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Evidence-Based Practice in Mental Health

with Virginia Selleck, PhD

Center for Prevention, Outreach, and Professional Education

Summary

We now know that people can and do recover from mental illness, and we know more and more about what treatment approaches work. An evidence-based practice has four key components: it must be a standardized treatment with guidelines or manuals; it must have been studied using a controlled research design; the research studies must have employed a variety of research teams; and, the outcomes must matter to the recipient of the care. Selection of an evidence-based practice must take into account not only the treatment, but the characteristics of the person and the desired effect. While evidence-based practices are proven, many good practices are still viable and should not be abandoned. In this presentation, Dr. Selleck discusses how a practice becomes evidence-based, what some examples of evidence-based practices are in the mental health field, and the ongoing evolution of mental health care.

Presenter

Virginia Selleck, PhD, is the Clinical Director for the Division of Comprehensive Psychiatric Services for the Missouri Department of Mental Health. Prior to that, she spent fifteen years in Minnesota as the Supervisor of Adult Mental Health Services with the Mental Health Division's Department of Human Services. That followed eighteen years in Chicago, at a psychiatric rehabilitation center called Threshholds, and time as a mental health counselor in rural Illinois.

Contact Hour

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References

www.samhsa.gov

Train Your Mind, Change Your Brain: How a New Science Reveals our Extraordinary Potential to Transform Ourselves by Sharon Begley

Glossary

Assertive Community Treatment - a practice that focuses on people with the most severe disabilities, enabling them to stay out of the hospital, increase their community tenure and move toward recovery goals

Evidence-based Practice - a practice or treatment approach that is standardized, includes manuals or guidelines, has been studied in controlled research designs using a variety of research teams, and produces outcomes that matter to its recipient

Family Psychoeducation - a practice that teaches families ways to work together to support recovery by solving problems that interfere with recovery

Fidelity - adhering to the protocols and guidelines developed for a specific practice

Illness Management and Recovery - a practice that strongly emphasizes helping people to set and pursue personal goals and to implement action strategies in their everyday lives

Integrated Dual Disorders Treatment - an approach to treatment that helps people recover by offering both mental health and substance abuse services at the same time and in one setting

Motivational Interviewing - an approach to counseling that helps clients to enhance their motivation to reach their personal goals. These techniques can also be used to help clients to become motivated for mental health treatment, or to make other changes in their lives.

Supported Employment - an approach to helping people with mental illnesses find and keep competitive employment within their communities

Key Concepts

The four major components to an evidence-based practice are:

- --It must be a standardized treatment that includes some sort of manuals or guidelines;
- --It must be studied using a controlled research design;
- --The outcomes must be important to the person receiving the practice;
- --The research must be conducted using a variety of research teams.

Some evidence-based practices important in the mental health field are:

- --Assertive Community Treatment;
- --Illness Management and Recovery;
- --Integrated Dual Disorders Treatment;
- --Supported Employment;
- --Family Psychoeducation.

Using an evidence-based practice requires adhering to the particular protocols developed for that practice, including making sure there are the right numbers of staff and that they are appropriately trained. This falls under the definition of "fidelity."

Many valued practices must continue to be used, even as we adopt evidence-based practices. Experience, training and sound clinical judgement still play important roles in day-to-day interactions.

Any practice chosen for implementation must be accepted by all stakeholders—the person receiving the care, the caregiver, the family and the community.

Transcript

TP: Thom Pancella **VS: Virginia Selleck**

Thom Pancella: Hello. Welcome to this MIMHTraining presentation on Evidence-Based Practices in Mental Health. I'm Thom Pancella with the Missouri Institute of Mental Health. With me today is Dr. Virginia Selleck. She is the Clinical Director for the Division of Comprehenisive Psychiatric Services for the Missouri Department of Mental Health. That's a fairly recent position for her. She came to us after, oh, fifteen years in Minnesota as the Supervisor of Adult Mental Health Services with the Mental Health Division's Department of Human Services. Before that, she did eighteen years in Chicago, at a psychiatric rehabilitation center called Threshholds. Before that she was a wandering mental health counselor around rural Illinois. She's done a wide variety of things, and we're pleased to have you with us today.

Virginia Selleck: Thank you. I'm delighted to be here.

TP: The title says, "Evidence-Based Practices in Mental Health," so why don't we start with a little bit of definition-building. So, when you say, "evidence-based practices," what are you talking about?

VS: There are four real components that we want to think about when we talk about Evidence-Based Practice, and I think this goes for just about any evidence-based practice, whether it's in mental health or whether it's in any other field, but essentially you're talking about a standardized treatment that includes some sort of manuals or guidelines. The idea is that if you have an evidence-based practice, you should be able to pick up a manual or have some guidelines, so you can do it the same way in Illinois as Missouri as wherever you happen to be. So that's an important feature.

Also, you want to make sure that these practices have been studied in controlled research designs. This is just like when you hear about drug testing or any kind of product testing, you want to know that there was actual science involved in figuring out whether the thing worked or not. So, there are hierarchies of evidence

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also. Some studies are, you've probably heard—you, of course have been in college, you know all about these scientific deals here—random assignment being the most stringent kind of evidence, where people are drawn by numbers or pulled out of a hat—in some way controlled as to what treatment they receive so that we know that the actual results of the treatment are due to the treatment, not chance or some other kind of selection bias. But of course in Social Service research, people sometimes are not so eager to be randomly assigned, and there are other statistical controls that have to be put into place. But the key here is to be sort of an informed reader or watcher about evidence-based practice. It's very important to know what people—what kinds of characteristics were the people—that were being tested using the practice; figuring out what was the practice actually supposed to affect—a particular practice might work great on helping get someone a job, might be really good methods for keeping people out of the hospital—but there's other things that are important in people's lives, and maybe each particular practice doesn't focus on a whole global category of issues but specifics. So you want to know what evidence, for what person, for what factors am I looking at.

And then the third thing is that you want to make sure that you're looking at important outcomes for people. This is all important stuff in people's lives. You want to make sure that you're focusing on things that matter to the consumer—to the recipient of the practice. People will not, basically, engage with you in a treatment that is unpalatable or scary or they don't like. The example that I've been using lately which people latch on to is, "Okay, we know we've got a problem with head lice in grade school, right?" Everybody knows that. You could probably solve that problem if you just shaved every kid baldheaded. Probably people wouldn't permit that. So, you wouldn't have any lice, but you'd have a bunch of little baldheaded kids running around. People aren't gonna like that. So you've got to have something that matters to people and that they're willing to accept the practice.

And the fourth factor is that you want to make sure that these research studies are conducted by a variety of research teams—not just at one college or university or one program site. You want to make sure that the findings and that the practices

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transcend the personality of the individual researcher; to make sure that it can really translate from one place to another. So those would be four ways to look at an evidence-based practice.

TP: Well, from our introduction, we know that you've been in the field for quite a while now. Is there something significantly different for people with serious mental illness?

VS: I think that there's been a huge change in terms of how we think about recovery. When I started, lo these many years ago, we didn't talk about recovery or resiliency; what we talked about was stabilizing people—maintaining, managing symptoms. The field, thanks to the efforts of the consumer movement--that is to say survivors of mental health care and treatment--have been very vocal, starting in the '70s and '80s and moving on to today, to really show that people do recover, and recover to a much more major extent than people ever thought about in the past. There is also a lot of new research coming out looking at the kinds of—well, we can talk more about some of these practices as we move along here—but, basically, there are things you can actually do that are different than what people used to know how to do. It's, I think, a transition and sort of a new frontier, akin to when they discoverered medication. It's almost as big of a deal. Maybe bigger, because it's all about people's—having the proactivity for themselves—to be able to actually take control of their own recovery in a way that people didn't used to have an opportunity to do.

TP: And, I think you kind of touched on this a little bit, but what makes something an Evidence-Based Practice?

VS: You've got to know that it worked. It has to be shown to do something important that matters to the person and that will remediate or affect some important part of their life. An example—shall I talk about some examples?

TP: Sure.

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VS: Okay. And a specific place to find them for people who are interested is the Center for—no, it's the Substance Abuse and Mental Health Administration—the federal substance abuse administration—SAMHSA, is what people often contract it as—have a website--for adults now I'm talking about—there are five well-established evidence-based practices. And on their website you can find toolkits and elaborate discussion about each of them. And some of them we are working on here in Missouri. Supported Employment is one. The point of Supported Employment is to help individuals obtain and retain competitive jobs in the community. There's a particular way to go about doing that that works better than other ways. Assertive Community Treatment is a practice that is very well researched—25 or 30 years' worth of research—that focuses on people with the most severe disabilities—helps them in their home communities and enables people to stay out of the hospital, increase their community tenure, move forward in their recovery goals. Illness Management and Recovery is another practice that is really a constellation of other practices, including things like Cognitive Behavioral Therapies and different learning techniques to help people become able to manage the symptoms of their illness, so that they can be a full participant and an active participant, instead of just a passive recipient of care. Another one is Integrated Dual Disorders Treatment for co-occurring mental health issues and substance abuse issues. That is very much on the threshhold of really taking hold here in Missouri, because the state has had a Co-occurring State Incentive Grant, I think it was called, for about four, three, years, and that material now is being rolled out to the field so that programs can know how to define themselves as working in an integrated fashion with people that have both of those issues. And Family Psychoeducation is a fifth, which really enables people—children, well not children but young adults and older adults—to work with their family members in a very specific way to enable them to recover. So those five, for example, are available to read about on the SAMHSA website, and people can, for free, download toolkits, fidelity scales—which is another thing I should mention. Fidelity. The word "fidelity" has a meaning that is similar but not exactly when you think about having fidelity in your marriage—it's about adhering to the particular protocols in doing these evidence-based practices. So that I, in the state of Missouri--we're going to be looking when we bring up some of these practices--people will have to

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come out to programs and compare what they're doing against these standardized manuals to see if people are using the right numbers of staff that are appropriately trained. Assertive Community Treatment for example, one of the hallmarks of that practice is that you serve people in the community. You go to where they are. And by community I don't mean a menta health center, I mean their home, their workplace—wherever they happen to be. Supported Employment is another example, where we're talking about competitive jobs; we're not talking about sheltered employment where people work at a sub-minimum wage in a congregate setting. We're talking about jobs like you and I have out in the community. So there are specific hallmarks for all of these practices, where you can know if you're doing it or not—separate the sheep from the goats—you know which is which, so it makes it more possible for people to know what they're getting. And it also makes it possible for consumers to really ask for evidence-based practice; to know what is it—what is their particular issue that they want help with, so that they begin to work collaboratively. And our big transformation grant that we've gotten here in Missouri really has a huge role for consumers and family members to help shape and drive the system as we move forward. And so that we want consumers to be every bit as well educated about what works and what doesn't work so that they can ask their providers for it.

TP: It sounds like great stuff. Why isn't it already widespread?

VS: This is a very good question, and it's one that plagues the field. There are a number of reasons. Sometimes people just say, "Oh, well, there's not enough money." Well, that's true. Mental health is always an underfunded system, and that's absolutely true. However, when you think about how the mental health system has been built and developed, there are rules, there are policies, there are old ways of doing things—programs provide services based on how they've been paid to provide them. So a new and great idea comes in, and we can say to people, "Here, this is a great new idea." And they might say, "Yup, great idea; love to do it." But if we haven't figured out how to reshape our policies and our funding mechanisms to support the new thing, sometimes it's not even a matter of getting more money, it's a matter of redirecting the old money—reshaping it.

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Very frequently, in all the states that I'm aware of—and I've done considerable work around the country, here in Missouri, in Illinois, in Minnesota—lot of rules that are conflicting with the actual thing that you're trying to get people to do. Because, progress gets made and people change. And we all read funny stories about old rules that we find about ceiling wax or buggy whips that they every now and then at the federal level have to go in and clean out these old antiquated rules—well, we have some similar problems. Also, because people with mental illness—that's one person, but they are served holistically often by—or maybe not as holistically--we'd like them to be served holistically—but they're served by a number of different bureaucracies. For example, mental health—the Mental Health Department, Comprehensive Psychiatric Services and the Department of Vocational Rehabilitation, or the Division of VR here, both might work together with someone to help them get a job. Well, there's different things that each entity can pay for. The integrated practice of Supported Employment needs to draw from both of those entities, and it can be very confusing and complicated. Not to mention the fact, people who are on Social Security Disability or are receiving Medicaid in order to pay for their medical care, there are specific rules around how much money you can make, what your incentives for getting off of those programs are—it's a complex thing. So it requires people to know a whole lot of rules and regulations sometimes, and it's scary. Sometimes people just throw up their hands and say, "It's too hard. I'm just gonna do my little thing in my little silo." So, part of the work of Transformation Grant, and part of our work just in general is—I should say it's really a responsibility to cut through some of that bureaucracy. We all have to do that. There's a role for everybody in trying to get to the evidence-based practices. And as people who are working in the field—entry level staff or people who are direct care workers—are in a really good position to know what are the barriers that are impeding them from doing this new practice. And they should talk with their administrators and their supervisors about stuff they find to be barriers. Because we in a more policy-oriented way need to hear from people at the street level about what's getting in the way. Sometimes we think know and we don't always know. So it's really important to keep that communication going. So that's one thing—rules, policies, barriers.

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Another thing is habit. People—I don't know if you've noticed—but, people don't like to change all that much. I always say that the only people that like change is a wet baby and they scream through it. People just don't wanna change doing what they do. So we have to motivate people; we have to train people—there's a big sales job involved. People have to believe that it really is gonna matter if they do it this way versus this way. So there's that—there's the education. Also, the need to have ongoing supervision and training—it's been found repeatedly, when researchers have looked at implemenation of a variety of evidence-based practices, that you can't just bring somebody in—as wonderful as we are here sitting and talking about it, somebody could watch me yammer away about evidence-based practice and say, "Okay, that's nice," and go on about their life. What they need, if this is a specific practice, is to have—they need to watch what somebody else does for a while often, to see how it works; they need to have ongoing support; they need to have a supervisor that understands it. The supervisor needs to have some help to know how to supervise that particular practice. One of the components of many of these practices is a thing called Motivational Interviewing that maybe you've heard of. It got started primarily in working with people with alcohol and drug abuse kinds of issues, but it's turned out to be a real fundamental core competency in working with many of these practices. But that's a skill; people need to learn that skill. And you can't learn it from a book. You can read about it, and understand cognitively what is Motivational Interviewing, but when it comes time to do that, you have to have had practice. You have to re—sort of re-gear your brain for how you work with someone using a Motivational approach. So having the time to go and get training translates into problems for a mental health center. If you're trying to generate billable hours; if you're trying to keep the boat afloat here, you've got peple that you need to serve, you can't just drag everybody out of their jobs and say, "Okay, go over here for a month and get this great training." So that's a challenge, just as it is for any evidence-based practice. If you're—if a doctor's going to learn how to learn to use a new piece of equipment, he has to stop doing the old one, go get training and come back. Well, every time that he's doing that, he's not making any money. So there are a number of barriers along those lines.

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And I think also, and this is just my own thoughts—maybe you have thoughts about this too—it seems like every time you turn around Time magazine will tell you, “Absolutely do not eat this thing.” Or, “Don’t eat vegetables/Only eat vegetables. Don’t eat fat/Yes, eat this kind of fat.” Research keeps coming out about all sorts of things, and people, I think, get a little bit jaded. It’s hard for people to believe that what they’re hearing really does make a difference. And so you really want people to be so informed about how to read the research, and how to know. One of our biggest concerns, in Missouri and in other states as well, about using evidence-based practices, is that people use them for the wrong populations. You wanna make sure that you are using a practice for people for whom it was designed. And that gets into a lot more complicated stuff, but there’s a lot of research available and a lot of work out there so that you can know that you’re using the correct practice for the correct person. That’s especially important with children and adolescents as those practices are evolving, because specific children come from a different socio-economic area, different ethnicities, may have different presenting problems, and as children are growing and changing, you really need to be careful that you’re using practices that are designed for the particular kid that you’re working with.

So it’s not a monolithic thing—that we’re gonna “Do” evidence-based practice. It’s more about what evidence for what person for what effect.

TP: I’m interested, when you talk about how things change—and you present—you’re gonna go out and present a lot of new information to people and, “This is how you’re supposed to be doing it,” and then, just as you said, the research changes—how do we convince people to change with the research and not say that that’s something “new”—a whole new thing—we’re throwing away evidence-based practice—how do we convince them of that?

VS: I think that we have to have some humility always with this, and understand that science is an evolving process. And so one of the ways that we can think about it—and we learned this recently as a way of shaping our thinking from this very brilliant woman named Julia Littell, who came from Bryn Mawr and gave

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some lectures here—we heard her speak of what she called adopting a "portfolio" approach. Which—I don't think it financial terms so much, sadly, which is why I'm going to be a poor person forever—the other way to think about it is your garden; you pick certain locations for doing what you're doing. In evidence-based practice, you wanna have—think of the universe of resources that we have—you wanna have some chunk of them to do the cutting-edge evidence-based stuff. But there's a lot of valued practices for which there is no evidence just yet. So you don't stop doing things that we need to do in order to keep people safe and to be humane and to do the kinds of interventions that social work training has been teaching us for years—that has to continue to happen. But we also have to have a corner of our work that provides for building the service-to -science. We talk about science-to-service, which is the evidence-based stuff I just talked about, but there's also service-to-science. An example in Missouri is Procovery—if people who are listening to us today are aware of Procovery they're aware that that's a method that really helps people move forward in their own recovery. It has not yet been scientifically, randomly assigned—that kind of stuff—but there's enough "evidence" from the qualitative side to want us to continue to explore it. We wouldn't take every single dollar in the system and throw it toward Procovery, even though we thought it was maybe a wonderful thing, we've got to make sure that we have balanced the level of our investments so that we have pure evidence-based practice, and that we are evolving toward keeping up. And you can't ever stop with research is the other thing, and that I have to say is a barrier probably nationally, is that it's hard to get funds to really continue to do research. So, there's also good clinical judgment, that people who have been clinicians for years have very great instincts and opportunities to sort of thnk of how to go forward with different things. And administrators at a local level have to figure out what's gonna work in their home community—which practices to concentrate on—is a thing that matters. In certain parts of the state or country there might be not such a big problem with employment but a much bigger problem with hospitalization. It depends on where you are as to what you focus on first. So, there's some of that that has to go into it.

I think being open to believing that things get better is very important. People

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now know that people do recover from mental illness, and the reduction in stigma that comes about when people are willing to talk about their own experiences—when you then personally know someone who's been seriously ill and you watch them recover—or they come to you and give you a testimonial about how their lives have changed—people are more willing, then, to believe that something can be done. I think that one of the biggest problems in mental health has always been that the stigma has kept people not talking about mental illness, or if you say "mental illness"—I used to do a lot of work with the Taniff—that's the welfare workers, people who are helping people get off of welfare—and a large number of people who are on welfare or Taniff are people who have barriers around mental health issues in addition to their other economic barriers. So, in Minnesota we used to a lot of training with those folks, and I would ask them, "What's the first thing that you think about when I say 'mental illness'?" And I would say, "You don't have to say it; just think it." And every now and then people would raise their hand, and, okay, they think about their Great-Aunt who went away and never came back. Or they think about the big State Hospital that they saw out in the country down the road. And they think about people in all the movies, that people are so stigmatized around mental illness in movies. These things really cause people to shy away and not want to get involved. And once people realize that people do recover, and when you find out that your co-worker has had a serious illness, when you find out that at the cocktail party half the people there are taking Prozac or whatever it is, you wind up feeling less scared about it. And then you have more interest, I think, in really looking at the research to find out what works better than other things.

I could ramble on here at length. I'll just use one more example, which is Depression. People are able to talk about Depression, usually, without getting too scared about it. There are different paths to getting well from Depression; some of them are medications, others are Cognitive Behavioral Therapies. There's a lot of research that's been done showing the difference in brain chemistry about whether you're using a Cognitive Behavioral Therapy approach versus a medication approach. There's a woman named Sharon Begley that just wrote a book that was on the best seller list recently who was the science writer for the Wall Street Journal,

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all about brain plasticity, and she has many many examples in there of how our brains are much more able to be "plastic" in the sense of growing and changing than we've believed in the past. So research—we are not frozen in time—we're not as evolved as we're gonna get, I hope—there's still room for more advances.

TP: Well you do hit on resources, on the fact that we don't have unlimited dollars. How is it that we decide where it goes? What's the process?

VS: Boy it is a hard process. And it's one that different states adopt differently. Some states have actually made a list of criteria, so they will say—Oregon is an example of such a state, where I believe they created a list saying—the hierarchy of evidence. The most—highest hierarchy part is random clinical assignment—did people really do enough experiments—all the way down to "This looks pretty good;" "we've had a study or two;" or "there's anecdotal reports." And then, whenever they're ready to fund a new thing, they kind of run it through that decision filter. That's one part.

The other part is again, those—the whole array of acceptability. Do people who are going to get the practice, are they willing to accept the practice? Does the community at large feel that it fits in the social fabric of where they are? The level of resources that we have, and the political will, and the conversation that has to go on between people making the decisions who are legislators or people such as that who are not in an everyday way usually all that exposed to the research—the communication that has to happen from the field, from the professional field, to help those folks be informed voters for what they're gonna get. And then, of course, the grass roots—when we have the advocacy movement such as the National Alliance for the Mentally Ill, who have been extremely formative around the country in getting states to fund Assertive Community Treatment because they know that this is a particular way of working with their loved one that really does work and has 30 years worth of research behind it—they can be a very persuasive force for the legislature or for other decision-makers because they are not seen to be acting out of any monetary interest kind of thing; they're not trying to feather their own nest. They're trying to get help for their families. And, I think they

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have a voice that can be more persuasive often than researchers' even. So there's a partnershipping effect here that has to happen. All parts of the system—consumers have to know what their goals are and what they want, the provider community has to work collaboratively with the consumers and the family members to make the case to people who are in charge of funding about what they need and what works and what doesn't work, and then we have to show the results. The outcomes are critical. We have to be able to measure outcomes so that people know that what they did mattered and made a difference. Ultimately, we want people to be able to work, to live independently, to have lives. You know, the joke that somebody—I forget who it was—talked about—it was a consumer who did some national speeches, who basically said what he wanted was a job, a home and a date on Saturday night—what everybody wants—to have a full life. So, I think most everyone can understand that. That's not jargon; that's not complicated—working, living, having a social fabric, having people who care about you and that you care about, being able to give back to the community—all those things are what people with mental illness want, just like everybody else. So our practices, if they're not driving toward that end, people don't value them. So we have to make sure that what we're trying to get funding for and what we're working for can be understood by the guy on the street.

TP: Well, let's bring this to a summary here. If you had a message or messages for the people all over who are doing the front line treatment—our clinical staff out there—you can't talk to all of them at once, but what would you tell them?

VS: I would tell them that mental health treatment works, that working toward an illness management approach with people—understanding that what they are doing is not just throwing somebody a sandwich or making sure they've got a roof over their head—what they're doing is helping people to learn to manage their own illnesses so that they can really have a full life and recover—is a thing to hold in their head. To remember that that is the key goal, even though on a day-to-day basis sometimes it feels like I'm just carting somebody from here to there, or I'm trying to get them to go to a group or whatever I'm doing, really what we all have to be remembering is that we now know things that we didn't used to know, and

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that people really can learn to manage their illnesses, and they can recover. That's a really important thing. And, that they should never feel bad about their work; they should be knowing that they are working in a very dignified profession, and they should feel good about that.

TP: Well, thank you, Dr. Selleck. That was a wonderful presentation. And thank you for joining us on this presentation today. If you have any information regarding topics that you'd like to see in this format or any other, the Missouri Institute of Mental Health is always looking for topic ideas. You can drop us a note at feedback@MIMHTraining.com. If you're watching this program online, and you'd like to receive Continuing Education credit for it, click on the Post Test button on this page, follow the instructions, take the Post Test and submit your CEU application. If you're watching off line, on a DVD, say, the instructions for submitting your CEU application should have been included with your materials. Or, you may also go online to MIMHTraining.com, find this program, take the Post Test and submit the CEU application. Again, thank you for joining us, and thank you, Dr. Selleck.

VS: Thank you.

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