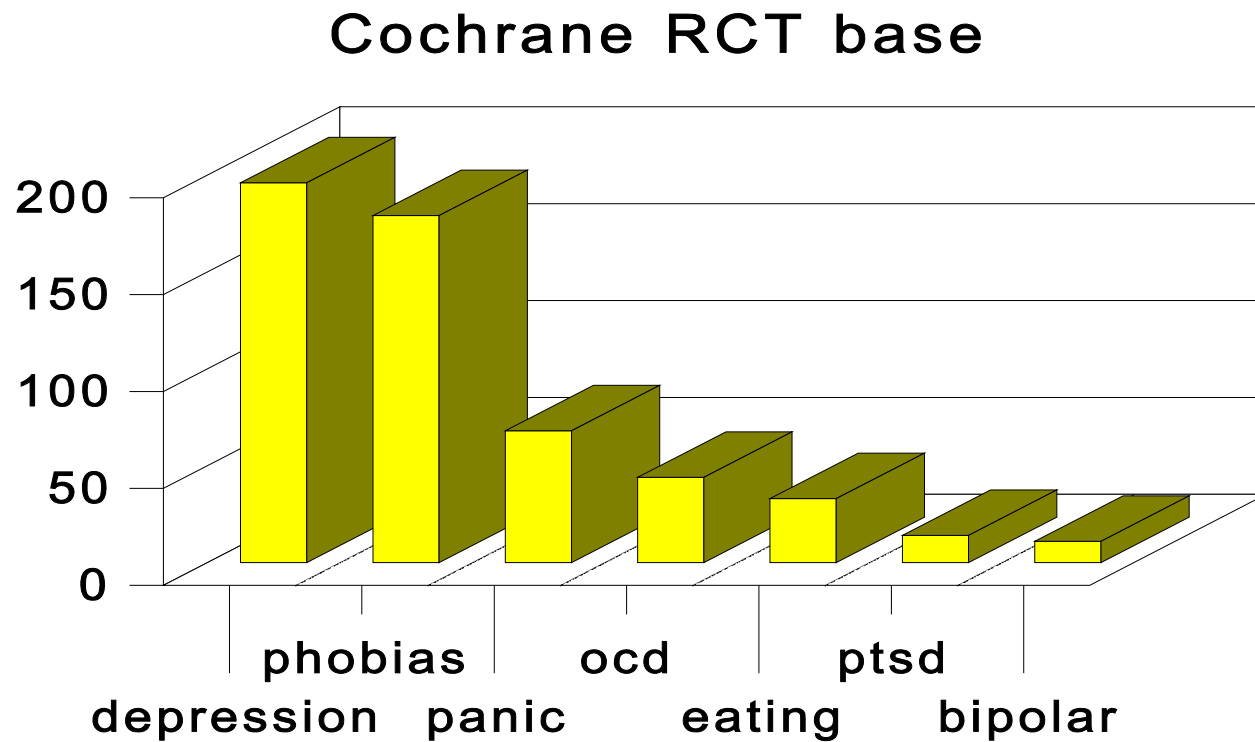


# Psychotherapies are Identified as an Empirically Supported Treatment If:

---

- treatment has been **compared either to a no-treatment control group or some other intervention** (e.g., standard, routine care, treatment as usual for the setting)
- the treatment is **statistically significantly different** in outcome from this other condition,
- **two or more randomized controlled** studies attest to the effects of treatment,
- the studies include replication of the findings **beyond the original investigator** or originator of the treatment,
- the patient sample has been **well specified** (inclusion, exclusion, and diagnostic criteria), and
- treatment **manuals** were used to guide the intervention(s)

The size of the database varies across diagnostic categories





# Limitations of the database

---

- few trials are **large enough** to meet the criteria for randomisation
  - and selective retention and selective **attrition** threatens randomisation even more
- close **monitoring** of patients and therapists tends to maximise therapeutic impact
- comparative trials are degraded if therapist **commitment and experience** is uneven
  - which it often is
- little parallel for **treatment protocols** in clinical practice
  - what is done, when, and for how long



# What can be said with certainty?

---

- overall, good evidence for the **efficacy** of psychological therapies
- in relation to major mental health conditions:
  - can achieve **symptom reduction** & in some cases freedom from symptoms
  - can improve **social adjustment** and work relationships



# What can be said with certainty?

---

- but some commonly-used therapies less well researched than others
- more evidence for CBT than other therapies (e.g. systemic or psychodynamic therapy)
- little evidence on 'eclectic' therapy
- good evidence for some little-used therapies e.g. Interpersonal Psychotherapy (IPT)
- absence of evidence limit scope and strength of EBP statements



# Brand names

---

- evidence for '**brand names**' not as strong as sometimes supposed
  - many comparisons between therapies show equal efficacy
- but there is clear evidence for efficacy of **specific interventions** with some presentations
  - e.g. CBT in anxiety disorders
- '**dodo-bird**' conclusion still valid in many areas but 'dodo-bird' is to be expected when we average impacts for average patients computed over many different conditions



# Evidence based treatments

---

- Anxiety and related conditions
  - Modelling, Reinforced exposure, CBT
- Depressive symptoms and disorders
  - CBT, Interpersonal therapy, activation therapy
- ADHD and related problems
  - CBT, relaxation and biofeedback training, behavioural parent and teacher training
- Conduct-related problems and disorders
  - Youth focused operant treatment, CBT (problem-solving skills), behavioural parent training, multisystemic therapy

# Drawing on the Evidence

*Advice for mental health professionals  
working with children and adolescents*

SECOND EDITION 2006

Miranda Wolpert  
Peter Fuggle  
David Cottrell  
Peter Fonagy  
Jeanette Phillips  
Steve Pilling  
Samuel Stein  
Mary Target

# CHOOSING WHAT'S BEST FOR YOU

What scientists have found  
helps children and young people  
who are sad, worried or troubled

November 2007





CAMHS  
Evidence  
Based  
Practice  
Unit

UCL & The Anna Freud Centre

Care Services Improvement Partnership **CSIP**

**Children Young People and Families**  
Programme

# Knowing Where to Look

## How to find the evidence you need

Psychological health, emotional  
wellbeing and mental health in  
children and young people

Author Paula Lavis






# A distinguished pioneer's warning

---

- “Between measurements based on RCTs and benefit . . . in the community there is a gulf which has been much under-estimated”
  - A L Cochrane, 1971
- Sources of worry about the evidence
  - Social context of treatment
  - Selection of therapists
  - Selection of patients
  - Non-service settings
  - Biases in reporting
  - Lack of information concerning mechanism



## The Social Context: Treatment Process Variables Predicting Outcome and/or Dropout from Treatments

---

- Perception of therapist as not **invested** in the child and/or parent (Shirk & Karver, 2003)
- Perception of therapist as not **competent** (Garcia & Weisz, 2002)
- Therapeutic **alliance** with child and/or parent (Hawley & Weisz, 2005)
- Creating sense of **hopefulness** about the treatment (Karver et al., 2005)
- Behavioral **participation outside** therapy sessions (McCarty & Weisz, 2007)



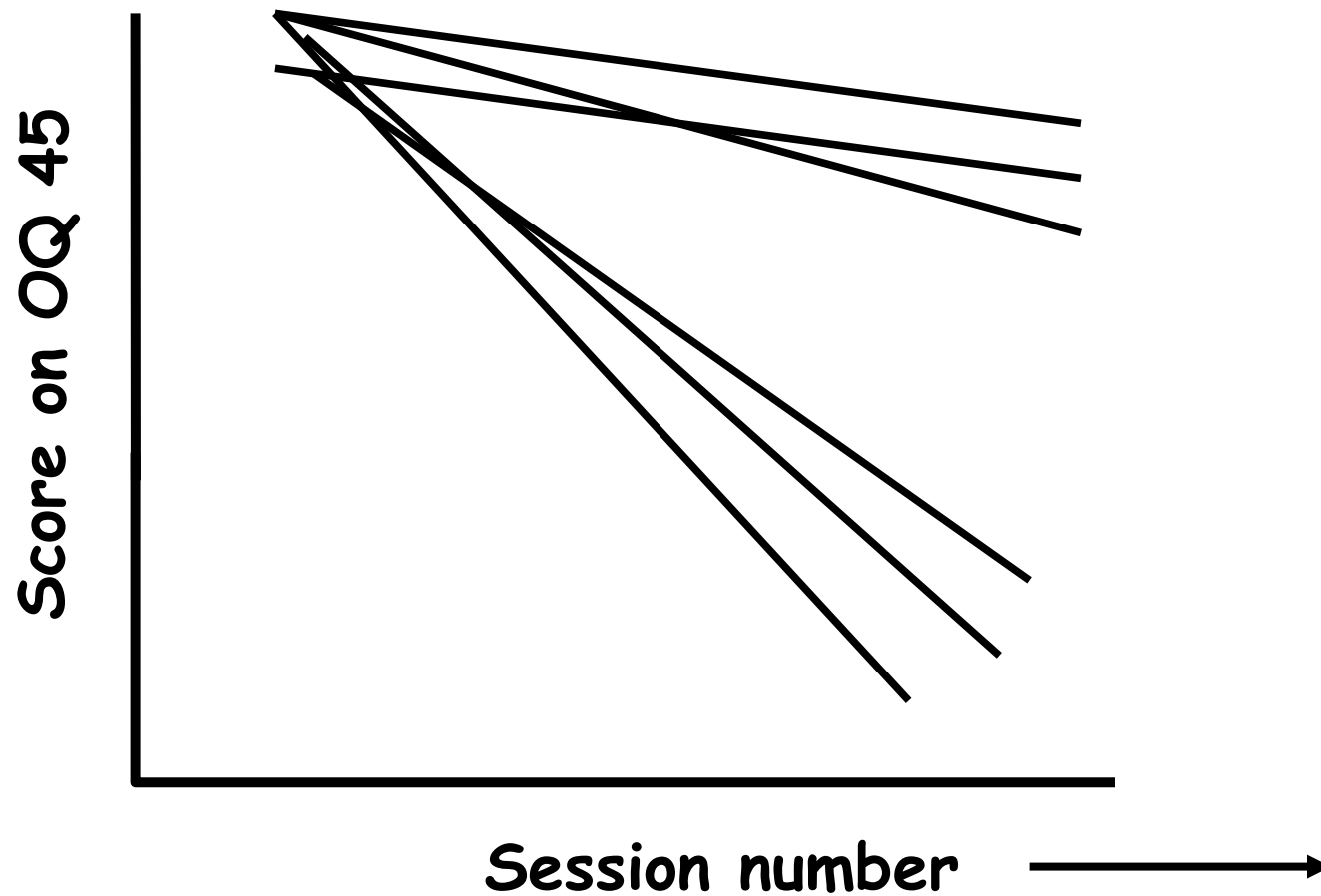
## **Variable impact of individual therapists in routine practice (Okiishi et al. 2006 )**

---

- 6,499 patients seen by 71 therapists
- therapists had to see at least 15 clients
  - on average saw 92
- number of sessions: range 1-203; mean 8.7
- therapists saw equivalent range of clients in terms of disturbance & presentation
- HLM used to compare 'trajectories' (recovery curves) of patients using OQ45

# Clients of Some Therapists Improve Faster or Slower Than Others

---





## ■ Slope of Improvement Across Therapists Unaffected by:

---

- therapist experience
- gender
- type of training
  - counselling psychology, clinical psychology, social work, marital/family therapist
- orientation
  - CBT, humanistic, psychodynamic



# Outcomes for Best and Worst Performing Therapists

---


	recovered	improved	deteriorated
top 10% therapists	22.4%	21.5%	5.2%
bottom 10% therapists	10.6%	17.4%	10.5%



# Incidence of Harmful Effects

---

- estimates are that 5-10% of therapy clients deteriorate
  - across all orientations, client groups, modalities
  - in RCTs of 'empirically supported treatments'
- rates higher than in control groups
  - e.g. NIMH reanalysis (Ogles et al. 1995)
  - 13/162 (8%) deteriorated, all in active treatments
- in Lambert's work therapists tend to be poor at:
  - *predicting* who will do badly
  - *recognising* failing therapies



# Do no harm... outcomes informed care

---

- Most therapists see themselves as better than average:

Dew & Riemer (2003)

- 143 counselors asked to grade their job performance on scale from A+ to F
  - 66% rate themselves as A or better
  - none rated themselves as below average

- Outcomes informed care may be a critical way of linking the EBP approach and practice based evidence



# Selection of Patients in RCTs

---

- Bias in terms of psychological and social characteristics (more severely disturbed, comorbid, miss appointments, drop out of treatment)
- Characteristics of families (parental psychopathology, family life event stressors, child maltreatment)
- Reasons for seeking treatments (not recruited through ads or screening but referred by desperate caregivers or court – only 13% across studies)



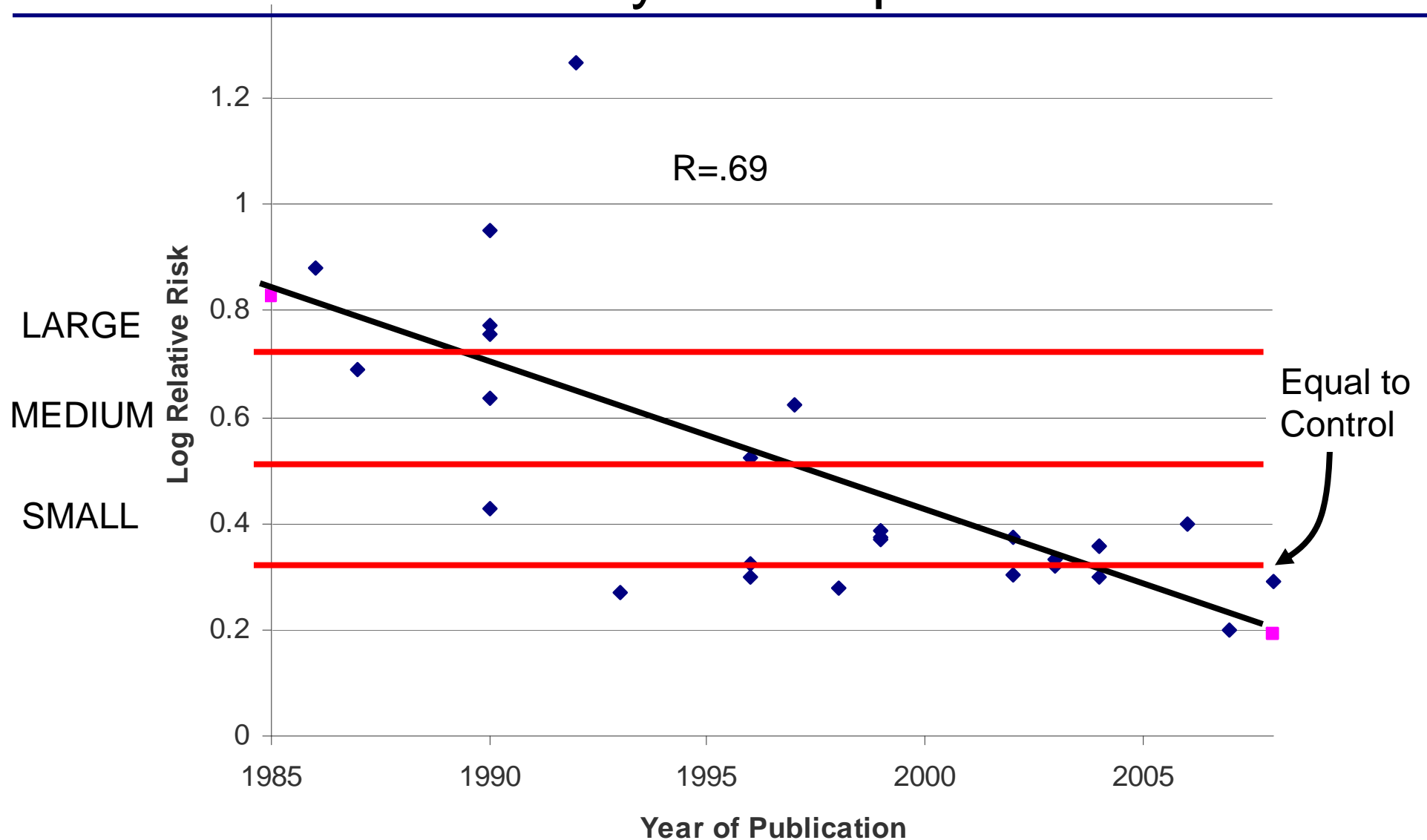
## Comparison of EBT trials and real life

---

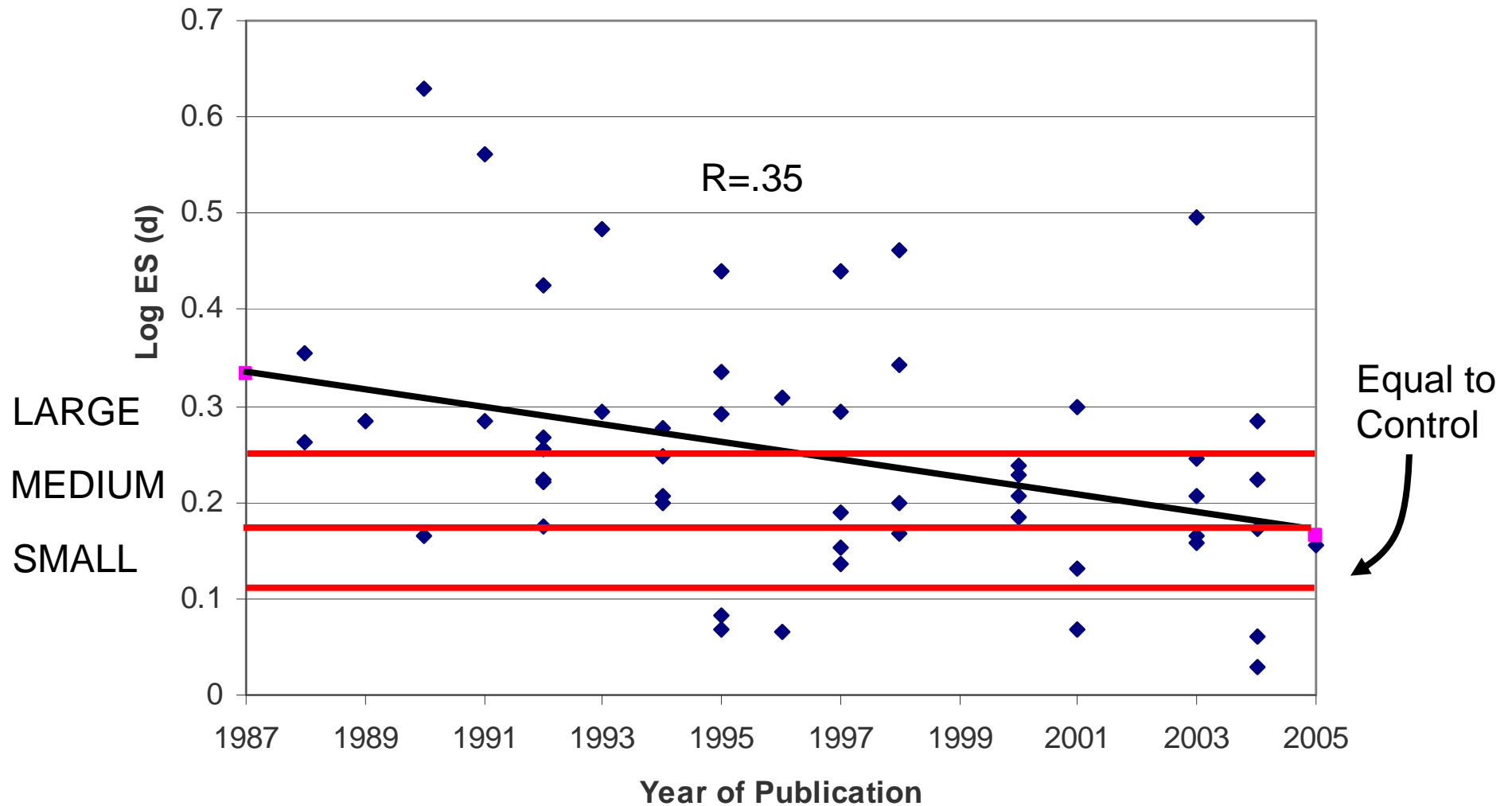
- Only 13% of study samples **clinically referred**
- Only 19% employed at least one **practising clinician**.
- In only 4% of studies was treatment provided in an **actual service setting** separate from the research
- Only 1% of studies include at least one practising clinician, clinically referred children and some treatment carried out in a service setting.
- **But**
  - **This pattern is changing, increased emphasis on “effectiveness” (vs. “efficacy”) in trials**

(Weisz, et al., 2006, Am. Psych.)

# Secular trends in ESs for EBTs: Effect size of CBT in 27 trials for youth depression



# Secular trends in ESs for EBTs: 55 psychosocial interventions for disruptive and aggressive behaviour





## EBT trials compared with usual care

---

- EBTs compared with usual care have reduced ESs
- ES of 32 RCTs of 36 EBTs
- Mean = .30 (95% CI: -.03, .63)
- 62% of EBT treated patients are better off than average normally treated child
- Only 22% of ESs medium or large (<.5)
- 38% small (.2-.5)
- 41% negative or insignificant
- We cannot expect large effects just because we do EBP

(Weisz, et al., 2006, Am. Psych.)



# Gaps in Outcomes Research

---

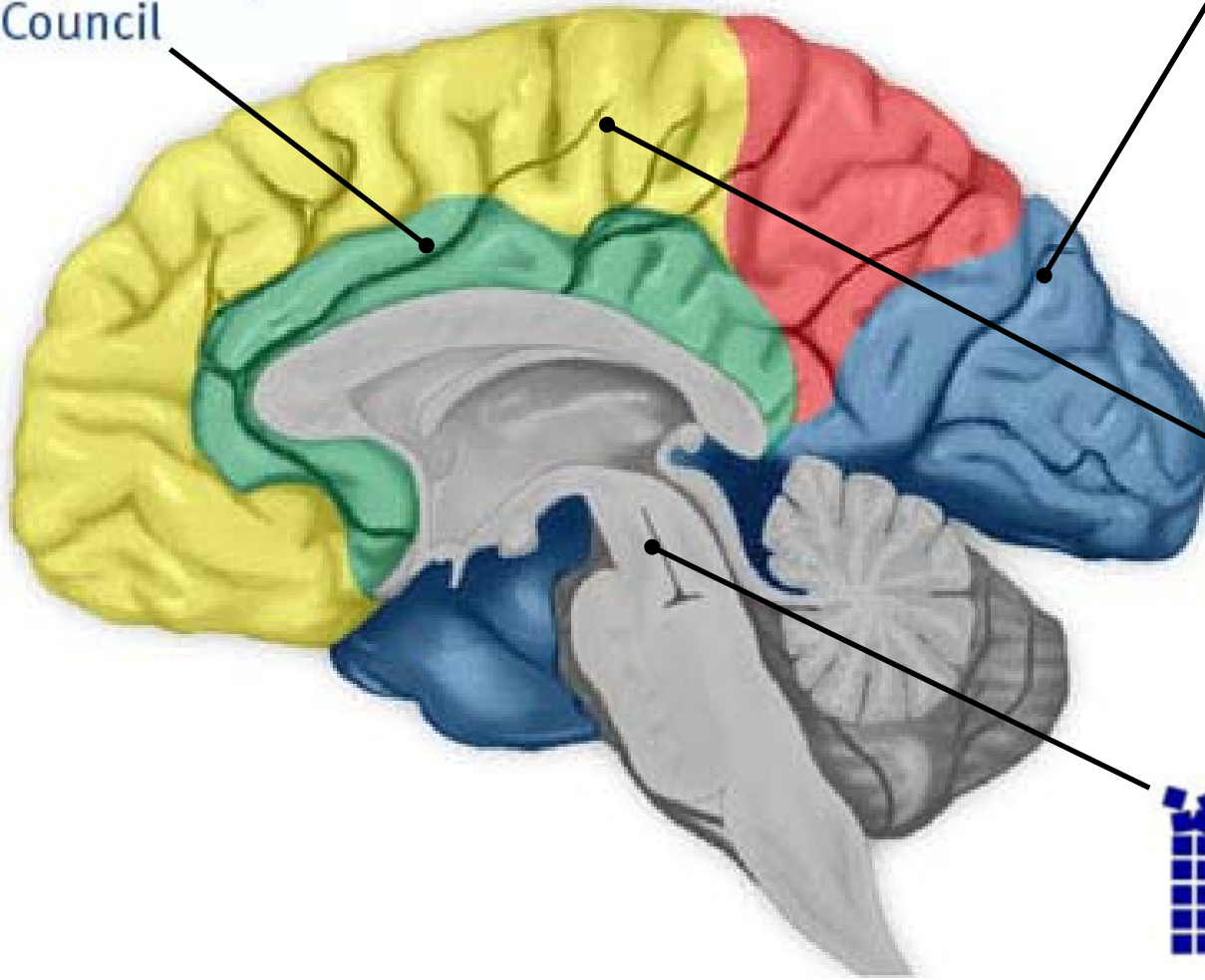
- No good evidence for who will benefit from what type of psychotherapy
- ‘Inexact therapies’ → partial effectiveness
- ‘Attachment to methods’ → ‘guildification’ of interventions



British  
Psychoanalytic  
Council



British Association for  
Counselling and Psychotherapy



**BABCP**

BRITISH ASSOCIATION FOR  
BEHAVIOURAL & COGNITIVE  
PSYCHOTHERAPIES  
Registered Charity No 1098704



**UKCP**

UK COUNCIL FOR PSYCHOTHERAPY



# New Intellectual Framework for Psychotherapy

---

- Continuous monitoring of treatment impact
- Consensus concerning impact of social relationships
- Develop treatments in the setting in which they are to be used (DFM – deployment focused model)



# Studying usual care with unusual care

---

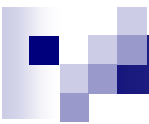
- Writing up (manualising) particularly effective usual care protocols
- Careful study of the implementation of EBTs (clinician adaptation, clinician selection, coaching, recipient and organisational preparation) (Fixsen et al., 2005, National Implementation Research Network)
- Psychosocial interventions normally tested on pharmacology models (Successive Efficacy Trials or SET)
  - lab, then efficacy studies under idealised conditions, then effectiveness studies under 'average' conditions
- Weisz et al. (2006) deployment trial where manual for treatment is developed in practice context



# New Intellectual Framework for Psychotherapy

---

- Developmental studies of adult psychopathology → identifying psychological and neural mechanisms underlying disturbance → better evaluation of treatment outcome
- Overcome major problems of measurement of psychological therapy outcomes literature
  - Arbitrary matrix
    - 2000 RCTs in schizophrenia identified 640 scales
  - Reactivity



# “Depression Reduced With Brussels Sprouts.” Kazdin (2006)

---

- “Self-report ratings of depression indicated change and support the proposition”
- Does change relate to how individuals are doing in everyday life?
- More we believe in BST for depression more likely we are to lose sight of the actual metric.
  - Depression actually has many referents to which the arbitrary metric could be linked (e.g. changes in eating or weight; crying; staying in bed during time ordinarily devoted to other activities; and interacting less with peers).
  - Cannot aggregate arbitrary matrices in meta-analyses.
- Small or large amounts of change on a measure with an arbitrary metric does not necessarily reflect small or large changes on the underlying construct.



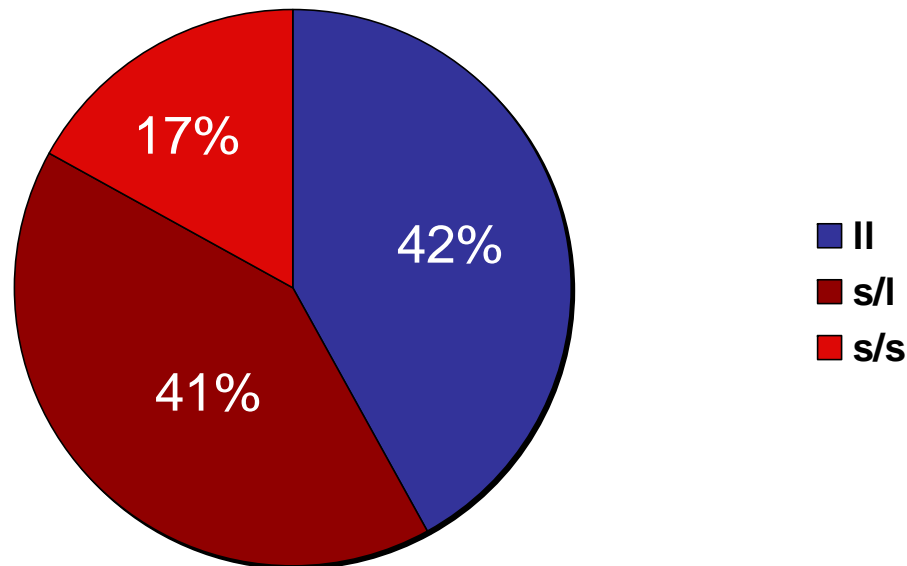
# New Intellectual Framework for Psychotherapy

---

- Variability of treatment response poorly accounted for by
  - Treatment orientation
  - Diagnostic grouping
  - Severity of condition
  - Therapist quality
- Integrating behavior genetics and outcomes data
  - Treatment response to SSRIs moderated by genetic predisposition that predicts metabolism

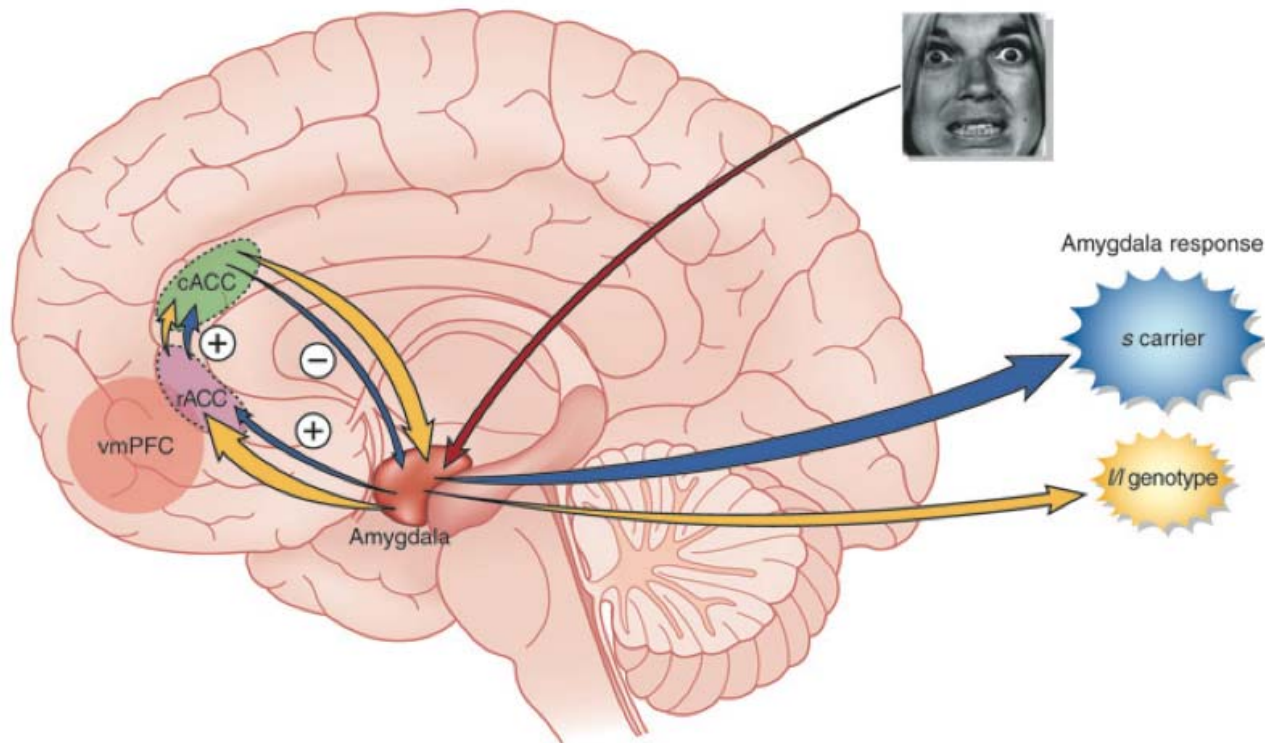
# 5-HT – Life-events and Depression

- There are different forms of the serotonin transporter gene (5-HTTLPR)
  - Short (s) allele
  - Long (l) allele
- Altered serotonin functioning associated with depression
- We each have two alleles - about 60% of us carry the s allele



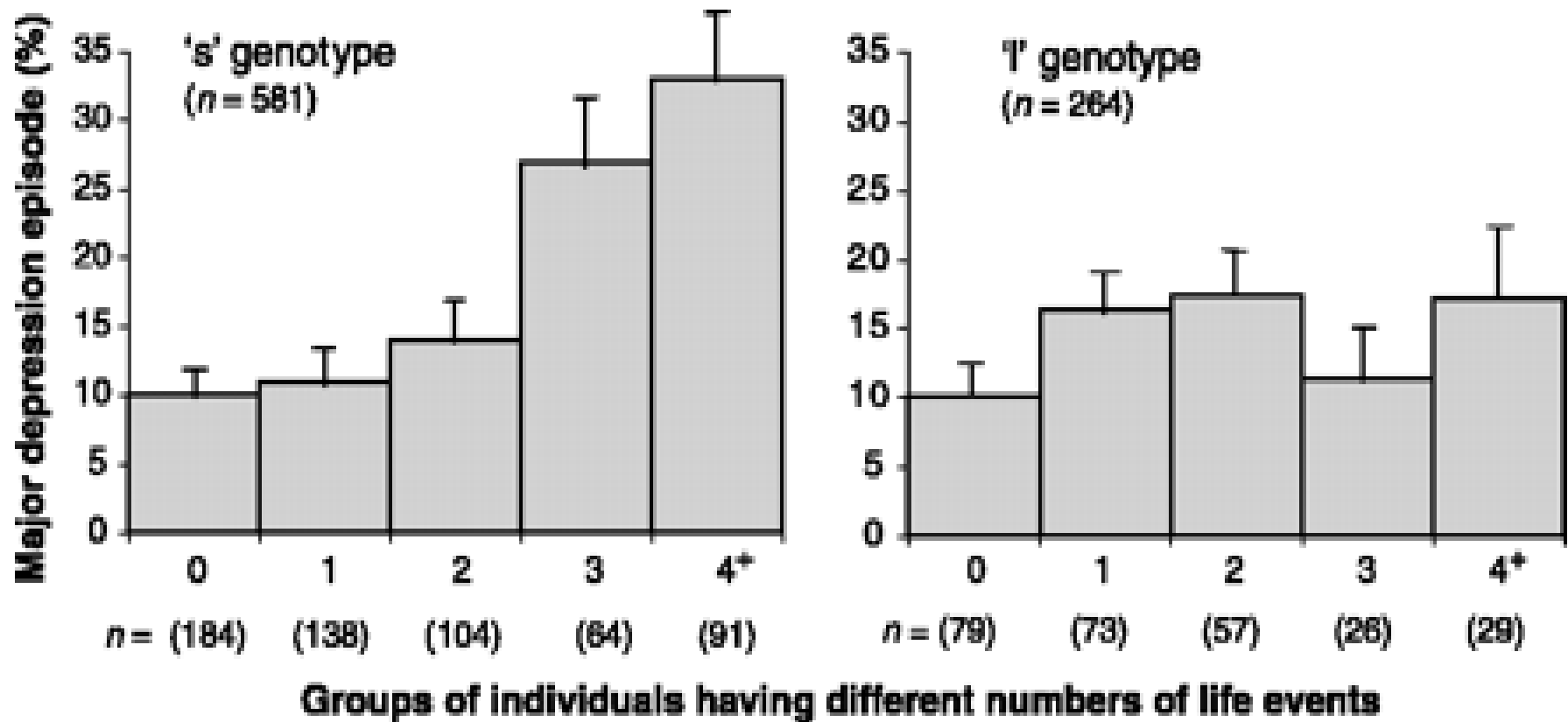
# 5-HT – Life-events - Depression

Individuals with the s allele reduced functional coupling between the cingulate cortex and the amygdala - this may be linked to an increased vulnerability for depression.



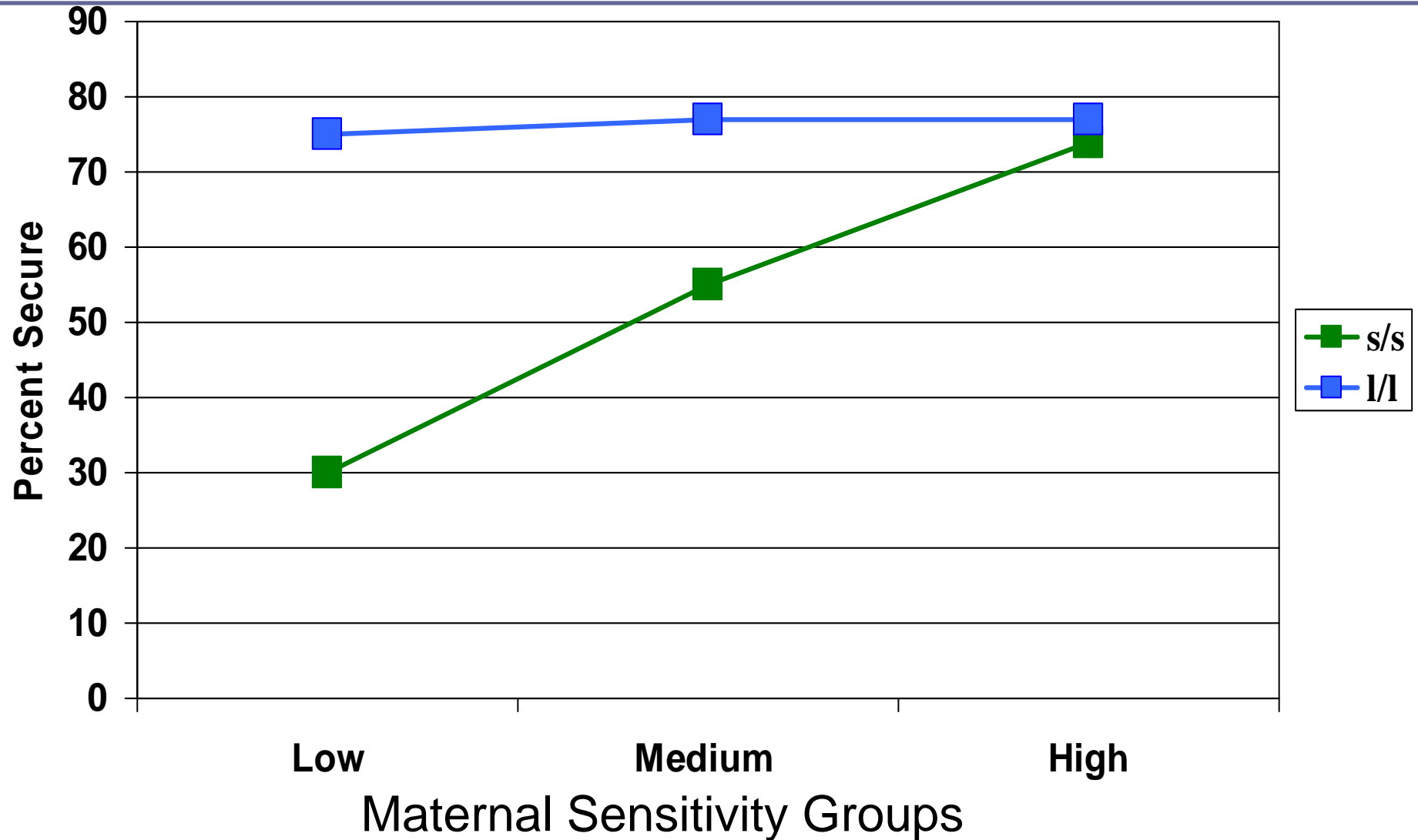
*S carriers show increased emotional hyper-responsivity*

Percentage of individuals meeting diagnostic criteria for depression at age 26 as a function of 5-HTT genotype and number of stressful life events between the ages of 21 and 26\*

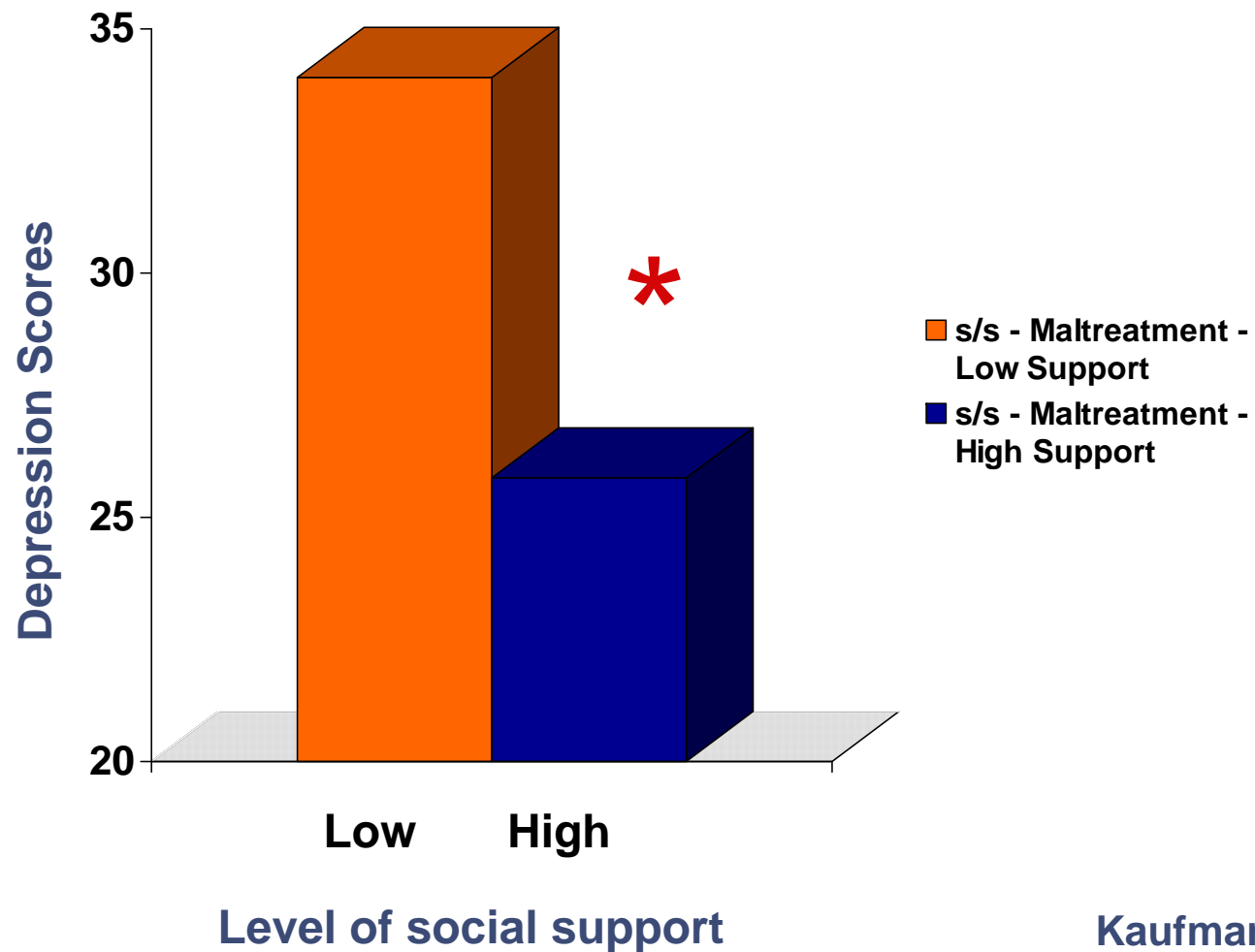


\*Caspi, Sugden, Moffitt et al. (2003), Science, 301, 386-389

The likelihood of infant security as a function of maternal sensitivity and 5-HTT phenotype (Kochanska et al., in press)



# 5-HT – Social support and depression



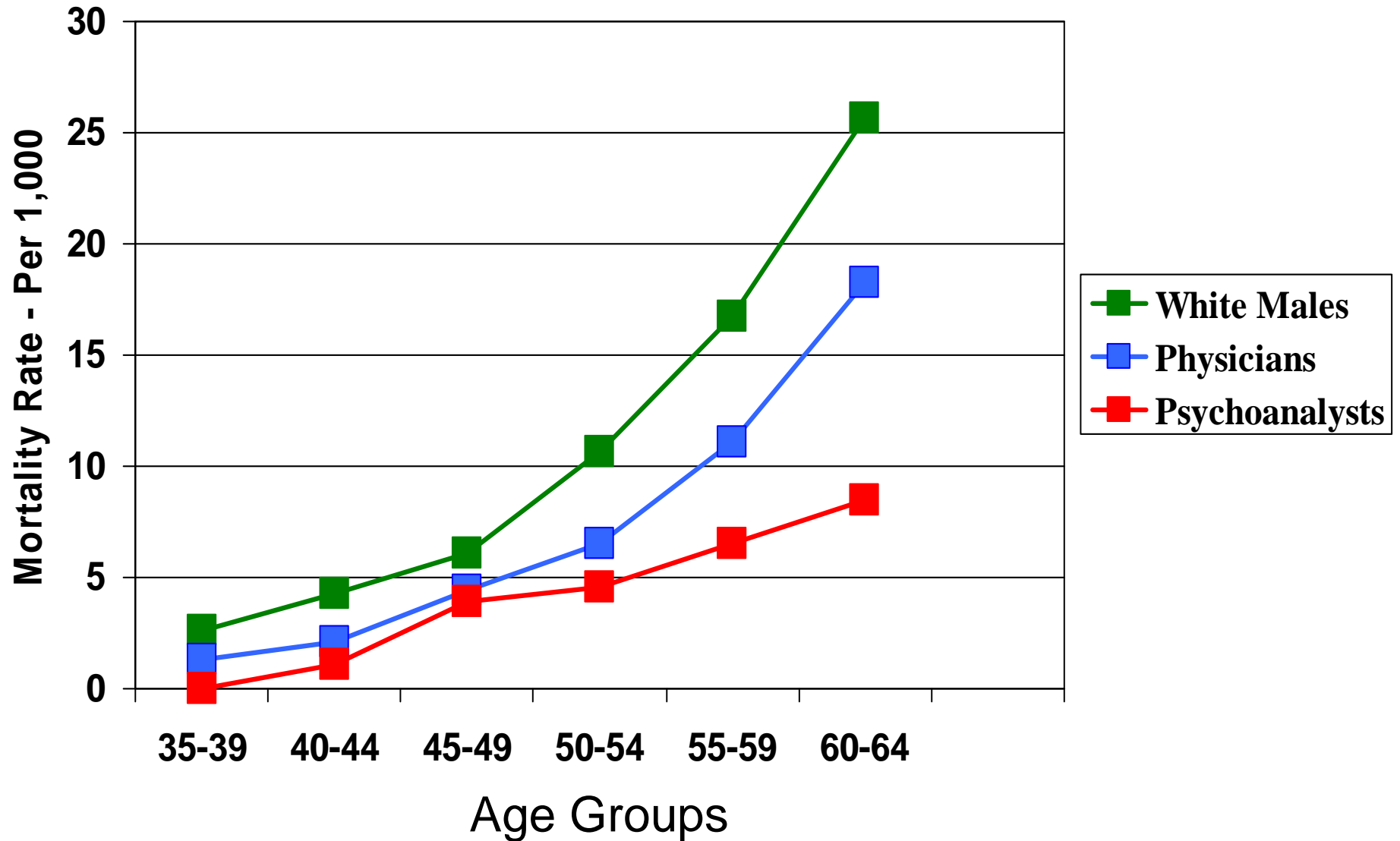


# Conclusion

---

- Science IS good for practice
  - Which form of care is best for children
  - What causal mechanisms play a role
  - What circumstances can interfere with a treatment working
- But practice is also excellent for science
  - Where knowledge is most needed
  - Ground science in everyday clinical care

# The Mortality Rates of Three White Male Groups as a Function of Age (Jeffery, 2001)





## And another pioneering warning

---

- ‘Science is built up with facts as a house is with stone but a collection of facts is no more a science than a heap of stones is a house’

➤ Jules Henri Poincaré