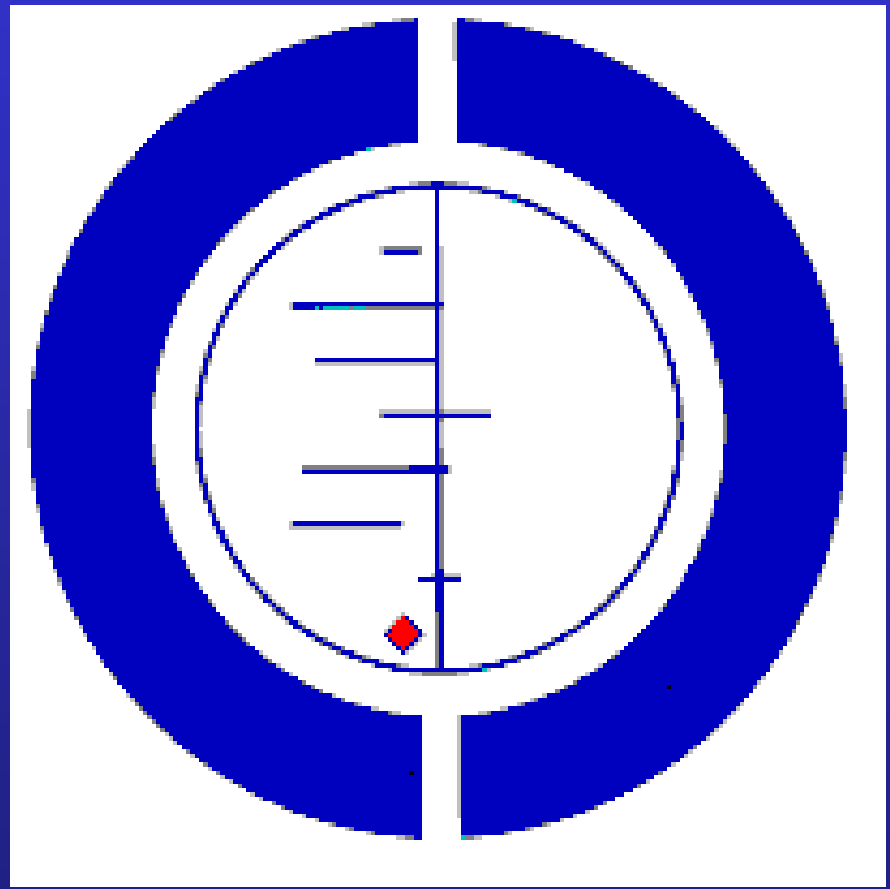


Evidence Based Mental Health

	Indice
1	Questions
2	Diagnosis
3	Treatment

1 Questions

Introduction

	To introduce partecipants to the basic skills necessary to apply the principles of evidence based psychiatry including:
1	Formulatin precise, answerrable, structured clinical question
2	Searching for evidence
3	Critical apraising evidence
4	Tailorig research finding to individual patient in clinical practice
5	Overcoming barriers to implementation of evidence based clinical practice

Well built clinical question can be divived into four section:

Patient or problem	Intervention	Comparison intervention	outcome
Describe your patient and their problem. This may be a diagnosis or a different kind of problem	Describe the main intervention or manouvre: -a treatment - a cause - a prognostic factor	In the case of treatment describe a comparative intervention	Describe what you hope to achieve or possibile effects that the manuovre could have on your patient

Patient or problem	Intervention	Comparison intervention	outcome
.....	.....	.....	.....
Describe your patiet and their problem. This may be a diagnosis or a diferent kind of problem	Describe the main intervention or manouvre: -a treatment - a cause - a prognostic factor	In the case of treatment describe a comparative intervention	Describe what you hope to achieve or possibile effects that the manuovre could have on your patient

Patient or problem	Intervention	Comparison intervention	outcome
In a middle aged male with schizophrenia	**What is likehood clozapine**	**Compared to aloperidolo**	**Producing fewer extra pyramidal side effects but similar better reduction in symptom**
Describe your patiet and their problem. This may be a diagnosis or a diferent kind of problem	Describe the main intervention or manouvre: - a treatment - a cause - a prognostic factor	In the case of treatment describe a comparative intervention	Describe what you hope to achieve or possibile effects that the manuovre could have on your patient

2 DIAGNOSIS

DIAGNOSIS

Aim	To develop the ability to:
	Determine whether the results and conclusion of a diagnostic study are valid
	Decide if the results are sufficiently focused and applicable to your problem
	Determine what the results are and apply them to the clinical problem

Critical apraisal checklist for an article on dignosis

	Are the result of this diagnostic study valid?
1	Was there an indipendet, blind, comparison with a reference ("gold") standar of diagnosis
2	Was the diagnostic test evaluated in an appropriate spectrum of patient (like thos in whombe used in practice?
3	Was the reference standard applied regarless of the diagnostic test result?

Critical apraisal checklist for an article on dignosis

	Disorder present	Disorder absent	Totals
Diagnostic test positive	a True positive	b True positive	a+b
Diagnostic test negative	c False negative	d True negative	c+d
Totals	a+c	b+d	a+b+c+d

Sensivity	**The proportion of true cases correctly identified by the test**	**a/(a+c)**
Specificy	**The proportion of true negatives correctly identified by the test**	**d/(b+d)**
Positive predictive value	**The proportion of test positives who have the target disorder**	**a/(a+b)**
Pretest probably	**the probably that a suject will have the disorder before the test (for a screenig test, this will be the same as the prevalence of the disorder)**	**(a+c)/ (a+b+c+d)**

Pre-test odds	The odds that a subject will have the disorder before the test	Pretest probability/ 1 - Pre-test probability
Likelihood ratio for a negative result (LR+)	The odds that a negative test result will be present in a patient with the target disorder compared to with a patiet without the target diroder	(1 – sensitivity)/ specifity
	Generally a LR – of 0.1 or less means that a positive test reuslt wil make a big change from pre-test to post-test probability – making the test useful for ruling IN the diagnosis (expecially when the pre-test is less than about 30%)	Pre-test odds x likelihood ratio = Post-test odds

Post-test probability	Is the probaility that the subject will havce the diorder after the test	Post-test odds/ Post-test odds + 1
Likelihood ratio for a positive result (LR +)	The odds that a positive test result will be present in a patient with the target disorder compared to with a patient without the ytarget disorder Generally, a LR + of 10 or more means that a positive test result will make a big change from pre-test to post-test probaility – making the test useful for ruling IN the diagnosis (expecially when the pre-test is 30% or more: NB a screening test will usually need to do better that this)	a/(a+c)/b/(b+d) = Sensitivity/(1-specificity)

Critical appraisal checklist form for a diagnostic study

	Is the research valid		
1	Was there an indipendent, blind comparison with a reference ("gold") standard of diagnosis?	Yes No	Comment
2	Was the diagnostic test evaluated in a appropriate spectrum of patiet (like those in whom it would be used in practice)?	Yes No	Comment
3	Was the reference standard applied regardess of the diagnostic test result?	Yes No	Comment

Critical apraisal checklist form for a diagnostic study

Is the research important?	Disorder present	Disorder absent	Totals
Diagnostic test positive	a True positive	b True positive	a+b
Diagnostic test negative	c Falese negative	d True negative	c+d
Totals	a+c	b+d	a+b+c+d

Sensivity a/(a+c)	Specifity d/(b+d)	LR + sens/(1-spec)	LR - (1-sens)/spec	Pre-test probability

Critical apraisal checklist form for a diagnostic study

Can I apply to my patient?

4	[redacted]	Yes No	Comment
5	[redacted]	Yes No	Comment
6	[redacted]	Yes No	Comment

3 THERAPY

Critical apraisal checklist for an article on therapy

Are the results of this single trial valid?

1.	The main question to answer
A	**Was the assignment of patient to treatment randomised?**
B	**Was the randomisation list concealed?**
C	**Were all subjects who estred in the trial accounted for a its conslusion?**
D	**Were they analysed in the groups to which they were randomised?**

2.	Some finer point to address:
A	**Were subjects and lclinicians "blind" to which treatmet was being recieved?**
B	**Aside from experimental treatment, were the groups treated equaly?**
C	**Were the groups similar at the start of the trial?**

Critical apraisal checklist for an article on therapy

Matrix	Yes	No	Totals
Control Group	a	b	a+b
Experimental group	c	d	c+d

Example	Yes	No	Totals
Control Group	40%	60%	a+b
Experimental group	60%	40%	c+d

Control Event Rate (CER)	**Risk of outcome event in crontol group**	**a/(a+b)**
Experimental Event Rate (ERR)	**Risk of outcome event in experimental group**	**C/(c+d)**
Relative Risk Reduction (RRR)	**The proportion of adverse events that would have occured in the control group that are avoided by the intervention**	**RRR=((CER-ERR)/CER)x100%**

Absolute Risk Reduction (ARR)	**The absolute artmetic difference in event rates of adverse events of interest between control group (CER) and experiemntal group (EER) qwhen the experiemntal treatment prevent harm occurring to more patients that in the control treatment**	**ARR=CER-ERR**
Number Needed to Treat (NNT)	**The number of patient that need to be treated to prevent one addctional adverse outcome. This is the inverse of the absolute risk reduction**	**NNT=1/ARR=1/CER-ERR**

ODDS	**The ratio of the nuber of people who experience yhe outcome of interest compared to the numeber who do not. If the event rate for a diseadìse is 0,1 (10%), its non event rate is 0,9 and therefore its odds are 1/9 or 0,111** **(if there are 10 horses in the race and you place a bet on one of the horses, what are the odds that your horse would win? 1/10)**	**a/b in the control** **O** **In the experimental** **c/d**

ODDS ratio	**Is the odds of having the target diorder (or event) in the experimental group relative to the odds of having the target disorder (or event) in teh control goup (in cohort studies, systematic reviews) or the odds in favour of being exposed in subjects with the target diosrder divided by the odds in favour of being exposed in control subjects i.e. without the target disorder (in case control studies)**	**a/b** **———** **C/d**

TREATMENT

Aim	To develop the ability to:
	Determine whether the results and conclusion of a research article about the effectiveness of a therapeutic intervention are valide
	Decide if the results are sufficiently focused and applicable to your problem
	Determine what the results are and apply them to the clinical problem

Critical appraisal form for a singlwe therapy styudies

	Is the research valid?		
1a	Was the assignment of patient to treatment randomized?		Comment
1b	Was the randomization list concealed?	Yes No	
1c	Were subjects and clinicinas “blind” to which treatment was being received?		

Is the research valid?

2a	Was all subjects who entred the trial accounted for at its conclusion?	Yes No	Comment
2b	Were they analyzed in the groups to which they were randomised?		
3a	Aside from the experimental treatment, were the groups treatted equally?	Yes No	Comment
3b	Were the groups similar at the starts of the trial?		

Is the reserach Important?		RRR (Relative Risk Reduction)	ARR (Abolute Risk Reduction)	NNT (Number Need to Treat)
CER (Control Evet Rate)	EER (Experimental Event Rate)	CER-ERR/CER	CER-EER	1/ARR
0.4	0.6	- 50	0,2	5

	Can I apply to my patient?		
4	Is the patient so different from those in the trial that the result don't apply?	Yes No	Comment
5a	How great would the benefit of therapy be for this particular patient?	Yes No	Comment
5b	What is the event rate in my practice for patiet like this one? (PERR- Patient Expexted Event Rate)		

	Is ti consistent with the patient values and preferences?		
6	Do I have a clear assessment of the patient's values and preferences?	Yes No	Comment
7	Do this intervention and its potential consequences meet them?	Yes No	Comment

Number Needed to Treat (NNT)	**The number of patient that need to be treated to prevent one addctional adverse outcome. This is the inverse of the absolute risk reduction**	**NNT=1/ARR** **NNT=1/CER-ERR**

ARR=CER- ERR	0,4 - 0,6 = - 0,2
CER = a/(a+b)	40/(40+60)=0,4
ERR = C/(c+d)	60/(60+40)=0,6

NNT=1/ARR	**1/0,2**

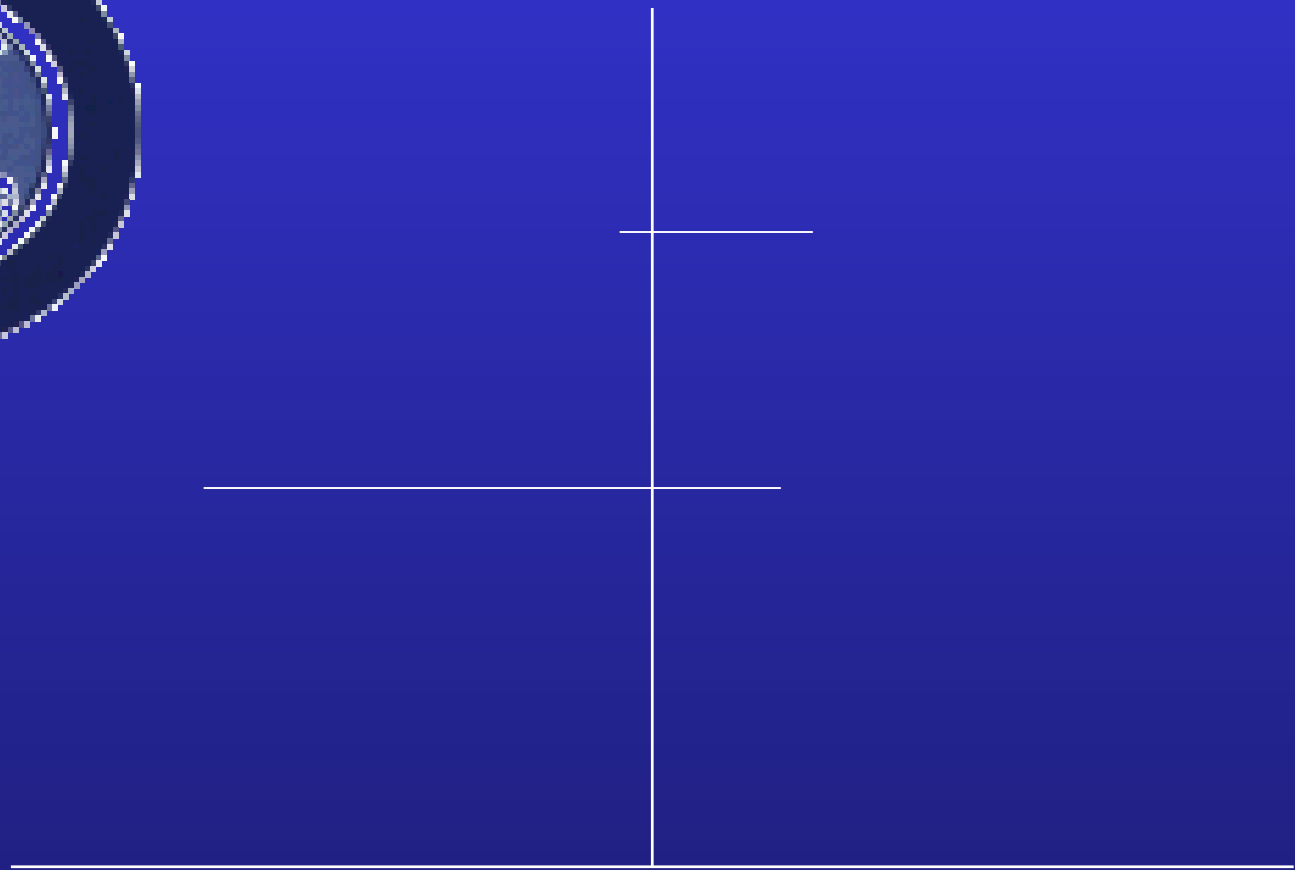
NNT	**5**

Example	better	No better
Control Group	40	60
Experimental group	60	40

a/b = ODD

c/d = ODD

$$\frac{60/40}{40/60} = \frac{\text{ODD}}{\text{ODD}} = \frac{1.5}{0.60} = 2.27 = \text{ODD ratio}$$



Stiffman AR, Dore P, Cunningham RM, Earls F.

Person and environment in HIV risk behavior change between adolescence and young adulthood.

Health Educ Q 1995 May;22(2):211-26

602 youths interviews first occurred in 1984-1985 and 1985-1986 when the youths were adolescents and were repeated again in 1989-1990 and 1991-1992 when they were all young adults.

---

longitudinal multivariate analysis 31% of the variance in HIV risk behaviors by inner-city young adults is predicted by a combination of adolescent risk behaviors,

- personal variables (suicidality, substance misuse, antisocial behavior),
- environmental variables (history of child abuse, poor relations with parents, stressful events, peer misbehavior, number of AIDS prevention messages),
- interactions between variables (number of neighborhood murders with child abuse, number of neighborhood murders with substance misuse, and unemployment rates with antisocial behavior).

Woody GE, Metzger D, Navaline H, McLellan T, O'Brien CP.Psychiatric symptoms, risky behavior, and HIV infection. NIDA Res Monogr 1997;172:156-70

Higher symptom levels were found among those who seroconverted in the 6 months following notification, but not thereafter.

Symptom levels did not distinguish between HIV-positive and HIV-negative individuals 24 months following notification of seropositivity.

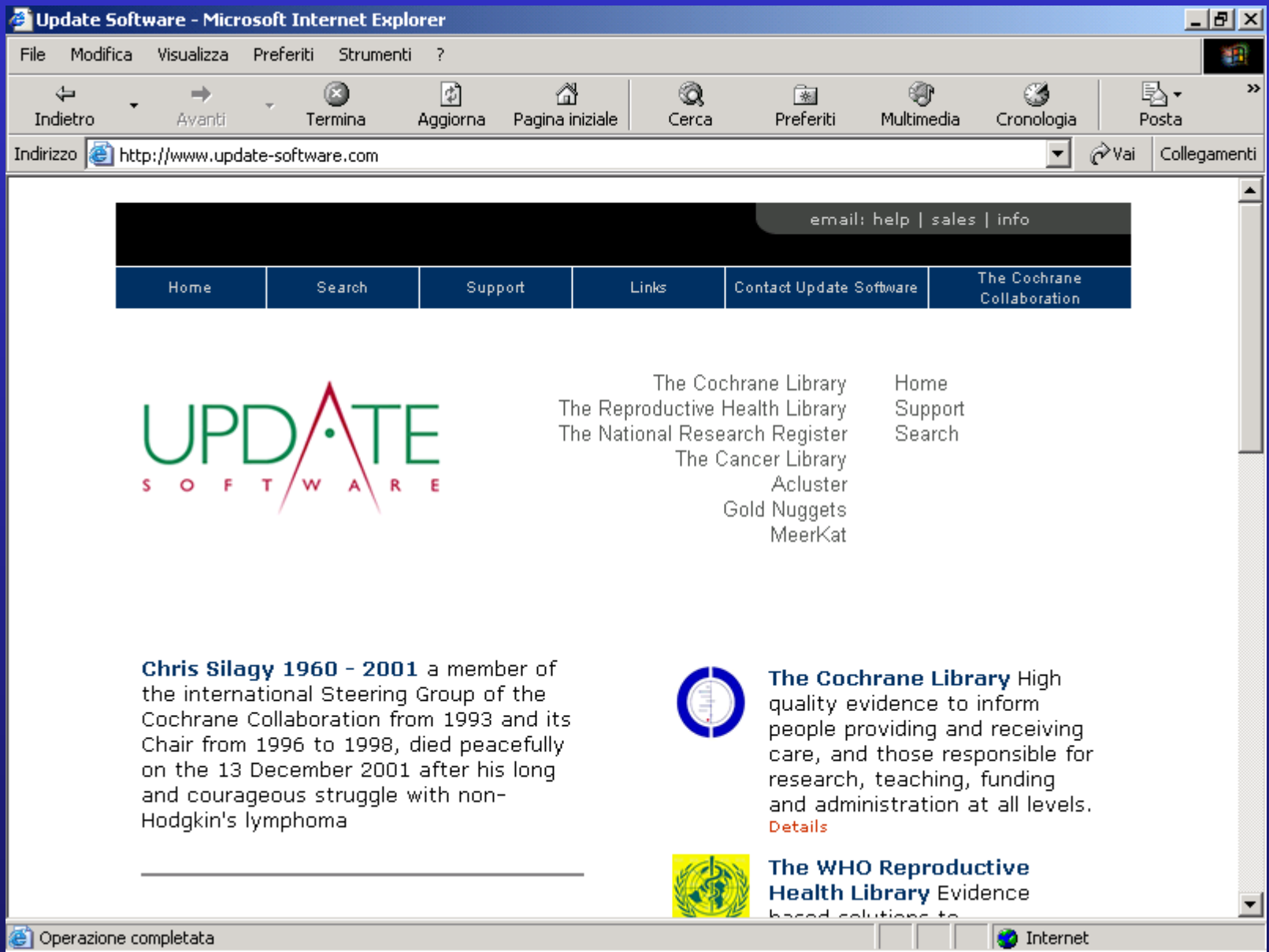
Taken together, these findings indicate that elevated psychiatric symptoms are risk factors for continued high risk behavior, as well as for seroconversion. The data add to those of Brooner and colleagues (1993), who demonstrated that ASPD serves as a risk factor for HIV infection.

The fact that antisocial personality disorder and psychiatric severity are associated with risky behavior and with actual HIV infection further expands earlier findings showing that these two factors are associated with poorer treatment outcome.

Other axis II disorders (e.g., borderline or narcissistic), as well as other axis I disorders with high symptom levels that were not well represented in these studies (schizophrenia, manic depressive illness), may also show similar elevated rates of risky behavior and seroconversion, although there is a scarcity of data currently available to assess the risk behavior of these patients

2 Implementing

	Resources
1	The Cochrane Library
2	PubMed (Internet Medline)
3	Embase
4	PsycInfo
5	Biological Abstracts
6	Cinahl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Chris Silagy 1960 - 2001 a member of the international Steering Group of the Cochrane Collaboration from 1993 and its Chair from 1996 to 1998, died peacefully on the 13 December 2001 after his long and courageous struggle with non-Hodgkin's lymphoma
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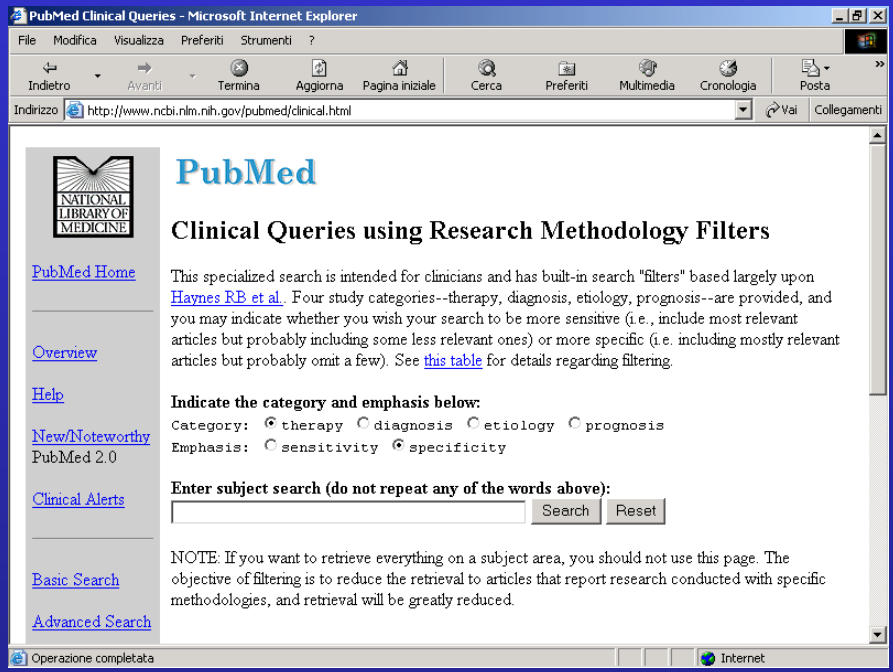
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Indicate the category and emphasis below:
Category: therapy diagnosis etiology prognosis
Emphasis: sensitivity specificity
Enter subject search (do not repeat any of the words above):
Search Reset
NOTE: If you want to retrieve everything on a subject area, you should not use this page. The objective of filtering is to reduce the retrieval to articles that report research conducted with specific methodologies, and retrieval will be greatly reduced.
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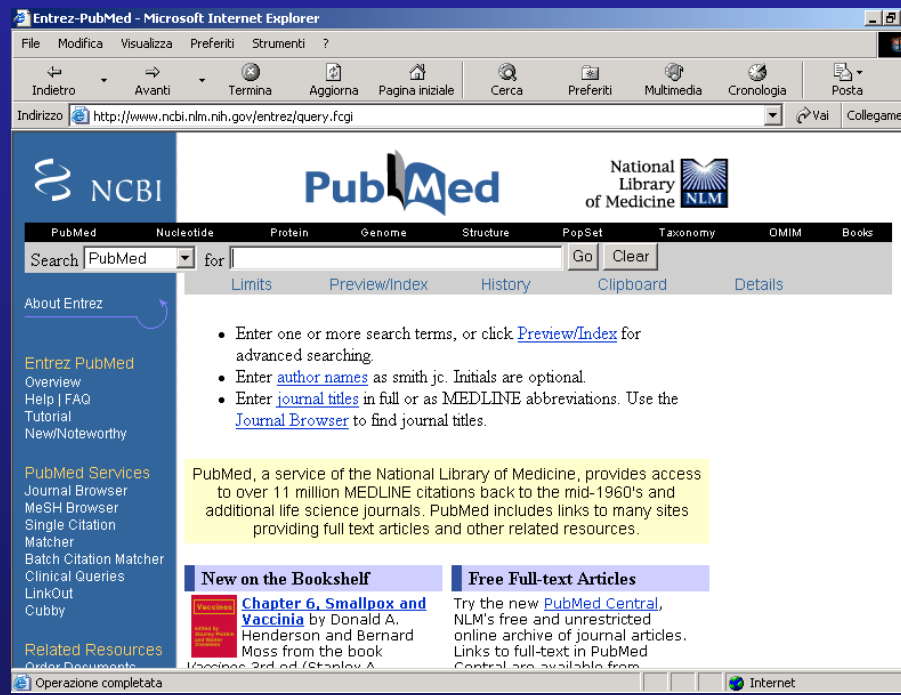
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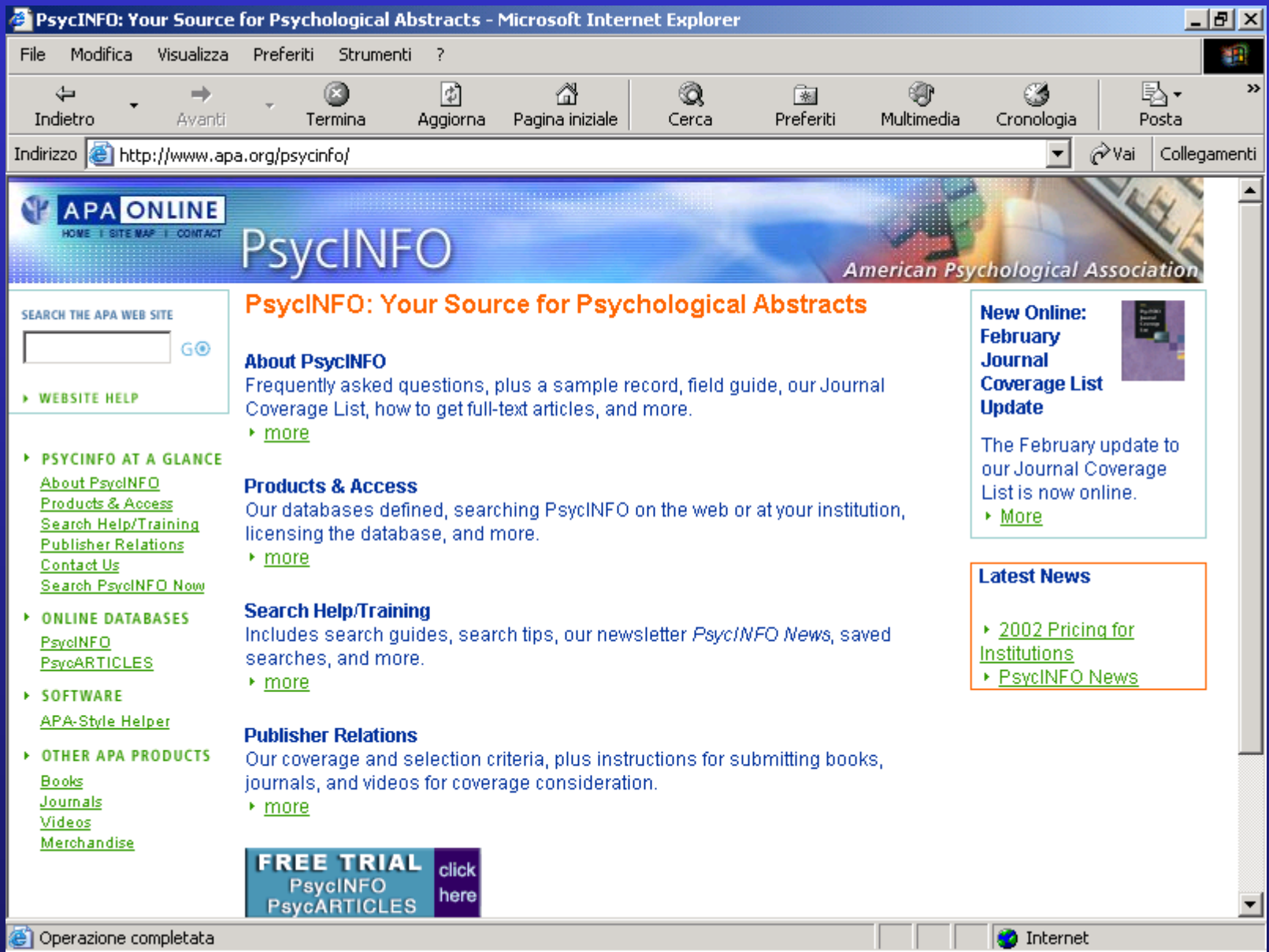
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The NeLMH is one of the first virtual branch libraries of the National electronic Library for Health (NeLH), an initiative announced in the Government's Information for Health strategy. The NeLMH is also one of the main areas of focus for the Mental Health Information Strategy announced in the National Service Framework for Mental Health.
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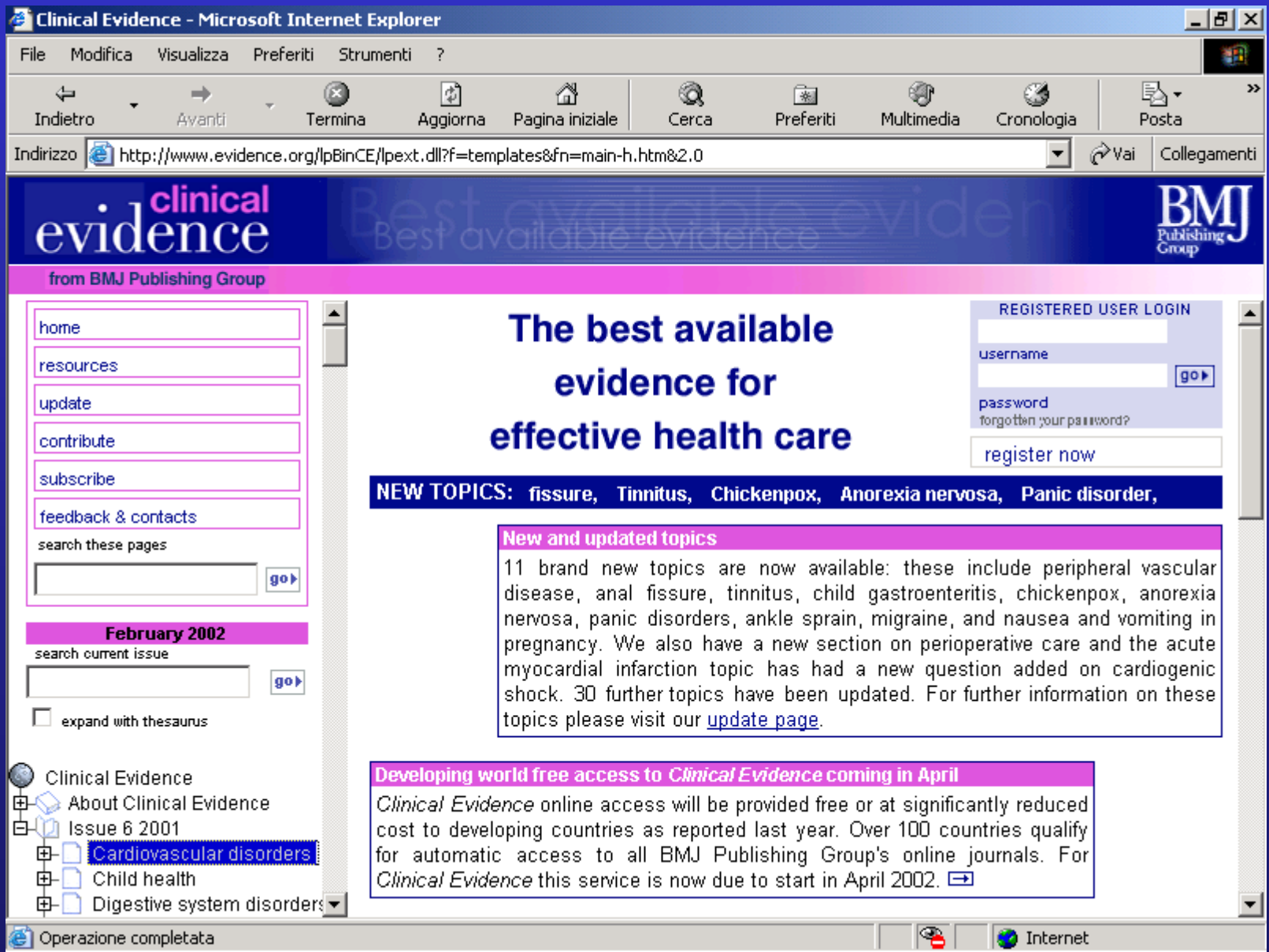
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Compton WM , Cottler LB , Ben-Abdallah A , Cunningham-Williams R , Spitznagel EL, The effects of psychiatric comorbidity on response to an HIV prevention intervention. Drug Alcohol Depend, 58(3): 247-57 2000

Drug abusers with psychiatric comorbidity are at high risk for becoming exposed to HIV. To address this compelling public health issue, our randomized HIV prevention study compares the effectiveness of the NIDA standard HIV testing and counseling protocol to a four session, peer-delivered, educational intervention for out-of-treatment cocaine users with and without antisocial personality disorder (ASPD) and major depression. Among the 966 out-of-treatment cocaine users who have completed the 3 month follow-up, all groups, regardless of assignment to standard vs. peer-delivered intervention or psychiatric status, improved significantly in: crack cocaine use, injection drug use, number of IDU sex partners and overall number of sex partners, but not in condom use. Nevertheless, when stratified by psychiatric status, ASPD was associated with significantly less improvement in crack cocaine use ($P = 0.04$) and with a trend for less improvement in having multiple sex partners and having IDU sex partners ($P = 0.06$ and 0.08, respectively). ASPD status was not associated with change in injection drug use or condom use. Depression was associated with a trend ($P = 0.07$) for greater improvement in crack cocaine use but not in any of the other behaviors. When examining the standard and peer intervention groups separately, no consistent differences in the association of psychiatric comorbidity with outcome were discerned between the two groups. We conclude that persons with ASPD and depression respond well to standard HIV prevention interventions, but these psychiatric disorders respectively attenuate and enhance response somewhat. Behavioral interventions tailored for persons with these conditions may be indicated if long-term change in HIV risk behaviors is to be achieved.

Research architecture

Research architecture

TYPES OF EPIDEMIOLOGICAL AND CLINICAL RESEARCH	
Observational studies	
Descriptive studies	Case reports
	Case series
	Cross-sectional studies sample (eg prevalene stuides)
	Outcome (or prognosis) studies
Analytic studies	Population
	Individuals
Intervention studies	
Uncontrolled intervention studies	
Controlled intervention satudies	Single case (N of 1) expèerimental designs
	Controlled clinical trials
	Randomized controlled trials

Descriptive studies	Case reports	
	Case series	Is a report on a group of patients without a control group
	Cross-sectional studies sample (eg prevalene stuides)	A defined population is observed for a presence/absence of an outcome of interest and possibile risk factors at a single poit in time or time intervl
	Outcome (or prognosis) studies	
Analytic studies	Population	
	Individuals	

Uncontrolled intervention studies		
Controlled intervention satudies	Single case (N of 1) expèerimental designs	
	Controlled clinical trials	
	Randomized controlled trials	A RCT is a trial in which a group of patients is randomized to either an experiemntal group (or groups) or a control group. The process of randomisation seeks to equalise all possibile prognostic factors, known and unknown, between the group, that is to reduce the risk of the results being due to counfonding factors. It should be noted that not alla stuidies described as randomized have been truly randomized.