NHS Education for Scotland

The Matrix Evidence Tables

AND HOW TO USE THEM

CLICK ANYWHERE TO CONTINUE

The Scottish Government

INTRODUCTION TO THE EVIDENCE TABLES AND HOW TO USE THEM

THE DEVELOPMENT OF 'THE MATRIX' - EVIDENCE TABLES

THE MATRIX IS INTENDED TO PROVIDE A SUMMARY OF THE INFORMATION ON THE EVIDENCE BASE FOR THE EFFECTIVENESS OF PARTICULAR PSYCHOLOGICAL THERAPIES FOR PARTICULAR SERVICE USER GROUPS.

Given that the evidence base for many common mental health problems has already been interrogated using a transparent and rigorous process in the production of the various SIGN and NICE guidelines, it was decided that these published documents would form the basis of the Matrix tables.

Within each diagnostic classification the evidence from the various guidelines was collated by specialists in that area, and further input was sought from individuals with identified expertise, and from the members of the Scottish Government Psychological Therapies Group.

Psychological therapies play a particularly important role in mental health services for children and young people. Although this remains an under-researched area compared to mental health overall, much of the evidence of 'what works for whom' in relation to children and young people comes from the psychological therapies literature.

It is also the case that various forms of psychological therapy contribute to "generic" CAMHS clinical practice, given the need for clinicians to develop skills in communicating effectively, for example, with small children or with families.

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HOW TO USE 'THE MATRIX' EVIDENCE TABLES

EFFECTIVENESS AND COST-EFFECTIVENESS

THE EVIDENCE BASE FOR ANY INTERVENTION, AS CURRENTLY DEFINED IN SIGN AND NICE GUIDELINES, WILL GENERALLY TELL US ONE OF THREE THINGS:

ONE That there is evidence in the literature for the effectiveness of that intervention;

AND

If this is the case the intervention will then be ranked on the quality of the available evidence.

TWO That there is no evidence in the literature for the effectiveness of that intervention. It is recognised that the absence of robust evidence for any particular approach does not prove that the approach is ineffective-it may simply be that the evidence has not yet been collected. However, in an environment where resources are limited it is prudent to focus on where we can have the greatest confidence in the maximum return for our investment.

THREE That there is evidence in the literature that the particular intervention is ineffective, or indeed harmful

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In the first and last cases the implications are clear:

- NHS Boards should provide interventions for which there is good evidence of effectiveness; and.
- Clearly, where an intervention has been proven ineffective or harmful, it should not be provided within the NHS.

Where little or no evidence has been collected, however, then there needs to be some flexibility of approach. In a number of areas, for example, there are longstanding services which are recognized as being of benefit to patients in spite of the lack of a tradition of collecting evidence in a way which would be recognised by SIGN or NICE.

There is no suggestion that these services should be summarily dismantled, but it is crucial that NHS Boards begin to collect their own good quality evidence around the effectiveness of such services. Not only is this essential for good governance, but it will contribute to the wider evidence base, and help ensure that what we invest in is effective in the longer term.

When using the tables as an aid to strategic planning, it is important to start off by scoping local expertise, and building on the experience already available. However, services need to be able to demonstrate that they are working towards providing evidence-based services in a developmental way.

IT IS CRUCIAL THAT NHS BOARDS BEGIN TO COLLECT THEIR OWN GOOD QUALITY EVIDENCE

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Where two or more treatment options are comparable in terms of effectiveness, then issues of cost-effectiveness should be considered. Factors which need to be taken into account include:

- the cost of treatment in terms of therapist time and other resources, taking account models of service delivery and the number of people who can be treated effectively within a specific time period;
- the investment required in training staff to deliver the intervention, taking into account levels of skills/knowledge already available within the system;
- the sustainability of the training and supervision necessary to maintain the service in the long term;
- the efficiency of training a particular staff group i.e. what percentage of time the trained staff are able to deliver the intervention within the service;
- the capacity of the system; and
- issues of patient choice.

IT IS IMPORTANT TO START OFF BY SCOPING LOCAL EXPERTISE, AND BUILDING ON THE EXPERIENCE ALREADY AVAILABLE

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WHICH THERAPIES?

AT SCOTTISH GOVERNMENT LEVEL THE STRATEGIC FOCUS HAS BEEN ON CBT IN THE FIRST INSTANCE BECAUSE IT IS THE THERAPEUTIC MODALITY WHICH CURRENTLY HAS THE WIDEST EVIDENCE BASE AND IS MOST CITED IN THE LITERATURE.

A strong CBT foundation will put NHS Boards in a good position both to provide many of the 'high intensity' interventions cited in the evidence tables , and to deliver psychological interventions at the 'low intensity' level appropriate for mild/moderate mental health problems. Most of the evidence-based 'low intensity' options, including self-help, problem- solving and computerised or online packages, are CBT based.

CBT, however, is not effective in every case, and beyond this it is expected that the requirement to provide safe and effective therapy across the range of common mental health problems, and to offer a choice of interventions where possible, will drive the provision of a wider range of evidence-based therapeutic approaches.

It is not expected that NHS Boards will provide all of the therapeutic approaches recommended in the tables for any particular patient group. The Psychological Therapies they choose to provide will be guided by:

- the services they already have;
- the expertise available locally; and
- the advice of the local Psychological Therapies planning group.

It is important that service users and careers are engaged meaningfully in this decision making process, and that issues of patient preference are given due consideration.

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It is also crucial that the field of Psychological Therapy continues to evolve, and we want to avoid the situation where either therapeutic advances or innovative service developments are stifled by the rigid application of current guidelines. Trials of new therapies, or of new applications of existing therapies, will generally be organized by national research networks, and local Psychological Therapies planning groups can contribute to this process by facilitating access to patients.

Local groups can also encourage service innovation, based on the evidence as it currently stands, and support the robust evaluation of new projects. However, the interests of service users must remain paramount, and appropriate research protocols must be adopted wherever innovative approaches are being trialled.

THE INTERESTS OF SERVICE USERS MUST REMAIN PARAMOUNT, AND APPROPRIATE RESEARCH PROTOCOLS MUST BE ADOPTED

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DEFINITIONS USED IN THE TABLES

LEVEL OF SEVERITY	A description of the level of severity of mental illness or disorder and an indicator of potential level of functioning.
LEVEL OF SERVICE	Where service users are most likely to be treated most effectively.
INTENSITY OF INTERVENTION	Low intensity interventions are standardised interventions aimed at transient or mild mental health problems with limited effect on functioning. High Intensity / specialist interventions denotes a formal psychological therapy delivered by a relatively specialist psychological therapist and are aimed at common mental health problems with more significant effect on functioning.
WHAT INTERVENTION?	The interventions are those that are recommended by guideline development groups such as NICE and SIGN.
LEVEL OF EVIDENCE	This is the level of evidence of efficacy that is reported in published national guidelines.

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RECOMMENDATIONS FOR PSYCHOLOGICAL THERAPIES

GRADING THE EVIDENCE

WHERE AVAILABLE, SIGN OR NICE GUIDELINES ARE USED TO COMPLETE THE TABLES FOR EACH DISORDER.

We are aware that different guidelines use different systems for grading evidence. We have therefore used a unified system for grading evidence and making recommendations. See Table X Grading of Evidence and Recommendations.

TABLE X. GRADING OF EVIDENCE (A) AND RECOMMENDATIONS (B)

(A) GRADING OF EVIDENCE

SIGN	NICE	Matrix
A At least one meta-analysis, systematic review, or RCT rated as 1++, and directly applicable to the target population; or A body of evidence consisting principally of studies rated as 1+, directly applicable to the target population, and demonstrating overall consistency of results	A At least one randomised controlled trial as part of a body of literature of overall good quality and consistency addressing the specific recommendation (evidence level-I) without extrapolation	A At least one high quality meta-analysis or systematic review, or RCT of high quality aimed at target population

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(A) GRADING OF EVIDENCE (CONT)

SIGN	NICE	Matrix
B A body of evidence including studies rated as 2++ (i.e. High quality systematic reviews of case control or cohort studies, directly applicable to the target population, and demonstrating overall consistency of results; or…	B Well-conducted clinical studies but no randomised clinical trials on the topic of recommendation	B Well-conducted non randomized clinical studies or RCT of lower quality on the topic of recommendation directly applicable to the target population, and demonstrating overall consistency of results
C A body of evidence including studies rated as 2+ (i.e. well conducted case control or cohort studies with a low risk of confounding or bias, directly applicable to the target population and demonstrating overall consistency of results	C Expert committee reports or opinions and/or clinical experiences of respected authorities (evidence level IV). This grading indicates that directly applicable clinical studies of good quality are absent or not readily available	C Expert opinions and/or clinical experiences of respected authorities

(B) RECOMMENDATION

A	HIGHLY RECOMMENDED
B	RECOMMENDED
C	NO EVIDENCE TO DATE BUT OPINION SUGGESTS THAT THIS THERAPY MIGHT BE HELPFUL

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