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Advance treatment directives for people with severe mental illness - THE LEADERS GUIDE

Produced by the Editorial base of the Cochrane Schizophrenia Group
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from

Campbell LA, Kisely SR. Advance treatment directives for people with severe mental illness. Cochrane Database of Systematic Reviews 2009, Issue 1. Art. No.: CD005963. DOI: 10.1002/14651858.CD005963.pub2.

Special points of interest:

- This should take no longer than 1 hour to prepare
- First time you undertake a journal club in this way it may be a bit nerve-wracking

but….

- It should be fun to conduct and attend
- It should begin and end on the practical day-to-day clinical situation

Inside this guide:

Background explanation

Thank you for giving this guide a go. The idea behind this is to make things easier for you when you lead the journal club.

Journal clubs are often difficult to conduct and far removed from clinical life. Even if the leaders do prepare well, those turning up may be more in need of lunch, coffee or a social time than practical academic stimulation and the implicit pressure to read a difficult paper.

This suggested design is an attempt to allow for those needs, whilst getting the very best out of the session.

This journal club design should really help those attending see that this research may have some clinical value.

What you will need to do is:

- ☑ Have a good read of this
- ☑ Then read the review to which this is attached.
- ☑ Distribute the review to those attending well before the club
- ☑ Make more copies for those turning up on spec
- ☑ Do not really expect many to have read the review

PRINTING GUIDE

Pages 1-4 - one copy for you

Pages 5-6 - one copy for each participant - distributed at **start** of journal club

Page 7– one copy for each participant distributed at **end** of journal club

Page 8 - one copy for you to collate feedback

Full review for everyone

Try to find a colour printer that does double sided printing

The three parts

Part 1. Set the clinical scene (5 mins)

Be clear, but really make the participants feel the pressure of the situation...just like you would in clinical life

Part 2. Critical appraisal of the review (20 mins)

Get participants to list what is needed from the review before the meeting with Department of Health, get them to talk, split into groups -with a feeling of urgency.

Part 3. Use of evidence in clinical life (20 mins)

Having distilled the evidence use role play to see how the participants would use what they have learned in everyday life.

Part 1.1 Setting the scene – The Department of Health

Introduce participants in the journal club to their scenario

You have been interested in the idea of advanced treatment directives for people with schizophrenia. This has been noted and the new government has organised a committee of experts to report back to them regarding this. You were rather flattered to be selected for this team of experts, but haven't had time, really, to do the homework. A meeting between you and the civil servants/ policymakers has crept up on you really without you noticing. You are due to meet them in about 40 minutes. You are forced to attend a Journal Club in the meantime and, fortunately, the Journal Club has focused around the appraisal of a review on the very subject of interest.

Questions for participants:

Q 1. What do you think the policymakers may ask?

A 1. [Suggestion] "Will this keep the people out of hospital?"

A 2. "Will this keep people out of trouble with the police ?"

A 3. "Will this help people's compliance with their treatment ?"

A 3. "Will this decrease people's *time* in hospital ?"

List the suggestions from participants as these are useful in the role play

Part 1.2 Setting the scene – the Journal club

Complicate the scenario by adding the need to attend this journal club

Knowing you are due to the civil servants/policymakers in less than an hour you are nevertheless compelled to attend journal club.

You have not had time to read the paper and need some lunch.

By a stroke of luck the paper for discussion focuses on the value of advanced treatment directives!

Questions for participants:

Q 1. If you had not had this paper fall into your lap where might you have gone for reliable information?

A 1. There are now lots of answers to this - The Cochrane Library, Clinical Evidence, NICE Technology Appraisals.

Anything that has a **reproducible method** by which results are obtained.

Part 2.1 Critical appraisal of the review

For every review there are only three important questions to ask:

1. Are the results valid?

2. What *are* the results?

3. Are the results applicable to service user?

You now have only 20 mins to get participants though this large review. To do this quickly is not easy, especially as many will not have read the paper in preparation.

Suggestion: Ask participants what salient facts they want to know - especially considering their tight time-scale.

Remind them that meeting with the Department of Health is due in about 20 mins.

You should be able to fit most of the suggestions supplied by participants into the three categories of question outlined above.

Read 2.2 as this give more detail of the issues that will, in some shape or form, be supplied by the participants.

If they are not lively - give them a hand.

Do not panic. Bright journal club attendees will come up with all the answers - your job is to help focus their efforts and categorise their answers.

Do not be worried by silence.

Take time to read and think about the review - this is the only time-consuming bit

LIST 1:

1.

2.

3.

4.

5.

List 2:

1.

2.

3.

4.

5.

Participants will think of most of the issues - you just need to catch them and write them on a board

Part 2.2 The three parts of appraising a review

1. Are the results valid?

There is no point looking at the result if they are clearly not valid.

a. Did the review address a clearly focused issue?

Did the review describe the population studied, intervention given, outcomes considered?

b. Did the authors select the right sort of studies for the review?

The right studies would address the review's question, have an adequate study design

c. Do you think the important, relevant studies were included?

Look for which bibliographic databases were used, personal contact with experts, search for unpublished as well as published studies, search for non-English language studies

d. Did the review's authors do enough to assess the quality of the included studies?

Did they use description of randomization, a rating scale?

2. What *are* the results?

a. Were the results similar from study to study?

Are the results of all included studies clearly displayed?

Are the results from different studies similar?

If not, are the reasons for variations between studies discussed?

b. What is the overall result of the review?

Is there a clinical bottom-line?

What is it?

What is the numerical result?

c. How precise are the results?

Is there a confidence interval?

3. Can I use the results in a way that will help these policymakers?

a. Can I apply the results to the current situation?

Are the patients in discussion so different from those in the trial that the results don't apply?

b. Should I apply the results to patients?

How great would the benefit of therapy be for patients?

Were all the clinically important outcomes considered?

Are the benefits worth the harms and costs?

Part 2.3 Doing the appraisal

Having managed the interactive session with the participants - acquiring the three questions that need to be addressed by those appraising a review and some idea of how to answer each of those questions - now divide the room into three.

Apportion one of the questions per group and ask each group to get a feel for the whole review (1 min) but to focus on answering their particular question for the rest of the participants (5 mins or so).

Encourage talking to each other.

Move round the room to help the groups if they seem to need it.

Have your copy of the review marked up with where they may look for answers - although in a good review it should be obvious.

Stop the flow after about 10 minutes and ask each group to report in turn.

Do Group 1 really think that the review uses valid methods? Why?

After the first group's report you may want to ask everyone to vote whether to proceed or not.
If they agree to proceed - see if you can **get Group 2 to give you the clinical bottom line.**

We suggest that Graph 1.2 'Overall psychiatric admissions' might initially best fit the policymaker's request regarding information about admissions.

And from **Group 3 get some feel of how applicable the findings are.**

There is no point proceeding to the second question if journal club participants think the results are not valid

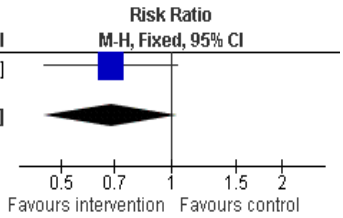
'Well Doc, are we going to save time and money with advanced directives?'

Part 2.4 A quick and dirty way to work out NNT

COMPARISON 1. ADVANCED DIRECTIVES vs USUAL CARE
Outcome 1.2 Overall psychiatric admissions

Study or Subgroup	Advanced directives Events	Total	Usual care Events	Total	Weight	Risk Ratio M-H, Fixed, 95% CI
Henderson 2004	24	80	35	80	100.0%	0.69 [0.45, 1.04]
Total (95% CI)		**80**		**80**	**100.0%**	**0.69 [0.45, 1.04]**
Total events	24		35			

Heterogeneity: Not applicable
Test for overall effect: Z = 1.77 (P = 0.08)



Using the above outcome as an example: 24 out of 80 (30%) people allocated to advanced directives have an admission within the index time period compared with 35 out of 80 (43%) people in the usual care group. You could turn this on its head and say that 70% of people in the advanced directive group do not get admitted compared with 57% in the usual care group. In any event, the proportion that seems to be attributable to the advanced directive, according to these results, is the difference between groups (or 70% - 57% = 13%).

Just round it up or down to make it easy. Let's say in this case 12%. So 12% out of every 100 people given advanced directives would be able to avoid an admission that would have otherwise have happened if given standard care - or put another way 100/12, or put another way NNT= about 8.

Part 3. The Policymakers arrive

This is the most important part of the journal club - the *practical application* of what knowledge you have gained.

This is one way of doing it. Set out two chairs in consultation style. Do not call for a volunteer- just nominate someone to be the Policymaker and you be the clinician. Make sure that the clinician feels they can have time to ask their [relieved for not being singled out] colleagues for help [remember- this has got to be a combination of practical and fun]. Back on page 2 there are suggestions for what the Policymakers may ask- use them.

Will this keep the people out of hospital?
See if they can put across in an objective way the best available evidence.

There is no perfect way to do this - but perhaps something like this:"The evidence we have is from the United Kingdom is largely based around one small, relatively short, trial. The study was quite good and it does suggest that there is a saving in the number of people hospitalised. But the certainty around the result is not great. It is even possible, although unlikely from the way the data lie at the minute, that the advanced directives increased the number of people that come into hospital. Should other trials replicate this finding, then advanced directives could represent a relatively simple intervention with considerable saving of hospitalisation."

Will this keep people out of trouble with the police ?
This is not an easy on to answer. Graph 1.10 reports a series of outcomes regarding the criminal justice system, but with no suggestion whatsoever that advance directives change these outcomes.

Will this help people's compliance with their treatment?

From Graph 1.7 you will see that a continuous measure (not very well explained within the graph) was used, but on this measure there was no real indication of the difference between the advanced directives and the controlled treatment. Again, somehow this needs explaining to the Policymakers.

Probably the best question for the Policymakers to ask is **"Will this decrease people's *time* in hospital?"**

Graph 1.5 suggests a difference in the average (mean) number of days spent in hospital, but the standard deviations around these are really quite enormous and probably it is ill-advised, that these are presented in a graph or analysed at all. They are very skewed data. They do not contain a suggestion of a difference favouring the advanced treatment directive group here. The doctor talking to the Policymakers has another difficult set of information to convey.

Again, there is no right way of putting this information across, but this is one way: "the best evidence we have is from an independent review that summarises the findings of two small trials. Only one trial provides information on the number of days in hospital and these data, probably should have been analysed a different way. They have some suggestion of a saving of bed-days. There are more hypothesis generating improving and again, they are even compatible with the possibility that advanced directives increase bed usage. Perhaps you, as policymakers, could contact the authors of this trial for these original data to log-transform them to make sure we are doing the right statistics. Even if, when analysing that way, they show a favourable result for advanced directives. This is only one trial, one swallow does not make a spring and probably policy shouldn't be made on the back of such thin and vulnerable evidence.

Please note, in this case because the confidence intervals cross the line of no effect, it is possible that the advanced directives also promote admission.

This can be part of a store of Critically Appraised Topics - see CATmaker online

Box 1. Additional Question

"Well, Doctor, do you think we should bring this in as a nationwide policy?"

It is very difficult when policymakers need more certainty than can be given from best evidence. There is the intuition that advanced directives, on the minority of people who find it acceptable (remember that only the minority of those approached agree to go into the trials) that the advanced directives do save on admissions and time in hospital, but the evidence is really not strong. Many policies have been rolled out on the back of even more thin evidence than this and vase amounts of money wasted for opportunities lost for people with serious mental illness. Perhaps a constructive suggestion might be that should the Department of Health feel that there is the possibility of a real positive effect for the benefit of service users in advanced directives that the policy would be rolled out in the context of a simple pragmatic and very large randomised study, where test regions would be randomly allocated to use advanced directives or not, and routine data on bed usage and criminal justice contacts recorded.

End on a positive note. Feedback how in a matter of minutes they have got though the bare bones of a big review, appraised and applied it - and, you hope, enjoyed doing it.

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Special points of interest:

- The idea of this is to lead you from the clinical situation, trough the research and back to the real-world situation again
- You may or may not have read the paper - but even if you have not that does not mean that you cannot get something out of this

- Make sure you participate, and speak up - you will have to in a real life situation
- There is no perfect way of doing this - each person has an individual way of interacting and conveying information

Advance treatment directives for people with severe mental illness - HANDOUT FOR PARTICIPANTS

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Policymakers will arrive soon

What do you think Policymakers may ask?

List:

1.

2.

3.

4.

If you had not had this paper fall into your lap where might you have gone for reliable information?

What key points do you need to know to see if this review can help?*

1.

2.

3.

4.

5.

***Policymakers arrive in 30 mins**

After discussion do you want to change the key points you need to know to see if this review can help?*

1.

2.

3.

***Policymakers arrive in 10 mins**

Can you extract numbers that will be useful to you and Policymakers?

Clue: focus on what you think Policymakers may ask - main effects and cost-effectiveness - graph number '1.2' may be a good one to use

1. Can you put relative risk into words?

2. Can you work out the proportion of improvements *attributable* to use of Advanced treatment directives?

3. Can you work out the number needed to treat?

4. Can you put that into words?

Policymakers arrive

Think about how you can put across in an objective way the best available evidence.

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Special points of interest:

- Best evidence suggests that clinically focused problem-based learning "has positive effects on physician competency" even long into the future. [1]

1. Koh GC, Khoo HE, Wong ML, Koh D. The effects of problem-based learning during medical school on physician competency: a systematic review. CMAJ 2008; 178(1):34-41. (free online)

CATmaker

This can be part of a store of Critically Appraised Topics - see CATmaker online

Advance treatment directives for people with severe mental illness - PARTICIPANTS' CRIB SHEET

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Thank you

This is one of 40 Cochrane Schizophrenia Group Guides for Journal Clubs

A full list is found on

http://szg.cochrane.org/journal-club

Advance treatment directives for people with severe mental illness - FEEDBACK

Date and place of journal club

1. How many attended?

About

2. What was the background of the people attending? (please tick)

Health care professionals

Consumers

Policymakers

Undergraduate

Postgraduate

Others

3. Marks out of ten compared with usual journal club

(10=much better, 5=same, 0 = much worse)

Free text feedback