Institute for Science in Medicine

MENTAL HEALTH SERVICES

THE PROBLEM

Mental health services currently offered to the public include an alarming number of unreliable assessments, false diagnoses, and interventions that are both ineffective and potentially harmful. The result has been a yawning deficit in mental health care that seriously compromises personal and family well-being; public safety and community functioning; and public/private resource allocation.[1] This situation is a direct consequence of the failure to promulgate and enforce scientifically sound standards for mental health practice.

BACKGROUND

Historical Development

1900-1950: Mental health services were provided by either psychiatrists who practiced "talk therapy" (often with a Freudian psychoanalytic approach), by psychologists who largely did guidance and counseling work, or by psychiatric social workers who counseled patients through practical problem-solving. Few of these practitioners were interested in establishing an evidentiary foundation for mental health services.

1950-1970: The development of pharmaceutical treatments for psychiatric conditions led many psychiatrists away from talking and insight-related therapies. The 1949 Boulder Conference on Graduate Education in Clinical Psychology had advocated the "scientist-practitioner" model for clinical psychologists and emphasized the need for a research-orientation.[2] Psychologists gradually adopt behavior-oriented treatments and question the effectiveness of older methods.

1970s and 1980s: A movement towards greater emphasis on just clinical practice culminated in the endorsement, in 1973, by the American Psychological Association of the Doctor of Psychology (PsyD) degree, with a reduced focus on research as compared to the traditional PhD. At first the PsyD was awarded by universities, but over time institutions unaffiliated with any college or university became a major source of these degrees, producing graduates less likely to have obtained a research grounding or a broad university education.

This was a time of increased public awareness about mental health issues, with an interest in "self-help" and a greater demand for professional services. This demand led to the establishment by state laws of the Licensed Professional Counselor (LPC) and the Licensed Marriage and Family Therapist (LMFT). These licenses demanded only training at the master's level, with typically little or no knowledge of research required. (In addition, today unlicensed practitioners, such as "parenting coaches" and "registered unlicensed psychotherapist" also offer therapy to the public.)

1990s: Some American psychologists pushed for more science-based clinical practice. The report of a task force of the Society for Clinical Psychology (Division 12 of the American Psychological Association) offered a definition of empirically supported treatments, i.e. interventions shown to work in rigorous controlled trials.[3] The report underscored the importance of identifying and employing such treatments. There have been attempts to weaken the movement toward science-based practice, most recently by including undefinable factors such as "practice wisdom" and "family values."[4]

Today: Growing criticism of graduate schools' lack of grounding in research has led to minimal improvement in psychology curricula.[5] With few exceptions, master's level practitioners have shown relatively little appreciation for the value of research and a greater tendency to use unvalidated mental health treatments, such as EMDR, Neurolinguistic Programming, Neurofeedback, Recovered Memory Therapy, cathartic therapies, Critical Incident Stress Debriefing, Thought Field Therapy, and Attachment Therapy. Unvalidated diagnoses, such as Attachment Disorder, Complex Trauma, and Dissociative Identity Disorder, have become a problem.

Problems in Professional Regulation

The increasing variety of mental health degrees and licenses has proven baffling to the public. Compounding that confusion is a proliferation unaccredited institutions and "vanity" boards which create the illusion of specialization and competency. Sometimes even licensing boards do not recognize vanity credentials for what they are.

The continuing education (CE) industry has also failed to monitor the appropriateness and quality of course content. National professional organizations, unable to bear the burden of surveillance over thousands of courses, have instead appointed "approved provider" institutions and depended on them to evaluate CE courses. Such evaluation is rarely done in terms of the evidentiary support for the methods taught.

Lagging Professional and Public Acceptance of Science-Based Treatment

Current evidence suggests that many mental health professionals neglect the importance of evidence bases for their practices. In a recent survey of college counseling centers, 25% of those surveyed said they did not use research articles to guide their counseling work.[6] Of licensed clinical social workers surveyed about their choice of techniques, 75% stated that they used methods with little or no empirical support.[7]

Consumer surveys show similar problems.[8] Data from the latest results from National Comorbidity Survey Replication[9] reveal that approximately one-third of all mental-health visits in the United States were for so-called "complementary and alternative medicine" treatments, in spite of the lack of evidentiary support for their efficacy. "Furthermore," state the authors of this large survey (n=9282 respondents), "only one-third of treatments meet minimal standards of adequacy based on evidence-based treatment guidelines…" Meanwhile, nearly one out of every three mental-health visits are by persons having no apparent disorder, suggesting a significant diversion of treatment resources from meeting the needs of people with well-defined mental disorders.

DISCUSSION

Continuing professional and public resistance to reliance on science-based mental health practices has compromised the quality of mental health services. Advocacy for science-based mental health practice progresses, but in the face of widespread professional and public ignorance about the importance of this issue. Variation in state licensing and continuing-education requirements add further complexity.

The proliferation of new mental health degree programs and licenses has made it difficult for established professional organizations to oversee educational and practice standards for those providing a wide range of mental health services.

A serious problem is the absence of any umbrella organization able to oversee the entire range of mental health professions and standards of practice. This, coupled with scope-of-practice disagreements between disciplines, makes it difficult for professional groups to even communicate effectively. At this time, suggestions for research training and awareness even within a single discipline are difficult to implement.

Meanwhile, some patient-support organizations are less concerned with the scientific validation of treatment than with patients having access to any and all desired care.

Reimbursement decisions by public and private insurance programs can play an important role in the encouragement of science-based practice. Private insurance companies are attentive to research evidence and often decline payment when it is weak or non-existent for a specific treatment. In the USA, Medicaid has declined to pay for "complementary and alternative" mental health interventions such as "Attachment Therapy," as have some private companies. The recently-established policy of insurance parity for mental and physical health care could well make insurers even more attentive to the evidence supporting specific mental health treatments and thereby potentially encourage the use of well-supported methods. (On the other hand, the US Patient Protection and Affordable Care Act of 2010 requires public and private insurers to reimburse any licensed practitioner's services, no matter how unhelpful or even dangerous.)

A research-grounded education can also have a bearing on the ethical conduct of mental health practitioners. For example, research involving human subjects stresses the importance of informed consent. The information that makes consent "informed" includes research-based material describing the probability that a treatment will be effective, the availability of efficacious alternatives, and the adverse events associated with the treatment. When individuals receiving mental health services are not given this kind of information, their consent to treatment is not fully informed. Many mental health practitioners have little or no training that enables them to offer appropriate informed-consent material.

As presently constituted, the "approved provider" system for continuing education is an open door for consumer fraud in mental-health care, providing a means of unvalidated therapeutic fads to enter the professional practicum. This will continue until a robust oversight of CE course content is put in place.

Scarce resources are often wasted on unsupported and potentially harmful methods. For example, the resources available to courts often involve the use of non-science-based assessments in recommendations about incarceration, adoption, child custody, and termination of parental rights, among others. And when mental health and educational services are combined, decisions are too often made without concern for the demonstrable effectiveness of interventions.

NEEDED POLICY

Mental health care needs to be rooted in a single, science-based standard of care for all practitioners. Effective, reliable care can only be delivered by qualified mental health professionals who practice within a single, consistent framework of scientific knowledge and standards. Use of any mental health assessment or treatment which lacks an established minimum of scientifically acceptable supportive evidence must be considered substandard care by licensing boards and professional associations. Because there are so many serious problems in the delivery of effective mental health care today, arising from a multitude of factors, they are best addressed by broad policy approaches rather than by mandating specific practice changes.

Science education and training. Professional organizations and educational accreditation institutions must together assure that all education which qualifies students for mental health licensure imparts sufficient scientific knowledge so that mental health professionals can base their practice on that knowledge. This can best be achieved through a consortium of all national mental health professional organizations.

Required continuing education. Professional mental health organizations should collectively establish recommended standards to regulators that preclude credit for the study of any mental health assessment or treatment method that lacks an established minimum of scientifically acceptable supportive evidence, except where it is disclosed to participants that the subject is considered investigational. This also can best be achieved through a consortium of all national mental health professional organizations.

Fraudulent Credentials. Governments should prohibit advertising with vanity credentials and degrees as false and deceptive claims of qualification. Such advertisements by licensed professionals should be treated by regulators as significant ethical violations.

Expert testimony. In judicial and other government proceedings, most especially during the adjudication of family and criminal matters, psychological testing which lacks an established minimum of scientifically acceptable supportive evidence should be considered unreliable. In the United States, all state judiciaries should adopt the standards for expert scientific testimony established by the US Supreme Court in *Daubert v. Merrell Dow Pharmaceuticals*.[10]

Insurance coverage. Public and private insurers should decline coverage for substandard mental health care, or for persons without a competent assessment of an apparent disorder. Concepts such as "practice wisdom" and "family values" should not take the place of a requirement for rigorous scientific evidence of efficacy in a decision for coverage.

Adopted by ISM Board of Directors
30 January 2011

FURTHER READING

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Endnotes

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[4] Jane F. Gilgun, "The four cornerstones of evidence-based practice in social work," *Research on Social Work Practice*, 2005 Jan; 15(1):52-61.

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[9] Philip S. Wang, Michael Lane, Mark Olfson, Harold A. Pincus, Kenneth B. Wells & Ronald C. Kessler, "Twelve-month use of mental health services in the United States: results from the National Comorbidity Survey Replication," *Archives of General Psychiatry*, 2005 Jun; 62(6):629-640. See particularly p. 634.

[10] 509 US 579 (1993), 113 SCt 2786, 125 LEd2 469, 1993 US Lexis 4408. Extended to expert testimony from non-scientists by *Kumho Tire v. Carmichael*, 526 US 137 (1999), 119 SCt 1167, 143 LEd2 238, 1999 USLexis 2189.

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