DOWNLOAD PDF EVIDENCE IN MENTAL HEALTH CARE

Chapter 1 : WHO | Mental health: massive scale-up of resources needed if global targets are to be met

A stronger focus on evidence presents an opportunity to improve the quality of mental health and substance use disorder care, to empower people in recovery and their families and friends to seek and demand continually improving care and services, to ensure that their care is effective, and to move toward more person-centered and person-reported.

Coalition 4 Evidence-Based Policy: Consequently, government agencies, private-sector health plans, academic research centers and other stakeholders are dedicating enormous resources to evaluating current science and practice, disseminating information about promising practices, and guiding the implementation and replication of such evidence-based approaches to healthcare. Ideally in the future, evidence produced from any source would be condensed and transmitted quickly as decision-making support for individuals and providers to use in setting goals and planning care. Until such decision-making supports are available and as evidence generated and evaluated from all sources must be synthesized and published in simplified language so that people seeking recovery and their friends and families can use the information in their healthcare decision-making. All Cochrane reviews include a plain language summary to make this evidence easy to use by the general public, and reviewers include people in recovery and family members who are educated in evidence development. To be considered for funding, all PCORI proposals must include a detailed plan for dissemination of the results. The Substance Use Challenge. Substance use conditions are a particularly neglected area of scientific study, with the persistence of punitive sanctions for relapses under current law enforcement and drug court procedures and overreliance on Alcoholics Anonymous. Given the prevalence of addiction in society and the extensive evidence regarding how to identify, intervene and treat it, continued failure to do so signals widespread system failure in health care service delivery, financing, professional education and quality assurance. It also raises the question of whether the low levels of care that addiction patients usually do receive constitutes a form of medical malpracticeâ€¦. The vast majority of people in need of addiction treatment do not receive anything that approximates evidence-based care. AA can be very helpful to many people drawn to it, but: A meticulous analysis of treatments, published more than a decade ago in The Handbook of Alcoholism Treatment Approaches but still considered one of the most comprehensive comparisons, ranks AA 38th out of 48 methods. At the top of the list are brief interventions by a medical professional; motivational enhancement, a form of counseling that aims to help people see the need to change; and acamprosate, a drug that eases cravings. The boundaries of scientific research are constantly being stretched, revealing new understandings and options for treating many chronic illnesses, including mental health and substance use disorders. Yet even as emerging science gives us information about how and why mental illnesses and addictions affect individuals, and about new sources of information such as genetic biomarkers that may better guide treatment choices, it also reveals the absence of universally effective treatments and practices. Even a very good medicine will rarely be effective in more than half of the people who take it, and new treatments are frequently approved after clinical trials that show that they are effective for only a small proportion of study participants, without comparing them to other drugs that may be more effective. In particular, pharmaceutical use by the general population commonly reveals a lack of real-world effectiveness and side effects that were not adequately evaluated in the preapproval clinical trials. For example, the common drug company practice of excluding potential trial participants who show a high placebo response and the use of washout periods that eliminate people who are unresponsive to the drug may exaggerate the relative effectiveness of the drug. This cultural humility and linguistic competency is an essential element of evidence-based healthcare. MHA recommends ongoing, real-world surveillance of evidence-based practices to better understand their effectiveness over time and how they may be improved. Department of Health and Human Services, has undertaken a comprehensive effort to recognize evidence-based practices for the prevention and treatment of mental health conditions and maintains a website that allows broad access: MHA hopes that, in the future, SAMHSA will be able to produce additional toolkits on a broader array of evidence-based and promising practices, including a focus on prevention and early intervention. The existing toolkits are available online and are summarized below: Assertive Community

Treatment ACT or PACT refers to a now widely-adopted and -accepted program to provide a full-range of services within a community setting to people who have severe mental illnesses such as schizophrenia, bipolar disorder, depression or schizoaffective disorder. The key to its success is a high staff to consumer ratio at least one to 10 consumers , provision of services where they are needed in the community , uninterrupted care as someone from the team is always available, a non-coercive and recovery-oriented approach, and time-unlimited support. Supported Employment is a program that aids people in recovery in finding competitive jobs defined as at least minimum wage jobs open to the general public that are well suited to their interests and abilities. Supported employment is based upon six principles which include: Employment specialists work alongside people in recovery to ensure that these six principles are met. Integrated treatment improves chances for meaningful recovery. Within this model, people in recovery receive case management, outreach and other much-needed services such as housing and supported employment. Counseling services are tailored to those who have dual disorders and include assessment, motivational treatment and substance abuse counseling. Family members are also educated about the mental illness and substance abuse, and are given support as well. Those with dual disorders are in a high-risk group and vulnerable to a host of corollary problems such as relapse, troubled finances, homelessness and health crises, which is why integrated treatment is so critical to successful outcomes. Families are given information about mental health and substance use conditions and develop coping skills. This practice has several phases. Illness Management and Recovery IMR is a psychiatric rehabilitative evidence-based practice that is designed to empower people who have serious mental illnesses to understand and manage their illness effectively. During a series of weekly sessions, mental health practitioners aid people in recovery in developing their own tailored strategies for coping with their illness, constructing their own goals for recovery and playing an integral role in decision-making about their treatment. Nine topic areas are covered in the program: Practitioners use a variety of techniques to accomplish these goals, such as cognitive-behavioral, educational and motivational strategies. Permanent Supportive Housing is a program to provide housing distinct from social supports for people with mental health and substance use disorders. As stated in 3 above, tenants have choices in the support services that they receive. Tenants have the opportunity to interact with neighbors who do not have psychiatric disabilities. They are asked about their choices and can choose from a range of services, and different tenants receive different types of services based on their needs and preferences 10 As needs change over time, tenants can receive more intensive or less intensive support services without losing their homes. This flexibility stands in sharp contrast to the residential treatment programs and transitional housing traditionally offered by mental health systems. In residential treatment programs, staff often provides support services and handles housing functions such as the application, move-in, rent collection, rule enforcement, and eviction. In Permanent Supportive Housing, housing and support services are handled separately to avoid all possibility of coercion. Medication Treatment, Evaluation and Management is an evidence-based approach for offering medication management to people with serious mental illnesses. Four factors are involved in providing evidence-based medication management: Treatment of Depression in Older Adults requires different interventions than those used for younger people. MHA has identified a number of wellness activities that can contribute to Aging Well [37] and has addressed dealing with the anxiety and psychosis than can accompany cognitive aging and dementia, but has not discussed the problem of depression in older adults. This toolkit remedies this omission. Although partially covered by 8 , MHA stresses the use of community-based, multidisciplinary mobile geriatric teams. Strategies such as behavioral coaching, behavioral rehearsal and role play, daily goal setting, and self-monitoring can be helpful in teaching students to manage their own behavior and emotions more effectively. The toolkit discusses oppositional defiant disorder and conduct disorder candidly and suggests the protective factors and the risk factors by developmental stage, suggesting eighteen kinds of psychosocial interventions that parents and caregivers can consider to respond to defiant behavior. It also describes the kind of medication management strategies that are recommended by clinical guidelines, given the frustrating fact that few of the medications have been clinically tested in children. Consumer-operated Services include single service providers for drop-in programs, support groups, housing, employment, training, and consultation; general recovery resource, education, and self-advocacy centers; and multiservice organizations that provide an array

of services and resources. Peer principle, helper principle, empowerment, choice, recovery, acceptance and respect for diversity, spiritual growth 12 Peer principle: Relationships are based on shared experiences and values. Self-disclosure is almost universal. Help and advice are offered in a friendly manner; compliance is not demanded. Virtually everyone agrees that being involved in the program has helped them make positive changes in their lives. Program staff and leaders encourage a high level of accountability and self-reliance by program participants. There is a feeling of membership in the group, which offers a great opportunity to contribute not only to internal program activities and on program-specific policies and issues, but also to contribute through community activities, networking, and other relationships external to the program. The mission statement and materials describing the program include a clear statement of its hope-oriented approach. Participants can articulate this approach. The expression of spiritual or religious insights is allowed within the program. Mutual support, telling our stories, consciousness-raising, crisis prevention, peer mentoring and teaching 1 Formal Peer Support: Numerous peer support activities are offered to program participants on a regular basis. The program provides opportunity for, and supports the development of, strong mutual peer relationships. The program provides numerous formal and informal opportunities for sharing stories within the program and with the larger community. Multiple regular outlets provide opportunity for artistic expression, with a variety of media. Opportunities are individualized, enabling all who are interested to participate. People recognize themselves as valuable members of a larger community with their own unique identities, and they feel confident contributing to this community. Multiple avenues are provided for formal crisis prevention, and these appear to be effective. Multiple avenues are provided for informal crisis prevention, and these appear to be effective in providing regular and sometimes face-to-face outreach to consumer-operated service participants. Virtually all participants report that there are others within the program they look up to and from whom they can receive guidance, support, and companionship. These relationships occur without regard to title or position within the program. Numerous opportunities and educational programs are offered to participants to learn practical skills relating to personal issues, treatment, and support needs. There is evidence of a formal curriculum in problem solving and self- management. There is evidence of informal exchange of personal experiences to enhance individual problem-solving abilities. Self-advocacy, peer advocacy, outreach 1 Formal self-advocacy activities: All participants are informed by the program through multiple channels, e. Advocacy content is regular and strong. Most participants are involved in providing peer advocacy. All members consider themselves peer advocates. It looked at several models of peer-operated services around the country to determine whether consumer-operated services are effective as an adjunct to traditional mental health services in improving the outcomes of adults with serious mental illness. This study found that consumer-operated services are effective, pointing specifically to the following: MHA is currently developing a nationwide peer-to-peer certification program to meet this need. Supported Education has emerged as promising practice in psychosocial rehabilitation for people with serious mental illnesses. However, effective outcomes and significant findings in program attendance, enrollment in postsecondary education, self-esteem, peer support and reduced healthcare costs make supported education a promising practice for the treatment and rehabilitation of adults with serious mental illness. It builds social capital, promotes community well-being, overcomes social isolation, increases social connectedness and addresses social exclusion. In addition, there is an opportunity to redeploy resources to programs, practices, and treatment regimens that are outcome-driven and to incorporate the recovery paradigm into mental health and substance use services and supports. There are several challenges to the effective realization of evidence-based healthcare: Need to Encourage Promising Practices. Of highest concern is the potential that reliance on narrowly defined evidence-based practices to the exclusion of promising or innovative treatments or programs will preclude the development of a rigorous evidence base for a broader range of options, or stop new treatments from being developed. Need to Encourage Precision Medicine Research. A new challenge is posed by precision medicine research. To achieve the goal of tailoring treatments to individuals, people in treatment and providers will have to collect and share data on genetics and epigenetics, the microbiome the collection of microorganisms in or on the body , lifestyle, specific experiences, and diet with one another and with researchers who can help determine the factors that predispose people to develop mental health and substance

use disorders and that influence the course of the disorders.

Chapter 2 : Bridging experience and evidence in mental health care reform

Welcome to the first issue of Evidence-Based Mental Health, a journal designed to help mental health clinicians stay up to date with the best available evidence as it is published. Evidence-Based Mental Health is one of a number of resources being developed to help clinicians who want to use the.

Internationally, increasing attention to such tools is found in the U. Enhancement of consumer autonomy PADs improve psychiatric and recovery-oriented outcomes by empowering consumers with serious mental illness to take an active role in their own care 5 , choosing among high-quality, evidence-based treatments in the least restrictive setting possible. PADs are thought to embody a recovery-oriented philosophy by encouraging consumers to preselect their treatments for times of future crises. Research has shown that consumers who have executed PADs endorse feelings of self-determination, autonomy, and empowerment 6 â€" 9. Improvement of consumer and treatment provider therapeutic alliance PADs also facilitate communication between providers and consumers about future treatment choices, and these discussions improve therapeutic relationships 7 as well as provide clinically relevant treatment information 10 , In the context of completing PADs, facilitation refers to a collaborative process between a consumer and a provider that informs the consumer about PADs, engages the consumer in a discussion of past treatment experiences, and helps the consumer work through the process of documenting future treatment preferences and instructions. Up to three quarters of consumers indicate they would complete a PAD if provided the choice and support 6 , 7 , Thus far, the facilitation process has significantly reduced barriers to PAD completion, with increases in completion of almost 30 times compared to non-facilitated PAD models 7 , PADs may also reduce negative coercive treatment experiences. Compared to consumers without PADs, consumers with facilitated PADs were approximately half as likely to require a coercive intervention during a mental health crisis over a month follow-up period Integration of care through system partnerships Despite these positive signs, mixed or even no evidence exists about the impact of PADs on primary outcomes such as psychiatric admissions, compliance with treatment, harm to self or others, or treatment utilization. There is mixed evidence, though, about the thoughts and practices of providers within single institutions e. Opponents and proponents alike acknowledge the low usage rates of PADs, which fall below the usage rates of advance directives focused on only end-of-life care An important recent advance in the consideration of barriers is the use of taxonomies. Barriers can be identified by the intervention stage at which they occur: Barriers can also be identified by the level at which they occur: Arguably, barriers begin even before PAD services are created, as many stakeholders continue to hold misperceptions or conflicting perceptions about PADs and their use e. Once implementation is undertaken, system-level barriers include legal impediments e. Agency-level barriers include difficulties in integrating a new practice into existing agency culture, need for training, lack of resources e. Finally, it is well worth noting that, although low- and middle-income countries may be expected to face additional barriers, recent research suggests that completion of PADs is feasible in those countries PROMISE The continuing appeal of PADs in the face of many challenges is likely based on several factors, one of which is the growing attention to patient autonomy across health care systems in several countries 25 and treatment ideologies that advance such moral principles â€" namely, recovery-oriented models 26 â€" As noted earlier, the U. The last decade and a half has seen similar policy and practice developments in the United Nations 32 ; European countries, such as Ireland, U. Virginia also adopted a presumption that all adults have capacity to make legally binding advance directives, and that a determination of incapacity cannot be based upon diagnosis alone The fact that PADs instantiate several desirable principles and concepts of care also lends to their appeal. The many facets of PADs may appeal differentially to various user groups: Some individuals and cultures value independence highly, so there is a natural draw to the self-determination that PADs can create. Thus, PADs have the ability to appeal to multiple audiences simultaneously 4 , A PAD is a single tool embodying multiple principles and care concepts meant to be used in different ways by several types of stakeholders across multiple providers in what are typically disjointed health care systems 19 , Efforts to embed use of PADs in routine mental health care can benefit from research on strategies for

increasing their usage and a burgeoning literature on dissemination and implementation of health care innovations e. Patient Self-Determination Act of Srebnik D, Fond JL. Advance directives for mental health treatment. Advance directives for medical and psychiatric care. Thomson Reuters, Lawyers Cooperative Publishing; Psychiatric advance directives as a complex and multistage intervention: Health Soc Care Comm. Srebnik D, Brodoff L. Implementing psychiatric advance directives: J Behav Health Serv Res. Psychiatric advance directives among public mental health consumers in five U. J Am Acad Psychol Law. Competence to complete psychiatric advance directives: From psychiatric advance directives to joint crisis plan. The content and clinical utility of psychiatric advance directives. Srebnik D, Russo J. Use of psychiatric advance directives during psychiatric crisis events. Adm Policy Ment Health. Psychiatric advance directives and reduction of coercive crisis interventions. Reducing barriers to completing psychiatric advance directives. Effect of joint crisis plans on use of compulsory treatment in psychiatry: Advance treatment directives for people with severe mental illness. Cochrane Database Syst Rev. Understanding the personal and clinical utility of psychiatric advance directives: Facilitated psychiatric advance directives: Implementing advance directives in mental health services: Embedding advance directives in routine care for persons with serious mental illness: Clinical decision making and views about psychiatric advance directives. A survey of stakeholder knowledge, experience, and opinions of advance directives for mental health in Virginia. Int J Soc Psychol. Principles of biomedical ethics. Oxford University Press; Recovery in serious mental illness: Prof Psychol Res Pract. Jacobson N, Greenley D. A conceptual model and explication. An analysis of the definitions and elements of recovery: National consensus statement on mental health recovery SMA Uses and abuses of recovery: New Freedom Commission on Mental Health. Eur J Health Law. Advance directives in mental health care: Med Leg J Ireland. Advance statements in the new Victorian Mental Health Act. Psychiatric advance directives and human rights. Indian J Med Ethics. Virginia Health Care Decisions Act of Preferences for psychiatric advance directives among Latinos: How should we implement psychiatric advance directives? Views of consumers, caregivers, mental health providers and researchers. The role of organizational processes in dissemination and implementation research. Dissemination and implementation research in health: Disseminating innovations in health care. Am J Commun Psychol. Carrots, sticks, and promises:

Chapter 3 : Access to Health Services | Healthy People

Evidence in Mental Health Care will prove vital for the successful extension of evidence-based evaluation to mental health services in general. It will be essential reading for researchers, students and practitioners across the range of mental health disciplines, health service managers and purchasers of services.

The US Community Mental Health Act of led to a deinstitutionalization process which proved to be a mixed failure, particularly when community ser- vices were not available in the catchment areas. The paper by Thornicroft et al uses an expert knowledge approach to frame community care on common sense and to describe ten key challenges to implement it and to improve balance of care. The paper is mainly focused on the challenges of care reform at individual ser- vices microlevel. A number of comments may be added to better understand the current trends of decision making and planning at the upper side of the Thornicroft and Tansella matrix 3: Mental health care in the real world performs as a complex environmental system characterized by multidisciplinarity, high dimensionality with ill-structured and nonlinear domains, and high uncertainty with heterogeneity of data and imprecise information 4 , 5. Complex care systems demonstrate other identifiable characteristics such as embeddedness, self-organization, or unpredictability. Under these conditions, evidence cannot be generated using the designs and statistical methods of evidence-based medicine. New health technology assessment tools include outcomes management, decision support systems and knowledge discovery from data KDD. KDD is a hybrid of statistics and artificial intelligence which incorporates implicit expert knowledge into the data analysis. In the analysis of complex systems, expert opinion is not a source of bias but a key component of the knowledge management and the development of mathematical models. Thus, experience is incorporated into evidence-base mental health care planning 5. The classical debate between hospital and community psychiatry is already closed. Although failures exist and they replicate at a stubborn pace, psychiatric hospitals have been successfully closed in several countries or regions, whilst in other areas these services have been changed into integrated health care systems 6. On the other hand, the closure of a psychiatric hospital produces similar social resistance and unrest as any other service in obsolete economic sectors, particularly when the hospital is a major source of employment in what are often isolated communities 7. Involving other ministries or national agencies may favour deinstitutionalization in middle income countries. As Thornicroft et al put it forward, the reform of psychiatric hospitals should be led by experience and common sense as much as by values. Bulgaria and other Eastern European countries provide a good example of the complexities of hospital reform. The balance of care approach may facilitate a better appreciation of these problems. Classical community psychiatry put major emphasis on closing psychiatric hospitals and on developing specialized community services, mainly residential and intermediate care for severe mental illness. During the last years, a new balance of care model is providing a broader view of the mental health system. Person-centered approaches and longitudinal perspectives are key to this new framework. It takes into consideration the equilibrium between residential and community care, primary and specialized care, or health, social and forensic care within an integrated multi-sectoral approach to the delivery of services 7. A special focus is provided on the transitional arrangements needed during the process of re-balancing care for people with mental health problems, or on the outputs at later stages of this process. For example, re-institutionalization has been identified as a worrying trend of well developed community care systems in Western Europe 8. To date, mental health systems have been extensively described by system characteristics, macro indicators of system development and the specific focus on deinstitutionalization and community psychiatry. However, little information has been provided on the financing of mental health systems until very recently. Care financing studies are concerned with the flow of expenditure throughout the care system. The Mental Health Economics European Network has described the financing systems of 17 European countries and identified commonalities and differences 9. A thorough information on the financing system of a number of these countries have been published separately 10 , The World Health Organization has also provided a framework to produce standard reports on mental health financing including pooling, context, mapping, resource base, allocation, budgeting, purchasing, and financing

analysis. Financing is a main policy tool to lead mental health reforms 12 , Stopping the revolving door â€" a study of readmissions to a state hospital. Tansella M, Thornicroft G. A conceptual framework for mental health services: Data Mining as a tool for environmental scientists. A framework for evidence based mental health care and policy. Between mind, brain and managed care. American Psychiatric Press; Shifting care from hospital to the community in Europe: Reinstitutionalisation in mental health care: Financing mental health care in Europe. Financing mental health care in Spain. Zechmeister I, Oesterle A. Distributional impacts of mental health care financing arrangements: J Ment Health Policy Econ. World Health Organization;

Chapter 4 : Evidence-Based Practices in Mental Health | MIMH

Evidence-based practice (EBP) is the subject of vigorous controversy in the field of mental health. In this paper I discuss three distinct but interrelated controversies: how inclusive the mental.

Equivalent recommendations apply to the Canadian equivalent of these associations. Pressure toward EBP has also come from public and private health insurance providers, which have sometimes refused coverage of practices lacking in systematic evidence of usefulness. Areas of professional practice, such as medicine, psychology, psychiatry , rehabilitation and so forth, have had periods in their pasts where practice was based on loose bodies of knowledge. Some of the knowledge was lore that drew upon the experiences of generations of practitioners, and much of it had no valid scientific evidence on which to justify various practices. In the past, this has often left the door open to quackery perpetrated by individuals who had no training at all in the domain, but who wished to convey the impression that they did, for profit or other motives. As the scientific method became increasingly recognized as the means to provide sound validation for such methods, the need for a way to exclude quack practitioners became clear, not only as a way of preserving the integrity of the field particularly medicine , but also of protecting the public from the dangers of their "cures. The notion of evidence based practice has also had an influence in the field of education. Here, some commentators[who? Opponents of this view argue that hard scientific evidence is a misnomer in education; knowing that a drug works in medicine is entirely different from knowing that a teaching method works, for the latter will depend on a host of factors, not least those to do with the style, personality and beliefs of the teacher and the needs of the particular children Hammersley Some opponents of EBP in education suggest that teachers need to develop their own personal practice, dependent on personal knowledge garnered through their own experience. Others argue that this must be combined with research evidence, but without the latter being treated as a privileged source. Its goal is to eliminate unsound or excessively risky practices in favor of those that have better outcomes. EBP uses various methods e. Where EBP is applied, it encourages professionals to use the best evidence possible, i. The core activities at the root of evidence-based practice can be identified as: Random Reflections on Health Services. It is now assumed that professionals must be well-informed and up-to-date with the newest knowledge in order to best serve their clients and remain professionally relevant Gibbs, ; Pace, ; Patterson et al. It recognizes that care is individualized and ever changing and involves uncertainties and probabilities. EBP develops individualized guidelines of best practices to inform the improvement of whatever professional task is at hand. Evidence-based practice is a philosophical approach that is in opposition to rules of thumb , folklore , and tradition. Examples of a reliance on "the way it was always done" can be found in almost every profession, even when those practices are contradicted by new and better information. However, in spite of the enthusiasm for EBP over the last decade or two, some authors have redefined EBP in ways that contradict, or at least add other factors to, the original emphasis on empirical research foundations. For example, EBP may be defined as treatment choices based not only on outcome research but also on practice wisdom the experience of the clinician and on family values the preferences and assumptions of a client and his or her family or subculture. The theories of evidence based practice are becoming more commonplace in nursing care. None of the articles specify what their biases are. Evidence based practice has gotten its reputation by examining the reasons why any and all procedures, treatments, and medicines are given. This is important for refining practice so the goal of assuring patient safety is met. In psychiatry and community mental health , evidence-based practice guides have been created by such organizations as the Substance Abuse and Mental Health Services Administration and the Robert Wood Johnson Foundation , in conjunction with the National Alliance on Mental Illness. Evidence-based practice has now spread into a diverse range of areas outside of health where the same principles are known by names such as results-focused policy, managing for outcomes, evidence-informed practice etc. This model of care has been studied for 30 years in universities and is gradually making its way into the public sector. EBPs are being employed in the fields of health care, juvenile justice, mental health and social services among others. The theories of evidence based practice are becoming more commonplace in the nursing care. One obvious

problem with EBP in any field is the use of poor quality, contradictory, or incomplete evidence. Evidence-based practice continues to be a developing body of work for professions as diverse as education , psychology , economics , nursing , social work and architecture. Criteria for empirically supported therapies have been defined by Chambless and Hollon Accordingly, a therapy is considered "efficacious and specific" if there is evidence from at least two settings that it is superior to a pill or psychological placebo or another bona fide treatment. If there is evidence from two or more settings that the therapy is superior to no treatment it is considered "efficacious". If there is support from one or more studies from just a single setting, the therapy is considered possibly efficacious pending replication. Following these guidelines, cognitive behavior therapy CBT stands out as having the most empirical support for a wide range of symptoms in adults, adolescents, and children. In reality, not all mental health practitioners receive training in evidence-based approaches, and members of the public are often unaware that evidence-based practices exist. However, there is no guarantee that mental health practitioners trained in "evidence-based approaches" are more effective or safer than those trained in other modalities. Consequently, patients do not always receive the most effective, safe, and cost effective treatments available. It should be noted that "evidence-based" is a technical term, and there are many treatments with decades of evidence supporting their efficacy that are not considered "evidence-based. ESTs have been defined as "clearly specified psychological treatments shown to be efficacious in controlled research with a delineated population. From the latter perspective, ESTs are understood to place primary or exclusive emphasis on the first "leg," namely, research evidence. Research evidence does not fall simply into "evidence-based" and "non-evidence-based" classes, but can be anywhere on a continuum from one to the other, depending on factors such as the way the study was designed and carried out. The existence of this continuum makes it necessary to think in terms of "levels of evidence", or categories of stronger or weaker evidence that a treatment is effective. To classify a research report as strong or weak evidence for a treatment, it is necessary to evaluate the quality of the research as well as the reported outcome. These included both the need for lower but still useful levels of evidence, and the need to require even the "gold standard" randomized trials to meet further criteria. A number of protocols for the evaluation of research reports have been suggested and will be summarized here. Some of these divide research evidence dichotomously into EBP and non-EBP categories, while others employ multiple levels of evidence. As the reader will see, although the criteria used by the various protocols overlap to some extent, they do not do so completely. The Kaufman Best Practices Project approach did not use an EBP category per se, but instead provided a protocol for selecting the most acceptable treatment from a group of interventions intended to treat the same problems. This protocol also requires absence of evidence of harm, at least one randomized controlled study, descriptive publications, a reasonable amount of necessary training, and the possibility of being used in common settings. Missing from this protocol are the possibility of nonrandomized designs in which clients or practitioners decide whether an individual will receive a certain treatment , the need to specify the type of comparison group used, the existence of confounding variables, the reliability or validity of outcome measures, the type of statistical analysis required, or a number of other factors required by some evaluation protocols. To be classified under this protocol, there must be descriptive publications, including a manual or similar description of the intervention. This protocol does not consider the nature of any comparison group, the effect of confounding variables, the nature of the statistical analysis, or a number of other criteria. Interventions are assessed as belonging to Category 1, well-supported, efficacious treatments, if there are two or more randomized controlled outcome studies comparing the target treatment to an appropriate alternative treatment and showing a significant advantage to the target treatment. Interventions are assigned to Category 2, supported and probably efficacious treatment, based on positive outcomes of nonrandomized designs with some form of control, which may involve a non-treatment group. Category 3, supported and acceptable treatment, includes interventions supported by one controlled or uncontrolled study, or by a series of single-subject studies, or by work with a different population than the one of interest. Category 4, promising and acceptable treatment, includes interventions that have no support except general acceptance and clinical anecdotal literature; however, any evidence of possible harm excludes treatments from this category. Category 5, innovative and novel treatment, includes interventions that are not thought to be harmful, but are not widely

used or discussed in the literature. Category 6, concerning treatment, is the classification for treatments that have the possibility of doing harm, as well as having unknown or inappropriate theoretical foundations. A protocol for evaluation of research quality was suggested by a report from the Centre for Reviews and Dissemination, prepared by Khan et al. The Khan et al. This protocol did not provide a classification of levels of evidence, but included or excluded treatments from classification as evidence-based depending on whether the research met the stated standards. An assessment protocol has been developed by the U. The NREPP evaluation, which assigns quality ratings from 0 to 4 to certain criteria, examines reliability and validity of outcome measures used in the research, evidence for intervention fidelity predictable use of the treatment in the same way every time , levels of missing data and attrition, potential confounding variables, and the appropriateness of statistical handling, including sample size. A protocol suggested by Mercer and Pignotti [16] uses a taxonomy intended to classify on both research quality and other criteria. In this protocol, evidence-based interventions are those supported by work with randomized designs employing comparisons to established treatments, independent replications of results, blind evaluation of outcomes, and the existence of a manual. Evidence-supported interventions are those supported by nonrandomized designs, including within-subjects designs, and meeting the criteria for the previous category. Evidence-informed treatments involve case studies or interventions tested on populations other than the targeted group, without independent replications; a manual exists, and there is no evidence of harm or potential for harm. Belief-based interventions have no published research reports or reports based on composite cases; they may be based on religious or ideological principles or may claim a basis in accepted theory without an acceptable rationale; there may or may not be a manual, and there is no evidence of harm or potential for harm. Finally, the category of potentially harmful treatments includes interventions such that harmful mental or physical effects have been documented, or a manual or other source shows the potential for harm. Protocols for evaluation of research quality are still in development. So far, the available protocols pay relatively little attention to whether outcome research is relevant to efficacy the outcome of a treatment performed under ideal conditions or to effectiveness the outcome of the treatment performed under ordinary, expectable conditions. Production of evidence[edit] A process has been specified that provides a standardised route for those seeking to produce evidence of the effectiveness of interventions. This can be an important contribution to the establishment of a foundation of evidence about an intervention. In other situations, facts about a group of study outcomes may be gathered and discussed in the form of a systematic research synthesis SRS. The results lead to a rank ordering of the 48 treatment modalities included and provide a basis for selecting supportable treatment approaches beyond anecdotes, traditions and lore. Social policy[edit] There are increasing demands for the whole range of social policy and other decisions and programs run by government and the NGO sector to be based on sound evidence as to their effectiveness. This has seen an increased emphasis on the use of a wide range of Evaluation approaches directed at obtaining evidence about social programs of all types. A research collaboration called the Campbell Collaboration has been set up in the social policy area to provide evidence for evidence-based social policy decision-making. This collaboration follows the approach pioneered by the Cochrane Collaboration in the health sciences. It is a UK-wide network that promotes the use of high quality evidence to inform decisions on strategy, policy and practice. The concept of Evidence-based policy and practice within international development is similarly being emphasized. For instance, in a literature review focused on development, an integrated, participatory, structured and enpowering approach to using evidence and data in decision-making to inform development decisions was tied to improved results.

Chapter 5 : Advance directives in mental health care: evidence, challenges and promise

The US Community Mental Health Act of led to a deinstitutionalization process which proved to be a mixed failure, particularly when community ser- vices were not available in the catchment areas. Ten years later, John Talbott 1 reported that hospital readmission or "revolving door" was a.

Printer-friendly version Although there is growing sentiment that strengthening behavioral health care services in primary care is critically needed, the majority of existing behavioral interventions were developed for settings very different from the fast paced environment of primary care. Current strategies require extensive clinical training and an unrealistic time commitment from both the patient and the provider. Although many psychotherapies require six to twelve sessions to be effective, in reality, most people only go to one or two. The lack of evidence-based behavioral interventions that are tailored to primary care poses a major barrier to their treatment. Effective integrated care models such as Collaborative Care use medications, behavioral interventions, or both, changing the treatment plan as necessary until the patient gets better. To be effective in primary care, a behavioral intervention should: A modularized treatment with clear steps keeps the provider and patient on track despite the distractions in primary care. The treatment should be able to be administered by non-specialists who work in a health care team. Of the multiple behavioral interventions in existence, only a few have been proven to work in primary care including Problem Solving Therapy-Primary Care, Cognitive Behavioral Therapy, Interpersonal Counseling, and Behavioral Activation. PST-PC has been found to significantly improve mental health treatment in a wide range of settings, including diverse provider and patient populations. An adaptation of Cognitive Behavioral Therapy CBT has also been found to be beneficial for both depression and anxiety in primary care. CBT uses short-term, goal-oriented therapy to interrupt patterns of thinking that prevent patients from feeling better. Brief Cognitive Therapy makes the intervention more accessible in primary care by using shorter and fewer sessions. Interpersonal Counseling IPC , an outgrowth of Interpersonal Therapy, may further reduce the time required to treat depression in primary care. The model was found to be more effective than normal care after six or fewer, minute sessions with some patients improving markedly after only one or two. Designed to be implemented by nurse practitioners in primary care, IPC focuses on current functioning, recent life changes, sources of stress and difficulties in interpersonal relationships. A fourth behavioral intervention proven to work in primary care is Behavioral Activation BA , an evidence-based psychotherapy that identifies work, social, health, or family activities patients have stopped engaging in because of their mood. The patient and provider create an action plan, including any obstacles, triggers, and consequences. While the above behavioral interventions have been proven to work in primary care, they all have constraints that make them difficult to implement, such as the amount of training and on-going supervision clinicians need, not to mention the time demands needed from patients. These new interventions will be based on advances in cognitive neuroscience, using input from patients and clinicians to inform the design of the intervention.

Chapter 6 : Evidence-Based Behavioral Interventions in Primary Care | University of Washington AIMS Ce

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.

Back to Top Emerging Issues in Access to Health Services Over the first half of this decade, as a result of the Patient Protection and Affordable Care Act of , 20 million adults have gained health insurance coverage. In addition, data from the Healthy People Midcourse Review demonstrate that there are significant disparities in access to care by sex, age, race, ethnicity, education, and family income. These disparities exist with all levels of access to care, including health and dental insurance, having an ongoing source of care, and access to primary care. Disparities also exist by geography, as millions of Americans living in rural areas lack access to primary care services due to workforce shortages. Future efforts will need to focus on the deployment of a primary care workforce that is better geographically distributed and trained to provide culturally competent care to diverse populations. Specific issues that should be monitored over the next decade include: Increasing and measuring insurance coverage and access to the entire care continuum from clinical preventive services to oral health care to long-term and palliative care Addressing disparities that affect access to health care e. Access to Health Care in America. National Academies Press; Agency for Healthcare Research and Quality; May Insurance coverage, medical care use, and short-term health changes following an unintentional injury or the onset of a chronic condition. Self-assessed health status and selected behavioral risk factors among persons with and without healthcare coverageâ€”United States, The medical home, access to care, and insurance. Provider continuity in family medicine: Does it make a difference for total health care costs? The importance of having health insurance and a usual source of care. The timing of preventive services for women and children; the effect of having a usual source of care. Am J Pub Health. Evidence from primary care in the United States and the United Kingdom. Balancing health needs, services and technology. Oxford University Press; Contribution of primary care to health systems and health. A national profile on use, disparities, and health benefits. Partnership for Prevention; Aug. Data needed to assess use of high-value preventive care: A brief report from the National Commission on Prevention Priorities. Future of emergency care series: Agency for Healthcare Research and Quality; April The increasing weight of increasing waits. Trends Affecting Hospitals and Health Systems. American Heart Association; Department of Health and Human Services; Mar 3.

Chapter 7 : Stigma as a Barrier to Mental Health Care â€“ Association for Psychological Science

The Healthy People evidence-based resources identified have been selected by subject matter experts at the U.S. Department of Health and Human Services. Each of the selected evidence-based resources has been rated and classified according to a set of specific criteria based, in part, on.

Key elements of EBPH have been summarized 3 as the following: Engaging the community in assessment and decision making; Using data and information systems systematically; Making decisions on the basis of the best available peer-reviewed evidence both quantitative and qualitative ; Applying program planning frameworks often based in health behavior theory ; Conducting sound evaluation; and Disseminating what is learned. Data for community assessment As a first step in the EBPH process, a community assessment identifies the health and resource needs, concerns, values, and assets of a community. This assessment allows the intervention a public health program or policy to be designed and implemented in a way that increases the likelihood of success and maximizes the benefit to the community. The assessment process engages the community and creates a clear, mutual understanding of where things stand at the outset of the partnership and what should be tracked along the way to determine how an intervention contributed to change. Often conducted through national or statewide initiatives, surveillance involves ongoing systematic collection, analysis, and interpretation of quantitative health data. Various health issues and indicators may be tracked, including deaths, acute illnesses and injuries, chronic illnesses and impairments, birth defects, pregnancy outcomes, risk factors for disease, use of health services, and vaccination coverage. National surveillance sources typically provide state-level data, and county-level data have become more readily available in recent years Box 1. State health department websites can also be sources of data, particularly for vital statistics and hospital discharge data. Additionally, policy tracking and surveillance systems Box 1 monitor policy interest and action for various health topics Other data collection methods can be tailored to describe the particular needs of a community, creating new sources of data rather than relying on existing data. Telephone, mail, online, or face-to-face surveys collect self-reported data from community members. Community audits involve detailed counting of factors such as the number of supermarkets, sidewalks, cigarette butts, or health care facilities. For example, the Active Living Research website www. Qualitative data collection can take the form of simple observation, interviews, focus groups, photovoice still or video images that document community conditions , community forums, or listening sessions. Qualitative data analysis involves the verbatim creation of transcripts, the development of data-sorting categories, and iterative sorting and synthesizing of data to develop sets of common concepts or themes No single source of data is best. Most often data from several sources are needed to fully understand a problem and its best potential solutions. Several planning tools are available Box 1 to help choose and implement a data collection method. Selecting evidence Once health needs are identified through a community assessment, the scientific literature can identify programs and policies that have been effective in addressing those needs. The amount of available evidence can be overwhelming; practitioners can identify the best available evidence by using tools that synthesize, interpret, and evaluate the literature. Systematic reviews Box 1 use explicit methods to locate and critically appraise published literature in a specific field or topic area. The products are reports and recommendations that synthesize and summarize the effectiveness of particular interventions, treatments, or services and often include information about their applicability, costs, and implementation barriers. Evidence-based practice guidelines are based on systematic reviews of research-tested interventions and can help practitioners select interventions for implementation. The Guide to Community Preventive Services the Community Guide , conducted by the Task Force on Community Preventive Services, is one of the most useful sets of reviews for public health interventions 27, The Community Guide evaluates evidence related to community or population-based interventions and is intended to complement the Guide to Clinical Preventive Services systematic reviews of clinical preventive services Not all populations, settings, and health issues are represented in evidence-based guidelines and systematic reviews. Furthermore, there are many types of evidence eg, randomized controlled trials, cohort studies, qualitative research , and the best type of evidence

depends on the question being asked. Not all types of evidence eg, qualitative research are equally represented in reviews and guidelines. To find evidence tailored to their own context, practitioners may need to search resources that contain original data and analysis. Peer-reviewed research articles, conference proceedings, and technical reports can be found in PubMed www. Maintained by the National Library of Medicine, PubMed is the largest and most widely available bibliographic database; it covers more than 21 million citations in the biomedical literature. Practitioners can freely access abstracts and some full-text articles; practitioners who do not have journal subscriptions can request reprints from authors directly. Economic evaluations provide powerful evidence for weighing the costs and benefits of an intervention, and the Cost-Effectiveness Analysis Registry tool Box 1 offers a searchable database and links to PubMed abstracts. These sources may provide useful information, although readers should interpret nonâ€"peer-reviewed literature carefully. Internet search engines such as Google Scholar http: Program-planning frameworks Program-planning frameworks provide structure and organization for the planning process. Public health interventions grounded in health behavior theory often prove to be more effective than those lacking a theoretical base, because these theories conceptualize the mechanisms that underlie behavior change 32, Logic models are an important planning tool, particularly for incorporating the concepts of health-behavior theories. They visually depict the relationship between program activities and their intended short-term objectives and long-term goals. The first 2 chapters of the Community Tool Box explain how to develop logic models, provide overviews of several program-planning models, and include real-world examples Box 1. Evaluation and dissemination Evaluation answers questions about program needs, implementation, and outcomes Ideally, evaluation begins when a community assessment is initiated and continues across the life of a program to ensure proper implementation. Four basic types of evaluation can achieve program objectives, using both quantitative and qualitative methods. Formative evaluation is conducted before program initiation; the goal is to determine whether an element of the intervention eg, materials, messages is feasible, appropriate, and meaningful for the target population Process evaluation assesses the way a program is being implemented, rather than the effectiveness of that program 36 eg, counting program attendees and examining how they differ from those not attending. Impact evaluation assesses the extent to which program objectives are being met and may reflect changes in knowledge, attitudes, behavior, or other intermediate outcomes. Ideally, practitioners should use measures that have been tested for validity the extent to which a measure accurately captures what it is intended to capture and reliability the likelihood that the instrument will get the same result time after time elsewhere. New survey questions receive a technical review, cognitive testing, and field testing before inclusion. Outcome evaluation provides long-term feedback on changes in health status, morbidity, mortality, or quality of life that can be attributed to an intervention. Because it takes so long to observe effects on health outcomes and because changes in these outcomes are influenced by factors outside the scope of the intervention itself, this type of evaluation benefits from more rigorous forms of quantitative evaluation, such as experimental or quasi-experimental rather than observational study designs. The Centers for Disease Control and Prevention CDC Framework for Program Evaluation, developed in , identifies a 6-step process for summarizing and organizing the essential elements of evaluation The related CDC website Box 1 maintains links to framework-based materials, step-by-step manuals, and other evaluation resources. After an evaluation, the dissemination of findings is often overlooked, but practitioners have an implied obligation to share results with stakeholders, decision makers, and community members. Often these are people who participated in data collection and can make use of the evaluation findings. Dissemination may take the form of formal written reports, oral presentations, publications in academic journals, or placement of information in newsletters or on websites. Top of Page Putting Evidence to Work An increasing volume of scientific evidence is now at the fingertips of public health practitioners. Putting this evidence to work can help practitioners meet demands for a systematic approach to public health problem solving that yields measurable outcomes. Practitioners need skills, knowledge, support, and time to implement evidence-based policies and programs. Many tools exist to help efficiently incorporate the best available evidence and strategies into their work. Improvements in population health are most likely when these tools are applied in light of local context, evaluated rigorously, and shared with researchers, practitioners, and other stakeholders. Top of Page Acknowledgments Preparation

of this article was supported by the National Association of Chronic Disease Directors; cooperative agreement no. Jacobs, Prevention Research Center in St. Am J Prev Med ;27 5: Toward a transdisciplinary model of evidence-based practice. Milbank Q ;87 2: Annu Rev Public Health ; Corsini encyclopedia of psychology. Encyclopedia of human behavior. Jones and Bartlett; Oxford University Press; Use of evidence-based interventions in state health departments: J Public Health Manag Pract ;16 6: Examining the role of training in evidence-based public health: Health Promot Pract ;10 3: Evidence-based interventions to promote physical activity: Am J Prev Med ;33 1 Suppl: Barriers to evidence-based decision making in public health: Public Health Rep ; 5: PubMed Healthy People framework: Accessed March 7, The effect of disseminating evidence-based interventions that promote physical activity to health departments. Am J Public Health ;97 CrossRef PubMed Core competencies for public health professionals. Designing competencies for chronic disease practice. Prev Chronic Dis ;7 2. PubMed Standards and measures. Public Health Accreditation Board. Training practitioners in evidence-based chronic disease prevention for global health. Promot Educ ;14 3: Teaching evidence-based public health to public health practitioners. Ann Epidemiol ;15 7: Improving the public health workforce: J Public Health Manag Pract ;14 2: Prev Chronic Dis ;2 2. Nurs Outlook ;58 6: What gets measured, gets changed: J Law Med Ethics ;39 Suppl 1 The practice of qualitative research.

Chapter 8 : WHO | Mental health evidence and research (MER)

Previous studies had shown that providing substance abuse and mental health treatment makes the individuals receiving that treatment better off. But these are the first studies showing that.

EBPs can save older adults from chronic disease and falls and can strengthen communities. Reduce Chronic Diseases and Falls: The percentage of older individuals in the population has increased with each decade, and the proportion of persons 75 years and older has grown even faster. As a result, chronic diseases and falls have increased and are now the leading causes of death and disability among older Americans. Fortunately, both chronic diseases and falls are highly preventable. Equally important, community organizations and health care entities can partner to implement EBPs. Making community-clinical linkages is integral to promoting good health and reducing disease and disability. What are the benefits of EBPs? They are based on rigorous study of interventions and model programs carried out with multiple populations in a variety of settings. Therefore, they are more likely to produce positive changes or outcomes for people who participate. Benefits to Older Adults: Increased or maintained independence, positive health behaviors, or mobility. Reduced disability fewer falls, later onset or fewer years of disability, etc. Reduced pain Improved mental health including delays in loss of cognitive function and positive effects on depressive symptoms Benefits to Community-Based and Health Care Organizations: More efficient use of available resources. Better health outcomes and a more positive health care experience. Fewer hospital and doctor visits and lower health care costs. Ease of replicating and spreading programs. Greater opportunity for varied funding sources, as programs get proven results. What programs can I offer? For more information about the Review Councils and upcoming opportunities to submit a program application, please click here.

Chapter 9 : care plans in mental health | Evidence search | NICE

The EPC Program synthesizes evidence on health care topics to help with clinical or policy decisionmaking or to help identify future research needs. Federal agencies can partner with AHRQ through an Interagency Agreement (IAA) to support systematic evidence reviews and technical briefs.