Quantitative recovery research: why it's needed, how it helps

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Aims

- Address some criticisms
- Give three rationales

Criticisms

- Quantitative research is reductionist of human experience
- Quantitative research lacks reflexivity – researcher are unaware of process / outcome biases
- Quantitative research leads to over-generalisation

Criticism 1: Reductionist

- So is qualitative

Ulysses Gramophone
by Jacques Derrida

An interpretation of "Yes" in James Joyce's Ulysses:

Oui, *oui*, you are hearing me well, these are French words. To be sure, and I do not need to confirm it with another sentence, it suffices that you have heard this first word, *oui*, to know, at least if you know enough French, that thanks to the authorization generously granted to me by the organizers of this James Joyce Symposium, I would address you, more or less, in the language supposed to be mine [*ma langue supposée*], this last expression nevertheless remaining a quasi-Anglicism. However, can *oui* be cited and translated? This is one of the questions...

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...The other signs. And the yes relaunches itself infinitely, much more than, and quite differently from, "yes, yes, yes, yes, yes, yes, yes," Mrs. Breen's week of seven *yeses* when she listens to Bloom tell her the story of Marcus Tertius Moses and Dancer Moses: "Mrs. Breen *(eagerly)* Yes, yes, yes, yes, yes, yes, yes" (U 15.575-76).

I decided to stop here because I almost had an accident as I was jotting down this last sentence, when, on leaving the airport, I was driving home returning from Tokyo.

Reductionist

- So is qualitative
- Most common usage is in RCTs but other less reductions designs (e.g. ABA, patient-rated outcome monitoring) are also possible
- Confusion of paradigm and methodology

Criticism 2: Reflexivity

Process evaluation

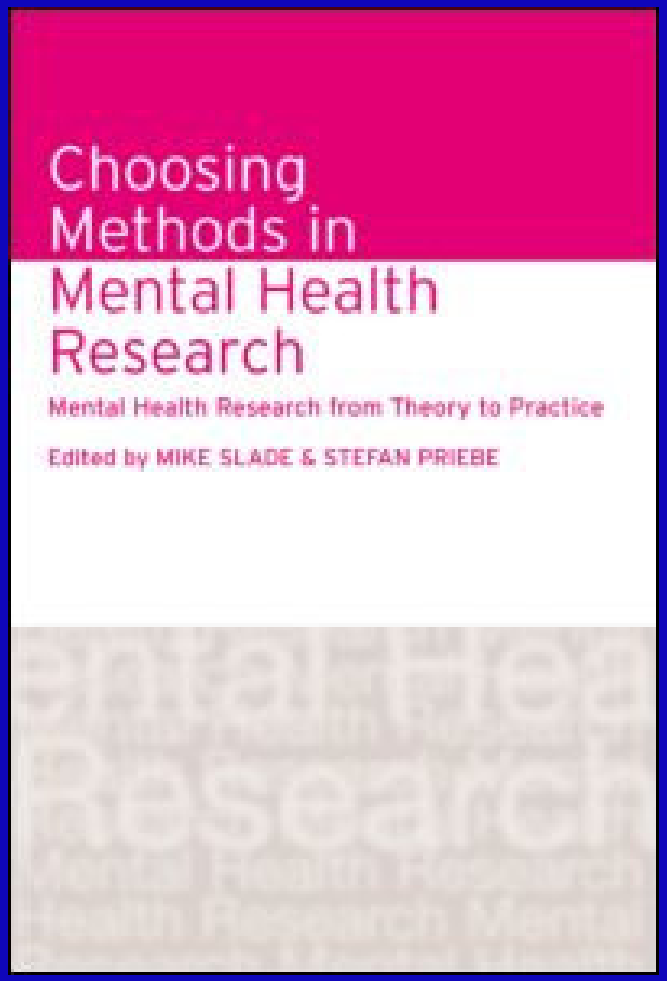
- Context
- Causal assumptions
- Implementation
- Mechanisms of impact
- Outcome

Moore et al (2015) *Process evaluation of complex interventions: Medical Research Council guidance*, BMJ 350, h1258.

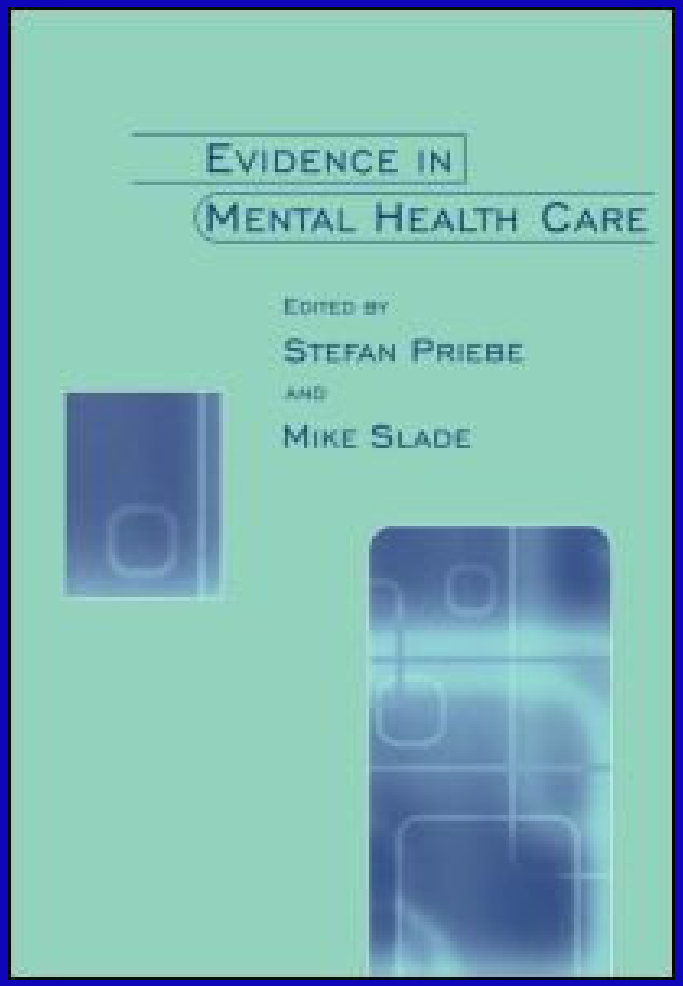
Outcome evaluation

Pesola F et al *Development and evaluation of an Individualised Outcome Measure (IOM) for randomised controlled trials in mental health*, International Journal of Methods in Psychiatric Research, in press.

Criticism 3: Generalisability



2006



2002

Generalisability is as big a problem for quantitative methodologies as reproducibility is for qualitative

Generalisability

Whilst it is often argued that generalizability is not the purpose of qualitative research, ...if qualitative research is not considered to be generalizable, then it is arguably of little use (and is unlikely to be funded).

...In quantitative work generalizability is statistical, i.e. the study sample is matched to the study population at large to ensure comparability of demographic characteristics and, if this is done correctly, then it is assumed that the findings are generalizable.

In qualitative work, participants are selected by means of theoretical sampling, i.e. for their ability to provide information (and consequent theory development) about the area under investigation. Situational, rather than demographic, representativeness is what is sought.

It may be said, then, that generalizability in qualitative research refers to the extent to which theory developed within one study may be exported…the aim is to make logical generalizations to a theoretical understanding of a similar class of phenomena rather than probabilistic generalizations to a population.

Horsburgh D (2003) *Evaluation of qualitative research*, Journal of Clinical Nursing, **12**, 307–312.

Three rationales

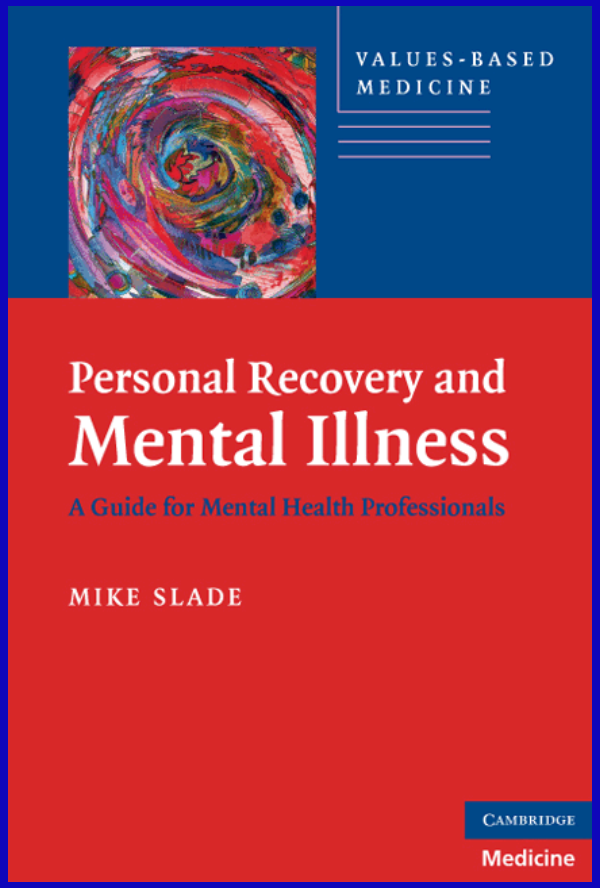
- Epistemologically necessary for blended knowledge
- Clinically important for decisions with low equipoise / contested issues
- Provides a strong form of social argument

Rationale 1: forms of knowledge

Interpersonal encounters are characterised by different forms of knowledge

- Nomothetic: group-based
- Idiographic: individual

Blended knowledge



Deep distinction: Apollonian vs. Dionysian

Co-produced knowledge will maximise the validity of conclusions (in research, clinical practice or life!)

2009

Rationale 2: equipoise

In situations requiring decision-making, especially those involving low certainty / equipoise and polarised opinions, heuristics are needed.

This is especially true where high apparent certainty conceals a highly contested issue.

Quantitative data can directly inform these heuristics.

Involvement in CDM

PASSIVE / PATERNALISTIC

to

SHARED

to

ACTIVE / INFORMED

Charles C et al (1999) *Decision-making in the physician-patient encounter: revisiting the shared treatment decision-making model*, Social Science & Medicine , **49,** 651-661.

Shared decision-making

A form of patient-provider communication where both parties are acknowledged to bring expertise to the process and work in partnership to make a decision.

Advocated on the basis that patients have a right to self-determination and also in the expectation that it will increase treatment adherence.

Duncan E, Best C, Hagen S (2010)
Shared decision making interventions for people with mental health conditions,
Cochrane Database of Systematic Reviews,CD007297.

Shared decision-making in MH

Under-researched in mental health: 2/11 RCTs

Joosten E et al (2008) *Systematic review of the effects of shared decision-making on patient satisfaction, treatment adherence and health status, Psychotherapy and Psychosomatics,* **77**, 219-226.

"Further research is urgently needed"

Duncan E et al (2010) *Shared decision making interventions for people with mental health conditions*, Cochrane Database of Systematic Reviews:CD007297.

Widely recommended: *"A shared decision making approach should be facilitated..."*

National Institute for Health and Clinical Excellence (2011) *Service user experience in adult mental health. CG136*. London: National Collaborating Centre for Mental Health .

Clinical Decision Making and Outcome in Routine Care for People with Severe Mental Illness (CEDAR)

Naturalistic prospective
longitudinal observational study

Bi-monthly assessments for 1 year

2009-2011

Out-patient / CMHT

Acta Psychiatrica Scandinavica

Acta Psychiatr Scand 2015: 131: 369–378

DOI: 10.1111/acps.12365

ACTA PSYCHIATRICA SCANDINAVICA

Empowerment and satisfaction in a multinational study of routine clinical practice

Clarke E, Puschner B, Jordan H, Williams P, Konrad J, Kawohl W, Bär A, Rössler W, Del Vecchio V, Sampogna G, Nagy M, Süveges A, Krogsgaard Bording M, Slade M. Empowerment and satisfaction in a multinational study of routine clinical practice.

Objective: Decision-making between mental health clinicians and patients is under-researched. We tested whether mental health patients are more satisfied with a decision made (i) using their preferred decision-making style and (ii) with a clinician with the same decision-making style preference.
Method: As part of the CEDAR Study (ISRCTN75841675), a convenience sample of 445 patients with severe mental illness from six European countries were assessed for desired clinical decision-making style (rated by patients and paired clinicians), decision-specific experienced style and satisfaction.
Results: Patients who experienced more involvement in decision-making than they desired rated higher satisfaction (OR = 2.47, $P = 0.005$, 95% CI 1.32–4.63). Decisions made with clinicians whose decision-making style preference was for more active involvement than the patient preference were rated with higher satisfaction (OR = 3.17, $P = 0.003$, 95% CI 1.48–6.82).
Conclusion: More active involvement in decision-making than the patient stated as desired was associated with higher satisfaction. A clinical orientation towards empowering, rather than shared, decision-making may maximise satisfaction.

E. Clarke[1], B. Puschner[2], H. Jordan[1], P. Williams[1], J. Konrad[2], W. Kawohl[3], A. Bär[3], W. Rössler[3], V. Del Vecchio[4], G. Sampogna[4], M. Nagy[5], A. Süveges[5], M. Krogsgaard Bording[6], M. Slade[1]

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Key words: decision-making; mental health

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Rationale 3: social argument

NICE to Commissioning to experience

Post-modern perspective: quantitative evidence as a form of social argument, not revealed truth

SPECIAL ARTICLE

Uses and abuses of recovery: implementing recovery-oriented practices in mental health systems

Mike Slade[1], Michaela Amering[2], Marianne Farkas[3], Bridget Hamilton[4], Mary O'Hagan[5], Graham Panther[6], Rachel Perkins[7], Geoff Shepherd[7], Samson Tse[8], Rob Whitley[9]

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An understanding of recovery as a personal and subjective experience has emerged within mental health systems. This meaning of recovery now underpins mental health policy in many countries. Developing a focus on this type of recovery will involve transformation within mental health systems. Human systems do not easily transform. In this paper, we identify seven mis-uses ("abuses") of the concept of recovery: recovery is the latest model; recovery does not apply to "my" patients; services can make people recover through effective treatment; compulsory detention and treatment aid recovery; a recovery orientation means closing services; recovery is about making people independent and normal; and contributing to society happens only after the person is recovered. We then identify ten empirically-validated interventions which support recovery, by targeting key recovery processes of connectedness, hope, identity, meaning and empowerment (the CHIME framework). The ten interventions are peer support workers, advance directives, wellness recovery action planning, illness management and recovery, REFOCUS, strengths model, recovery colleges or recovery education programs, individual placement and support, supported housing, and mental health trialogues. Finally, three scientific challenges are identified: broadening cultural understandings of recovery, implementing organizational transformation, and promoting citizenship.

Key words: Recovery, mental health services, peer support workers, advance directives, wellness recovery action planning, individual placement and support, supported housing, mental health trialogues, organizational transformation, promoting citizenship

(World Psychiatry 2014;13:12–20)

However, the broadest and most important challenge is societal change, which will involve professionals and people with lived experience becoming partners and social activists, to challenge stigmatizing assumptions that people with mental illness cannot, or should not, have the same citizenship entitlements as anyone else in their community.

Supporting recovery in patients with psychosis through care by community-based adult mental health teams (REFOCUS): a multisite, cluster, randomised, controlled trial

Mike Slade, Victoria Bird, Eleanor Clarke, Clair Le Boutillier, Paul McCrone, Rob Macpherson, Francesca Pesola, Genevieve Wallace, Julie Williams, Mary Leamy

Summary

Background Mental health policy in many countries is oriented around recovery, but the evidence base for service-level recovery-promotion interventions is lacking.

Methods We did a cluster, randomised, controlled trial in two National Health Service Trusts in England. REFOCUS is a 1-year team-level intervention targeting staff behaviour to increase focus on values, preferences, strengths, and goals of patients with psychosis, and staff–patient relationships, through coaching and partnership. Between April, 2011, and May, 2012, community-based adult mental health teams were randomly allocated to provide treatment as usual plus REFOCUS or usual treatment alone (control). Baseline and 1-year follow-up outcomes were assessed in randomly selected patients. The primary outcome was recovery and was assessed with the questionnaire about

Lancet Psychiatry 2015

King's College London, Health Service and Population Research Department, Institute of Psychiatry, Psychology and Neuroscience, Denmark Hill, London, UK (M Slade PhD, V Bird BSc, E Clarke MBBS, C Le Boutillier MSc, P McCrone PhD, F Pesola PhD, G Wallace BSc, J Williams MSc,

Fully supporting recovery, therefore, might require interventions across the whole mental health service, including the patient as an active partner and involving a combination of evidence-based patient-level interventions, team-level interventions, such as REFOCUS, and organisational transformation approaches.

Thank you

More information at researchintorecovery.com

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