

TECScript 5

Evidence-based Treatments (EBTs)

& Measuring Fidelity to EBTs

Messages from 12 January 2002 – 3 February 2002



*H. Stephen Leff, Ph.D., Jeremy Conley, B Phil.,
Theodora Campbell-Orde, MPA.; Valerie Bradley, MA
Human Services Research Institute,
Cambridge Massachusetts*

*An Unedited Compilation of Email Messages from the Outcomes
Evaluation Topical Evaluation Network (OUTCMTEN) at
outcmten@world.std.com*



Human Services Research Institute
2269 Massachusetts Avenue
Cambridge, MA 02140
www.tecathsri.org



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
www.samhsa.gov

This **TECScript** was compiled by *the Evaluation Center@HSRI*. The Center is funded through a cooperative agreement with the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. The mission of the Evaluation Center is to provide technical assistance to the evaluation of adult mental health system change.

TECScripts are one component of the **Topical Evaluations Networks (TENs) Program**. The purpose of this program is to provide mental health system stakeholders (consumers, providers, researchers and families) with the opportunity to communicate directly with each other, and with Evaluation Center associates about topics of specific interest in adult mental health system change evaluation. The Networks Program makes use of electronic mailing lists to allow subscribers who have access to the Internet to participate in ongoing discourse about the specific topics listed below.

The **TECScripts** are designed to provide interested persons with unedited compilations of email messages from the various mental health electronic mailing lists that the Evaluation Center operates. The only changes that have been made to the original messages are to correct for misspelled words. Messages are in chronological order. Time stamps are Eastern Standard Time. If the message being replied to is not the original message but is still in the same topic thread, this message is in italics and precedes the response, which is in plain text.

The Center operates four electronic mailing lists that deal with different aspects of mental health evaluation. Following are descriptions and subscribing instructions for the four lists:

- **Legal and Forensic Issues in Mental Health Topical Evaluation Network (LEGALTEN)**
The purpose of the LEGALTEN list is to facilitate the implementation and use of rigorous evaluations at the interface of the mental health system, the criminal justice system, and the courts.
- **Managed Behavioral Health Care Evaluation (MBHEVAL)** The purpose of the MBHEVAL list is to discuss the evaluation of managed care as it affects the delivery, outcomes and costs of mental health care and substance abuse treatment services at the state, local, program, or consumer level.
- **Multicultural Mental Health Evaluation (MCMHEVAL)** The purpose of the MCMHEVAL list is to foster discussion of issues related to the evaluation of mental health services for diverse cultural, racial and ethnic populations. Potential issues for discussion include measuring ethnocultural identity, cultural competence, and access to mental health services for diverse groups.
- **Outcomes Evaluation Topical Evaluation Network (OUTCMTEN)** The purpose of the OUTCMTEN list is to develop a broad collective expertise with respect to problems of assessing and analyzing outcomes of interventions aimed at improving mental health systems. The list also serves to provide assistance, information, and contacts regarding (1) issues in evaluation, (2) experimental and quasi-experimental design, (3) instrument and survey development, and (4) statistical analysis for mental health.

If you would like to subscribe to LEGALTEN, MBHEVAL, MCMHEVAL or OUTCMTEN visit the list subscription page of our web site at <http://tecathsri.org/lists-form.asp> or send an email message to:

imailsrv@tecathsri2.org

containing only the following words (leaving the subject line blank):

subscribe list name email address

For example:

subscribe legalten jones@yahoo.com

Transcripts of on-line discussions, as well as printed copies of archived documents are made available in **TECScripts** by email or mail to interested stakeholders; especially those who do not have Internet access. Visit the publications section of our web site at <http://www.tecathsri.org/pubs.asp> to view available **TECScripts**. For more information contact Clifton Chow at *the Evaluation Center*@HSRI by phone (617) 876-0426 x 2510 or by email chow@hsri.org.

H. Stephen Leff, Ph.D.

Director & Principal Investigator

Clifton Chow

Program Manager

TECScript 5: Evidence-Based Treatments
12 January 2002 – 3 February 2002

Date: Sat, 12 Jan 2002 10:46AM
From: Stephen E Beller <nhdspres@bestweb.net>

Dear colleagues,

I just read a just published article that closely reflects what I've been saying for a decade about the need for a real commitment to evidence-based treatments (EBT) in psychotherapy, and for which I've been repeatedly ridiculed, denounced, or just plain dismissed/ignored. See the closing paragraph of the article below and a link to the entire thing on Medscape.

Care to share your thoughts?

Steve Beller

<http://www.medscape.com/Medscape/psychiatry/journal/2002/v07.n01/mh0111.01.sand/mh0111.01.sand-01.html>

Are Evidence-Based Psychological Interventions Practiced by Clinicians in the Field?
Column Editor: William C. Sanderson, PhD, Rutgers University, Piscataway, New Jersey.

Closing paragraph:

“The poor record of disseminating EBTs from research settings to clinical practitioners in the field has resulted in the lack of availability of many of these treatments. Ultimately, this may have a disastrous impact on the viability of psychotherapy as the healthcare system evolves. The increasing proliferation of managed care, as well as the continued development of clinical practice guidelines and treatment consensus statements, has raised the stakes for accountability, and the failure to train practitioners in EBTs may lead to the fall of psychotherapy as a first-line effective treatment -- even though considerable data support its efficacy. If psychotherapy providers are not trained to provide EBTs, where do they fall in this new healthcare scheme? All psychotherapists should be concerned with this issue, as it is paramount to the survival of psychotherapy as a viable treatment.”

TECScript 5: Evidence-Based Treatments
12 January 2002 – 3 February 2002

Date: Sat, 12 Jan 2002 11:20AM
From: Steven Walfish, PhD <mohsw@aol.com>

Steve,

There is quite a bit of controversy (with very distinguished and reputable researchers on both sides) regarding the use of EBTs in clinical practice. After reviewing the controversy I believe that managed care companies will be treading on thin ice if they insist that clinicians use them at this time. From my perspective it is too premature. The classic psychotherapy research question posed by Hans Strupp is: What treatments, under what conditions, and with what clients are effective? I don't think EBTs are anywhere near answering these questions especially given (in my opinion) the generalizability question of clinical research to the clinical client that will show up in my office for the first time on Monday afternoon.

Just my \$.02

For interesting discussion check out this issue from Clinical Psychology: Science and Practice

<http://clipsy.oupjournals.org/content/vol6/issue4/>

Same journal but a discussion on manualized treatments

<http://clipsy.oupjournals.org/content/vol5/issue3/>

Steve

Steven Walfish Ph.D.
Bay Psychiatric Center
1823 37th Street, Second Floor
Everett, Washington 98201
(425) 252-9216

TECScript 5: Evidence-Based Treatments

12 January 2002 – 3 February 2002

Date: Sat, 12 Jan 2002 12:00PM

From: Lee B Sechrest <sechrest@u.arizona.edu>

On Sat, 12 Jan 2002 11:20AM Steven Walfish PhD <mohsn@aol.com> wrote:

Steve,

There is quite a bit of controversy (with very distinguished and reputable researchers on both sides) regarding the use of EBTs in clinical practice. After reviewing the controversy I believe that managed care companies will be treading on thin ice if they insist that clinicians use them at this time. From my perspective it is too premature. The classic psychotherapy research question posed by Hans Strupp is: What treatments, under what conditions, and with what clients are effective? I don't think EBTs are anywhere near answering these questions especially given (in my opinion) the generalizability question of clinical research to the clinical client that will show up in my office for the first time on Monday afternoon.

Just my \$.02

For interesting discussion check out this issue from Clinical Psychology: Science and Practice
<http://clipsy.oupjournals.org/content/vol6/issue4/>

Same journal but a discussion on manualized treatments
<http://clipsy.oupjournals.org/content/vol5/issue3/>

Steve

*Steven Walfish Ph.D.
Bay Psychiatric Center
1823 37th Street, Second Floor
Everett, Washington 98201
(425) 252-9216*

Steve,

You may be right in thinking that EBTs may not be the best option for all patients. In large part that may be because EBTs are not within the competencies of all therapists. But, granting that some patients may do better with other treatment modalities, how will clinicians know that to be the case? Is there any reason whatsoever to suppose that clinicians in general have, a priori, the capacity to sense what treatment approach may be better than the EBT for which there is at least some evidence? Wouldn't one expect that EBT would be tried first (after all, most of them are quite brief relative to psychodynamic--yeah, just leave the typo in there--"therapy")? If someone goes to a physician with a medical problem, one certainly does not expect that the physician will begin with an unproven treatment modality on the grounds that he or she just thinks that the proven one might not be best.

Lee

TECScript 5: Evidence-Based Treatments

12 January 2002 – 3 February 2002

Date: Sun, 13 Jan 2002 4:35PM

From: Steven Walfish, PhD <mohsw@aol.com>

On Sat, 12 Jan 2002 12:00PM Lee B Sechrest <sechrest@u.arizona.edu> wrote:

Steve,

You may be right in thinking that EBTs may not be the best option for all patients. In large part that may be because EBTs are not within the competencies of all therapists. But, granting that some patients may do better with other treatment modalities, how will clinicians know that to be the case? Is there any reason whatsoever to suppose that clinicians in general have, a priori, the capacity to sense what treatment approach may be better than the EBT for which there is at least some evidence? Wouldn't one expect that EBT would be tried first (after all, most of them are quite brief relative to psychodynamic--yeah, just leave the typo in there--"therapy")? If someone goes to a physician with a medical problem, one certainly does not expect that the physician will begin with an unproven treatment modality on the grounds that he or she just thinks that the proven one might not be best.

Lee

Lee,

Let me preface my remarks by saying that I primarily do brief cognitive behavior therapy with my clients. For people that I see more than once, two thirds are done in 6 sessions or less, 80% in ten sessions or less. On the other hand I have seen a few people for years and counting.

That being said, I think there is something to be said for first trying EBTs with a client, if and only if one thinks the client will respond to it. Using your medical example, this past week one of my clients was evaluated to see if medication would be helpful for her symptoms. She was prescribed an antidepressant and also a small dose of an antipsychotic (not because she was crazy, but rather to help with flooding of emotions and sleep). However, the prescriber failed to take into consideration that the client also had Restless Leg Syndrome and the antipsychotic made this condition flare up worse. Modifications then had to be made. My personal belief is that I think the same is true for implementing EBTs. My problem with the EBT studies, as eloquently written by others, is that the clients that appear in my office will only sometimes fit the clinical profile of those who were part of the therapeutic trial. There are so many rule outs in clinical research (e.g., no secondary diagnosis, no psychosis, no active use of alcohol or drugs, no history of brain trauma) that for the most part they don't look the same as the vast majority of my clients. Not that these principles may not apply in some way to their treatment, but I believe that I would be neglectful for not taking these other factors into consideration.

In addition, clinicians should have an idea of what treatment approach should be helpful based on their assessment of the client and a knowledge of their history. Of course while clinicians, as a whole, do believe they are capable of doing this I am not sure this is true. I also believe that clinicians overestimate their abilities (probably myself included!). If you have any interest (and a student available to help out) I have an easy way to test this hypothesis. If so please let me know. Steve

TECScript 5: Evidence-Based Treatments
12 January 2002 – 3 February 2002

Date: Mon, 14 Jan 2002 10:23AM

From: Geoffrey Gray <ggray@oqsystems.com>

On Sat, 12 Jan 2002 12:00PM Lee B Sechrest <sechrest@u.arizona.edu> wrote:

Steve,

You may be right in thinking that EBTs may not be the best option for all patients. In large part that may be because EBTs are not within the competencies of all therapists. But, granting that some patients may do better with other treatment modalities, how will clinicians know that to be the case? Is there any reason whatsoever to suppose that clinicians in general have, a priori, the capacity to sense what treatment approach may be better than the EBT for which there is at least some evidence? Wouldn't one expect that EBT would be tried first (after all, most of them are quite brief relative to psychodynamic--yeah, just leave the typo in there--"therapy")? If someone goes to a physician with a medical problem, one certainly does not expect that the physician will begin with an unproven treatment modality on the grounds that he or she just thinks that the proven one might not be best.

Lee

The emphasis on psychosocial interventions seems misplaced. Increasingly patients seek pharmacological treatment, e.g. in 1987 only 37 % of patients received antidepressants for depression, by 1997 (after the intro of ssris) 75% were receiving antidepressants while the percent receiving psychotherapy declined from 71% to 60%. The proportion of patients treated by physicians also increased to 87% from 69% (JAMA, 2001). Adult patients increasingly understand their problems as akin to general medical disorders--disorders of the brain rather than problems of the mind. Psychotherapeutic modalities account for only about 10-15% of the variance in outcome and most data suggest that most brief therapies result in equivalent outcomes. Since most psychological problems rising to the medical necessity level require medication as a first line treatment (surely 80% or more) it would seem that a useful strategy would be to focus on medication treatment as well as combined medication and psychotherapeutic treatment and not psychological treatment alone.

TECScript 5: Evidence-Based Treatments

12 January 2002 – 3 February 2002

Date: Mon, 14 Jan 2002 11:12AM

From: Robin Jenkins <rjenkins@cccommunicare.org>

On Mon, 14 Jan 2002 10:23AM Geoffrey Gray <ggray@oqsystems.com> wrote:

The emphasis on psychosocial interventions seems misplaced. Increasingly patients seek pharmacological treatment, e.g. in 1987 only 37 % of patients received antidepressants for depression, by 1997 (after the intro of ssris) 75% were receiving antidepressants while the percent receiving psychotherapy declined from 71% to 60%. The proportion of patients treated by physicians also increased to 87% from 69% (JAMA, 2001). Adult patients increasingly understand their problems as akin to general medical disorders--disorders of the brain rather than problems of the mind. Psychotherapeutic modalities account for only about 10-15% of the variance in outcome and most data suggest that most brief therapies result in equivalent outcomes. Since most psychological problems rising to the medical necessity level require medication as a first line treatment (surely 80% or more) it would seem that a useful strategy would be to focus on medication treatment as well as combined medication and psychotherapeutic treatment and not psychological treatment alone.

I would personally argue that although patients are being seen more for pharmacological intervention, it is as much the "science" of psychiatry, and the reimbursement system, that pushes folk into medical/medication interventions as them "seeking antidepressants for depression" (+ our cultural bent on wanting an immediate "fix", or pill, to solve our problems). Clearly, the empirical work justifies combined (drug-psychotherapeutic) approaches; the field results from SSRIs are impressive, and argue for their use in a significant number of depressive episodes. Additionally, however, and esp. in the public sector, the driving dynamics of practice reinforce for the medical providers that you get paid most efficiently by prescription and numbers served, not by number of psychological problems alleviated. The "medical necessity" requirement for documentation of payment in managed and public health care is the standard by which this dynamic is further reinforced. So I'm not convinced that this trend as reported in JAMA is consumer driven, as much as it is by our own "system" of providing care for those who seek it.

While I strongly support the combined approach based on the literature and field results, the statement "Since most psychological problems rising to the medical necessity level require medication as a first line treatment (surely 80% or more)... is a bit far reaching, IMHO. Most psychological problems requiring meds???? Again, our science has documented combined approaches in many forms and approaches; but I don't think I'm ready to say that psychological disorders and medical necessity are mutually inclusive constructs. One is a permutation of QA/QI and managed care, the other the development of emotional/psychosocial/biological problems.

Robin Jenkins, Ph.D.

Cumberland County CommuniCare, Inc.

www.cccommunicare.org

TECScript 5: Evidence-Based Treatments
12 January 2002 – 3 February 2002

Date: Mon, 14 Jan 2002 11:46AM

From: Dave Colton <dcolton@ccca.state.va.us>

I think it might be helpful to define what is meant by evidence-based treatment. From what I've seen of clinical protocols, most are open-ended, suggesting a variety of approaches, based on the clinician's assessment of the client's needs and situation. A managed care organization's limiting of types of treatments that are less costly (as compared to cost effective) is quite different than research based treatment that suggests effective outcomes across a population.

David Colton, Ph.D. (for the record, I'm not a clinical psychologist)
Commonwealth Center for Children and Adolescents
Staunton, Virginia 24401
Telephone: 540-332-2144
dcolton@ccca.state.va.us

TEC*Script* 5: Evidence-Based Treatments
12 January 2002 – 3 February 2002

Date: Mon, 14 Jan 2002 11:50AM

From: Cynthia Jonsson <jonssonc@idhw.state.id.us>

I agree that evidence based treatment interventions should be used as a guide. For SPMI (seriously persistently mentally ill) I have found that practitioners who do not use research-based models get more reactionary and less strategic. Chart notes reflect this. What should be opportunities for skill-building (especially in Psychosocial Rehab) turns into advice-giving chats? My experience has been that with this population, practitioners get better outcomes if their interventions follow practice guidelines and/or research based models.

TECScript 5: Evidence-Based Treatments

12 January 2002 – 3 February 2002

Date: Mon, 14 Jan 2002 12:24PM

From: Geoffrey Gray <ggray@oqsystems.com>

On Mon, 14 Jan 2002 11:12AM Robin Jenkins <rjenkins@cccommunicare.org> wrote:

I would personally argue that although patients are being seen more for pharmacological intervention, it is as much the "science" of psychiatry, and the reimbursement system, that pushes folk into medical/ medication interventions as them "seeking antidepressants for depression" (+ our cultural bent on wanting an immediate "fix", or pill, to solve our problems). Clearly, the empirical work justifies combined (drug-psychotherapeutic) approaches; the field results from SSRIs are impressive, and argue for their use in a significant number of depressive episodes. Additionally, however, and esp. in the public sector, the driving dynamics of practice reinforce for the medical providers that you get paid most efficiently by prescription and numbers served, not by number of psychological problems alleviated. The "medical necessity" requirement for documentation of payment in managed and public health care is the standard by which this dynamic is further reinforced. So I'm not convinced that this trend as reported in JAMA is consumer driven, as much as it is by our own "system" of providing care for those who seek it.

While I strongly support the combined approach based on the literature and field results, the statement "Since most psychological problems rising to the medical necessity level require medication as a first line treatment (surely 80% or more)... is a bit far reaching, IMHO. Most psychological problems requiring meds???? Again, our science has documented combined approaches in many forms and approaches; but I don't think I'm ready to say that psychological disorders and medical necessity are mutually inclusive constructs. One is a permutation of QA/QI and managed care, the other the development of emotional/ psychosocial/ biological problems.

Robin Jenkins, Ph.D.

Cumberland County CommuniCare, Inc.

www.cccommunicare.org

I think it is a mistake to assume the moral superiority of psychotherapy, to view it as the preeminent road to well being. Many mental health service users are not interested in talking about their problems, they want to take a pill in order to feel better as quickly as possible. Is that benighted? It may be, but I don't think it is proper for clinicians to impose their prejudices on the consumer.

TECScript 5: Evidence-Based Treatments

12 January 2002 – 3 February 2002

Date: Mon, 14 Jan 2002 12:45PM

From: Paul Cook <pcook@scriptassistllc.com>

On Mon, 14 Jan 2002 10:23AM Geoffrey Gray <ggray@oqsystems.com> wrote:

The emphasis on psychosocial interventions seems misplaced. Increasingly patients seek pharmacological treatment, e.g. in 1987 only 37 % of patients received antidepressants for depression, by 1997 (after the intro of ssris) 75% were receiving antidepressants while the percent receiving psychotherapy declined from 71% to 60%. The proportion of patients treated by physicians also increased to 87% from 69% (JAMA, 2001). Adult patients increasingly understand their problems as akin to general medical disorders--disorders of the brain rather than problems of the mind. Psychotherapeutic modalities account for only about 10-15% of the variance in outcome and most data suggest that most brief therapies result in equivalent outcomes. Since most psychological problems rising to the medical necessity level require medication as a first line treatment (surely 80% or more) it would seem that a useful strategy would be to focus on medication treatment as well as combined medication and psychotherapeutic treatment and not psychological treatment alone.

This JAMA article is interesting in that it shows a much larger number of patients overall (6.3 million in 1997, compared to 1.7 million in 1987) receiving treatment for depression. Of those who receive treatment, the proportion treated with medication doubled. Both data points are based on large-scale patient surveys.

There are probably multiple explanations for these findings (direct-to-consumer marketing of SSRIs, increased patient demand for a "quick fix," etc.), but better efficacy of medication is not one that the research supports. In terms of long-term effects (which managed care companies may or may not be interested in), psychotherapy produces better results.

A more parsimonious explanation for the JAMA findings is that the availability of new medications led to more "case-finding" in primary care settings. It may be that physicians always knew their patients were depressed, but didn't bring it up because they didn't feel there was anything they could do about it; or that increased pharma marketing of antidepressants has led to a greater awareness of depression among physicians (or among patients, who then request treatment from their PCP). If a case of depression is identified in primary care, the physician probably prescribes medication--because that is what he/she is most comfortable with, because he/she is not comfortable making a referral to behavioral health, or because he/she is not familiar with EBTs as a treatment option. If more depressed patients are identified in primary care, but there is no corresponding increase in the identification and treatment of depression through other means, then we have (a) a genuine increase in the total number of depressed patients treated, and (b) a genuine increase in the number of patients who receive antidepressant treatment, but (c) an artifactual increase in the _percentage_ of all depressed patients who receive antidepressant treatment.

Paul Cook, Ph.D.

P.S. It seems strange to argue that medication is needed whenever depression is severe enough to warrant "medically necessary" treatment. All of the randomized clinical trials of psychotherapy for depression are based on patients with diagnosable DSM disorders, and demonstrate therapy's ability to treat this condition without medication (although there may be benefits of using the two together).

TEC*Script* 5: Evidence-Based Treatments

12 January 2002 – 3 February 2002

P.P.S. It's also a misrepresentation to say that "psychotherapeutic modalities account for only 10-15% of the variance in outcome." It's true, based on Lambert's research, that specific techniques or methods account for only this much of the outcome variance. However, other factors common to all psychotherapies account for a large additional proportion of the outcome variance--something like 40%. I've seen reports claiming that medication only accounts for 25%-33% of the outcome variance in depression in clinical drug trials.

TECScript 5: Evidence-Based Treatments
12 January 2002 – 3 February 2002

Date: Mon, 14 Jan 2002 1:14PM
From: William Berman <wberman@echoman.com>

On Mon, 14 Jan 2002 12:24PM Geoffrey Gray <ggray@oqsystems.com> wrote:

I think it is a mistake to assume the moral superiority of psychotherapy, to view it as the preeminent road to well being. Many mental health service users are not interested in talking about their problems, they want to take a pill in order to feel better as quickly as possible. Is that benighted? It may be, but I don't think it is proper for clinicians to impose their prejudices on the consumer.

It is my consistent experience that people who view psychotherapy as morally superior to medication either have not had a major mental illness (including severe depression), have not had a family member who has a major mental illness, or do not treat people with serious mental illnesses.

Within the past year, I have heard a licensed clinician state that it was "Too bad" that a patient was getting better on medications, because it meant they were losing motivation to work in therapy.

Bill Berman, Ph.D.

TECScript 5: Evidence-Based Treatments

12 January 2002 – 3 February 2002

Date: Mon, 14 Jan 2002 1:18PM

From: Robin Jenkins <rjenkins@cccommunicare.org>

On Mon, 14 Jan 2002 12:24PM Geoffrey Gray <ggray@oqsystems.com> wrote:

I think it is a mistake to assume the moral superiority of psychotherapy, to view it as the preeminent road to well being. Many mental health service users are not interested in talking about their problems, they want to take a pill in order to feel better as quickly as possible. Is that benighted? It may be, but I don't think it is proper for clinicians to impose their prejudices on the consumer.

Thank you for the clarification. This is, in fact, part of the point I was attempting to make. Many consumers do, for whatever reason, seek "pills" -- does that mean we should always do what's expedient? Not in my opinion. Expedience doesn't necessarily predict more positive outcomes. What if they asked for therapy only; we wouldn't suggest that either. We'd do a thorough clinical assessment, then recommend pharmacotherapy, psychotherapy, or a combination (this discussion was about depressive disorders). We wouldn't default to the "medical" or pharmacotherapeutic intervention just because we decided that the disorder had reached medical necessity criteria for treatment, nor because treatment literature shows that so many consumers are treated with SSRIs or other drugs as a "first line" treatment. I think we owe the customer to ask the question, "why is this mode of treatment so common"? Is it due to empirical clinical success; efficiency of care; consumer preference; system consequence? In the context of Evidence-based treatments, typically manualized by definition at this point, if the empirical data supported use of the approach we would recommend that approach....based on presenting symptoms and complaints, resources, family supports, etc. -- not because of what the consumer directly asked for. Surely we consider their requests and even try to honor them given the need to work collaboratively in mutual problem solving. I don't consider that passing moral judgment in favor of one approach or the other. I've seen just as many consumers negatively affected by an ineffective psychotherapeutic approach as ineffective medications. I would hope that we couch our clinical recommendations in empirical thought, juxtaposed with consumer requests and mental status among the other variables we must consider. It is my contention that our system of care, however you define that system, tends to favor the expedient (financial incentives, both for payor and payee) while keeping consumer outcomes as a stated optimal objective -- but the actual results are often very different. The same incentives affect psychotherapeutic outcomes as well.

Robin Jenkins, Ph.D.

Cumberland County CommuniCare, Inc.

www.ccccommunicare.org

TECScript 5: Evidence-Based Treatments
12 January 2002 – 3 February 2002

Date: Tue, 15 Jan 2002 4:22PM

From: Lorna Simon <lorna.simon@umassmed.edu>

On Mon, 14 Jan 2002 1:14PM William Berman <wberman@echoman.com> wrote:

It is my consistent experience that people who view psychotherapy as morally superior to medication either have not had a major mental illness (including severe depression), have not had a family member who has a major mental illness, or do not treat people with serious mental illnesses.

Within the past year, I have heard a licensed clinician state that it was "Too bad" that a patient was getting better on medications, because it meant they were losing motivation to work in therapy.

Bill Berman, Ph.D.

Thank you very much! This was just what I was getting ready to send off an e-mail about! I am one of those people who has a major mental illness, as well as family members who also have them. I have been in the position of not being referred for psychiatric evaluation by a psychologist when I was so severely depressed that I could not even get out of bed. Once a medication was prescribed, of course, I got out of bed and went about my life, although I had lost a couple of months, a semester of school and quite a few friends in the meantime. This was over 20 years ago, so it surprises me (and scares me) that there are still people in the field who think that medication is a "quick fix," or that someone should receive psychotherapy 1st. Whether someone needs psychotherapy or not (and I think in most cases they do), not referring someone who is depressed for psychiatric evaluation is malpractice, and I would argue, medication is necessary for someone to do the work of therapy. How can someone participate in therapy if they're too depressed to get out of bed and go to see the therapist?

TECScript 5: Evidence-Based Treatments
12 January 2002 – 3 February 2002

Date: Tue, 15 Jan 2002 4:37PM
From: Scott Hickey, PhD <shickeys@pdq.net>

On Mon, 14 Jan 2002 1:18PM Robin Jenkins <rjenkins@cccommunicare.org> wrote:

Thank you for the clarification. This is, in fact, part of the point I was attempting to make. Many consumers do, for whatever reason, seek "pills" -- does that mean we should always do what's expedient? Not in my opinion. Expedience doesn't necessarily predict more positive outcomes. What if they asked for therapy only; we wouldn't suggest that either. We'd do a thorough clinical assessment, then recommend pharmacotherapy, psychotherapy, or a combination (this discussion was about depressive disorders). We wouldn't default to the "medical" or pharmacotherapeutic intervention just because we decided that the disorder had reached medical necessity criteria for treatment, nor because treatment literature shows that so many consumers are treated with SSRIs or other drugs as a "first line" treatment. I think we owe the customer to ask the question, "why is this mode of treatment so common"? Is it due to empirical clinical success; efficiency of care; consumer preference; system consequence? In the context of Evidence-based treatments, typically manualized by definition at this point, if the empirical data supported use of the approach we would recommend that approach....based on presenting symptoms and complaints, resources, family supports, etc. -- not because of what the consumer directly asked for. Surely we consider their requests and even try to honor them given the need to work collaboratively in mutual problem solving. I don't consider that passing moral judgment in favor of one approach or the other. I've seen just as many consumers negatively affected by an ineffective psychotherapeutic approach as ineffective medications. I would hope that we couch our clinical recommendations in empirical thought, juxtaposed with consumer requests and mental status among the other variables we must consider. It is my contention that our system of care, however you define that system, tends to favor the expedient (financial incentives, both for payor and payee) while keeping consumer outcomes as a stated optimal objective -- but the actual results are often very different. The same incentives affect psychotherapeutic outcomes as well.

*Robin Jenkins, Ph.D.
Cumberland County CommuniCare, Inc.
www.cccommunicare.org*

Agree that improvements in antidepressant drugs likely have something to do with all of this. It is a continuing matter of interest that diagnosis is a function of available effective treatments. I guess we tend to see those problems that we can fix.

Also, increases in numbers of consumers treated for depression may be due to concerted efforts to raise level of awareness among both primary care physicians (e.g. NIMH DART Project of the late 80's early 90's) and among consumers (e.g. MHA-sponsored Depression Awareness Days). Maybe some of that actually put a dent in the problem!

In my humble view (as supported by professional practice guidelines), evidence supports use of either or both approaches in most, but not all cases of depressive disorders. In instances when both types of treatment are supported by evidence, then consumer preferences, costs become even more important in treatment planning.

TECScript 5: Evidence-Based Treatments
12 January 2002 – 3 February 2002

Date: Tue, 15 Jan 2002 5:25PM

From: William Berman <wberman@echoman.com>

On Tue, 15 Jan 2002 4:37PM Scott Hickey, PhD <shickey@pdq.net> wrote:

Agree that improvements in antidepressant drugs likely have something to do with all of this. It is a continuing matter of interest that diagnosis is a function of available effective treatments. I guess we tend to see those problems that we can fix.

Also, increases in numbers of consumers treated for depression may be due to concerted efforts to raise level of awareness among both primary care physicians (e.g. NIMH DART Project of the late 80's early 90's) and among consumers (e.g. MHA-sponsored Depression Awareness Days). Maybe some of that actually put a dent in the problem!

In my humble view (as supported by professional practice guidelines), evidence supports use of either or both approaches in most, but not all cases of depressive disorders. In instances when both types of treatment are supported by evidence, then consumer preferences, costs become even more important in treatment planning.

This is not the most common interpretation I have heard regarding projects like the NIMH Collaborative study. My understanding has been that the equality of treatments for depression does not hold for the most severe cases in that study. And it is important to remember that that study eliminated all inpatient cases and all cases who were suicidal, so by definition they eliminated people who would clearly benefit differentially from somatic treatments.

Bill Berman

TECScript 5: Evidence-Based Treatments
12 January 2002 – 3 February 2002

Date: Wed, 16 Jan 2002 9:12AM
From: Geoffrey Gray <ggray@oqsystems.com>

On Tue, 15 Jan 2002 5:25PM William Berman <wberman@echoman.com> wrote:

This is not the most common interpretation I have heard regarding projects like the NIMH Collaborative study. My understanding has been that the equality of treatments for depression does not hold for the most severe cases in that study. And it is important to remember that that study eliminated all inpatient cases and all cases who were suicidal, so by definition they eliminated people who would clearly benefit differentially from somatic treatments.

Bill Berman

Another fact to keep in mind--one the mental health community has been slow to recognize--is that the de facto mental health system in America is Primary Care. Most people get mental health care through PCPs, only 28% through specialists. Patients trust their PCPs and want treatment from them, i.e. many will not take a referral to a specialist. The increase in the identification and treatment by PCPs of depressed patients with antidepressants is not as has been suggested artifactual. It is factual. It is the market and the world we live in.

TECScript 5: Evidence-Based Treatments
12 January 2002 – 3 February 2002

Date: Wed, 16 Jan 2002 12:28PM

From: Lorna Simon <lorna.simon@umassmed.edu>

On Wed, 16 Jan 2002 9:12AM Geoffrey Gray <ggray@oqsystems.com> wrote:

Another fact to keep in mind--one the mental health community has been slow to recognize--is that the de facto mental health system in America is Primary Care. Most people get mental health care through PCPs, only 28% through specialists. Patients trust their PCPs and want treatment from them, i.e. many will not take a referral to a specialist. The increase in the identification and treatment by PCPs of depressed patients with antidepressants is not as has been suggested artifactual. It is factual. It is the market and the world we live in.

More likely, I think is that PCPs are reluctant to refer patients to psychiatrists, &/or they have typically get so little exposure to psychiatry in med school & residency that they are not inclined to refer someone for psych treatment. While I agree that some people are reluctant to see a psychiatrist because of the stigma associated w/ mental illness, I think this is becoming less and less of a problem, when there are so many effective treatments for mi. In other words, I think the fault is more likely to be w/ the health care system rather than the patient. A lot of this discussion has seemed to me to be perilously close to "blaming the victim," which surprises me given the knowledge one would expect mental health professionals to have.

TECScript 5: Evidence-Based Treatments
12 January 2002 – 3 February 2002

Date: Wed, 16 Jan 2002 12:39PM

From: Paul Cook <pcook@scriptassistllc.com>

On Wed, 16 Jan 2002 9:12AM Geoffrey Gray <ggray@oqsystems.com> wrote:

Another fact to keep in mind--one the mental health community has been slow to recognize--is that the de facto mental health system in America is Primary Care. Most people get mental health care through PCPs, only 28% through specialists. Patients trust their PCPs and want treatment from them, i.e. many will not take a referral to a specialist. The increase in the identification and treatment by PCPs of depressed patients with antidepressants is not as has been suggested artifactual. It is factual. It is the market and the world we live in.

True enough, and there are advantages to a better integration between behavioral health and primary care. I just don't think we should make the leap from "factual" (i.e., current system) to "best available form of care" or "the form of care that most patients, if they were given all the facts, would choose for themselves." Both patients and PCPs make treatment decisions under conditions of limited information. In survey research that I have seen, 50% of PCPs said that they did not even know how to refer to mental health specialty care, much less how to refer patients for a particular empirically supported form of treatment.

Patients would be better served if they were educated about the full range of available treatments, including the fact that some types of therapy have research support (similar to FDA drug trials) and others do not (and therefore should be regarded in the same way as experimental treatments or off-label uses of a drug). Until then, the form of treatment selected is an artifact of the system of care, rather than a true reflection of patient preference or differential treatment efficacy.

TECScript 5: Evidence-Based Treatments
12 January 2002 – 3 February 2002

Date: Wed, 16 Jan 2002 3:05PM

From: Stephen E Beller <nhdspres@bestweb.net>

It seems from the discussion thus far that there is general consensus that EBT (evidence based treatment) has merit, at least conceptually. There is also consensus, however, that EBTs currently existing don't have much practical value/utility in clinical practice.

Personally, I have little faith in existing practice guidelines for lots of reasons, not the least of which is the DSM, which was never designed to be a diagnostic classification system for treatment efficacy research or decision support. So, EBT research based on DSM patient groupings is highly suspect. We need a better diagnostic system.

Other problems include our failure to really understand the mind-body connection when determining psychological treatment, the politics of healthcare and money/insurance, professional fear, ignorance, ego, self-deception ... and the list goes on!

The field is not yet ready or willing to do what it takes to change in a positive way.

Thus, it seems to me that EBT in mental/behavioral health is in its early infancy. As a matter of fact, it has been in its infancy for the past decade or two! And I don't see any real progress being made now, as evidence by the article I referred to last week.

Steve Beller, Ph.D.

TECScript 5: Evidence-Based Treatments

12 January 2002 – 3 February 2002

Date: Wed, 16 Jan 2002 3:52PM

From: Daniel Fallon <psychling@worldnet.att.net>

On Wed, 16 Jan 2002 3:05PM Stephen E. Beller <nhdspres@bestweb.net> wrote:

It seems from the discussion thus far that there is general consensus that EBT (evidence based treatment) has merit, at least conceptually. There is also consensus, however, that EBTs currently existing don't have much practical value/utility in clinical practice.

Personally, I have little faith in existing practice guidelines for lots of reasons, not the least of which is the DSM, which was never designed to be a diagnostic classification system for treatment efficacy research or decision support. So, EBT research based on DSM patient groupings is highly suspect. We need a better diagnostic system.

Other problems include our failure to really understand the mind-body connection when determining psychological treatment, the politics of healthcare and money/insurance, professional fear, ignorance, ego, self-deception ... and the list goes on!

The field is not yet ready or willing to do what it takes to change in a positive way.

Thus, it seems to me that EBT in mental/behavioral health is in its early infancy. As a matter of fact, it has been in its infancy for the past decade or two! And I don't see any real progress being made now, as evidence by the article I referred to last week.

Steve Beller, Ph.D.

I am finding this thread very helpful and stimulating.

I recently returned from several days with members of the Multisystemic Treatment team <MSTServices.com> in Charleston, SC. Drs. Henggeler, Borduin and Schoenwald, et al, have been implementing a straightforward treatment model that is strictly evidence-based. Key to successful implementation is intense clinician training and consultation before and during the application of treatment. Ongoing training, consultation and metricized adherence to the treatment model is conducted weekly by supervisors and consumers in both 'online' and telephonic methods.

In other words, to implement EBTs one must perceive of it as an ongoing QA process, as well.

Their work is quite impressive and we should expect to see it as particular curricula in graduate training programs.

Daniel Fallon, Psy.D.
Chicago

TECScript 5: Evidence-Based Treatments

12 January 2002 – 3 February 2002

Date: Wed, 16 Jan 2002 6:25PM

From: Tom Trabin <tom@trabin.com>

On Wed, 16 Jan 2002 3:05PM Stephen E. Beller <nbdspres@bestweb.net> wrote:

It seems from the discussion thus far that there is general consensus that EBT (evidence based treatment) has merit, at least conceptually. There is also consensus, however, that EBTs currently existing don't have much practical value/utility in clinical practice.

Personally, I have little faith in existing practice guidelines for lots of reasons, not the least of which is the DSM, which was never designed to be a diagnostic classification system for treatment efficacy research or decision support. So, EBT research based on DSM patient groupings is highly suspect. We need a better diagnostic system.

Other problems include our failure to really understand the mind-body connection when determining psychological treatment, the politics of healthcare and money/insurance, professional fear, ignorance, ego, self-deception ... and the list goes on!

The field is not yet ready or willing to do what it takes to change in a positive way.

Thus, it seems to me that EBT in mental/behavioral health is in its early infancy. As a matter of fact, it has been in its infancy for the past decade or two! And I don't see any real progress being made now, as evidence by the article I referred to last week.

Steve Beller, Ph.D.

I wouldn't agree with the email below that EBTs have no practical value/utility in clinical practice, and that there is consensus to that effect. I think that's an unwarranted leap. Nor would I agree that EBTs are all diagnosis-driven.

The recent discussion of EBTs on this listserve has been quite general, when actually there are over a hundred EBTs with tremendous variety. Compare, for instance, the components of a diagnosis-driven EBT for persons with panic disorder that can be delivered by an individual clinician (e.g. in vivo desensitization, cognitive restructuring, etc.) with the components of an EBT for persons with high risk for rehospitalization due to serious mental illness (characterized by any of several possible diagnoses) delivered by a sizable team of clinicians and case managers (e.g. assertive community treatment). Or consider some of the seemingly "non-clinical" EBTs coming out for treatment of persons with serious mental illnesses, again not diagnosis-specific, such as supportive employment and illness self-management.

Finally, I disagree about the field's readiness to change, although I think the challenges are daunting. Practice guidelines and EBTs have already made an impact on what clinicians seek for continuing education, what some gradual school programs teach, and what some treatment delivery organizations are offering consumers. It hasn't resulted in widespread adoption of manualized treatments, but that's probably not a desired goal nor an appropriate measure of impact anyway. Perhaps of greatest significance, we are on the verge (this year!) of a huge rollout of evidence-based practices in state public mental health systems, with

TEC*Script* 5: Evidence-Based Treatments

12 January 2002 – 3 February 2002

evaluations to be coordinated at the national level by NASMHPD Research Institute. The design of these rollouts is attending to research findings from diffusion of innovation literature on effective ways to generate adoption of new practices. It will be interesting to watch (and for some of us, participate in).

In my humble opinion, our field needs this kind of focused change and is ready for it. I think the time has come.

Tom Trabin, Ph.D., M.S.M.
tom@trabin.com

TECScript 5: Evidence-Based Treatments

12 January 2002 – 3 February 2002

Date: Thu, 17 Jan 2002 9:29AM

From: Neal Adams <nadamsmd@pacbell.net>

On Wed, 16 Jan 2002 6:25PM Tom Trabin <tom@trabin.com> wrote:

I wouldn't agree with the email below that EBTs have no practical value/utility in clinical practice, and that there is consensus to that effect. I think that's an unwarranted leap. Nor would I agree that EBTs are all diagnosis-driven.

The recent discussion of EBTs on this listserve has been quite general, when actually there are over a hundred EBTs with tremendous variety. Compare, for instance, the components of a diagnosis-driven EBT for persons with panic disorder that can be delivered by an individual clinician (e.g. in vivo desensitization, cognitive restructuring, etc.) with the components of an EBT for persons with high risk for rehospitalization due to serious mental illness (characterized by any of several possible diagnoses) delivered by a sizable team of clinicians and case managers (e.g. assertive community treatment). Or consider some of the seemingly "non-clinical" EBTs coming out for treatment of persons with serious mental illnesses, again not diagnosis-specific, such as supportive employment and illness self-management.

Finally, I disagree about the field's readiness to change, although I think the challenges are daunting. Practice guidelines and EBTs have already made an impact on what clinicians seek for continuing education, what some gradual school programs teach, and what some treatment delivery organizations are offering consumers. It hasn't resulted in widespread adoption of manualized treatments, but that's probably not a desired goal nor an appropriate measure of impact anyway. Perhaps of greatest significance, we are on the verge (this year!) of a huge rollout of evidence-based practices in state public mental health systems, with evaluations to be coordinated at the national level by NASMHPD Research Institute. The design of these rollouts is attending to research findings from diffusion of innovation literature on effective ways to generate adoption of new practices. It will be interesting to watch (and for some of us, participate in).

In my humble opinion, our field needs this kind of focused change and is ready for it. I think the time has come.

*Tom Trabin, Ph.D., M.S.M.
tom@trabin.com*

Tom--

As you know, I couldn't agree more--I'd been sitting on the sideline of this discussion and I appreciate your stating it so clearly.

Neal

Check out the American College of Mental Health Administration's web page www.acmha.org <<http://www.acmha.org>> for information on Summit 2002: Crossing the Quality Chasm--Translating the IOM Report for Behavioral Health to be held in Santa Fe March 15-18.

TEC*Script* 5: Evidence-Based Treatments
12 January 2002 – 3 February 2002

Date: Thu, 17 Jan 2002 1:59PM

From: Dave Colton <dcolton@ccca.state.va.us>

Thanks to Neal Adams for reference to the American College of Mental Health Administration's web page: www.acmha.org. There's also an excellent article in the newsletter on this site, which discusses the issue of evidence-based practice as it relates to the current state of treatment for children (First, Do No Harm: Children as "Therapeutic Orphans" By Sonja Schoenwald, PhD).

Dave Colton

David Colton, Ph.D.
Commonwealth Center for Children and Adolescents
Staunton, Virginia 24401
Telephone: 540-332-2144
dcolton@ccca.state.va.us

TECScript 5: Evidence-Based Treatments
12 January 2002 – 3 February 2002

Date: Thu, 17 Jan 2002 2:31PM
From: William Berman <wberman@echoman.com>

On Thu, 17 Jan 2002 9:29AM Neal Adams <nadamsmd@pacbell.net> wrote:

Tom--

As you know, I couldn't agree more--I'd been sitting on the sideline of this discussion and I appreciate your stating it so clearly.

Neal

Check out the American College of Mental Health Administration's web page www.acmba.org <<http://www.acmba.org>> for information on Summit 2002: Crossing the Quality Chasm--Translating the IOM Report for Behavioral Health to be held in Santa Fe March 15-18.

To clarify the issue on evidence-based care, this is not just an issue for American behavioral health. There is extensive work being done internationally on this issue, including the UK (<http://cebm.jr2.ox.ac.uk/>), Europe (<http://www.evimed.ch/>), Canada (<http://www.cebm.utoronto.ca/>), Japan (http://www.med.nihon-u.ac.jp/department/public_health/ebm/) and other places.

In the US, dozens of AMC's are working on the development and enhancement of these protocols. It is an explicit priority of the Surgeon General's office with regard to both adult and child mental health.

In other words, it seems apparent to me that the world is increasingly interested in the demonstration of efficacy in the treatment of illnesses, or which mental illness are one. The same may not be true with what Szasz called problems in living, but to the extent that we are talking about mental illnesses, there seems to me to be an international mandate to move what is known in the empirical research literature into the practice arena, like Yesterday.

William H. Berman, Ph.D.
The Echo Group

TEC*Script* 5: Evidence-Based Treatments
12 January 2002 – 3 February 2002

Date: Thu, 17 Jan 2002 3:04PM

From: Lee B Sechrest <sechrest@u.arizona.edu>

I can't for the life of me think what it is that practitioners are supposed to do if they do not rely on evidence-based interventions.

If they do not, what is their warrant for practicing at all, let alone for requiring reimbursement from public funds for their "services?"

Lee

TECScript 5: Evidence-Based Treatments
12 January 2002 – 3 February 2002

Date: Thu, 17 Jan 2002 4:06PM
From: John Ward <ward@fmhi.usf.edu>

On Thu, 17 Jan 2002 3:04PM Lee B Secbrest <secbrest@u.arizona.edu> wrote:

I can't for the life of me think what it is that practitioners are supposed to do if they do not rely on evidence-based interventions.

If they do not, what is their warrant for practicing at all, let alone for requiring reimbursement from public funds for their "services?"

Lee

The art of practicing a science depends heavily on there being a science!

John C. Ward, Jr., Ph.D.
Associate Professor
Department of Mental Health Law and Policy
Louis de la Parte Florida Mental Health Institute
University of South Florida
Tampa, Florida
813-974-1929

TECScript 5: Evidence-Based Treatments
12 January 2002 – 3 February 2002

Date: Thu, 17 Jan 2002 4:10PM

From: Stephen E Beller <nhdspres@bestweb.net>

WOW! Tom Trabin points out that the field is on the verge of "... a huge rollout of evidence-based practices in state public mental health systems." And since we don't have an effective diagnosis system, many of the EBT's aren't diagnosis driven. And rather than being generic manualized practices, they are apparently individualized treatment protocols in a format that is useful to practicing clinicians. This is apparently going to be a coordinated effort, nationwide, in which researchers and practitioners collaborate to validate the guidelines over time and adjust them as necessary.

I assume the guidelines are precise enough to match specific the biopsychosocial needs of each patient with the treatment regimens (biologic/medical and non-biologic) proven in the lab and/or field to be the most effective and efficient!

And best of all, our field is ready for it and is willing to embrace such changes!

In light of this new knowledge, I stand corrected in my dismal outlook. The field ought be congratulated for this radical transformation!

Steve Beller

TECScript 5: Evidence-Based Treatments
12 January 2002 – 3 February 2002

Date: Thu, 17 Jan 2002 4:33PM

From: Geoffrey Gray <ggray@oqsystems.com>

On Thu, 17 Jan 2002 3:04PM Lee B Sechrest <sechrest@u.arizona.edu> wrote:

I can't for the life of me think what it is that practitioners are supposed to do if they do not rely on evidence-based interventions.

If they do not, what is their warrant for practicing at all, let alone for requiring reimbursement from public funds for their "services?"

Lee

Guidelines are good. So is apple pie. There are plenty of guidelines in psychiatry. To be sure, in some delimited areas more needs to be done (spmi). How specific do guidelines need to be? Global guidelines work fine in much of medicine. A medical guideline for a cut finger: wash with soap and water and use a Band-Aid. Would a better guideline define the type of soap, the length of washing? Would the improvement in outcome be worth the investment in the development of such a guideline? Is there much benefit in more specific guidelines for psychotherapy? Some clinicians such as Beutler think so and would micromanage the psychotherapy process: what technique with what patient and what point in treatment. But would the benefit be worth the investment given the fact that modality accounts for only 10-15% of the variance in outcome? Real time feedback to clinicians on patient progress can enhance outcomes much more robustly than can modality but modalities seem to compel the attention of clinicians more than seems warranted by the evidence.

TECScript 5: Evidence-Based Treatments
12 January 2002 – 3 February 2002

Date: Thu, 17 Jan 2002 5:22PM

From: Lorna Simon <lorna.simon@umassmed.edu>

On Thu, 17 Jan 2002 4:33PM Geoffrey Gray <ggray@oqsystems.com> wrote:

Guidelines are good. So is apple pie. There are plenty of guidelines in psychiatry. To be sure, in some delimited areas more needs to be done (spmi). How specific do guidelines need to be? Global guidelines work fine in much of medicine. A medical guideline for a cut finger: wash with soap and water and use a Band-Aid. Would a better guideline define the type of soap, the length of washing? Would the improvement in outcome be worth the investment in the development of such a guideline? Is there much benefit in more specific guidelines for psychotherapy? Some clinicians such as Bentler think so and would micromanage the psychotherapy process: what technique with what patient and what point in treatment. But would the benefit be worth the investment given the fact that modality accounts for only 10-15% of the variance in outcome? Real time feedback to clinicians on patient progress can enhance outcomes much more robustly than can modality but modalities seem to compel the attention of clinicians more than seems warranted by the evidence.

I agree that micro-managing psychotherapy is silly, & probably more harmful to the patient in the long run, but guidelines are just that - guidelines, not rules. And the whole idea behind evidence-based practice guidelines, as I understand it, is to develop these guidelines through evaluation of how well specific modalities work, and in what circumstances & for whom. While the evaluating psychotherapy is much more difficult than evaluating a procedure, we are getting better at doing it, and as we do it more, we'll probably get even better. And the difficulty in doing the evaluation speaks, in part, to how much we can learn about psychotherapy through this evaluation process.

TECScript 5: Evidence-Based Treatments
12 January 2002 – 3 February 2002

Date: Thu, 17 Jan 2002 5:46PM
From: Daniel Fallon <psychling@worldnet.att.net>

On Thu, 17 Jan 2002 3:04PM Lee B Secbrest <secbrest@u.arizona.edu> wrote:

I can't for the life of me think what it is that practitioners are supposed to do if they do not rely on evidence-based interventions.

If they do not, what is their warrant for practicing at all, let alone for requiring reimbursement from public funds for their "services?"

Lee

As a friend recently described non-EBT work:

‘aesthetic’ therapy;

"Heinz 57"

Daniel Fallon, Psy.D.

TECScript 5: Evidence-Based Treatments
12 January 2002 – 3 February 2002

Date: Fri, 18 Jan 2002 8:14PM

From: Darren Bowd <darren.bowd@dhs.sa.gov.au>

On Thu, 17 Jan 2002 5:22PM Lorna Simon <lorna.simon@umassmed.edu> wrote:

I agree that micro-managing psychotherapy is silly, & probably more harmful to the patient in the long run, but guidelines are just that - guidelines, not rules. And the whole idea behind evidence-based practice guidelines, as I understand it, is to develop these guidelines through evaluation of how well specific modalities work, and in what circumstances & for whom. While the evaluating psychotherapy is much more difficult than evaluating a procedure, we are getting better at doing it, and as we do it more, we'll probably get even better. And the difficulty in doing the evaluation speaks, in part, to how much we can learn about psychotherapy through this evaluation process.

Reading this thread I'm reminded of a saying, "Don't offer me perfection when excellence will suffice."

TECScript 5: Evidence-Based Treatments
12 January 2002 – 3 February 2002

Date: Fri, 18 Jan 2002 8:28AM

From: William Berman <wberman@echoman.com>

On Wed, 16 Jan 2002 12:39PM Paul Cook <pcook@scriptassistllc.com> wrote:

True enough, and there are advantages to a better integration between behavioral health and primary care. I just don't think we should make the leap from "factual" (i.e., current system) to "best available form of care" or "the form of care that most patients, if they were given all the facts, would choose for themselves." Both patients and PCPs make treatment decisions under conditions of limited information. In survey research that I have seen, 50% of PCPs said that they did not even know how to refer to mental health specialty care, much less how to refer patients for a particular empirically supported form of treatment.

Patients would be better served if they were educated about the full range of available treatments, including the fact that some types of therapy have research support (similar to FDA drug trials) and others do not (and therefore should be regarded in the same way as experimental treatments or off-label uses of a drug). Until then, the form of treatment selected is an artifact of the system of care, rather than a true reflection of patient preference or differential treatment efficacy.

Interesting idea. Maybe we should try to get funding to do direct-to-consumer marketing of mental health, like they are doing with direct-to-consumer marketing of pharmaceuticals?

TECScript 5: Evidence-Based Treatments
12 January 2002 – 3 February 2002

Date: Fri, 18 Jan 2002 8:29AM

From: William Berman <wberman@echoman.com>

On Thu, 17 Jan 2002 3:04PM Lee B Secbrest <secbrest@u.arizona.edu> wrote:

I can't for the life of me think what it is that practitioners are supposed to do if they do not rely on evidence-based interventions.

If they do not, what is their warrant for practicing at all, let alone for requiring reimbursement from public funds for their "services?"

Lee

Same thing MD's have been doing for years: Their best clinical judgment. Sometimes good, sometimes not.

TECScript 5: Evidence-Based Treatments
12 January 2002 – 3 February 2002

Date: Fri, 18 Jan 2002 10:27AM
From: Sheila Baer <smbaer@aol.com>

On Fri, 18 Jan 2002 8:28AM William Berman <wberman@echoman.com> wrote:

Interesting idea. Maybe we should try to get funding to do direct-to-consumer marketing of mental health, like they are doing with direct-to-consumer marketing of pharmaceuticals?

This is something I've been increasingly in favor of -- the general public, I'm afraid, is being educated/socialized (mostly by wealthy pharmaceutical companies) to believe that all emotional disorders are biological in origin. Where is APA on this issue? We need to provide rebuttals or public service announcements so the general public understands there are often alternatives to taking drugs for social anxiety, etc.

TECScript 5: Evidence-Based Treatments

12 January 2002 – 3 February 2002

Date: Fri, 18 Jan 2002 11:12AM

From: Scott Hickey, PhD <shickeys@pdq.net>

On Fri, 18 Jan 2002 10:27AM Sheila Baer <smbaer@aol.com> wrote:

This is something I've been increasingly in favor of -- the general public, I'm afraid, is being educated/ socialized (mostly by wealthy pharmaceutical companies) to believe that all emotional disorders are biological in origin. Where is APA on this issue? We need to provide rebuttals or public service announcements so the general public understands there are often alternatives to taking drugs for social anxiety, etc.

Agree! Have been frustrated over the years in work with SPMI that clinicians do not inform consumers about available treatment alternatives/choices. I harbor doubts that the treatment planners actually consider many treatment options. When they step up to the counter, almost everybody gets plain vanilla ice cream, despite the fact that other flavors are available. Vanilla is the default setting. Consumers do get medication. Consumers are often unaware of rehab services, psychosocial therapies, psychotherapy, services that evidence suggests could positively impact outcomes. It is a delicate matter to bypass the clinicians and market directly to consumers. Seems to stir up control issues for the treatment planners. Nevertheless, it appears that consumers do request these services when the sales pitch is taken directly to them.

It is relatively easy to find much of the potential market, to locate the potential SPMI customers for these services and market to them. It is interesting but more difficult to find the audience for psychotherapy services. I guess one would have to consider marketing these psychological services to the general public, using mass media. The wealth is increasingly concentrated in the hands of the managed care companies, though, and it's probably not in their business interest to market psychosocial therapies. Who would pay for an ad campaign?

I also harbor some hope that moves towards EBT will broaden the treatment choices for the average consumer by forcing consideration of all evidence-supported treatment options. The informed consent process might be much more meaningful.

TECScript 5: Evidence-Based Treatments
12 January 2002 – 3 February 2002

Date: Fri, 18 Jan 2002 11:19AM

From: Paul Cook <pcook@scriptassistllc.com>

On Fri, 18 Jan 2002 10:27AM Sheila Baer <smbaer@aol.com> wrote:

This is something I've been increasingly in favor of -- the general public, I'm afraid, is being educated/ socialized (mostly by wealthy pharmaceutical companies) to believe that all emotional disorders are biological in origin. Where is APA on this issue? We need to provide rebuttals or public service announcements so the general public understands there are often alternatives to taking drugs for social anxiety, etc.

We do need to educate the general public about psychotherapy as a valid treatment, and about the fact that you can't talk only about biology (diathesis) without also talking about psychosocial factors (stress) for any mental health issue. But this is a big job. I wonder if we shouldn't start by educating primary care physicians--if they are the de facto mental health system, they are in an excellent position to pass this information along to patients who need it.

Physicians receive most of their continuing education from drug companies. Here's an interesting report on this issue: <http://phth.allenpress.com/phthonline/?request=get-document&issn=1060-0280&volume=035&issue=12&page=1661>

If each physician spends 15 minutes with a drug rep, 2-4 times annually, for each of the various SSRIs marketed to primary care (at least six: Prozac, Paxil, Zoloft, Celexa, plus non-SSRIs Effexor and Remeron), then this is 5-6 hours per year being educated about the benefits of antidepressant medications. Not that there's anything wrong with antidepressants, but contrast this to 0 hours per year being educated about equally well-researched psychosocial treatments for depression (Cognitive-Behavioral Therapy, Interpersonal Psychotherapy, etc.).

TECScript 5: Evidence-Based Treatments
12 January 2002 – 3 February 2002

Date: Fri, 18 Jan 2002 11:36AM

From: Geoffrey Gray <ggray@oqsystems.com>

On Fri, 18 Jan 2002 10:27AM Sheila Baer <smbaer@aol.com> wrote:

This is something I've been increasingly in favor of -- the general public, I'm afraid, is being educated/ socialized (mostly by wealthy pharmaceutical companies) to believe that all emotional disorders are biological in origin. Where is APA on this issue? We need to provide rebuttals or public service announcements so the general public understands there are often alternatives to taking drugs for social anxiety, etc.

Better bet: APA market directly to PCPs. PCPs have the referrals to make (25% of their patients have a mental disorder). But MBHOs are in the way. Carve in/DM arrangements which are becoming more prominent (see Medica in MN) could change the landscape.

TECScript 5: Evidence-Based Treatments
12 January 2002 – 3 February 2002

Date: Fri, 18 Jan 2002 12:37PM
From: Lorna Simon <lorna.simon@umassmed.edu>

On Fri, 18 Jan 2002 10:27AM Sheila Baer <smbaer@aol.com> wrote:

This is something I've been increasingly in favor of -- the general public, I'm afraid, is being educated/ socialized (mostly by wealthy pharmaceutical companies) to believe that all emotional disorders are biological in origin. Where is APA on this issue? We need to provide rebuttals or public service announcements so the general public understands there are often alternatives to taking drugs for social anxiety, etc.

I agree that the public should be made aware of the benefits of psychotherapy in treating psych disorders as an adjunct to medication, but not as an alternative to it. In the vast majority of cases, medication is not only necessary, but also enhances the effectiveness of the psychotherapy (as well as psychotherapy enhancing the effect of drug treatment. Again, I find it surprising, as well disheartening that so many people on this list seem to think that psychotherapy can replace drug treatment for serious mental illness.

TECScript 5: Evidence-Based Treatments
12 January 2002 – 3 February 2002

Date: Fri, 18 Jan 2002 1:39PM

From: Sherry Kimbrough <sherry@lanstat.com>

On Fri, 18 Jan 2002 11:19AM Paul Cook <pcook@scriptassistllc.com> wrote:

We do need to educate the general public about psychotherapy as a valid treatment, and about the fact that you can't talk only about biology (diathesis) without also talking about psychosocial factors (stress) for any mental health issue. But this is a big job. I wonder if we shouldn't start by educating primary care physicians--if they are the de facto mental health system, they are in an excellent position to pass this information along to patients who need it.

Physicians receive most of their continuing education from drug companies. Here's an interesting report on this issue: <http://phtb.allenpress.com/phtbonline/?request=get-document&issn=10600280&volume=035&issue=12&page=1661>

If each physician spends 15 minutes with a drug rep, 2-4 times annually, for each of the various SSRIs marketed to primary care (at least six: Prozac, Paxil, Zoloft, Celexa, plus non-SSRIs Effexor and Remeron), then this is 5-6 hours per year being educated about the benefits of antidepressant medications. Not that there's anything wrong with antidepressants, but contrast this to 0 hours per year being educated about equally well-researched psychosocial treatments for depression (Cognitive-Behavioral Therapy, Interpersonal Psychotherapy, etc.).

Thank you, Paul, for that interesting article.

We haven't even begun to talk about educating PCPs about addiction issues... and not JUST to pharmaceuticals, either.

Sherry

Sherry Kimbrough, M.S., NCAC
sherry@lanstat.com

TECScript 5: Evidence-Based Treatments
12 January 2002 – 3 February 2002

Date: Fri, 18 Jan 2002 2:14PM
From: Sheila Baer <smbaer@aol.com>

On Fri, 18 Jan 2002 12:37PM Lorna Simon <lorna.simon@umassmed.edu> wrote:

I agree that the public should be made aware of the benefits of psychotherapy in treating psych disorders as an adjunct to medication, but not as an alternative to it. In the vast majority of cases, medication is not only necessary, but also enhances the effectiveness of the psychotherapy (as well as psychotherapy enhancing the effect of drug treatment. Again, I find it surprising, as well disheartening that so many people on this list seem to think that psychotherapy can replace drug treatment for serious mental illness.

Perhaps the confusion lies in the definition of "serious mental illness." I do not consider social anxiety a "serious" mental illness (ref the Paxil TV ads), or in the same class as chronic and severe disorders such as schiz or bipolar disorder. Assuming a biological etiology for all mental or emotional disorders simply encourages a "take a pill" philosophy that is not necessarily conducive to long term mental health and self management.

Sheila Baer

TECScript 5: Evidence-Based Treatments
12 January 2002 – 3 February 2002

Date: Fri, 18 Jan 2002 2:57PM

From: Lorna Simon <lorna.simon@umassmed.edu>

On Fri, 18 Jan 2002 2:14PM Sheila Baer <smbaer@aol.com> wrote:

Perhaps the confusion lies in the definition of "serious mental illness." I do not consider social anxiety a "serious" mental illness (ref the Paxil TV ads), or in the same class as chronic and severe disorders such as schiz or bipolar disorder. Assuming a biological etiology for all mental or emotional disorders simply encourages a "take a pill" philosophy that is not necessarily conducive to long term mental health and self management.

Sheila Baer

I agree w/ you to a certain extent that anxiety d/os are often not as "serious" as mood d/os and schizophrenia. However, that is not always the case. Anxiety d/os can be so debilitating that one is unable to carry out usual occupational &/or interpersonal activities. There are many people w/ anxiety d/os who are eligible for SSDI and collecting SSDI. In addition, even if these d/os are not severe enough to render one unable to work &/or to have significant relationships, medication can, & often does enhance the effectiveness of behavioral therapy.

TECScript 5: Evidence-Based Treatments
12 January 2002 – 3 February 2002

Date: Fri, 18 Jan 2002 4:16PM

From: Stephen E Beller <nhdspres@bestweb.net>

The question came up as to where the APA stands in regards to EBTs.

My personal experience with the APA has proven it is primarily a political organization focused on maintaining the status quo. Since psychodynamic-oriented therapists have tended to complain about EBTs being “unfair” to their practice, and since well-established “old-timer” practitioners tend to resent having their clinical acumen questioned, and since there has always been a large rift between clinicians and researchers, the APA has forever been paralyzed and incapable of taking a firm stand.

Thus, we cannot, imo, count on the APA for any sort of real vision and leadership. At best you'll get meaningless lip service, and they will continue to cave into pressure from its anti-EBT constituency.

TECScript 5: Evidence-Based Treatments

12 January 2002 – 3 February 2002

Date: Fri, 18 Jan 2002 4:28PM

From: Tom Trabin <tom@trabin.com>

On Fri, 18 Jan 2002 11:12AM Scott Hickey, Ph.D. <shickeys@pdq.net> wrote:

Agree! Have been frustrated over the years in work with SPMI that clinicians do not inform consumers about available treatment alternatives/choices. I harbor doubts that the treatment planners actually consider many treatment options. When they step up to the counter, almost everybody gets plain vanilla ice cream, despite the fact that other flavors are available. Vanilla is the default setting. Consumers do get medication. Consumers are often unaware of rehab services, psychosocial therapies, psychotherapy, services that evidence suggests could positively impact outcomes. It is a delicate matter to bypass the clinicians and market directly to consumers. Seems to stir up control issues for the treatment planners. Nevertheless, it appears that consumers do request these services when the sales pitch is taken directly to them.

It is relatively easy to find much of the potential market, to locate the potential SPMI customers for these services and market to them. It is interesting but more difficult to find the audience for psychotherapy services. I guess one would have to consider marketing these psychological services to the general public, using mass media. The wealth is increasingly concentrated in the hands of the managed care companies, though, and it's probably not in their business interest to market psychosocial therapies. Who would pay for an ad campaign?

I also harbor some hope that moves towards EBT will broaden the treatment choices for the average consumer by forcing consideration of all evidence-supported treatment options. The informed consent process might be much more meaningful.

I think the "marketing" to consumers of greater treatment choices is an excellent idea. I also think its already well under way, particularly in general healthcare but also in our field. A recent study--reported at the 2001 American Medical Informatics Association Annual Conference and I think funded by the Pugh Foundation--discovered that the number of healthcare-related Internet "hits" annually now surpasses the number of healthcare provider visits. Increasingly, consumers are inquiring over the Internet about what's known and recommended for their problems, and bringing what they've learned to their physicians and allied health professionals. Interestingly, the study also found that people know the quality of information on websites is variable, so they search through multiple sites and tend to view the information critically. So the stage is well set. The Internet in general and the Web in particular have enormous potential for reaching out to consumers. And the democratization of access to healthcare information through these media will enable all of us increasingly to take a more proactive role in our healthcare.

TECScript 5: Evidence-Based Treatments
12 January 2002 – 3 February 2002

Date: Fri, 18 Jan 2002 5:36PM
From: Tom Trabin <tom@trabin.com>

On Fri, 18 Jan 2002 8:14PM Darren Bowd <darren.bowd@dhs.sa.gov.au> wrote:

Reading this thread I'm reminded of a saying, "Don't offer me perfection when excellence will suffice."

My sentiments exactly, Darren. As someone else put it, "Don't let perfection be the enemy of the good".

If guidelines are introduced in a rigidly exacting manner—strictly according to narrow diagnostic specifications and treatment manuals developed for experiments—then I think Steve Beller's points are well taken about the field's lack of readiness. But even some of the most esteemed scientists in this area are suggesting that broad implementation should be attempted more flexibly, since the experimental evidence doesn't translate as perfectly to field conditions. I think one of our field's many challenges will be in how we translate "flexibly" in practice--can we discern and use at least the most effective components of an evidence-based treatment for a given situation? And can we also attend to the vitally important therapist variables that Larry Beutler so eloquently described in his research? Not simple tasks.

My sense is that initiatives to adopt evidence-based practices have been placed squarely at or near the top of our field's agenda this year. To succeed, these initiatives will have to address substantial concerns and pockets of resistance, as Steve Beller pointed out. Training and several other aspects of implementation will prove expensive in time and money, at a time when organizational and program leaders struggle with financial margins that are thin at best. And most clinicians are comfortable with what they do, not eager for substantial change. These initiatives won't be successful easily or immediately. However, I think the very gradual change towards adoption of evidence-based practice components over the coming years will improve the overall level of care for consumers, our credibility as a field, and consequently our field's ability to capture a greater percentage of the healthcare dollar to fund our services.

TECScript 5: Evidence-Based Treatments
12 January 2002 – 3 February 2002

Date: Sat, 19 Jan 2002 1:29AM

From: Tuan Nguyen <tuan.nguyen@mhmraharris.org>

On Fri, 18 Jan 2002 8:14PM Darren Bowd <darren.bowd@dhs.sa.gov.au> wrote:

Reading this thread I'm reminded of a saying, "Don't offer me perfection when excellence will suffice."

At some points, the thread even sounded like, "Don't talk about excellence. Perfection will suffice." i.e., because evidence-based arguments can't yet cover all clinical situations, therefore let's not even bother with it! And Steve Beller's comment about the APA reminds me also of the Kuhnian paradigmatic traps that we heard about some time back concerning other sciences. On the other hand, the discussion is a true reflection of the human dilemma between idiographic concerns and nomothetic rules or laws. Because of this dilemma, there will always be people who do not believe that "in the long run" you can't win at black jack in Las Vegas and so will play the game for its excitement, "art", highs, short-run wins, etc. Sadly, health care professionals who behave that way gamble with other people's lives and public money. Then too, guidelines and protocols and upper and lower boundary constraints, by definition, violate the deep-seated sense of professional autonomy that higher education (at least to date) instills in practitioners. In the late sixties I used to rely on an auto mechanic who diagnosed my Chevy Manza by applying the handle of a very long screwdriver to his ear and its tip to different parts of the running motor. His was an "art" that did not and cannot survive in today's automotive repair scene. But it was such a wonderful manifestation of human-object relation! I wonder how long before today's "art" of clinical intervention(s) will follow the same fate. The speed of its demise, I think, is inversely related to the effort to resist the cold- and hard-] evidence-base movement, albeit plagued still by methodological, conceptual, resource, and coverage limitations, as amply documented by the current thread. But it will soon be time to begin waxing nostalgic. This is a long-winded way of saying I agree with Lee Sechrest, Neil Adam, and Tom Trabin.

Tuan D. Nguyen, PhD

TEC*Script* 5: Evidence-Based Treatments
12 January 2002 – 3 February 2002

Date: Sat, 19 Jan 2002 11:42AM
From: Sylvia Caras <sylvia@peoplewho.org>

Evidence is not a neutral word.

Someone decides, according to some *value* system, what counts and what doesn't.

How much does the personal individual anecdotal reaction to treatment count as evidence?

How much does the outcome the customer wants, not the outcome the provider wants, count as evidence?

Sylvia

Sylvia Caras, PhD
www.peoplewho.org
"Nothing About Me, Without Me"

TECScript 5: Evidence-Based Treatments

12 January 2002 – 3 February 2002

Date: Sat, 19 Jan 2002 11:47AM

From: Geoffrey Gray <ggray@oqsystems.com>

On Sat, 19 Jan 2002 1:29AM Tuan Nguyen <tuan.nguyen@mhmrharris.org> wrote:

At some points, the thread even sounded like, "Don't talk about excellence. Perfection will suffice." i.e., because evidence-based arguments can't yet cover _all_ clinical situations, therefore let's not even bother with it! And Steve Beller's comment about the APA reminds me also of the Kuhnian paradigmatic traps that we heard about some time back concerning other sciences. On the other hand, the discussion is a true reflection of the human dilemma between idiographic concerns and nomothetic rules or laws. Because of this dilemma, there will always be people who do not believe that "in the long run" you can't win at black jack in Las Vegas and so will play the game for its excitement, "art", highs, short-run wins, etc. Sadly, health care professionals who behave that way gamble with other people's lives and public money. Then too, guidelines and protocols and upper and lower boundary constraints, by definition, violate the deep-seated sense of professional autonomy that higher education (at least to date) instills in practitioners. In the late sixties I used to rely on an auto mechanic who diagnosed my Chevy Manza by applying the handle of a very long screwdriver to his ear and its tip to different parts of the running motor. His was an "art" that did not and cannot survive in today's automotive repair scene. But it was such a wonderful manifestation of human-object relation! I wonder how long before today's "art" of clinical intervention(s) will follow the same fate. The speed of its demise, I think, is inversely related to the effort to resist the cold- and hard-] evidence-base movement, albeit plagued still by methodological, conceptual, resource, and coverage limitations, as amply documented by the current thread. But it will soon be time to begin waxing nostalgic. This is a long-winded way of saying I agree with Lee Sechrest, Neil Adam, and Tom Trabin.

Tuan D. Nguyen, PhD

Evidence based guidelines are essential and inevitable. My concern is with the approach of many psychologists. There is a bias toward psychosocial approaches. Borkovec, for instance, in describing a practice research network describes researching the use of a variety of psychotherapeutic techniques--techniques that have been studied to death. Judgment needs to be exercised as to the level of specificity of guidelines. What we are seeing on the psychotherapy front looks to me like micromanagement, rather than a focus on key clinical turning choice points, e.g. what are the indications for medication, etc.

TECScript 5: Evidence-Based Treatments
12 January 2002 – 3 February 2002

Date: Sat, 19 Jan 2002 6:00PM

From: Tuan Nguyen <tuan.nguyen@mhmraharris.org>

On Sat, 19 Jan 2002 11:47AM Geoffrey Gray <ggray@oqsystems.com> wrote:

Evidence based guidelines are essential and inevitable. My concern is with the approach of many psychologists. There is a bias toward psychosocial approaches. Borkovec, for instance, in describing a practice research network describes researching the use of a variety of psychotherapeutic techniques--techniques that have been studied to death. Judgment needs to be exercised as to the level of specificity of guidelines. What we are seeing on the psychotherapy front looks to me like micromanagement, rather than a focus on key clinical turning choice points, e.g. what are the indications for medication, etc.

About micromanagement: one needs to ask why and under what circumstances it happens. I acknowledge ignorance about any literature and research addressing such a question [and welcome pointers to such]. If none exists, then it would be a good topic for organizational and social psychologists. From my own organizational experience, the following seem to bring about micromanagement. First, when the performer has not reached a desired skill level. Second, when it is judged that the output or outcome does not match the price/reimbursement. Third, when performance falls short of contractual promises or past levels of output or outcome or relative to new/higher standards. Fourth, when the supervisor/manager is him/herself incompetent, inadequate, naive, etc. Fifth, mean managers. Sixth, and as a corollary of numbers 2, 3, 4, and 5, there is a hidden agenda to create an untenable situation so that the micromanaged performer leaves the scene (quits). Seventh, the production process is overcomplicated for the competence of the performer. One can add more reasons to this list. But, the overall theme seems to be that micromanagement occurs when performance is perceived to fall short of expectations or to be less than cost-beneficial. To reverse the trend, one needs evidence to the contrary or fight it out legally and politically. [And as Sylvia Caras indicated, evidence should include customers' opinion and testimony as well.] Whining (I am a victim of bias or prejudice) does not seem to work well these days. The irony concerning the research into the use of psychotherapeutic techniques is that on the one hand, they have been studied to death while on the other hand they are so varied [in approaches and methods] and variable [in terms of who, when and for whom] that, taken together, they don't provide a convincing evidence of their worth (about 10% of the variance only!). Could this be the motivation for attempts at cookbook psychotherapeutic guidelines, making them "unduly" specific?

Tuan Nguyen, PhD

TECScript 5: Evidence-Based Treatments

12 January 2002 – 3 February 2002

Date: Sun, 20 Jan 2002 11:01AM

From: Geoffrey Gray <ggray@oqsystems.com>

On Sat, 19 Jan 2002 6:00PM Tuan Nguyen <tuan.nguyen@mhmrharris.org> wrote:

About micromanagement: one needs to ask why and under what circumstances it happens. I acknowledge ignorance about any literature and research addressing such a question [and welcome pointers to such]. If none exists, then it would be a good topic for organizational and social psychologists. From my own organizational experience, the following seem to bring about micromanagement. First, when the performer has not reached a desired skill level. Second, when it is judged that the output or outcome does not match the price/reimbursement. Third, when performance falls short of contractual promises or past levels of output or outcome or relative to new/higher standards. Fourth, when the supervisor/manager is him/herself incompetent, inadequate, naive, etc. Fifth, mean managers. Sixth, and as a corollary of numbers 2, 3, 4, and 5, there is a hidden agenda to create an untenable situation so that the micromanaged performer leaves the scene (quits). Seventh, the production process is overcomplicated for the competence of the performer. One can add more reasons to this list. But, the overall theme seems to be that micromanagement occurs when performance is perceived to fall short of expectations or to be less than cost-beneficial. To reverse the trend, one needs evidence to the contrary or fight it out legally and politically. [And as Sylvia Caras indicated, evidence should include customers' opinion and testimony as well.] Whining (I am a victim of bias or prejudice) does not seem to work well these days. The irony concerning the research into the use of psychotherapeutic techniques is that on the one hand, they have been studied to death while on the other hand they are so varied [in approaches and methods] and variable [in terms of who, when and for whom] that, taken together, they don't provide a convincing evidence of their worth (about 10% of the variance only!). Could this be the motivation for attempts at cookbook psychotherapeutic guidelines, making them "unduly" specific?

Tuan Nguyen, PhD

To clarify my point: the data on psychotherapy over 50 years is that brief therapy works with a broad range of patients with distress. And psychotherapy is probably one of the most studied forms of treatment. While modest advances in psychotherapy will no doubt be achieved, we now know that vast majority of treatment for patients with mental disturbance will involve combined treatment. Thus, it seems to me that psychologists ought to focus their research on combined treatment, identifying when and to what extent complementary psychosocial interventions are of value. However, from what I read, it seems to me that instead of addressing the realities of current practice, many psychological researchers have embraced a research agenda that overvalues the contribution of psychotherapy and would seek to analyze it beyond the point where reasonable societal benefit is likely to be realized.

TECScript 5: Evidence-Based Treatments
12 January 2002 – 3 February 2002

Date: Tue, 22 Jan 2002 9:51AM
From: William Berman <wberman@echoman.com>

On Fri, 18 Jan 2002 12:37PM Lorna Simon <lorna.simon@umassmed.edu> wrote:

I agree that the public should be made aware of the benefits of psychotherapy in treating psych disorders as an adjunct to medication, but not as an alternative to it. In the vast majority of cases, medication is not only necessary, but also enhances the effectiveness of the psychotherapy (as well as psychotherapy enhancing the effect of drug treatment. Again, I find it surprising, as well disheartening that so many people on this list seem to think that psychotherapy can replace drug treatment for serious mental illness.

There is no question that this is not an either or issue, but rather a medication and other treatment issue. And just as there are persons who, as Dr. Gray described, refuse counselling of any sort, there are many persons who are very resistant to medication, despite our best efforts to get them to take them.

But I am not advocating for a balanced approach, but rather an effort to educate consumers about the psychosocial options. I would personally be very reluctant to use the APA for any of this, as the political forces in APA are so dominant that they would consume either 80% of the energy, the money, or the inertia. Possibly federal grants to consumer-based organizations to work with agencies that do direct to consumer marketing for pharmaceuticals could yield the level of exposure and quality of presentation that is needed. This takes millions of dollars, but the yield would be worth it.

Bill Berman

TECScript 5: Evidence-Based Treatments
12 January 2002 – 3 February 2002

Date: Tue, 22 Jan 2002 1:38PM

From: William Berman <wberman@echoman.com>

On Sat, 19 Jan 2002 11:42AM Sylvia Caras <sylvia@peoplenho.org> wrote:

Evidence is not a neutral word.

*Someone decides, according to some *value* system, what counts and what doesn't.*

How much does the personal individual anecdotal reaction to treatment count as evidence?

How much does the outcome the customer wants, not the outcome the provider wants, count as evidence?

Sylvia

Sylvia Caras, PhD

www.peoplenho.org

"Nothing About Me, Without Me"

When I take my son for treatment of sleep apnea, I sure hope that the evidence used by his doctor is not individual anecdotal reaction, but rather an understanding of controlled clinical trials and carefully conducted effectiveness research. And when I take medicine for hypertension, it better be based at least on what the FDA considers to be evidence.

I agree that there is an inherent value system, but even the drug companies have to include the value known as "people get better" along with the profit motive.

TECScript 5: Evidence-Based Treatments

12 January 2002 – 3 February 2002

Date: Tue, 22 Jan 2002 2:49PM

From: Sylvia Caras <sylvia@peoplewho.org>

On Tue, 22 Jan 2002 1:38PM William Berman <wberman@echoman.com> wrote:

When I take my son for treatment of sleep apnea, I sure hope that the evidence used by his doctor is not individual anecdotal reaction, but rather an understanding of controlled clinical trials and carefully conducted effectiveness research. And when I take medicine for hypertension, it better be based at least on what the FDA considers to be evidence.

I agree that there is an inherent value system, but even the drug companies have to include the value known as "people get better" along with the profit motive.

Better according to ... ?

For instance, the mental health system might believe that ending hearing voices, at the cost of some sedation is "better."

The voice hearer might believe that tools to manage the voices while remaining more alert is "better."

Sylvia

TECScript 5: Evidence-Based Treatments
12 January 2002 – 3 February 2002

Date: Tue, 22 Jan 2002 4:15PM

From: William Berman <wberman@echoman.com>

On Tue, 22 Jan 2002 2:49PM Sylvia Caras <sylvia@peoplenho.org> wrote:

Better according to ... ?

For instance, the mental health system might believe that ending hearing voices, at the cost of some sedation is "better."

The voice bearer might believe that tools to manage the voices while remaining more alert is "better."

Sylvia

In general, better refers to a reduction in distressing symptoms, an increase in one's ability to engage in useful and productive activities, and a feeling of satisfaction with various aspects of one's life. People of course have options as to how to achieve these goals, and if a consumer wants to try to get "better" through psychosocial means rather than pharmacologic means, then he/she should have the option to do that, of course. My brother-in-law had the choice of reducing his cholesterol by dietary restraint or by medication; he chose the former and was successful. But if he had not been successful, his doctor would have been remiss to not strongly recommend medication rather than risk a 3rd heart attack. The same is true for persons who hear voices. If he/she wants to learn to cope with the voices, that is certainly an option. But should that prove unsuccessful (e.g., the person hurts themselves or others, is unable to go to work or live with family members, etc.), then we as professionals would be remiss not to strongly encourage medications to facilitate the coping process.

I feel there is a difference between what we as professionals recommend and what persons with mental illness can choose to do in determining their treatment choices. It is my interpretation that this thread has been about the former, not the latter.

Bill Berman

TECScript 5: Evidence-Based Treatments

12 January 2002 – 3 February 2002

Date: Tue, 22 Jan 2002 4:48PM

From: Scott Hickey, PhD <shickeys@pdq.net>

On Tue, 22 Jan 2002 1:38PM William Berman <wberman@echoman.com> wrote:

When I take my son for treatment of sleep apnea, I sure hope that the evidence used by his doctor is not individual anecdotal reaction, but rather an understanding of controlled clinical trials and carefully conducted effectiveness research. And when I take medicine for hypertension, it better be based at least on what the FDA considers to be evidence.

I agree that there is an inherent value system, but even the drug companies have to include the value known as "people get better" along with the profit motive.

Sure hope so. And you may also at some point wonder what it means that your son has an illness. Older, more expensive forms of psychosocial treatment used to tackle these issues as well. Whatever else may be said of them, they were ambitious. Today's CBT practitioner is likely more effective, but doesn't have a model for putting suffering in context or providing meaning. Nor do the managed care companies wish to pay for this. The culture seems to have decided that these are spiritual/religious matters rather than health care issues.

I work both sides of the fence, doing program evaluation as well as clinical work. As an outcomes evaluator, I rankle at the clinicians who assert that our measurements can never capture the whole picture. In my clinician role, I feel as if the pressures of managed care have turned me into a fast order cook. I feel sometimes as if I'm cranking out Egg McMuffins, uniformly mediocre food, when I'd rather be back making soufflés, even if some of the soufflés fall. I echo Dr. Nguyen's observation that we may feel nostalgic in the near future for the days when, among other things, we could think about the whole person, including meaning and values. I already miss the time when there was enough money that we could bake a mean soufflé. On the other hand, I don't yet have to ask, "Do you want fries with that?"

TECScript 5: Evidence-Based Treatments

12 January 2002 – 3 February 2002

Date: Tue, 22 Jan 2002 5:13PM

From: Lorna Simon <lorna.simon@umassmed.edu>

On Tue, 22 Jan 2002 4:15PM William Berman <wberman@echoman.com> wrote:

In general, better refers to a reduction in distressing symptoms, an increase in one's ability to engage in useful and productive activities, and a feeling of satisfaction with various aspects of one's life. People of course have options as to how to achieve these goals, and if a consumer wants to try to get "better" through psychosocial means rather than pharmacologic means, then he/she should have the option to do that, of course. My brother-in-law had the choice of reducing his cholesterol by dietary restraint or by medication; he chose the former and was successful. But if he had not been successful, his doctor would have been remiss to not strongly recommend medication rather than risk a 3rd heart attack. The same is true for persons who hear voices. If he/she wants to learn to cope with the voices, that is certainly an option. But should that prove unsuccessful (e.g., the person hurts themselves or others, is unable to go to work or live with family members, etc.), then we as professionals would be remiss not to strongly encourage medications to facilitate the coping process.

I feel there is a difference between what we as professionals recommend and what persons with mental illness can choose to do in determining their treatment choices. It is my interpretation that this thread has been about the former, not the latter.

Bill Berman

Why does it have to be either or? What's wrong w/ using both medication and some kind of behavioral intervention? In fact, this is what the research shows works best. And I think any doctor who would not prescribe medication to stop someone from hearing voices irrespective of any behavioral treatment would not only be remiss, his/her actions would constitute malpractice.

TECScript 5: Evidence-Based Treatments

12 January 2002 – 3 February 2002

Date: Tue, 22 Jan 2002 5:23PM

From: William Berman <wberman@echoman.com>

On Tue, 22 Jan 2002 4:48PM Scott Hickey, PhD <shickey@pdq.net> wrote:

Sure hope so. And you may also at some point wonder what it means that your son has an illness. Older, more expensive forms of psychosocial treatment used to tackle these issues as well. Whatever else may be said of them, they were ambitious. Today's CBT practitioner is likely more effective, but doesn't have a model for putting suffering in context or providing meaning. Nor do the managed care companies wish to pay for this. The culture seems to have decided that these are spiritual/religious matters rather than health care issues.

I work both sides of the fence, doing program evaluation as well as clinical work. As an outcomes evaluator, I rankle at the clinicians who assert that our measurements can never capture the whole picture. In my clinician role, I feel as if the pressures of managed care have turned me into a fast order cook. I feel sometimes as if I'm cranking out Egg McMuffins, uniformly mediocre food, when I'd rather be back making soufflés, even if some of the soufflés fall. I echo Dr. Nguyen's observation that we may feel nostalgic in the near future for the days when, among other things, we could think about the whole person, including meaning and values. I already miss the time when there was enough money that we could bake a mean soufflé. On the other hand, I don't yet have to ask, "Do you want fries with that?"

I think an issue that has been plaguing mental health for a long time is the conflict between meaningfulness and effectiveness. This was described in an article by Kish and Kroll many years ago (I've long since lost the reference). We and many of our clients/patients/consumers tend to pay much more attention to the meaningfulness of our clinical activities, rather than the effectiveness of those activities. Humans tend to think (erroneously) that meaningfulness = effectiveness, but we as psychologists know they do not. Many of us have been able to help people find meaning in their lives, but show no measurable change in symptoms or functioning. I am not saying this is not valuable. But it is clear that the medical insurance world (including the federal government, who pays 1/2 of all medical bills) is not interested in paying for this. I think the dilemma of meaningfulness and effectiveness in a medically funded mental health system is the critical issue we are really talking about here.

Bill Berman

TECScript 5: Evidence-Based Treatments

12 January 2002 – 3 February 2002

Date: Tue, 22 Jan 2002 6:24PM

From: Tuan Nguyen <tuan.nguyen@mhmrharris.org>

On Tue, 22 Jan 2002 4:48PM Scott Hickey, PhD <5hickey@pdq.net> wrote:

Sure hope so. And you may also at some point wonder what it means that your son has an illness. Older, more expensive forms of psychosocial treatment used to tackle these issues as well. Whatever else may be said of them, they were ambitious. Today's CBT practitioner is likely more effective, but doesn't have a model for putting suffering in context or providing meaning. Nor do the managed care companies wish to pay for this. The culture seems to have decided that these are spiritual/religious matters rather than health care issues.

I work both sides of the fence, doing program evaluation as well as clinical work. As an outcomes evaluator, I rankle at the clinicians who assert that our measurements can never capture the whole picture. In my clinician role, I feel as if the pressures of managed care have turned me into a fast order cook. I feel sometimes as if I'm cranking out Egg McMuffins, uniformly mediocre food, when I'd rather be back making soufflés, even if some of the soufflés fall. I echo Dr. Nguyen's observation that we may feel nostalgic in the near future for the days when, among other things, we could think about the whole person, including meaning and values. I already miss the time when there was enough money that we could bake a mean soufflé. On the other hand, I don't yet have to ask, "Do you want fries with that?"

"I feel there is a difference between what we as professionals recommend and what persons with mental illness can choose to do in determining their treatment choices. It is my interpretation that thread has been about the former, not the latter." Bill Berman

While I agree that the thread has received mostly input from professionals, I feel the discussion of evidence-based treatment or intervention (and attempts to ascertain their worth in terms of evidence) should incorporate evidence from all sources at the stage of determining the efficacy of these products. Then later-i.e., at the utilization and implementation stage—evidence can be used by professionals to recommend courses of action or by consumers to accept or reject the recommended course of action.

Incorporating consumer-based evidence during the early stage, instead of waiting until the implementation stage, should help to lessen the likelihood of developing products that prove irrelevant or unacceptable. I am reminded of the development and distribution of sun-activated and operated stoves to people in northern Africa deserts (a place of sure abundance of sunshine and heat). The stoves were technologically correct and would have provided free energy to those who did not and still do not have easy access to energy sources like oil, wood and coal. However, they require that one cooks outdoors and during daytime in cultures where cooking is a very private matter that happens at night! So they were gracefully accepted but not used.

Closer to home, our recent survey of consumers who stopped taking the newer generation medications found that side effects constituted a major reason among many consumers who did not stay with the treatment regimen. The second most prevalent reason was the feeling that the medication did no good. As well, the long time that it takes for psychosocial intervention to achieve its outcomes (e.g., housing stability and employment, which requires at least 18 months of participation) coupled with the recent unrealistic expectations, brought about by managed care, resource shortage, etc., that mental illnesses could be handled as

TEC*Script* 5: Evidence-Based Treatments

12 January 2002 – 3 February 2002

acute conditions has probably been the major culprit in removing these interventions from or decreasing their importance in the mental illness treatment arsenal. Concerning this last types of outcome, evidence should probably include well-documented guidelines concerning the expected stages of achievement of the goal or guidelines about the gradient, over time, of movement toward the goal(s) as well as documented levels of acceptance/dropping out/dissatisfaction among participants or subgroups of consumers. Without this type of evidence, unrealistic expectations of outcome will surely arise, muddling the understanding of the process necessary to arrive at outcomes.

TECScript 5: Evidence-Based Treatments
12 January 2002 – 3 February 2002

Date: Tue, 22 Jan 2002 6:30PM

From: William Berman <wberman@echoman.com>

On Tue, 22 Jan 2002 5:13PM Lorna Simon <lorna.simon@umassmed.edu> wrote:

Why does it have to be either or? What's wrong w/ using both medication and some kind of behavioral intervention? In fact, this is what the research shows works best. And I think any doctor who would not prescribe medication to stop someone from hearing voices irrespective of any behavioral treatment would not only be remiss, his/her actions would constitute malpractice.

If I said or implied that medication v. therapy was the issue, please accept my apologies. I did not mean or intend that. I certainly would agree that both is often the right choice, along with other types of intervention such as vocational training, club-houses, etc.

TECScript 5: Evidence-Based Treatments
12 January 2002 – 3 February 2002

Date: Tue, 22 Jan 2002 6:55PM

From: Sheila Baer <smbaer@aol.com>

I agree -- meaningfulness and effectiveness are hugely different concepts. Similarly, mental health/wellness is a value-laden construct that can be interpreted and defined several ways with respect to both functioning and phenomenology, although each provides a valid perspective of "feeling good." Whether, and to what degree, an individual seeks to be effective or find meaning (or a researcher seeks to investigate effectiveness or meaningfulness) is a personal choice related to individual personality characteristics and values. Relativism aside, individuals grow up with different ideas of what is worth having and doing and what is not, and what price one is willing to pay. This perspective, however, has little meaning within the medicalized mental health system, which is \$-driven to find the cheapest and easiest course of treatment. Mental health falls somewhere between psychology, biology, and philosophy, and I doubt if a single perspective is sufficient to capture all of its meaning for all people. McHugh and Slavney wrote an excellent book on this topic -- "Perspectives of Psychiatry" -- that distinguishes four very different but equally valid perspectives of mental health/illness.

TECScript 5: Evidence-Based Treatments
12 January 2002 – 3 February 2002

Date: Tue, 22 Jan 2002 7:00PM
From: Tom Trabin <tom@trabin.com>

Dear fellow listserve members,

I have been enjoying the discussion regarding evidence-based practices immensely. A closely related issue, and one I would think to be central to this listserve's interests, is how to measure adherence to evidence-based practices. Or, more fundamentally, how to measure/track any of the kinds of treatments that clinicians are providing within a given mental health/substance abuse system of care.

It is one thing to track treatment interventions delivered in closely monitored experiments, quite another to do so throughout a large system of care. We have a coded taxonomy for diagnoses, but not for treatment interventions (beyond level of care and some very gross distinctions of modalities). There are a few inroads being made with measures of fidelity to certain treatments like ACT, but not much (at least that I know of). I am involved in a couple of projects to address this, and would appreciate learning of any compelling measures of fidelity to specific treatments that are currently being deployed by large organizations or systems of care.

Thanks,
Tom Trabin

TECScript 5: Evidence-Based Treatments
12 January 2002 – 3 February 2002

Date: Tue, 22 Jan 2002 10:36PM

From: Tuan Nguyen <tuan.nguyen@mhmraharris.org>

Tom: When participating in some CMHS grant reviews, I found proposals that included methods to measure model fidelity. One grant program comes to mind: Consumer-operated programs. However, as a reviewer I had to destroy all proposals, so cannot tell you whom to contact for information about how they went about measuring fidelity. Perhaps grant officers for such grants could help point you to investigators who were awarded funds to implement their proposals.

Tuan

PS, like Tom, I would definitely welcome info re measurement of model fidelity.

TECScript 5: Evidence-Based Treatments
12 January 2002 – 3 February 2002

Date: Wed, 23 Jan 2002 8:07AM
From: Mark Salzer <salzer@cmhpsr.upenn.edu>

On Tue, 22 Jan 2002 10:36PM Tuan Nguyen <tuan.nguyen@mhmraharris.org> wrote:

Tom: When participating in some CMHS grant reviews, I found proposals that included methods to measure model fidelity. One grant program comes to mind: Consumer-operated programs. However, as a reviewer I had to destroy all proposals, so cannot tell you whom to contact for information about how they went about measuring fidelity. Perhaps grant officers for such grants could help point you to investigators who were awarded funds to implement their proposals.

Tuan

PS, like Tom, I would definitely welcome info re measurement of model fidelity.

I am one of the investigators on the consumer-operated services program funded by CMHS (<http://www.cstprogram.org/>). Our group has been working on a method to assess common ingredients of consumer-operated services. Contact Jean Campbell (campbelj@mimh.edu) or Matt Johnsen (matthew.johnsen@umassmed.edu) for more information about this instrument.

Also, HSRI (www.hsri.org, I think) has a recent publication on assessing program fidelity.

TECScript 5: Evidence-Based Treatments
12 January 2002 – 3 February 2002

Date: Wed, 23 Jan 2002 8:35AM
From: Jennifer Pyke <jpyke@cmha-toronto.net>

On Tue, 22 Jan 2002 10:36PM Tuan Nguyen <tuan.nguyen@mbmrharris.org> wrote:

Tom: When participating in some CMHS grant reviews, I found proposals that included methods to measure model fidelity. One grant program comes to mind: Consumer-operated programs. However, as a reviewer I had to destroy all proposals, so cannot tell you whom to contact for information about how they went about measuring fidelity. Perhaps grant officers for such grants could help point you to investigators who were awarded funds to implement their proposals.

Tuan

PS, like Tom, I would definitely welcome info re measurement of model fidelity.

I would like to obtain a copy of the fidelity measure for ACT. Who can I contact?

Jennifer Pyke
CMHA/Toronto Branch
970 Lawrence Ave. W.,
Suite 205,
Toronto, Ontario
Canada M6A 3B6
Tel: (416) 789-7957 ext. 270
Fax: (416) 789-9079
e-mail: jpyke@cmha-toronto.net

TECScript 5: Evidence-Based Treatments
12 January 2002 – 3 February 2002

Date: Wed, 23 Jan 2002 8:47AM
From: Mark Salzer <salzer@cmhpsr.upenn.edu>

On Wed, 23 Jan 2002 8:35AM Jennifer Pyke <jpyke@cmha-toronto.net> wrote:

I would like to obtain a copy of the fidelity measure for ACT. Who can I contact?

*Jennifer Pyke
CMHA/Toronto Branch
970 Lawrence Ave. W.,
Suite 205,
Toronto, Ontario
Canada M6A 3B6
Tel: (416) 789-7957 ext. 270
Fax: (416) 789-9079
e-mail: jpyke@cmha-toronto.net*

Greg Teague at FMHI has done some work on measuring fidelity to ACT, as have the PACT folks at Wisconsin (Test et al.).

Advances in measuring fidelity have also been made in the Clubhouse area (see Macias's article published in Mental Health Services Research journal in 2001 -- this journal is now available online from Kluwer). I also understand that Matt Johnsen, referred to in my previous email on fidelity, is also working on measuring fidelity of Clubhouses.

Mark

TECScript 5: Evidence-Based Treatments

12 January 2002 – 3 February 2002

Date: Tue, 29 Jan 2002 2:37PM

From: Greg Teague <teague@fmhi.usf.edu>

I have responded directly to Jennifer. For this discussion, here is additional information on ACT fidelity measurement.

The Dartmouth Assertive Community Treatment Scale is described in the following article: Teague, G.B., Bond, G.R., & Drake, R.E. (1998). Program fidelity in Assertive Community Treatment: Development and use of a measure. *American Journal of Orthopsychiatry*, 68, 216-232.

The other main ACT fidelity approach of which I am aware in the literature is that of John McGrew and colleagues: McGrew, J.H., Bond, G.R., Dietzen, L., & Salyers, M. (1994); Measuring the fidelity of implementation of a mental health program model; *Journal of Consulting and Clinical Psychology*, 62, 670-678.

Also, NAMI has sponsored the work by Deborah Allness and William Knoedler, a detailed handbook on PACT: Allness, D.J., Knoedler, W.H. (1998); *The PACT Model of Community-Based Treatment for Persons with Severe and Persistent Mental Illnesses: A Manual for PACT Start-Up*; Arlington, VA: NAMI Anti Stigma Foundation. This manual includes a set of program standards that are much more specific and detailed than any fidelity measure could hope to be. The NAMI website should lead you to information both on obtaining this and on a program checklist, which is more like a fidelity measure.

Greg

TECScript 5: Evidence-Based Treatments
12 January 2002 – 3 February 2002

Date: Sun, 03 Feb 2002 12:08PM
From: teclists@hsri.org

On Wed, 23 Jan 2002 8:07AM Mark Salzer <salzer@cmhpsr.upenn.edu> wrote:

I am one of the investigators on the consumer-operated services program funded by CMHS (<http://www.cstprogram.org/>). Our group has been working on a method to assess common ingredients of consumer-operated services. Contact Jean Campbell (campbellj@mimh.edu) or Matt Johnsen (matthew.johnsen@umassmed.edu) for more information about this instrument.

Also, HSRI (www.hsri.org, I think) has a recent publication on assessing program fidelity.

The following publications from the Evaluation Center@HSRI might be of interest to list members in light of the recent discussion on measuring fidelity to treatments. For more information on these publications please contact Terry Camacho-Gonsalves at tcamacho@hsri.org.

Psychiatric Rehabilitation Fidelity Toolkit, November 2000 (PN-44).

Gary Bond, Jane Williams, Lisa Evans, Michelle Salyers, Hea-Won Kim, Heather Sharpe, and H. Stephen Leff.

This toolkit presents a working guide for the development of fidelity measures to be used in assessing the implementation of psychiatric rehabilitation program models. This toolkit describes the origins of fidelity measures and discusses their research and practical applications, reviews current models in psychiatric rehabilitation, and provides a detailed guide for developing fidelity measures. The Appendix gives examples of instruments currently in use for psychiatric rehabilitation.

Measuring Conformance to Treatment Guidelines: The Example of the Schizophrenia PORT, August 2001 (PN-46).

The Schizophrenia Patient Outcomes Research Team, University of Maryland School of Medicine, and John Hopkins School of Hygiene and Public Health (Anthony Lehman, M.D., M.S.P.H., Principal Investigator, and Donald Steinwachs, Ph.D., Co-Principal Investigator).

The use of adherence to guidelines to measure quality of care has emerged as a major tool in the quality management arsenal. This toolkit has been developed to illustrate how to design a measurement strategy around a set of guidelines as a means of assessing how well an organization is actually implementing those guidelines. This toolkit is not a guide to the treatment of schizophrenia. A major reason is the PORT guidelines, as described in this Toolkit, may have been subsequently updated since the toolkit was compiled. Nevertheless, the PORT process described serves to illustrate how one might begin to build a guideline based quality assessment system. A secondary purpose of this toolkit is to illustrate how evaluation evidence can be used to develop guidelines for specific disorders. The PORT Tools for assessing care (the PORT Mental Health Survey, and the Schizophrenia PORT Inpatient and Outpatient Record Review forms) are included in the toolkit.