Evaluation FastFacts

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This is one in a series of briefings on new and current mental health services evaluations, resources, and methods. We hope FastFacts will be a quick and easy way for you to learn important information in the field of evaluation. If you have any ideas on how FastFacts could be more useful to you, please contact Dow Wieman, Ph.D. at 617-876-0426 x2503 or dwieman@hsri.org.

Clinical Evidence Concise: A Model for Dissemination of Evidence-Based Treatment in Behavioral Health Care?

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THE PUSH TO DEVELOP AND IMPLEMENT EVIDENCE-BASED PRACTICES (EBPs) continues to gain force throughout the behavioral health care field. High-profile policy initiatives such as the President's New Freedom Commission on Mental Health, as well as policy makers at every level, private foundations, researchers, advocates, providers, and consumers are moving evidence-based practices to the head of the agenda for mental health systems change.

Goal 5 of the President's Commission Report states, "In a transformed mental health system, research will be used to develop new evidence-based practices to prevent and treat mental illnesses. These discoveries will be immediately put into practice." The emphatic tone of the second sentence conveys a strong message about what should be a primary goal in the movement to promote EBPs: shortening the delay between the development of research knowl-

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The Evaluation Center@HSRI

is a technical assistance center funded by the federal Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA), and operated by the Human Services Research Institute (HRSI). The mission of the Center is to provide evaluation technical assistance to state and non-profit and private entities including, but not limited to, consumers, families and provider groups. The Center presently has six programs designed to fulfill this mission—

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edge and its implementation in the field. The President's Commission Report quotes a statement from the Institute of Medicine's report, Crossing the Quality Chasm (2001), that "the lag between discovering effective forms of treatment and incorporating them into routine patient care is unnecessarily long, lasting about 15 to 20 years." The New Freedom Commission's reference to the work of the IOM suggests the possibility that recent initiatives to disseminate evidence-based treatments in the field of medicine may offer models for behavioral health care.

MULTIPLE OBSTACLES identified by the IOM report explain why the "uptake" of research knowledge into practice historically has been so slow. The relevance of these factors for behavioral health varies, but certainly one that applies directly is the lack of easy access to the current state of knowledge, presented in usable forms. Simply stated, busy clinicians confronted with an immediate and complex patient problem, have no way to quickly acquire the information they need to make an informed decision about treatment. Overburdened and underfinanced provider organizations and public agencies have difficulty obtaining information needed to assess the benefits and tradeoffs of adopting new programs. The opportunity of consumers to choose among treatment options in the new patient-centered system envisioned by the IOM and the President's Commission will be curtailed by the unsystematic, highly technical form in which information about treatments is now available.

STUDIES OF RESEARCH AND TECHNOLOGY DISSEMINATION have demonstrated that the problem of accessibility has no one simple solution, and the IOM and other groups have proposed a wide variety of methods to overcome the problem. Space does not permit a comprehensive overview of these proposed approaches here; instead we describe one well-developed initiative in the field of medicine: Clinical Evidence Concise.

CLINICAL EVIDENCE CONCISE (CEC) is an initiative to disseminate information about treatment options for a wide range of medical conditions (now more than 160). Produced by a collaboration between the United Health Foundation and BMJ Publishing Group, the CEC is available through three media: a "pocketbook", published every six months (now in its 10th edition), a mini-CD-ROM packaged with the pocketbook, and a regularly updated website, www.clinicalevidence.com. A variety of subscription options are available, as described on the website.

CEC is designed to provide ready access to the evidence base for treatments. For each condition, CEC identifies available treatments and summarizes the evidence for each. Treatments are classified according to the relative strength of available evidence about effectiveness and safety. Categories in the classification system are: beneficial, likely to be beneficial, unknown effectiveness, ineffective or harmful, unlikely to be beneficial, and trade-off between benefits and harms. The rationale for the classification of the treatment is provided in the form of a very brief (1-2 sentence) summary of the current evidence. Each section concludes with a definition of that condition and a brief summary of findings about incidence/prevalence, etiology/risk factors and prognosis.

Though primarily medical as noted, CEC does include treatments, including psychosocial interventions, for a variety of mental health conditions including bipolar disorder, schizophrenia, depression, and others. Under schizophrenia, for example, CEC cites eight pharmacological and seven psychosocial treatments. The latter includes interventions such as psychoeducation and cognitive behavioral therapy for the purpose of re-

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ducing relapse rates or improving adherence. This section does not include less medically-oriented interventions such as ACT or supported employment.

AN IMPORTANT BENEFIT OF INCLUDING TREATMENTS FOR WHICH THERE IS LITTLE OR NO EVIDENCE OF EFFECTIVENESS is that research gaps may be readily identified. This more inclusive approach also serves consumers who are in the position of making decisions about treatment options where there are tradeoffs involving safety risks. Lastly, it serves clinicians in discussing the range of treatment options with their patients.

BY USING THE MULTIPLE MEDIA OF BOOK, CD-ROM AND WEBSITE, CEC incorporates a key finding of dissemination research, that widespread adoption of innovations requires information to be accessible through multiple channels and to be organized in multiple formats. Due to the multiplicity of users' purposes, capabilities, cognitive styles, physical environments, and individual preferences, information disseminated through a single mode, however widely, will be used only by a small proportion of the intended audience.

The CEC website and CD-ROM present all the information contained in the pocketbook, but add a variety of search options and options for choosing the desired level of detail. Thus, for schizophrenia, the CD-ROM describes the same treatment options as those in the pocket book, but the pocketbook's generic question, "What are the effects of treatments?" is expanded into more specific questions: What are the effects of drug treatments? Of treatments for people resistant to standard treatments? Of interventions to improve adherence and to reduce relapse rates? The user is able to drill down to more detailed descriptions of the relevant research, including references to published studies and hyperlinks to PubMed entries. The website also offers regular updates to conditions and treatments, as they become available. As a final access option, the CD-ROM also provides software for downloading the CEC Issue 10 to a PDA, using either Palm OS or Pocket PC platforms.

SOME APPROACHES COMPARABLE TO CEC have been initiated in the behavioral health field, and others are in various stages of development. As the pressure for increased availability of evidence based practices grows, the need for information presented in many forms and through many channels will become imperative.

References

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