When the original report on the Schizophrenia Patient Outcomes Research Team (PORT) was published in this journal (Lehman, Steinwachs et al. 1998), it marked the first systematic, practice-oriented review of treatment approaches for one of the most disabling illnesses. In the intervening years, study has contributed to major changes in approaches to schizophrenia treatment—at least to the early stages of such change. Now, the Schizophrenia PORT “sequel” has been released (Lehman et al. 2004). Like a good sequel, it builds on a familiar story line, but adds twists, with information about new somatic treatments and further evidence about psychosocial interventions. It is exceptional work—representative of the best that medical science has to offer mental health care. At the same time, the updated treatment recommendations are still limited by the constraints and biases of medical science. The updated PORT treatment recommendations, with these strengths and limits, are a welcome contribution, but not the breakthrough approach to schizophrenia treatment and mental health care that is needed.

Commenting on the original study, I noted: “The Schizophrenia PORT has accomplished a great deal for schizophrenia research by demonstrating that a body of knowledge does exist, that it is possible to delineate valid versus inappropriate treatments, and that much current care does not match these standards” (Hogan, 1998, p. 29).” I still believe that praise was appropriate. However, advances in research have value (beyond satisfying intellectual curiosity) only when they are able to contribute to improved patient care. From this more important but unquestionably more challenging standard, how do we judge this work and how does the new work contribute? How have developments in mental health care, policy, and science in the intervening years shaped our assessment of the original work? And how do the updated treatment recommendations affect the worth and value of the overall project?

Recent Developments in Mental Health Care, Policy, and Science

The years since publication of the PORT study have been extremely generative ones in mental health, and the study likely contributed to these developments. The most notable milestones were publication of the first Surgeon General’s Report on Mental Illness (U.S. DHHS 1999) and the work of the first President’s Commission on mental health in a quarter-century (President’s New Freedom Commission on Mental Health 2003).

The Surgeon General’s report emphasized that the science of mental health care has advanced to the point where patients should feel confident in seeking care. By carefully establishing the efficacy of selected treatments for schizophrenia, the PORT helped form the foundation of the Surgeon General’s work. Additionally, by documenting how usual care so infrequently uses research-validated methods, the PORT revealed the “quality chasm” in mental health care. This step was essential to motivating funders (e.g., States) and providers to begin to consider adopting what we now call “evidence-based practices.”

Certainly, these funders and providers might have pointed out that until this time, science had never defined what patterns of care were effective. How could anyone expect care to be evidence based if there was no integrated, published evidence available for providers? These concerns represent ironies or concerns regarding the role of science, but mounting data about the poor quality of services call us to make significant changes regardless. The first PORT recommendations were the
first major, objective line of quality traced in the sand regarding the care of people with serious mental illness. Catalyzing a shift in conversations about the quality of care for people with the most serious mental illness—from opinion and anecdote to scientific evidence—is a most substantial achievement.

The Surgeon General’s report accelerated this shift. The gap “between what we know and what we do” started to emerge as a mainstream idea, not just an analytic tool. By 2002, when President Bush created the President’s New Freedom Commission on Mental Health, the logic of evidence-based care found its way into the Executive Order establishing the Commission (Executive Order 13263): “The Commission shall . . . identify innovative mental health treatments, services, and technologies that are demonstrably effective and can be widely replicated in different settings . . . [and] consider how mental health research findings can be used most effectively to influence the delivery of services.”

The commission’s final report responded to this charge in several ways. It recommended a national strategy for moving evidence-based services and supports—like those validated by the PORT—into systems of care. And, recognizing that one critical link in use of these interventions is funding (and that Medicaid has become the single largest payer for mental health treatment), the commission recommended that the Centers for Medicare and Medicaid issue guidance on how Medicaid can be used appropriately to pay for evidence-based treatment approaches.

These observations make it clear that the Schizophrenia PORT was a very good study at the right time. It helped create a foundation of scientific legitimacy for schizophrenia research and for mental health care that the Surgeon General and a President’s Commission relied on. The study was also a catalyst for concrete efforts to improve the quality of care. A collaborative group headed by Bob Drake (with PORT team members and investigators who contributed much of the work that the PORT relied on) has produced a number of “tool kits” to aid in developing community mental health programs that can deliver evidence-based interventions.

The use of these tool kits to develop treatment programs that are evidence based is being tested formally across five different program types in eight States, with an evaluation being conducted by the MacArthur Foundation’s Network on Mental Health Policy Research.

Efforts to develop mental health services in communities are increasingly concentrated on implementation of evidence-based treatment approaches. According to the National Association of State Mental Health Program Directors Research Institute (2004), all 50 States are currently implementing at least one evidence-based practice; the majority are implementing several. States are using many approaches to facilitate adoption of these practices beyond and including the tool kits that follow from the Schizophrenia PORT: training institutes (e.g., Ohio’s Coordinating Centers of Excellence), special grants, and changing reimbursement models.

The effort to better align services with the evidence about what works is, despite impressive progress, still in its infancy. And the effort is not without its challenges. There is a paucity of evidence about some services and populations that are very high priorities, given the inherent conservatism of the clinical trials approach. (For example, most clinical trials emphasize well-refined interventions by highly trained professionals with homogeneous populations. On the other hand, community care systems serve diverse populations and use staff with varied and often paraprofessional-level training.) There are concerns that a commitment to an evidence-based care model can drive out creativity. University training programs are still teaching, and professional guilds still credentialing practitioners, based on “the old ways.” Increasingly, mental health community services are delivered by minimally trained paraprofessionals who may not have the capacity to easily learn or adhere to complex protocols. Medicaid and Medicare, as the largest Federal programs funding mental health treatment, have not adjusted their benefits substantially in favor of reimbursing evidence-based treatments.

A long view, however, will see these challenges as growing pains, not insurmountable problems. The scope and pace of change—in the direction of ensuring that consumers have access to interventions with proven effectiveness—is quite impressive. And the Schizophrenia PORT has played a major role in catalyzing and accelerating this shift. The field thus owes a debt to the PORT team for both the original and the updated recommendations.

 Unsolved Problems at the Interface of Science and Services

In my earlier commentary on the original study, while praising the work, I also lamented the gaps or “blinders” in the methods and priorities of medical research that limit the utility and impact of research. These limits (generally, and in the PORT itself) include: the narrow focus of clinical trials (e.g., populations studied, intervention specificity); a failure to incorporate theory and findings from other fields; an orientation to the technique or technology of interventions (and not to the broader processes of healing or recovery); and a failure to appreciate or investigate processes of learning, quality improvement,
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and what might be termed “adaptive variability.” These limits also point to a question that is emerging as the evidence-based practice movement advances: What are the circumstances under which practice can be improved, and that encourage the adoption of proven methods—especially in a time of constrained budgets and an increased severity and heterogeneity of consumer needs? The issues related to successful adoption of evidence-based practices in Ohio are being studied, and the early information that is emerging is substantial. In general, we know far less about how to make change than we do about which changes are desirable.

With respect to these larger, more difficult, and perhaps more important challenges, I see little that has changed in the past few years, although current conversations about the “science to services cycle” have a helpful tone. Certainly, the updated PORT recommendations stay within the lines of the original study’s science methods. It is perhaps both appropriate and also sad to comment on these issues in what may be one of the last issues of Schizophrenia Bulletin, for this journal has—far more than most—carefully given voice to thoughtful and innovative perspectives that enriched and complemented the studies with small samples, exquisite designs, and modest questions that have come to dominate too much research in mental health. The Bulletin, while holding to high scientific and editorial standards, has provided a forum for thoughtful research using qualitative methods; for dialogue among researchers, policymakers, and practitioners; and perhaps most significantly, for the experiences of people who have lived with and learned from schizophrenia.

We must hope that the unique voice of this journal is kept alive. There must be vehicles where we can learn from consumers, practitioners, other fields of inquiry, other methods other than clinical trials, and the wisdom of innovators. The Schizophrenia PORT studies stand as a strong reminder that studies within the “NIH mold” are necessary but not sufficient to improve the lot of people with serious mental illness.

References


The Author

Michael F. Hogan, Ph.D., is Director, Ohio Department of Mental Health, Columbus, OH.