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Issue Brief

Use of Clinical Practice Guidelines in Outpatient Treatment

Jennifer Taub, Ph.D.

With the recent focus in mental health care on evidence-based and efficacious treatments, many clinics and managed care organizations have adopted the use of clinical practice guidelines (CPGs) to aid in the treatment of patients with mental health disorders. CPGs have been defined as "Systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances."[1] They are patient focused, and they tend to be condition or treatment specific. Guidelines are viewed by policy makers as an important factor in decision-making about payment practices and other policy issues, but they can provoke controversies among providers and researchers.[2]

To address the issues in the implementation and use of CPGs in clinical settings, a set of studies was sponsored by the Florida Agency for Health Care Administration (AHCA) and undertaken by this author and researchers at the University of S. Florida.[3] First, a review of the CPGs used by local CMHCs and MCOs was undertaken. Next, interviews and focus groups were conducted with administrators and clinicians to learn more about the process of adopting and using CPGs in clinical practice.

Review of Clinical Practice Guidelines

Previous studies have indicated great variation in the CPGs in use by MCOs,[4-5] and our review was in keeping with these findings. Review of the CPGs in use at the time indicated tremendous variation. Some CPGs indicated very specific treatments in line with current literature on efficacious treatment for a variety of mental disorders. At the same time, other CPGs focused primarily on guidelines for level of treatment (e.g. inpatient vs. outpatient). Some covered all DSM disorders, while others focused on only the most prevalent or most costly disorders to treat, with the goal of cost containment rather than clinically efficacious care.[5]

Interviews with administrators

A total of 7 CMHC administrators and 5 MCO administrators participated in telephone interviews. Main topic areas addressed in the interviews were whether clinicians used CPGs, how and when the organizational decision to use protocols took place, how use is monitored, and a description of benefits and disadvantages of CPG use. All but one MCO and all CMHCs reported requiring that clinicians use a specific set of CPGs. Results indicated that MCO administrators reported CPGs as promoting quality and consistency in service provision as the primary reason for use, while CMHC administrators' primary motivation for use is that it is a requirement imposed by MCOs for reimbursement or accrediting agencies for licensing and accreditation. Noted benefits of CPGs included shorter treatment, less room for clinician error, and greater standardization of treatment. Some respondents noted no disadvantages to CPGs. Noted disadvantages included negative perceptions of CPGs by clinicians, highly detailed CPGs can be difficult to follow, and CPGs don't address the range of the clientele they serve. Training offered to clinicians for use of CPGs was highly variable, from "clinicians are always welcome to ask questions, but formal training isn't offered" to training during orientation at time of hire, to an unspecified "unified effort to provide training."

Focus groups with clinicians

Four focus groups, with a total of 32 therapists, were conducted. One group (n=8) were in private

practice while the rest worked at CMHCs. Among clinicians, most reported that they were unfamiliar with CPGs, even when their agencies required their use. Those who knew of them typically had only seen them during orientation, exemplified by the comment "I know what shelf they are on." There was little to no training on CPGs reported by most participants. Those who did have more than passing familiarly with the CPGs used by the organizations they worked for or with, tended to be private practitioners. These clinicians sometimes reported consulting them in their roles as "self-administrators" when dealing with insurance companies. A main theme was that of clinician resentment of the CPGs. Those with the least familiarly were also the most likely to express resentment that CPGs call into question their clinical judgment, training and expertise. Additional themes included concern that CPGs are related to doing more "band-aid therapy" (e.g. treating only the surface symptoms and not the underlying problems), treatment must focus only on the presenting problem, clinicians can only treat the very ill since the number of sessions is limited unless the client has a severe condition, the number of sessions approved may not match the treatment recommended by the therapist. There were concerns that "as soon as clients reach an O.K. stage they are discharged", not allowing for treatment to reach a stage that would prevent relapse.[3]

Issues and Implications

There are different viewpoints about CPGs between administrators and clinicians. Administrators report requiring use of CPGs primarily for quality and consistency in clinical services, and because funders and accreditors require them. Clinicians report using them to satisfy administrators, not to guide clinical services.

It is important to examine how much clinicians may already be doing in routine care that is congruent with CPGs. We don't really know what differences compliance may make at the practice level.

CPGs vary tremendously in breadth, depth, quality and intended use.

If CPGs are to have meaningful clinical utility, they should 1) Reflect the current empirical research base, 2) Be updated regularly, 3) Include known efficacious and effective treatments, 4) Have clearly defined terminology (e.g. what is meant by "cognitive therapy"), 5) Account for moderating variables (e.g. functional impairment, ethnic background, co-morbidity)

There are many barriers to the use of CPGs at the practice level, including: 1) lack of exposure to CPGs, 2) clinician resentment, 3) concern that compliance will be too difficult, and 4) many CPGs don't reflect the research base.

Barriers 1, 2 & 3 can be addressed with education and training in content and clinical utility of CPGs in use. In agency settings, meetings with both clinical staff and administrators can address concerns and differences of opinion. Barrier 4 can be addressed by only utilizing and drawing from scientifically sound and up to date protocols. Administrators need to be aware of where their CPGs are sound, and where they may fall short of the current knowledge base.

CPGs aren't all-encompassing. There are gaps in time, resources and training between the randomized controlled clinical trials which form the knowledge base for efficacious treatments, and the real world practice settings of CMHCs and private practices.

Training and support for clinicians is needed. Research is needed to assess if CPGs can be successfully imple-mented in community settings. Funding and evaluation of the application of efficacious treatments for children and adolescents in practice settings is needed. Training is needed for clinicians at CMHCs in efficacious treatments for clinical issues they frequently encounter (such as MST for treatment of Conduct Disorder) is needed.

References

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