Maryland Psychiatrists' Perspectives on Evidence-based Guidelines

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Evidence-based Practice

- Studies, including the Schizophrenia PORT study have found low rates of conformance with evidence-based treatments (Lehman 1998)
- Comparable low rates have been found in Maryland
- Survey seeks to understand attitudes and barriers to adoption of evidence-based treatments
- Schizophrenia PORT 2004 update of 5 treatment recommendations used in survey (Lehman 2004)

Outline

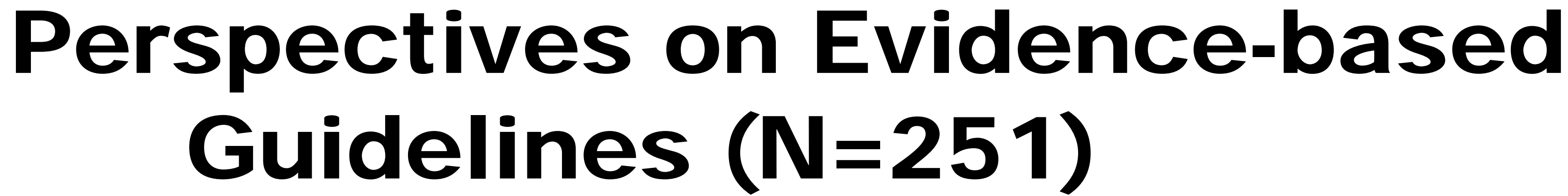
- General attitudes toward guidelines
- Schizophrenia PORT updated treatment recommendations
- Readiness to adopt
- Beliefs and attitudes related to readiness for adoption
- Practice characteristics related to level of reported adoption
- Discussion

Methods

- Mail survey of practicing psychiatrists in Maryland and nationally
- Respondents were presented with 5 updated treatment recommendations from Schizophrenia PORT Study (Lehman, et al 2004)
- For each recommendation, respondents rated on a 7-point scale factors that might facilitate or impede its adoption in practice
- Sampling frame from AMA Physician Masterfile
- Eligibility criteria:
  - Primary specialty psychiatry, child/adolescent psychiatry, psychoanalysis, addiction psychiatry, forensic psychiatry
  - Direct patient care
  - Not a first-year resident
- Stratification
  - Urban/rural location
  - Maryland/other continental US

Sample and Response Rates

- AMA files: 1688 psychiatrists (61 in rural counties)
- Sample: 600: 61 rural and 539 urban/suburban
- Response: 251 of 442 eligible (57%)
- Psychiatrists reporting treating schizophrenia in the past year = 166 (66% of respondents)



Perspectives on Evidence-based Guidelines (N=251)

- 16% reported not being familiar with guidelines
- 21% reported not important to use
- 59% had not or only infrequently changed their practices as a result of guidelines
- 21% were generally not ready to adopt guideline practices

Recommendation #1: **Antipsychotic dosing**

"The daily dosage of conventional antipsychotic medications for an acute symptom episode should be in the range of 300-1000 chlorpromazine (CPZ) or 5-20 haloperidol (HPL) equivalents. The daily dosage of second-generation antipsychotic medications for an acute symptom episode should be: 2-8 mg for risperidone; 10-20* mg for olanzapine; 300-750mg* for quetiapine; 120-160mg* for ziprasidone; and 10-30 mg for aripiprazole. Reasons for dosages outside of this range should be documented. *(* The upper effective dose limit is not yet determined.)*"

Recommendation #2: Depression treatment

"Persons who experience an episode of depression, despite an adequate reduction in positive psychotic symptoms with antipsychotic therapy, should receive treatment for this episode, which may include an antidepressant or dosage reduction if the patient is receiving a conventional antipsychotic agent. The reasons for the absence of an intervention for appropriate patients should be documented."

Evidence-based Treatment Recommendations

Recommendation #3: **Cognitive Behavioral Therapy**

“Persons with schizophrenia who have residual psychotic symptoms while receiving adequate pharmacotherapy should be offered cognitive behaviorally oriented psychotherapy. The key elements of this intervention include a shared understanding of the illness between the patient and therapist, identification of target symptoms, and the development of specific cognitive and behavioral strategies to cope with these symptoms.”

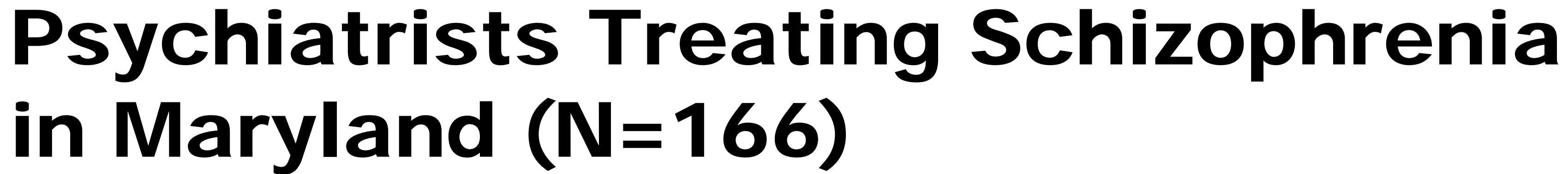
Recommendation #4: Family Interventions

“Persons with schizophrenia and their families who have ongoing contact with each other should be offered a family intervention, the key elements of which include a duration of at least nine months, illness education, crisis intervention, emotional support, and training in how to cope with illness symptoms and related problems.”

Recommendation #5: **Supported Employment**

“Persons with schizophrenia should be offered supported employment, the key elements of which include individualized job development, rapid placement emphasizing competitive employment, ongoing job supports, and integration of vocational and mental health services.”

Psychiatrists Treating Schizophrenia in Maryland (N=166)

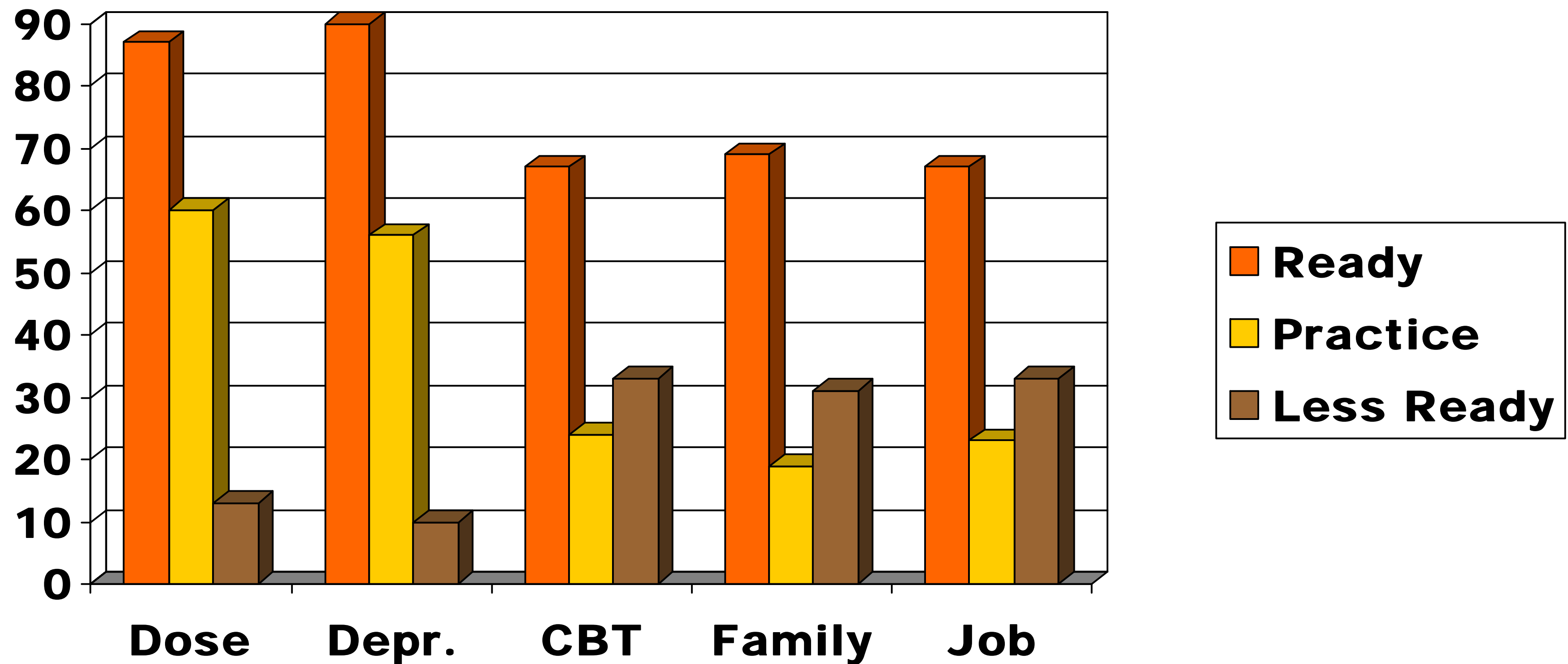


- Race: 71% Caucasian, 6% African American, 6% Hispanic, 24% Asian, 2% other
- Gender: 38% Female, 62% Male
- Age: 31% Under 45, 52% 45-64, 17% 65+
- 77% board certified, 22% eligible, 1% neither
- 57% academic appointment in medical school
- 44% have published in peer reviewed journal

Practice Characteristics

- 90% Urban, 10% Rural (over-sample)
- Majority practice: 32% solo office, 4% multi-specialty group, 9% specialty group, public hospital:18% inpatient and 3% outpatient, private hospital:11% inpatient and 12% outpatient, 5% other
- Patients seen per week: 82% with 20 or more
- Hospital admissions: 72% admit 1+ per month

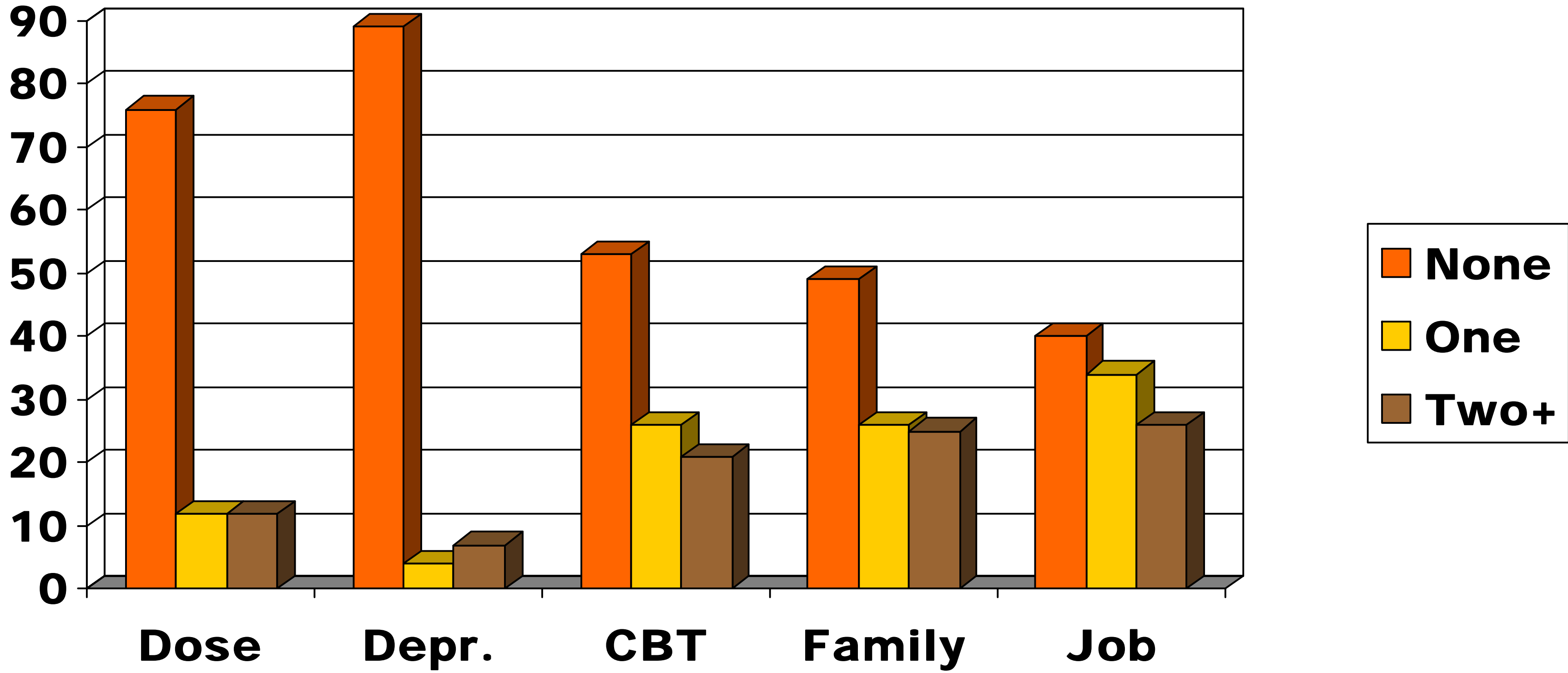
Ready to Adopt (5-7), Current Practice (6-7), Less Ready (1-4)



Barriers to Adoption (1-3): Vary with Recommendation

- 25% did not agree with content of at least one recommendation, ranging from 1%-12%.
- 58% reported patients would be unwilling to accept at least one recommendation, ranging from 6%-31%.
- 21% said at least one recommendation would worsen patient outcomes, ranging from 2%-15%.
- 68% reported not being confident could provide at least one treatment, ranging from 3%-45%.
- 40% reported not being ready to adopt at least one recommendation, ranging from 6%-21%.

Barrier: Disagreements with Recommendation (Range: None-5)



Attitudes and Beliefs

- Experience more important than RCT
- Comfortable practicing in ways different from other doctors
- Evidence based medicine makes a lot of sense to me
- Don't have time to read
- Change treatment when peers do
- Follow guidelines if not too much hassle
- Respected authorities should guide practice
- Too busy to keep up with literature
- Experience way to know what work
- Prefer to practice as trained
- Often critical of accepted practices
- Treatment should be based on RCT instead of respected authority
- Colleagues see me marching to my own drummer
- Use guidelines as long as they do not interfere with patient flow
- Not prudent to practice differently from other physicians in area
- Best guidelines based on RCT
- EBM not very practical
- Guidelines useful to practicing MDs
- Patients benefit from guidelines

Psychiatrists Report Ready to Adopt or Have Adopted (5-7)

Antipsychotic Dose:

- *Follow guidelines if not too much hassle
- *Experience best way to know what works
- Guidelines useful to practicing physicians
- Patient benefit from guidelines

(p<.05, *p<.10)

Depression:

- *Comfortable practicing in ways different from other MD

Psychotherapy-CBT:

- *EBP not very practical in real patient care

Psychiatrist Reports Ready to Adopt or Have Adopted

- **Family Education**:
- **Not too busy to keep up with literature*
- *EBP not very practical in real patient care
- **Vocational:**
- **Have time to read*
- *Experience best way to know what works
- *Patients benefit from guidelines

Discussion

<u>40% not ready to adopt one or more recommendations</u>

- 25% do not agree with the evidence for one or more recommendations
- Most commonly cited barriers to adoption:
  - Patient would be unwilling (58%)
  - Not confident can provide the treatment (68%)
    - 76% CBT difficulty to obtain in the community
    - 68% family education difficult to obtain in community
    - 77% vocational difficult to obtain in the community

Discussion (continued)

- Attitudinal barriers include:
  - Guidelines on medications dosage judged useful, but not significant for other treatments.
  - Experience best way to know what works: how often does experience conflict with evidence?
  - Guidelines not very practical in real patient care: how might guidelines be modified to work better in real patient care?