BJPsych | The British Journal of Psychiatry (2019) 214, 52–54.

Correspondence

Edited by Kiriakos Xenitidis and Colin Campbell

Contents

Psychiatry does need more randomised controlled trials

In their editorial, Duncan *et al* claim that 'Conventional approaches to evidence that prioritise randomised controlled trials appear increasingly inadequate for the evaluation of complex mental health interventions'.[1] Nothing could be further from the truth. The exaggerated distinctions presented between research in psychiatry and that in the rest of medicine are in a long tradition of special pleading that does our discipline no favours.

Randomised controlled trials (RCTs) seek to identify what works for whom – careful identification of the target population and appropriate outcome measures are key to all successful trials. Their findings do, indeed, 'apply to groups …not equally to everyone' – clinicians are still needed to interpret and apply their findings. RCTs do not seek to substitute for the exploration of mechanisms, nor the creative development of alternative approaches to treatment. Their purpose is to reduce persisting doubts about the effectiveness or otherwise of an intervention. If there are no doubts they are not needed. But where there is doubt about treatment effects (highly likely in the long-term relapsing–remitting disorders in psychiatry with their probabilistic outcomes over extended periods) their superiority has proved itself time and time again. One simply needs to observe the staggering improvements in evidence-based medicine over the past 50 years.

The authors' implication that in general medicine trials are so much simpler, interventions less complex, or treatments less 'personalised' would receive a dusty response from our colleagues in oncology or cardiology. Where interventions are complex they need to be carefully dissected to determine what is potentially effective and what is potentially redundant. Such hard-nosed examination is sorely needed in psychiatry and it can be highly productive in its own right, even without RCTs to test core components.

Psychiatry is not handicapped by the dominance of 'positivistic' research favouring RCTs and systematic reviews. On the contrary it is handicapped by there not being anywhere near enough of them, and not enough weight being given to their results. In their contrast between 'realist' and 'positivist' research the authors omit to acknowledge what Karl Popper considered scientific method's cardinal virtue – its ability to falsify hypotheses.[2]

Rigorously designed and conducted RCTs have an almost unique power to reverse strongly held clinical convictions. It was Acker *et al*'s 1957 RCT that ended insulin coma's two decades of dominance in schizophrenia treatment.[3] Twice I have been forced, painfully, to abandon cherished beliefs when confronted by RCT evidence. Assertive community treatment teams did not, despite my enthusiasm and commitment to it, deliver superior care to community mental health teams,[4,5] nor do community treatment orders stabilise severe psychosis in the community.[6,7] Would the proposed realist studies have anything like the power of RCTs to achieve this?

Our current demand is for parity of esteem. We are more likely to get equal respect and funding if our practice matches that of our medical colleagues. Holding psychiatry's practice to the same rigorous standards in research will go a long way to establishing society's trust and, through that, genuine parity of esteem for our profession and patients.

1 Duncan C, Weich S, Fenton SJ, Twigg L, Moon G, Madan J, et al. A realist approach to the evaluation of complex mental health interventions. *Br J Psychiatry* 2018; **213**: 451–3.

2 Popper K. *The Logic of Scientific Discovery*. Routledge, 1959.

3 Ackner B, Harris A, Oldham A. Insulin treatment of schizophrenia; a controlled study. *Lancet* 1957; **272**: 607.

4 Burns T, Creed F, Fahy T, Thompson S, Tyrer P, White I. Intensive versus standard case management for severe psychotic illness: a randomised trial. *Lancet* 1999; **353**: 2185–9.

5 Burns T, Catty J, Dash M, Roberts C, Lockwood A, Marshall M. Use of intensive case management to reduce time in hospital in people with severe mental illness: systematic review and meta-regression. *BMJ* 2007; **335**: 336.

6 Burns T, Rugkåsa J, Molodynski A, Dawson J, Yeeles K, Vazquez-Montes M, et al. Community treatment orders for patients with psychosis (OCTET): a randomised controlled trial. *Lancet* 2013; **381**: 1627–33.

7 Kisely S, Hall K. An updated meta-analysis of randomized controlled evidence for the effectiveness of community treatment orders. *Can J Psychiatry* 2014; **59**: 561–4.

Tom Burns, Professor of Social Psychiatry Emeritus, Oxford University, UK. Email: tom.burns@psych.ox.ac.uk

doi:10.1192/bjp.2018.216

Authors' reply

We would like to thank Professor Burns for his thoughtful reply to our recent editorial and we are grateful for this opportunity to respond. To clarify: we would be happy to see more RCTs in psychiatry, but only as one form of evidence among others. Interestingly, the same work of Karl Popper referred to in the reply is drawn on by a leading proponent of realism to support such a position.[1]

Professor Burns gives two examples of RCTs of complex interventions to demonstrate their value. Our view of the implications of these trials is, unsurprisingly, different. We find it hard to believe that assertive community treatment teams and community treatment orders are not effective for anyone, anywhere, or in any way. And although we agree with Professor Burns that the scarcity of trials evidence is problematic – in the case of community treatment orders, there have only been three RCTs with a total sample size of 749 patients[2] – we also believe that RCTs alone will never be the whole answer.

Rather than privileging a method designed to estimate singular 'average treatment effects' and whether a treatment does or does not 'work', we would argue that a more sensible way to proceed is to develop approaches intrinsically attuned to detecting variation and difference and, most importantly, understanding what gives rise to it.[3] Where RCTs design out the effects of context, realist approaches see this as key.

We agree that other medical and healthcare specialities rely on evidence for the effectiveness of complex interventions. But what distinguishes mental health is the preponderance of interventions that require human agency, and factors such as therapeutic alliance, empathic communication and motivation:

https://doi.org/10.1192/bjp.2018.216 Published online by Cambridge University Press