Real-World Use of Evidence-Based Treatments in Community Behavioral Health Care

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Introduction by the column editor:
It is one thing to tout "best practices" and another thing to actually employ them. The author of this month's column provides us with a "fly on the wall" view of the experience of one community mental health center in implementing evidence-based treatments for mental illnesses. If you have ever sat in a meeting at which you are supposed to be generating a best-practice approach and all you are hearing is a discussion of procedures rather than outcomes measurement, this column will be of interest.

The term "best practices" encompasses a variety of treatment interventions, including practice guidelines, treatments that are probably efficacious, and evidence-based treatments (EBTs). Of these, EBTs are arguably the standard. However, the level of rigor needed to meet this standard makes EBTs seem out of reach—or even irrelevant—to many providers. Some believe that these treatments cannot be transported into a "real" clinical environment, particularly a community-based setting.

Many factors are involved in the debate about EBTs. Some of these arguments have merit, but arguing that EBTs cannot be transported to community-based settings is not one of them. Our experience at the Center for Behavioral Health (CBH) indicates that community-based settings can, if they choose, successfully implement EBTs.

CBH is a community mental health center located in Bloomington, Indiana. We have implemented more than 20 EBTs for adults and youths with mental illness or chemical dependencies. The center is a private not-for-profit organization, not an academic institution—an important distinction given that most EBTs were developed in academia, where there are strict controls on the clinical population being assessed. Such controls are needed to prevent unwanted variance in the research protocol. However, their presence calls into question the protocols' applicability in settings in which presenting problems are more complex and providers do not have the luxury of excluding patients from treatments because of concomitant problems. Our experience has shown that, in general, EBTs can be transported to applied settings with little—if any—decrement in outcomes as a result of clinical complexity. If organizations want to incorporate EBTs into their clinical repertoire, they should address the "three C's": commitment, culture change, and clinical discipline.

Commitment

Before embarking on the path toward clinical enlightenment, the organization must commit to doing so from the highest level. For a community-based setting, this usually means board-level commitment. In 1989, the board of directors of CBH issued the following mandate: "The Center will operate only those mental health treatments, services, and programs for which there exists evidence in the professional literature of their efficacy."

Making this statement today would be bold; in 1989 it was prescient. The statement set the future course for the organization by setting an expectation that EBTs would drive high-quality, ethical treatment in our organization. Depending on the nature of the relationship between the board and senior management, it may be more appropriate but equally effective to have this type of mandate come from the organization's chief executive. However, it would not be advisable to go any lower in the organization, because this change will likely require allocation of resources and potential staffing changes. Once the commitment has been made and communicated, the real work begins.

Culture change

The implementation of EBTs is not so much about getting trained in the right protocol—although that will be necessary—as it is about changing the culture of the organization to one that is measurement and outcomes oriented. The ultimate goal of implementing EBTs is improved outcomes for patients (1). EBTs accomplish this goal, but they also have a significant impact on clinical processes.

Unfortunately, many clinicians do not think in terms of measurable and demonstrable change in the industry. Because many clinicians were not trained to integrate data into their treatment decisions, their theoretical orientation became the rationale for the work they did. They believed in

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the theory without regard to whether there was any empirical evidence on its effectiveness. Interestingly, when one looks at the research on common factors in psychotherapy, one could argue that clinicians' belief in their theory did make them more effective clinically, regardless of the theory (2). Providing treatment on the basis of a theory and then gauging one's competence solely on the basis of fidelity to that theory constitutes a circular barrier that is impenetrable to external accountability.

The move to an outcomes orientation, with its commensurate accountability, will be threatening to some individuals and completely foreign to many. Nonetheless, this is exactly the change that must occur in the hearts and minds of clinical professionals if an organization is to evolve—and evolve it must. As management guru Peter Drucker (3) has noted, the reason organizations fail is that the "assumptions on which the organization has been run no longer fit reality." Or, as David Barlow (4) observed, " If we do not promote and disseminate existing evidence for the efficacy of our psychological interventions, then we will put psychotherapy at a severe disadvantage and risk a substantial deemphasis if not elimination of psychological interventions in our health care delivery system."

To change any organizational culture is not easy. To change a culture of clinical professionals is particularly difficult because of their concern about behaving ethically. For most, this concern is an honest fear of the unknown; they are being asked to abandon the system of treatment they have spent their careers developing. They may be willing to change, but they must first be convinced that this "new" way of treating patients is ethical. Given that one of the reasons organizations seek to implement EBTs is that these treatments are often more efficient, clinicians may interpret this request as a demand to decrease clients' lengths of stay solely for economic reasons, thereby validating their fear of providing inadequate care. From the clinician's perspective, then, the ethical considerations must be addressed early and directly.

There will also be those who use the ethical argument as a way to resist change, but our experience suggests that these individuals are in the minority. If clinicians cannot be assured that the move to EBTs and outcomes-based treatments is clinically appropriate, the fear of providing unethical treatment will prevent even the most motivated clinicians from changing their practice patterns. However, once the ethical hurdle has been cleared, issues related to the relative treatment efficiency of different approaches can be more easily addressed.

It is important to keep in mind that the culture change advocated here is a fundamental and profound challenge to the values and day-to-day operations of the organization. But this change does not represent an overlay to the organization's existing values system; it is a change so deep that the organization's entire value system will be confronted. When the board of directors of CBH issued its directive that we provide only treatments that work, many of the tenets and traditions we practiced were challenged. For example, what should we do with clinicians who cannot or will not adapt to EBTs? What should we do if we identify long-standing treatment groups that both clinicians and clients liked but that showed no evidence of fostering improvement? How do we handle the public reaction when we terminate a program that had strong support among local judges but showed no evidence of treatment efficacy? All these issues were addressed, and in each case the effects on the culture of the organization were significant. It was difficult, but it was necessary.

Culture change requires that measurement and outcomes become integrated into all aspects of the organization's clinical thought and behavior. In many cases it changes the values of the organization. The challenges that CBH faced after the board of directors issued its directive have led the organization to clarify its values relative to personnel and public relations. It is more important to provide efficacious treatment than to keep employees we like or to provide ineffective programming that influential stakeholders want. Too many providers view EBTs as techniques to be learned rather than new ways of conceptualizing care. One indicator that the culture change had been successful was that clinicians began debating which outcomes instrument or EBT to use instead of whether these treatments should be used.

Clinical discipline

If the leadership has committed to the new direction and has begun the necessary culture changes, staff must be held to the new expected levels of clinical practice. It is not uncommon for individuals in the organization to appear to be supportive of major initiatives while in reality conducting business as usual. In this industry we employ smart people, and smart people—sometimes unintentionally—can say the right things about changing but continue with the same old behaviors, for several reasons.

One reason is denial. It is very curious to watch otherwise smart, insightful people go through the motions of change knowing full well that they are denying that the change will actually occur. For some individuals, resistance is more conscious. Some simply do not want to change their behavior, for reasons that are self-centered. For others, the fears described above about ethics and clinical appropriateness are real professional dilemmas that must be resolved before the changes can be enacted.

Management will have to set expectations and monitor compliance with those expectations. To ensure compliance, the tools being implemented—outcomes—should be used. Measuring clinicians' outcomes and then benchmarking these outcomes against those of their peers, either inside or outside the organization, provides the feedback necessary to effect change. Management's job is to collect, aggregate, and publish—preferably in graphical form—data that demonstrate clinicians' compliance relative to other clinicians.

There are compelling arguments on both sides as to whether clinicians' identities should be visible to others through these reports. Either way, it is management's job to provide only the information, without judgment or

contingencies. This reasoning is based on the premise that clinicians want to continuously strengthen their clinical skills, and it is not the job of management to cajole them but, rather, to give them the necessary tools to effect this change. In most cases, this approach is all that is necessary. However, occasionally there will be an individual who cannot or will not adapt to the new way of doing things. Surprisingly, these people often realize they no longer fit in the "new" organization and move on. However, in cases in which the employee is not making the necessary change, management must intervene if the organizational change process is to be taken seriously.

This advice may seem obvious, but our experience suggests that managers, particularly those with clinical roots, usually undermanage. The suggestions listed here provide clinical managers the opportunity to change their employees' behavior without actively disciplining them. Initially, such an approach is appropriate. But managers must still manage, and these suggestions are not intended to suggest otherwise. Rather, it is a matter of timing as to when to confront clinical staff. These are not easy decisions, but management must demonstrate the discipline to see the culture change through to completion. During our change to an EBT-based organization, some of our clinicians left—usually of their own accord—but it was a small number, and both the individual clinicians and the organization are better off.

Impact

As noted above, to date CBH has implemented more than 20 EBTs. We have published the results of some of our studies in which we benchmarked our implementation of previously published efficacy studies in a real-world setting (5,6). In those articles we showed how a 15-session cognitive-behavioral treatment for panic disorder could be successfully implemented in a community-based setting without decrement in outcomes relative to those of the original research, which was conducted with more homogeneous populations than we routinely see.

The protocol itself consisted of psychoeducation that covered panic disorder, cognitive restructuring, diaphragm breathing retraining, interoceptive exposure, and naturalistic exposure. The first session was provided to participants and their significant others. Sessions 2 through 14 were conducted in a 90-minute group format. In the study noted above, 83 percent of the 110 participants completed the protocol in a group. Unlike the original researchers, we included clients who were experiencing concurrent agoraphobia but offered two optional sessions for these individuals that provided agoraphobic exposure. The complete protocol has been published elsewhere (7).

The positive results have been maintained one year posttreatment for this population. In 1999, CBH was the first behavioral health care organization to be awarded the Earnest A. Codman award for excellence in outcomes measurement by the Joint Commission on Accreditation of Healthcare Organizations.

Conclusions

It is hoped that organizations that are motivated to implement EBTs will understand that doing so is possible even in community-based settings. Although the suggestions listed above are fairly straightforward, they do require significant commitments and much professional and managerial discipline. Clinicians have to be trained in EBT protocols, and their adherence to the protocol—sometimes relevant to "fidelity to the model"—must be monitored as well. A method for using EBTs without maintaining fidelity to the model by means of a continuous quality improvement approach has been presented previously (1). However, if the organization is in need of outcomes and process control, fidelity must be maintained. In any event, it is important to remember that the ultimate goal is not outcomes or processes per se but improved patient care and EBTs, and outcomes are but a means to that end. ♦

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