

Tavistock and Portman Staff Publications Online

JOURNAL ARTICLE

Original citation:

Wren, Bernadette (2015) '*There is no room in Child and Adolescent Mental Health Services (CAMHS) for providing intervention without an evidence base: The case against.* Context (139). pp. 27-31.

© Bernadette Wren, 2015

This version available at: <http://repository.tavistockandportman.ac.uk/>

Available in Tavistock and Portman Staff Publications Online

The Trust has developed the Repository so that users may access the clinical, academic and research work of the Trust.

Copyright © and Moral Rights for the papers on this site are retained by the individual authors and/or other copyright owners. Users may download and/or print one copy of any article(s) in Tavistock and Portman Staff Publications Online to facilitate their private study or for non-commercial research. You may not engage in further distribution of the material or use it for any profit-making activities or any commercial gain.

You may freely distribute the URL (<http://repository.tavistockandportman.ac.uk/>) of Tavistock and Portman Staff Publications Online.

This document is the published version '*There is no room in Child and Adolescent Mental Health Services (CAMHS) for providing intervention without an evidence base: The case against.*' It is reproduced here by kind permission of AFT Publications. You are encouraged to consult the remainder of this publication if you wish to cite from it.

Jenkins, H. & Asen, K. (1992) family therapy without the family: A framework for systemic practice. *Journal of Family Therapy*, 14: 1-14.

Knott, F. & Espie, C. (1997) Families' perceptions of the one-way screen in the first meeting. *Journal of Family Therapy*, 19: 431-439.

Lang, W.P., Little, M. & Cronen, V. (1990) The systemic professional: Domains of action and the question of neutrality. *Human Systems: The Journal of Systemic Consultation and Management*, 1: 39-56.

Mally, M. & Hurst, A. (2005) "Alice and Alice not through the looking glass": Therapeutic transparency and the therapeutic and supervisory relationship. In C. Flaskas, B. Mason & A. Perlesz (eds.) *The Space Between: Experience, Context, and Process in the Therapeutic Relationship*. London: Karnac.

Mason, B. (1993) Towards a position of safe uncertainty. *Human Systems: The Journal of Systemic Consultation & Management*, 4: 189-200.

Mason, B. (2005) Relational risk-taking and the training of supervisors. *Journal of Family Therapy*, 27: 298-301.

Pearce, B. (2007) *Making Social Worlds – A Communication Perspective*. Malden: Blackwell.

Pearson, A. (2012) CAMHS and the art of outreach. *Context*, 120: 3-5.

Protinsky, H. (1997) Dismounting the tiger: Using tape in supervision. In T.C. Todd, & C.L. Storm (eds.) *The Complete Systemic Supervisor: Context, Philosophy and Pragmatics*. Needham Heights, MA: Allyn & Bacon, Choice Press.

Roper-Hall, A. (1998) Working systemically with older people and their families who have 'come to grief'. In P. Sutcliffe, G. Tufnell & U. Cornish (eds.) *Working with the Dying and Bereaved: Systemic Approaches to Therapeutic Work*. London: Macmillan.

Smith, D. & Kingston, P. (1980). Live supervision without a one-way screen. *Journal of Family Therapy*, 2: 379-387.

Totsuka, Y. (2014) "Which aspects of social GRRRAAACCEESSS grab you most?" The Social GRRRAAACCEESSS exercise for a supervision group to promote therapists' self-reflexivity. *Journal of Family Therapy*, 36 (Suppl. 1): 86-106.

Vetere, A. & Cooper, J. (2001) Working systemically with family violence; Risk, responsibility and collaboration. *Journal of Family Therapy*, 23: 378-396.

White, M.B. & Russell, C. (1997) Examining the multi-faceted notion of isomorphism in marriage and family supervision: A quest for conceptual clarity. *Journal of Marital and Family Therapy*, 23: 315-333.



Jenny Summer is a senior systemic psychotherapist and supervisor. She works as systemic lead and trainer for Morning Lane Associates and is also employed in Cambridgeshire Social Care as a specialist clinician in a child in need unit.

'There is no room in CAMHS for providing intervention without an evidence base': The case against

Bernadette Wren

This article summarises the arguments I made at a debate in January 2013 on the importance of the 'evidence base' for clinical work in CAMHS. The debate was hosted by the Association for Child and Adolescent Mental Health at their headquarters in London. Speaking for the motion, *'There is no room in CAMHS for providing intervention without an evidence base'*, was Miranda Wolpert of the Evidence-Based Practice Unit at University College London and Anna Freud Centre. I spoke against the motion. My aim was to articulate my exasperation at the simplifications and sloganising that dog discussions about the use of 'evidence' in CAMHS – in particular, to speak against the ways in which the knowledge from the intervention science in our field is misrepresented as coherent, assured and un-ambiguous when, in fact, it is mostly provisional, partial, and deeply contested. I also wanted to highlight the way un-grounded ideas about 'the evidence base' are making inroads into service planning, and the likely consequences of this.

As I predicted, I lost the vote, not least because I was basing my arguments on the usual conception of 'evidence' in our field, as referring to good-quality research studies from a wide range of research programmes – research that may partly serve to underpin clinical practice and help to make it credible. I was surprised and puzzled that Miranda seemed to take the view that almost any empirical findings can count as 'evidence', however flimsy and irregular the data and research method. In

that sense, we were speaking at cross purposes, and Miranda's position appeared tame and uncontested. Nevertheless, I made some substantive points about current practice-issues which people seemed to think were worth making, and I offer a summary of them here.

To position myself at the outset, I am happy to admit that, as a clinician, I am fascinated by research and am not inherently sceptical about its importance and value. I teach research methods to trainee family therapists at the Tavistock and Portman, encouraging them to explore the research literature widely, to develop their confidence in critically appraising what they find, and to understand why certain kinds of evidence can be considered sound and when that seeming soundness should be contested. I try to inspire intellectual curiosity about what can be learned from the science of evidence. If I refer to research findings extensively in this article, I do so out of a conviction that empirical studies can be immensely suggestive for clinicians, challenging fixed ideas and biases and provoking creative adaptations.

On the other hand, I am deeply troubled by the insistence that the 'evidence base' should determine the scope of how we practice in CAMHS: it is an unwarranted response to the policy-makers' question about how services should be run. My concern is that the relationship of science to service developments is far from straightforward. Policy-making is at once a science, an art and a politics, with

There is no room in CAMHS for providing intervention without an evidence base: the case against

policy decisions necessarily made in response to a wide range of competing problems and demands. The arguments of politicians and policy-makers rely very selectively on scientific data, because they express broader relations of power and particular sets of values and beliefs: 'evidence' is generated, or spun, to support an agenda. As the celebrated champion of evidence-based policy, Pawson (2006) writes, "As one ascends the intervention hierarchy from practitioners to managers to bureaucrats to the political classes, the capacity to absorb complex information dwindles by the bullet point" (p. 175). Policy-making is about money and power. Over-confident pronouncements about 'what works' often reveal a narrow preference for linear explanations, a taste for top-down managerialism, careerist scheming and, currently, in the case of mental health, a readiness to tailor practice to make it ready for easy pricing and commodification.

We must not be misled by these reductionist accounts of research findings. So, here are my ten simplifications of the intervention science that are prevalent in discussions about CAMHS.

Simplification 1 relates to the status of the accumulated knowledge from outcome-research studies.

Research on outcomes does not deliver thumping facts about 'effective' treatments. The existing data support a far more nuanced and balanced view of treatment efficacy than implied by widespread use of terms such as 'empirically-validated treatment'. Most psychological interventions are not reliably and predictably effective. They have dramatic outcome-swings, variable reach and a short shelf life, yielding a knowledge base that is patchy, inconsistent and inconclusive. In comparing results from dozens of studies of diverse treatments, outcomes do not show significant variation by unique model, nor can systematic reviews hammer the evidence into delivering unconditional verdicts on the efficacy of interventions.

Leading researcher in childhood anxiety, Klein, wrote in a 2009 Association for Child and Adolescent Mental Health Research Review that

the research literature "abounds with irreconcilable results", with the literature reminiscent of the "dialogue of the deaf" (2009, p. 158). In the same issue, notable eating disorders researcher, Halmi expressed the view that, "Despite massive amounts of correlational research, it is still not possible to predict which type of patient will respond to what type of therapy" (Halmi, 2009, p. 163). These are the voices of active researchers, engaged in the task of science, not seeking to conjure policy directives. Notably, they are very much focused on what they do not know, rather than spuriously talking up the outcome research.

In a few areas, we have some modest research evidence and some consensus about how to proceed therapeutically (e.g. some form of exposure is probably required in treating anxiety). But, in most areas, we have very limited certainty about the value of the research evidence and little agreement about how best to proceed. As clinicians, we operate in the zone of complexity where we must go forward on a trial and error basis, conscious of our fallibility, where creativity and innovation are required to develop new understandings of how to act (understandings in time to be duly explored in systematic research). At best, randomised controlled trials may be a tentative starting point for clinical teams to work out what kind of intervention to try with each new person referred. To both safeguard our credibility, and strengthen the quest for greater understanding, we need to acknowledge the limits of our knowledge.

Simplification 2 relates to the way knowledge accumulates and progresses in our field.

Knowledge in our field grows not in a gentle progressive curve towards enlightenment, but erratically, with many setbacks, false starts and cul-de-sacs. Typically, research studies report limited findings of uncertain generalisability. These, in turn, may be supported, amplified, challenged or dramatically undermined by further studies. This is how research advances. Sometimes, several research studies from different centres hang together, and we seem to be building up confidence in an approach. But further research-analyses frequently undermine confidence in aspects of

the original work. For example, one meta-analysis of a broad range of child and adolescent interventions showed that any difference found in the effects of interventions was wiped out if you took into account the allegiance of the researcher to the treatment being studied (Miller *et al.*, 2008). The evidence-based treatments for children and adolescents were superior to usual care only if the treatment was developed by the researcher. This finding will itself be subject to scrutiny in future. We are not left knowing nothing about treatment effects, but we are left with a picture of the huge complexity of the issues.

Some of the very premises of randomised controlled trials are increasingly being attacked as unreliable: for example, the way researchers handle issues of generalisation, assuming away the inferential leap required to apply aggregate findings in individual cases. Even the use of diagnostic categories to define research samples is under critical scrutiny. We are coming to question whether diagnostic classification-systems possess scientific validity, despite repeated and costly efforts at refinement. Many leading commentators believe that virtually all designated disorders are heterogeneous with respect to risk factors and likely mechanisms. For some, the preferred response to this is greater diagnostic differentiation. Others, like Bentall (2009), want to take research forward on the basis of a grasp of the client's 'complaints'.

Even the idealisation of cognitive behaviour therapy (CBT) is under reconsideration as results come in from further trials pitting it unimpressively against once-discredited forms of therapy like Rogerian counselling (e.g. Cottraux *et al.*, 2008). In the last couple of decades, we have had too many confident but premature pronouncements about psychotherapy, from groups with an axe to grind and power to wield: the mythologisation of CBT has just been the latest and most widespread fad.

Simplification 3: Talk of psychotherapy as an 'intervention' is itself a gross simplification.

An intervention is not a unitary 'product', available to be delivered in more or less dummy-proof fashion. In reality, any single psychosocial

intervention consists of multiple components deployed in non-linear fashion, embedded in multiple, complex social systems (Wren & Cooper, 2012). And crucially, most of the individual elements of an intervention are themselves untested as to their power in creating change. We can think of the therapeutic relationship as a bio-psycho-dynamic system of emotional communication and affect regulation – not purely a site for simple ‘instructional interaction’. As Marks, the distinguished behaviour-therapist, writes:

Even the most tightly researched psychotherapies have a tangled thicket of components. Take CBT for panic. Its components differ hugely from one therapist to another, with varying mixtures of: relevant exposure (diverse forms of which have over 65 labels); interoceptive exposure (stress immunisation); cognitive restructuring; slow, deep breathing; relaxation; diary keeping; particular homework; family work; reward for progress; getting a treatment rationale; and expecting to improve. One therapist may use a bit of this, a lot of that and none of all of a third component from the list. Another might give none or all of those three components in equal proportion. Yet all these therapists call their method CBT. (2002, p. 203)

Simplification 4 relates to how evidence can serve as a basis for clinical activity.

What is in question here is the practical applicability of ‘evidence-based’ interventions with our distinct populations in CAMHSs, whether South Camden or South Shields. We know the effectiveness of models of intervention, when rolled out to diverse community settings, is typically very mixed, relative to treatment as usual. The knowledge of what worked ‘there’ cannot easily be applied ‘here’ (Cartwright & Hardie, 2012). A treatment model only yields a best guess about how far it will work on different children in different contexts. Multiple client-factors beyond the child’s disorder influence how potent a treatment will be, including the impact of culture, class and co-morbidities. Furthermore, the circumstances in any clinical service will tend to be very different – relative to the setting where the research was carried out – in terms of the money and time available, the

structures for assessment, the kind and level of training of the therapists, their practice skills and allegiances, the motivation of their leaders and supervisors. It is simply not clear which interventions are effective when moved to other settings.

Simplification 5 relates to our knowledge of whether models of working, validated with specific populations, can be adapted.

As clinicians, we are tempted to adapt the language and the content of ‘evidence-based’ approaches, giving consideration to the different risks and protective factors operating. But evidence (and opinion) vary about how far we should stick to any individual protocol or try blending elements from different models. Some researchers have shown variations from the protocol reduce effectiveness. Others are prepared to support the clinician to shape and refine the intervention according to perceived need in a new setting, e.g. to engage the client, or to strengthen the therapeutic alliance by addressing contextual factors in creative ways (Green, 2015). In Chorpita’s ‘common elements’ model (Chorpita *et al.*, 2011), it is suggested some modifications and merging of elements may create a powerful beneficial treatment. But, other blends may create a weak or troublesome intervention. And yet, to preclude practitioner adaptations of any sort would make implementations in many settings difficult or impossible.

Simplification 6 relates to how evidence-based models of practice can serve as a basis for service design.

With such a proliferation of guidelines and ‘best practice’ lists as we have on offer today, it is harder and harder to identify the ‘best candidate’ intervention for any one child. How do we choose between the different brands, between those underpinned by two randomised controlled trials and those by twelve? Attempts to create thorough-going evidence-based practitioners can involve training people in a dozen different treatment-protocols, which are often not compatible and consistent in terms of day-to-day case management.

Besides, the manuals for many evidence-based treatments are not easily obtained. If available, most are costly. Do

we require CAMHSs to have libraries full of hundreds of independent treatment-protocols? The initial investment required to develop a workforce with expertise in multiple evidence-based interventions is prohibitive, and coordinating multiple manualised-treatments within a single agency would create a complicated infrastructure of different forms, fidelity arrangements and monitoring tasks.

Simplification 7 relates to the idea staff can be both compliant evidence-based practitioners, and thoughtful, effective therapists.

The aim of a rules-based system is to reduce or eliminate the use of discretion and judgment. If we insist on a narrow range of evidence-based, protocol-driven treatments to be delivered in CAMHS, we will employ people to do a known, defined activity, frozen for a period of time; there will be little scope for knowledge development. But there is growing evidence only certain organisational cultures favour the uptake of innovation and new technologies, including evidence-based practice (Hemmelgarn *et al.*, 2006). These are cultures that are flexible, risk-tolerant and collaborative, and open to change in general. Such constructive cultures seem to be characterised by organisational norms of achievement and motivation, self-actualisation and supportiveness for and between clinicians. Studies in mental health settings, including child and adolescent services, have shown that a more positive climate produces better outcomes. Emotionally exhausted, low-morale and defensive organisations react negatively to engaging with evidence-based practice. Munro (2011) has written about the ‘ripple effects’ in social work: the processes by which an increase in rules and guidance covering child and family social-work activity creates a host of unintended consequences for the health of the professions and for the outcomes for vulnerable children and young people.

Simplification 8 relates to the way knowledge from research – in all its complexity and contingency – can serve as a basis for training curricula.

A host of skills, understandings, well-honed intuitions and personal qualities must underpin the effective execution of evidence-based interventions, and



these are typically taken for granted by protocol devisers. The tricky issue here is what trainee clinicians need to learn before they learn evidence-based interventions. There is a great deal of data from research to suggest the effectiveness of all treatments is due, in some part, to factors common to all treatments: client hope and expectancy, therapist allegiance, and so on (Wampold & Budge, 2012). And there is a range of evidence suggesting the therapist is a key change-ingredient in most successful therapy (Blow *et al.*, 2007). Research has accumulated to

indicate therapists need to be responsive to their clients; lack of therapeutic empathy seems to be a strong predictor of poor outcome in psychotherapy. The goal of treatment should be to engage the client in a change process, not blindly adhere to a model.

But, how can we square a future of compliance to treatment protocols decided by committee with the need to develop trainees as sensitive, observant, self-reflexive and motivated therapists, with a wide-ranging awareness of differing social and cultural systems, able to engage and join with families,

to select the most effective therapeutic move in moment-by-moment acts of deliberation and judgment? There is also evidence which points to a strong allegiance to a model of therapy as a powerful factor in therapist effectiveness (Munder *et al.*, 2013). How will that be operative in an 'evidence-based' CAMHS world, when in fact most of us feel our model chose us, rather than vice versa?

Simplification 9 relates to the way good research depends on the imaginative leaps of clinicians.

It is critical that new and innovative ideas about effective treatment continue to emerge, develop and be nurtured in the field of psychotherapy. To be sure, some new approaches appear as a by-product of research activity itself – systematic studies can help to generate novel approaches to clinical work. But it is not just a one-way street, with scientific knowledge offering benefits to practitioners. It is also the case that researchers draw on the clinical hunches of insightful and observant clinicians. Practitioners articulate the emotional and relational 'happenings' in therapy that can in turn be taken up in systematic investigations. The problem is, if we insist that the 'evidence base' should direct what therapists do, we may lose many of the novel clinical perspectives that offer important benefits to science.

Simplification 10, finally and briefly, relates to the way research evidence is misleadingly portrayed as confirming psychological interventions as quasi-technological solutions to discrete problems.

I see effective psychotherapy – even behavioural approaches – as a set of interpersonal craft-skills and techniques, framed and given meaning within an *ethical framework* for responding to people's suffering with compassion and hope. If we feel cast down by the thought that intervention science

has delivered very modest findings, we should remind ourselves that our immense and extraordinary task is attending to and trying to heal the pains and uncertainties of living – within the limits of our particular, constraining, cultural world – helping people struggle to maintain self-belief, trust in others, interpersonal understanding and communication, tolerance of pain, fear and disappointment (capacities that may have never become established, or have faltered).

To think the state of the intervention science justifies the imposition of a 'no room' rule is to believe in a benign, well-ordered world. In this world view, problems in CAMHS practice are 'tame' problems: occurring in closed systems with clear boundaries, capable of being resolved with clear rules, compliant professionals and sufficient resources. But in my world view, these problems are 'wicked', occurring in open social systems, where regularities are ill-behaved, and where solutions are not 'true' or 'false', but contingently 'better' or 'worse'.

Two paradoxes

I concluded my presentation at the debate by highlighting two paradoxes.

One paradox is that research on the 'evidence base' for intervention in CAMHS seems to hold out the promise of energising staff with liberating knowledge about 'what works'. And yet, access to so much information can have a paralysing effect. We have a surfeit of detailed empirical studies available for contemplation, but little certainty about which, if any, actually apply to *this* child now, with *this* therapist, in *this* context. It can seem that the more information we have, the less we can rely on it.

The second paradox is that 'evidence-based' service models require, on the one hand, staff that are intellectually compliant, to carry out work that was sanctioned by studies carried out at a past time, usually in a distant place. On the other hand, effective clinical practice seems to require staff who are capable

of curiosity and fine judgment, able to make sense of multiple and complex pieces of data and subtle contextual clues, flexibly deploying a range of personal and technical skills, rooted in warmth and empathy, and a passionate allegiance to a model that makes sense to them, given their own experience of the world. The more compliant the staff, the less effective might be the work.

In summary, I believe, on the one hand, that there is no room in CAMHS for practitioners, trainers and managers who take no interest in new findings from research into the processes of psychotherapy, its possible causal mechanisms, its impact on clients (short-term, long-term, intended and unintended), its delivery, its relationship to context and its association to theory. In other words, no room for staff who are impervious to learning anything new from such research – in all its acknowledged uncertainty, fallibility and contingency.

But I also passionately believe there is no room in CAMHS for practitioners, trainers and managers who peddle exaggerated claims about research findings in our immature field, who make unrealistic promises about what 'evidence-based' interventions can achieve, and who should know better than to use this misrepresentation of the science to call for rigid top-down service models.

References

- Bentall, R.P. (2009) *Doctoring the Mind: Why Psychiatric Treatments Fail*. London: Penguin.
- Blow, A.J., Sprenkle, D.H. & Davis, S.D. (2007) Is who delivers the treatment more important than the treatment itself? *Journal of Marital and Family Therapy*, 33: 298-317.
- Cartwright, N. & Hardie, J. (2012) *Evidence Based Policy: A Practical Guide to Doing it Better*. Oxford: Oxford University Press.
- Chorpita, B.F., Bernstein, A.D. & Daleiden, E.L. (2011) Empirically guided coordination of multiple evidence-based treatments: An illustration of relevance mapping in children's mental health services. *Journal of Consulting and Clinical Psychology*, 79: 470-480.
- Cottraux, J., Note, I., Yao, S.I., de Mey-Guillard, C., Bonasse, F., Djamoussian, D., Mollard, E., Note, B. & Chen, Y. (2008) Randomized controlled

- comparison of cognitive behavior therapy with Rogerian supportive therapy in chronic post-traumatic stress disorder: A 2-year follow-up. *Psychotherapy and Psychosomatics*, 77: 101-10.
- Green, J. (2015) Editorial: Process to progress? Investigative trials, mechanism and clinical science. *Journal of Child Psychology and Psychiatry*, 56: 1-3.
- Halmi, K. (2009) Perplexities and provocations of eating disorders. *Journal of Child Psychology and Psychiatry*, 50(1-2): 163-169.
- Hemmelgarn, A.L., Glisson, C. & James, L.R. (2006) Organizational culture and climate: Implications for services and interventions research. *Clinical Psychology: Science and Practice*, 13: 73-89.
- Klein, R. (2009) Anxiety Disorders. *Journal of Child Psychology and Psychiatry*, 50 (1-2): 153-162.
- Marks, I. (2002) The maturing of therapy: Some brief psychotherapies help anxiety/depressive disorders but mechanisms of action are unclear. *The British Journal of Psychiatry*, 180: 200-204.
- Miller, S., Wampold, B. & Varhely, K. (2008) Direct comparisons of treatment modalities for youth disorders: A meta-analysis. *Psychotherapy Research*, 18: 5-14.
- Munder, T., Brüttsch, O., Leonhart, R., Gerger, H. & Barth, J. (2013) Researcher allegiance in psychotherapy outcome research: An overview of reviews. *Clinical Psychology Review*, 33: 501-11.
- Munro, E. (2011) *The Munro Review of Child Protection: Final Report, a Child-centred System*. London: The Stationery Office.
- Pawson, R. (2006) *Evidence-based Policy: A Realist Perspective*. London: Sage.
- Wampold, B.E. & Budge, S.L. (2012) The relationship – and its relationship to the common and specific factors of psychotherapy. *The Counselling Psychologist*, 40: 601-623.
- Wren, B. & Cooper, A. (2012) Front line services, complexity, research and policy. *Psychoanalytic Psychotherapy: Applications, Theory and Research*, 26: 199-210.

Bernadette Wren trained as a clinical psychologist and systemic psychotherapist, and is now consultant clinical psychologist and systemic psychotherapist and trust-wide head of psychology at the Tavistock and Portman NHS Trust. She has degrees in philosophy and psychology and a continuing interest in the relevance of each discipline to the other. She works clinically with transgendered young people and their families in the trust's gender identity development service. She teaches clinical research methods across a number of Tavistock courses, including the qualifying masters course in systemic psychotherapy, and for many years she co-chaired the Tavistock-UCL doctorate in systemic psychotherapy. She is an honorary senior research-associate in the Department of Clinical, Educational and Health Psychology at UCL. Email: bwren@tavi-port.nhs.uk