

# Evidence Based Practice and Practice Based Evidence

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# Evidence Based Practice and Practice Based Evidence

We did not see ourselves as experts,  
therefore we did not know what could not  
be done..

# What is evidence based medicine?

The National Service Framework for Mental Health (1999) clearly stated a hierarchy of evidence, with randomised double blind controlled trials, RCT's, being regarded as the highest form of evidence..

(p.6, Type 1 evidence)

# Randomised Control Trials

Randomised control trials identify (a statistically significant) effect in a population..

- It assumes that you have correctly identified the population – concept of schizophrenia.
- Critically it does not tell you anything about the individual or differences or between individuals.

(user involvement)

How then does this inform practice, that is based on working with individuals, not populations?

# Limits of Randomised Control Trials

Example..

- We know from practice that medications work with some individuals (better, if at all) and not others. We have little or no evidence about why. And yet it is a treatment of choice for the whole population of people diagnosed with schizophrenia.

How much should be prescribed?

Pharmacogenetic knowledge: Poor Metaboliser (PM) (primarily connected to hepatic enzymes); 10% Caucasian and 40-50% Asians, Pacific Islanders, African and African Americans are PM having no functional activity. Medication is eliminated from body at slower rate and as medication accumulates in the body, so does the toxicity that causes adverse drug reactions. This scenario is similar to experiencing an overdose of medication.

# Limits of Randomised Control Trials

Do the traditional expert ideas about voices and schizophrenia, around which evidence is based, stand up when you talk to individuals?

Does the evidence also help to understand the process of adapting research findings to the reality of people's lives? At what point does the limitations of being able to apply research suggest that there is a bigger problem?

## Practice based evidence

- Practice is based on working with people, not populations. Do the traditional expert ideas about voices and schizophrenia stand up when you talk to individuals?
- Practice is based on working in real-world situations, with all the 'variables' that entails, both for the 'service provider' and the 'service user'. Does the expert evidence apply?

# Practice based evidence *with* voice hearers

*We still do not know enough about the experience:*

In a group of patients *diagnosed* with schizophrenia identify how many of them experienced traumatic experiences in Childhood or in adulthood of abuse or emotional neglect, (plus high stress, drugs, being bullied or other trauma or developmental problems)

## **Practice based evidence *with* voice hearers**

*We still do not know enough about the narratives of voice hearers*

Explore the relationship between recovery and the ability to make sense of/ find meaning/ integrate, the voice hearing experience into daily life.

## Practice based evidence *with* voice hearers

*We do not know enough about group based working with people who have similar experiences.*

- Identify the helpful (recovery/ 'curative') factors of individual voice hearers being in contact with each other, for example in a hearing voices group. Possibly compare a cognitive based group, a Ex-in group, and Hearing Voices Network group.



What can we do next?



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# Potential research areas *with* other experiences

- Long Term Care:  
*Rehabilitation/Recovery & Assertive Outreach*
- Acute Care:  
*Home Treatment & Residential Services*

**PRIMARY CARE**  
**mental health**

**Acute care:**  
**HOME TREATMENT**

**Acute care: Hospital Beds,  
Day services Crisis Homes Family Placement**

**Long-term care:**

**CONTINUING  
NEEDS SERVICES**

- **Assertive Outreach**
- **Recovery & Rehabilitation**

# Primary Care Liaison

- Interface between primary care and specialist service
- Gateway to specialist service
- All new referrals
- Key workers with variable case load
- Clinics, groups, home based intervention
- Multidisciplinary team

# Rehabilitation and Recovery

- People with SMI
- Complex social and health care needs
- Long term service use
- Need for *community based* rehabilitation
- Recovery and social integration
- Intensive case management

# Assertive Outreach

- Team based approach
- Team responsible for meeting all needs
- Assistance in obtaining basic needs
- Primary goal→Improved client functioning
- Assistance with symptom management

# Assertive Outreach

- One team member is care coordinator
- Small case load (<15:1)
  - Treatment is individualised
  - Services provided “out of office”
  - Assertive “can do” approach

# Acute Home Treatment

- Acute psychiatric care at home
- Mobile, 24 hour 7 days a week service
- Crisis resolution *and* Home Treatment
- Access to hospital beds
- Alternative to psychiatric hospitalisation
- Multidisciplinary team
- Community resources

# Home Treatment and Crisis Resolution

- 24/7 services dealing with psychiatric emergencies or crisis and providing intensive psychiatric care at home as an alternative to hospital admission
- Different from CMHTs
- Part of an integrated system of mental health care

**PRIMARY CARE  
LIAISON SERVICE**

**CONTINUING  
NEEDS SERVICES**

➤ **Assertive Outreach**

➤ **Recovery & Rehabilitation**

**HOME TREATMENT**

**Hospital Beds**

**Crisis Homes**

**Family Placement**

# The Birmingham Experience

- Psychiatric hospital should not be the mainstay of mental health services
- Alternatives to institutional care
- Locally based, locally accountable services
- Prioritise the needs of severely mentally ill
- Integrated system of care