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Supportive therapy for schizophrenia - THE LEADERS GUIDE

Produced by the Editorial base of the Cochrane Schizophrenia Group
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from
Buckley LA, Pettit TACL, Adams CE. Supportive therapy for schizophrenia. Cochrane Database of Systematic Reviews 2007, Issue 3. Art. No.: CD004716. DOI: 10.1002/14651858.CD004716.pub3.

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 1-5 - one copy for you

Pages 6-7 - one copy for each participant - distributed at **start** of journal club

Page 8– one copy for each participant distributed at **end** of journal club

Page 9 - 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 Auditors arrive, get them to talk, split into groups—with a feeling of urgency.

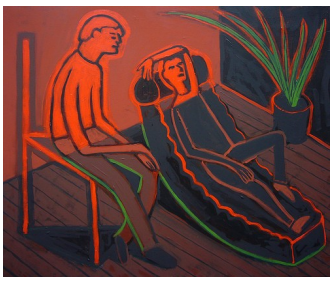
Part 3. Use of evidence in clinical life (20 mins)

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 – Auditors

Introduce participants in the journal club to their scenario

National guidelines encourage the use of cognitive behavioural therapy for everyone with schizophrenia. And this has not proved practical within normal everyday practice, and you are concerned that in Trust-wide audit, it's been find that you've not been providing the service when other teams are. You, however, have ensured that all your team members are trained in a lower grade, simpler, supportive therapy skill-set.



Questions for participants:

Q 1. What do you think people doing an audit may ask?

A 1. [Suggestion] "Why do you not stick to national guidelines, is CBT not better than this simpler approach?"

Q 2. What do you think they mean by 'better'?

A 2. ***List*** the suggestions from participants as these are what Auditors will come back to 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 see the auditors 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 supportive therapy

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 the service users?

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 Auditors now arrive 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 or flip chart

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 to help the Auditors?

a. Can I apply the results to my clinical service?

Are my service users so different from those in the trial that the results don't apply?

b. Should I apply the results to my service users?

How great would the benefit of therapy be for my service users?

Is the intervention consistent with the service users' values and preferences?

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 the Graph providing data for 'Mental state: 1. No clinically important improvement in general mental state' best fits Auditor's request of information about getting 'better'.

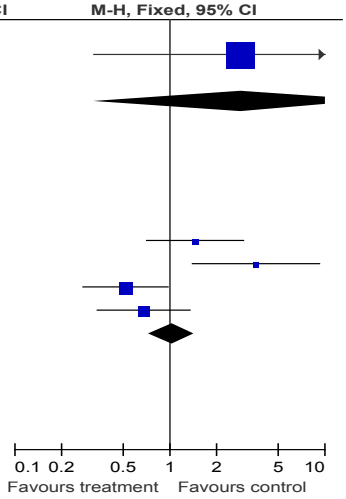
And from **Group 3 get some feel of how applicable the findings are.**

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

"Why do you not stick to national guidelines, is CBT not better than this simpler approach?"

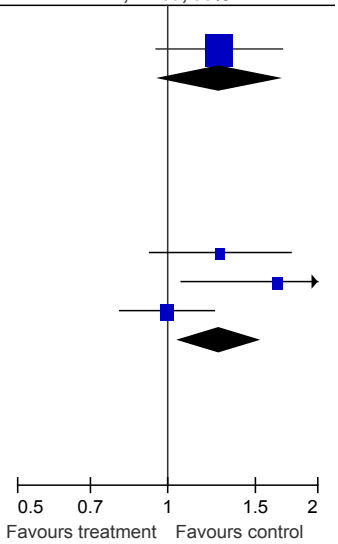
COMPARISON 4: SUPPORTIVE THERAPY versus COGNITIVE BEHAVIOURAL THERAPY
Outcome: 4.2 Global state: Relapse

Study or Subgroup	Supportive therapy Events	Total	CBT Events	Total	Weight	Risk Ratio M-H, Fixed, 95% CI
4.2.1 medium term						
Pinto 1999	3	21	1	20	100.0%	2.86 [0.32, 25.24]
Tarrier 1998	0	26	0	33		Not estimable
Subtotal (95% CI)		**47**		**53**	**100.0%**	**2.86 [0.32, 25.24]**
Total events	3		1			
Heterogeneity: Not applicable						
Test for overall effect: Z = 0.94 (P = 0.34)						
4.2.2 long term						
Haddock 1999	8	11	5	10	13.6%	1.45 [0.71, 2.98]
Hogarty 1997-study 1	15	24	4	23	10.6%	3.59 [1.40, 9.23]
Hogarty 1997-study 2	9	29	15	25	41.7%	0.52 [0.28, 0.97]
Tarrier 1998	8	26	15	33	34.2%	0.68 [0.34, 1.35]
Subtotal (95% CI)		**90**		**91**	**100.0%**	**1.02 [0.72, 1.45]**
Total events	40		39			
Heterogeneity: Chi² = 13.64, df = 3 (P = 0.003); I² = 78%						
Test for overall effect: Z = 0.13 (P = 0.89)						



COMPARISON 4: SUPPORTIVE THERAPY versus COGNITIVE BEHAVIOURAL THERAPY
Outcome: 4.4 Mental state: 1. No clinically important improvement in general mental state

Study or Subgroup	Supportive therapy Events	Total	CBT Events	Total	Weight	Risk Ratio M-H, Fixed, 95% CI
4.4.1 medium term						
Tarrier 1998	22	26	22	33	100.0%	1.27 [0.95, 1.70]
Subtotal (95% CI)		**26**		**33**	**100.0%**	**1.27 [0.95, 1.70]**
Total events	22		22			
Heterogeneity: Not applicable						
Test for overall effect: Z = 1.60 (P = 0.11)						
4.4.2 long term						
Durham 2003	20	23	15	22	27.1%	1.28 [0.92, 1.77]
Sensky 2000b	27	44	17	46	29.4%	1.66 [1.06, 2.59]
Tarrier 1998	22	26	28	33	43.6%	1.00 [0.80, 1.24]
Subtotal (95% CI)		**93**		**101**	**100.0%**	**1.27 [1.04, 1.54]**
Total events	69		60			
Heterogeneity: Chi² = 6.05, df = 2 (P = 0.05); I² = 67%						
Test for overall effect: Z = 2.40 (P = 0.02)						



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

69 people out of 93 given supportive therapy were **not** clinically improved in the long term (**74%**) but 60 people out of 101 allocated to CBT did not improve in the long term (**59%**).

So, because a few people would have got better with supportive therapy, the proportion *attributable* to taking CBT, according to these results, is the difference between the groups (or 74% minus 59% = 15%). Just round the percentage up or down to make it easy.

So 15% of people in these trials, in the long term, have the 'mental state impression of an improvement' – or put another way, 1 in 7, or put another way NNT = 7.

Limitations of using this means of calculating NNT is that is does not take into account the baseline risk of the control group and does not give confidence intervals.

In this case factoring in baseline risk of the control group does not make a difference.

NNT = 7, 95% CI 43-4

http://www.nntonline.net/ebm/visualrx/what.asp

Part 3. The Auditors meeting

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 clinician and you be the Auditor.

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 Auditors s may ask—use them.

"Why do you not stick to national guidelines, is CBT not better than this simpler approach?"

See if they can put across in a supportive way the best evidence as they understand it.

There is no perfect way to do this—but perhaps something like this:

"The best evidence we have is from a Cochrane review, which shows that for clinically important outcome, such as relapse, supportive therapy is just as effective as CBT ."

What do you think they mean by 'better'? would be a good next question.

Again there is no right answer but think about how to put into words what the research outcome really means.

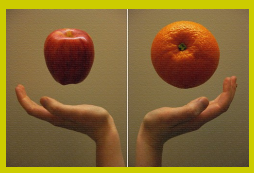
Perhaps - "There is no strong evidence to suggest that CBT is better than supportive therapy. For clinically important outcomes, such as relapse, there is no significant differences between the two therapies. Data on mental state improvement does favour CBT, but it was heterogeneous. Therefore, we cannot conclude that CBT is better than supportive therapy."

As has been said—there is no right answer and all depends on personal style and situation. Your job is to encourage the best answer out of the clinician.

If it is going well there are other questions that you may ask—see side **Box 1.**

Box 1. Additional questions

☑ **Is, from the NNT we have calculated, CBT therefore better than supportive therapy?**



First, where it comes to relapse prevention there is little or no clear difference between the two approaches. Second, the mental state data are heterogeneous (I^2 is quite high so apples and oranges may have been added together) and most of the trialists have been heavily associated with promotion of CBT and may find it difficult to be objective in their evaluation. There is still a good argument to have here. How do the people in the role play do this openly and honestly?

☑ **Do cost data help settle any arguments?**

Not really—promotes more arguments, really. The data are difficult to present, suggest that CBT is less expensive, but are very skewed so there may well be no difference - and, remember, all are produced by trialists who are very encouraging of CBT being widely implemented.

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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 clinical 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 the real clinic
- There is no perfect way of doing this - each person has an individual way of interacting and conveying information

Supportive therapy for schizophrenia

- HANDOUT FOR PARTICIPANTS

Produced by the Editorial base of the Cochrane Schizophrenia Group
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Auditors *will* arrive soon

What do you think the Auditors may ask?

List:

1.

2.

3.

4.

5.

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.

***Auditors 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.

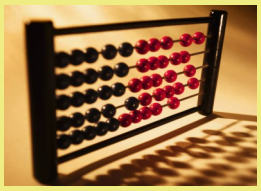
3.

***Auditors arrive in 10 mins**

Can you extract numbers that will be useful to you and the Auditor?

Clue: focus on what you think Auditor may ask - clinically important outcome, e.g. relapse - graph number '4.4.2' may be a good one to use

1. Can you put relative risk into words?



The arithmetic is not complicated

2. Can you work out the proportion of improvements *attributable* to use of supportive therapy (or CBT)?

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

4. Can you put that into words?

Auditors arrive

Is there a good use of words you would want to use?

Please: Let the journal club leader know what you thought of this format. We wish to gather feedback to improve things.

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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

Supportive therapy for schizophrenia - PARTICIPANTS' CRIB SHEET

The three parts of appraising a review

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

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Is the intervention consistent with the service users' values and preferences?

Were all the clinically important outcomes considered?

Are the benefits worth the harms and costs?

A quick and dirty way to work out NNT (Graph 4.4.2)

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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

Supportive therapy for schizophrenia

- 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