How Practice Guidelines Can Rescue Psychotherapy in Public Systems

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The Code of Hammurabi decreed, "If a physician . . . open a tumor (over the eye) with an operating knife, and saves the eye, he shall receive ten shekels in money. . . . [If he] cut out the eye, his hands shall be cut off" (1).

This regulation likely achieved several purposes. First, it established a quality outcome standard. Second, it assured any Babylonian entering a local health care system that quality standards were taken seriously. Third, it established a motivation for physicians to perform high-quality work. An additional and perhaps unintended consequence of the decree may have been that it gave physicians a greater interest in developing better practice guidelines for patient selection and treatment.

Practice guidelines serve as a basis for developing clinical quality standards and measures. They also control decisions about resource allocation and medical liability (2,3). Armed with the proper set of practice guidelines, the Ur-physician might have successfully argued that inadvertent enucleation was not due to technical failure. Backed against the ziggurat, he might plausibly have decried the insufficient organizational commitment of shekels to physician training or support.

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Modern psychiatrists, especially those who struggle with overwhelming clinical responsibilities and limited resources in public mental health systems, can probably empathize with their ancient physician brethren. Practice guidelines can have a powerful influence on decisions about quality and support. This potential motivated us in the Los Angeles County Department of Mental Health to undertake the development of clinical guidelines. What follows is an account of our rationale for developing the psychotherapy guidelines quickly and of the process we used to do so. Interested readers can find the guidelines on our Web site at http://dmh.co.la.ca.us/.

The rationale

Our drive to develop psychotherapy guidelines arose from our belief that the sorry state of psychotherapy in many public mental health systems may be a perverse consequence of the exuberant growth of psychopharmacologic guidelines. Guidelines provide a blueprint for realizing the "highest quality of care" (4) in the practice areas they describe—even at the expense of practice areas that do not have such guidelines. "What gets measured gets done." Practice guidelines and the concerns about education, quality, and liability that they gestate may lead to decisions to preferentially place resources into areas in which guidelines are used. Consensus has been established on the powerful positive effect that guidelines have on quality standards (5). In contrast, debate continues about the optimum methods for guideline development and about whether familiarity with guidelines directly changes physicians' practice (6).

The recent exponential increase in clinical knowledge has engendered a profusion of practice guidelines, but these guidelines have been developing at different rates across fields. This variation may be partly due to variations in the amount of clinical knowledge that has accrued in different fields. Guideline design is favored in areas in which research is better supported or more easily accomplished. Even in these privileged—and usually pharmacologic—areas, the ponderous process of developing purely evidenced-based guidelines is often outpaced by more nimble construction of practice guidelines that place more emphasis on expert- or consensus-based processes.

One motivation for developmental haste may be the impact that guidelines have on treatment resources. Consider, for example, the histories of pharmacotherapy and psychotherapy in the public sector over the past 20 years. Psychiatrists of a certain age remember the situation in public mental health before the advent of psychopharmacology guidelines. Often the bulk of treatment planning meetings consisted of lengthy discourse and debate about psychological etiologies and interventions. This was followed by brief palaver about whether to "medicate the patient," often with little understanding of or interest in psychopharmacology on the part of most multidisciplinary team members.

The looming presence of expert- and consensus-based pharmacologic guidelines has remarkably altered the picture (7). Guidelines open windows onto the pharmacologic treatment process that may preferentially direct finite resources to areas in which quality becomes visible (8). Commu-

nity demand for high-quality psychopharmacologic treatment mushrooms, and fiscal resources devoted to formulary soar (9).

Psychotherapy in the public sector may suffer as a result. During these recent decades of unparalleled creativity and rigor in the development of and research on psychotherapies (10), resources for psychotherapy paradoxically withered (11). Meetings of multidisciplinary treatment teams today are more likely to consist of erudite discussion about pharmacologic and social interventions, followed by cursory mention of some unspecified "psychotherapy," often provided by someone who has minimal psychotherapy training.

Resources in public-sector psychiatry have in large measure been redirected from psychotherapy to areas where there are relatively more guidelines and associated quality measures. The area that falls behind in guideline development starves despite the fact that associated treatment techniques may be cost-effective and potent. The American Psychiatric Association (APA) committee on the practice of medical psychotherapy noted, "The conditions for psychotherapy must be preserved. . . . Anecdotal reports from psychiatrists indicate that the quality of psychiatric treatment is not preserved in managed care systems that reduce mental health expenditures through denial of medically necessary care. . . . Advice and referral to self-help groups, as commonly advocated in managed 'behavioral health care' organizations, cannot adequately substitute for skilled psychotherapy" (12).

Well-trained psychiatrists in public mental health systems are only too aware of the inadequate attention devoted to the psychotherapy of their patients. Often their psychiatric skills are considered too valuable to be "wasted" on providing psychotherapy. Despite evidence that "split treatment" is not necessarily more costly (13,14), the public psychiatrist is forced to concentrate on somatic treatments, hoping that someone else is providing effective psychotherapy.

The promulgation of accepted psychotherapy guidelines in public programs might be expected to have an effect similar to that of psychopharmacology guidelines, enhancing the resources devoted to psychotherapy. It is likely that purely evidence-based psychotherapy practice guidelines for use in the public sector are still some way off. For example, the APA commission on psychotherapy by psychiatrists found that the research literature on the role of psychotherapy in treatment of medical illness was "underdeveloped" for the purposes of guideline development (15).

The process

When we first began our effort at the Los Angeles County Department of Mental Health in 1999, we found few existing general psychotherapy guidelines from which to generate quality standards. Lacking the raw material for purely evidence-based guidelines but in need of a foundation on which to build appropriate psychotherapeutic resources, we set out to construct utilitarian expert- or consensus-based guidelines. Our 18-month project to develop psychotherapy guidelines followed a similar effort the year before in which psychopharmacology guidelines were created. The method consisted of assembling a group of recognized multidisciplinary psychotherapy experts from the local clinical academic community that represented expertise in major forms of psychotherapy. With added clinical leaders from within the department, including the medical directors of its clinical services, the full group numbered about 15 persons.

The focus of the workgroup was entirely pragmatic: the areas on which it concentrated were those issues that had immediate applicability to our system. We first built a universal set of guidelines applicable to the supportive psychotherapy that is necessarily the current mainstay of psychotherapy in public settings. We followed this core set with guidelines associated with specific clusters of techniques: psychodynamic, behavioral, cognitive, interpersonal, and family.

The guideline sets describe the features that are critical for measuring quality. They include therapeutic goals; specific techniques to be available; necessary therapist training; access—that is, frequency and duration; associated support resources—assessments, monitoring, physical space, documentation, and consultation; essential and optional applications; and contraindications.

The groups dispensed with development of guidelines for purely manual-driven therapies that are often well described and researched but rarely practical in our public clinics. We also eschewed any scholarly elaboration of research findings and descriptions of controversies, as we found that although such material was critically important, it was of less relevance to our purposes.

Given the need to produce a practical work product in a finite period, the format of the guidelines and first drafts for each section were sequentially written by small subgroups after general group discussions. Drafts were circulated for extensive comments that were then redacted and recirculated. Discussions followed to achieve consensus wherever possible. Two recirculations of revised drafts usually resulted in a final draft. The Department of Mental Health clinical policy committee approved the final products, which were then promulgated in hard copy and posted on the department's public Web site to facilitate access and updates.

It is too soon to assess the effect of the new psychotherapy guidelines on psychiatric practice in the department, but the process has already stimulated renewed interest in psychotherapy. Psychiatrists in the department may soon take a more active role in prescribing, providing, and supervising the more specialized forms of psychotherapy. The guidelines are expected to aid in treatment planning and to serve as guidelines for the continuing medical education programs under the department's auspices. Other departmental workgroups are using the guidelines as a template for creating psychiatric quality standards and measures. Ultimately these products will help determine the provision of resources for psychotherapy.

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Challenges remain. A particularly sensitive task that has risk management implications is designing the manner in which practice guidelines are formally linked to the department's clinical policies. The policy that results will likely follow the established model of encouraging psychiatrists and other clinicians to carefully document the reasons for deviation from guidelines whenever such deviation is indicated.

In the opening years of the new millennium, practice guidelines may well encourage public-sector psychiatrists to keep their hands in psychotherapy without fear of losing them. ♦

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