Problem Statement, Background, & Our Assumptions:

Failure to apply recent research findings about effective treatments is a critical problem that spans all areas of medicine, including child and adolescent mental health services. According to the Institute of Medicine, the lag between discovery of a new or more effective form of treatment and its widespread application averages 17 years across all areas of medicine. In the mental health arena specifically, experts estimate that more than 50% of adults with depression do not receive appropriate care. In the child mental health area, McLennan and colleagues noted that research-practice gaps can be considered to fall into 4 different categories – in essence one sin of omission and 3 sins of commission: 1) failing to implement procedures that have been shown to be effective; 2) implementing procedures that have been shown to be harmful; 3) implementing procedures that have no effect; and 4) implementing approaches that have not been studied (McLennan et al., 2006).

In this paper we take a “big picture view” of what we believe are some of the key policy, structural, and economic problems in closing the research practice gap, and offer several potential pathways for future progress, in terms of necessary new policies, structures, incentives, and conceptual paradigms that may enable the child mental health field to shorten the research-practice gap.

Background: Despite the general awareness of the field of the quality chasm in translating research findings into practice, in the child mental health services area there has been little explicit study of the extent and nature of this research-practice gap, in
terms of formally documented reasons for the gap, and the extent to which it applies across specific childhood disorders, treatment types, provider disciplines, clinical populations, or environmental contexts. Even within the best-studied disorder area of ADHD, evidence indicates that clinicians do not apply recent research findings developed by multiple professional and advocacy organizations. While accreditation measures have been developed for ADHD, the National Committee on Quality Assurance studies indicate widespread failure to implement basic standards. No measures have been developed or applied for any other area of child mental health diagnosis and treatment services, not even common problems such as adolescent depression across most settings or plans.

In other areas of medicine, the research to practice translation gap has been more thoroughly examined (e.g., cancer, diabetes). Generally speaking, four major reasons for translation difficulties have been identified: 1) Intervention characteristics (e.g., cost, time demands, level of staff expertise required, difficulties learning the intervention, failure to package “manualize” the approach, failure to develop the intervention considering users’ needs, failure to consider how to make the intervention self-sustaining, failing to make the intervention modular or customizable, intervention specificity to a particular setting, etc.); 2) problems with studies’ research designs (e.g., study populations not relevant or representative, failure to identify critical outcome variables for the intervention; failure to study key variables needed by policy makers and communities prior to adoption, such as cost, reach, implementation, maintenance, and/or sustainability factors); 3) problems with intervention adoption settings (e.g., competing demands, program imposed from outside, financial/organizational instability, specific needs of clients and setting, limited resources, time, or organizational support; misaligned incentives or regulations; competing prevailing practices; and challenges to intervention implementation quality), and 4) Interactions among the three above barrier types (participation barriers reduce program reach or participation, inflexible interventions, interventions not appropriate for the target population; organization and intervention philosophies not aligned, etc.).

While we agree with the general outline of these “reasons” for translation difficulties, these reasons tend to be rather molecular in focus, and in fact might mislead healthcare system organizers, policy-makers, and planners to simply continue to tweak existing interventions in order to try to close the research-practice gaps, piece by piece, bit by bit. While we believe that such an approach has some merit, we also believe that such an approach will yield modest (if any!) results in closing the gap. The current list of reasons does not fully consider the backdrop of larger clinical and community factors and forces, against which new evidence-based interventions must compete, if they are to be successfully implemented. Taking these factors into account must be considered as paramount for a successful strategy in closing the research practice gaps.

We also note that the research-practice gap also partly overlaps with other known gaps in access and effectiveness, such as health care disparities as a function of ethnicity, region, and income. These gaps must also be considered as a part of the overall difficulties in improving care and closing the research-practice gaps. The strategies we outline below are based on 4 key assumptions, or beliefs. While we believe our assumptions are reasonable and likely correct, each assumption itself might be the subject of study and debate; this is a task beyond our immediate scope of responsibility.

1. Many current “evidence-based practices” in mental health assessment, prevention, and psychosocial and pharmacologic treatment are available, but are not well-
implemented. Even in instances where health care barriers are minimal (e.g., with 100% insurance and health care access), clinicians do not deliver (and families fail to receive) treatments consistent with the most recent evidence. To illustrate,

*Within the well-studied disorder area of ADHD, decades of research findings are available, and treatment standards based on recent research findings have been developed by multiple professional and advocacy organizations and the NCQA. Yet in a recent NCQA validation study across 6 health plans for the “ADHD diagnosis initiation quality indicator,” applying the simple standard of requiring an ADHD diagnosis to be captured in the follow-up claim, with ≥ 2 additional follow-up visits in the next 11 months, plans’ average visit compliance rates were 19 percent and 23 percent for commercial and Medicaid plans, respectively. Across all commercial plans providing information 2005-2007, 90% of insurers averaged less than 45% on the quality measure of achieving minimal follow-up visits after ADHD diagnosis, with the mean percentile across all health plans of less than 33%. No evidence of change was noted across the years 2005-2007.*

This example of ADHD reflects only a limited view of what is widely believed by most scientists as the much larger research-practice translation problems across all of medicine. We note, however, that the IOM’s assumption of a 17-year research-practice gap across all of medicine may or may not be correct, and this concept of a 17-year research-practice gap has never been operationalized and rigorously applied to child mental health. We believe that we lack any specific details of the research-practice gap, in terms of which areas are most affected, i.e., populations, disciplines, disorders, settings, etc. For child mental health researchers, policy makers, and the general public to fully tackle this problem, the gap needs to be defined and operationalized with publicly vetted and accepted scientific measurement approaches, so that the gap indicator itself can be used as a feedback tool for the field to monitor its difficulties and measure its progress (or lack thereof).

2. We believe that the current alignment of federal, state, and local economic incentives that a) pay for health and social problems but not their prevention; b) pay for clinical and educational training models that consider children’s mental health and educational outcomes as discrete rather than inter-twined, c) stove-pipe funds and responsibilities for care and outcomes within but not across systems; d) focus solely on treatment of individuals vs. the management of populations; and e) assume patients to be passive recipients of an expert-delivered, short-term, finite/discrete product or service -- all 5 of these factors distort/prevent the application of more efficient, evidence-based procedures. Health care organizations as bureaucracies are usually organized around these distorted economic incentives, so rather than taking advantage of new information systems and findings from social neuroscience about how to best design optimal human service organizations, health care systems tend to perpetuate the older, familiar models. We believe that without fundamental changes that tie incentives to outcomes-based feedback and performance for individuals, populations, and health care organizations, change and application of EBPs will spotty at best.

To test the assumption that economic incentives will facilitate the adoption of EBPs seems reasonable, but it is important to note that previous studies indicate an uncertain relationship between economic incentives and subsequent provider/clinician behavior (REFS). Perhaps even more importantly for child EBPs, the questions of whether EBPs
make economic sense might be evaluated using a range of tools, including benefit-cost analyses (BCA) and cost-effectiveness analyses (CER). BCA provides a full accounting of the resource implications of an intervention, policy, or program. One measures both the costs and benefits of the intervention and then calculates net benefits—that is, the benefits of the intervention less its costs. If the net benefits are positive, then the intervention or treatment is desirable. Unlike BCA, cost-effectiveness analysis (CEA) does not require one to measure outcomes in dollar terms. Rather, the outcome measures remain in their natural metric (e.g., a 1-point difference on a symptom checklist or a percentage point reduction in the number of teenagers giving birth). The analyst then compares interventions or programs in terms of their added (or incremental) costs per added unit of the outcome measure (Zerbe & Dively, 1994). One could calculate such ratios for a variety of outcome measures, comparing a standard treatment vs. an EBP.

Other areas might also be examined vis-a-vis EBPs, such as mining various state, insurance, or federal data sets to examine the vast differences in children’s mental health services from county to county and state-to-state, or within and across service systems, to determine factors such as cost-shifting when funds are constrained in one setting, yet result in additional costs in other settings. Optimal vs. non-optimal treatments for disorders like ADHD might be analyzed in various data sets to show how costs accrue over time to various service settings among families with unaddressed risk factors. Likewise, studies need to be mounted that examine how changes in the organization of how care is paid for (e.g., payment to a provider for treatment of discrete illness episodes vs. payment to a health care organization in terms of preventing illness in a population of patients).

The current lack of coupling of children’s mental health services, outcomes, financial incentives, and economic understanding of this decoupling may be most evident in current situations where only persons with substantial economic resources may receive mental health care from a child psychiatric specialist, yet may or may not have any better outcomes (Bickman refs?)!

3. Researchers who have developed EBPs often have little know-how how to take well – established programs out into “the real world”. In fact, follow-up interviews of well-established investigators who have developed EBPs suggest that they often have disincentives for doing so, ranging from 1) lack of understanding how to adapt interventions to make them feasible and sustainable in the real world, 2) how to develop fiscal and business models to sustain EBPs deployment, to 3) ethical restrictions imposed by IRBs and universities if the possibility exists that researchers might profit from continuing to study and deploy the intervention. In several instances, researchers have developed a business model (sometimes in partnerships with the university), have drawn upon SBIR funding, or have set up independent businesses. These various strategies each have a number of advantages and disadvantages, and each entails a whole new set of activities which must be learned and mastered, for which many investigators appear unprepared or unwilling to pursue.

In the area of evidence-based school mental health interventions, for example, a review by Forman, Olin, Hoagwood et al. (in press) identified 25 EBPs for which 24 intervention developers were interviewed, fiscal stability was consistently cited as the most critical factors. For example, one intervention developer stated in describing a self-perceived lack of knowledge and skill to deal with implementation and sustainability
issues, “I’m just a college professor who created a program.” The unexpected and
complex processes that are set in motion when a new program is introduced require
preparation, a long-term commitment to overcoming numerous challenges, and many
partners, much more like starting a successful business than conducting a narrowly
defined research study. Additional efforts are needed to ensure that future EBPs can be
implemented and sustained in practice settings. We believe that stable business-savvy
dissemination organizations and mechanisms that can assist researchers to “take research
to market” are very much needed or at the least, integrated delivery systems with
motivation to provide the best possible care must be linked with scientists who create
such programs.

4. The child and adolescent mental health system with its emphasis almost exclusively on
the individual clinician patient-encounter is seriously flawed. Attempts to close the
research-practice gap by focusing solely on this encounter will not succeed, due to range
of factors that will prevent full implementation of EBPs, such as stigma about
identification and treatment of mental health problems, problems with access to clinical
services separated from community locations such as schools, etc. We believe that
effective strategies to close the research-practice gap (as well as other treatment
disparities) will ultimately require a public health approach (e.g., see IOM Prevention
Report, 2009), and other research-to-practice translational efforts will be incremental at
best.

Studies that could be mined to help establish this point might include several of the
recent child mental health clinical trials (MTA Study, TAD Study, and others), where
data show that extra-treatment factors such as parent depression, family stress, social and
community factors usually explain the largest bulk of variance in outcomes, particularly
over longer-term periods. RCT data from studies such as the MTA also show that access,
stigma, family concerns with specific treatments, etc., often undermine optimal
deployment in clinical settings.
Solutions:

Below we sequentially outline strategies that we feel may help close the research-practice gap in child mental health services, addressing each of the beliefs/problems we identified above.

Problem/Assumption #1: We lack specific details of the research-practice gap, in terms of which areas are most affected, i.e., populations, disciplines, disorders, settings, etc.

Solution/Strategy #1. Define and operationalize the gap with publicly vetted and accepted scientific measurement approaches, so that the gap indicator itself can be used as a feedback tool for the field to monitor and measure its progress (or lack thereof). Key stakeholders in the child mental health field must conduct systematic examination of the research translation problems of the major areas of child mental health services along a minimum of 3 parameters: a) by disorder (e.g., ADHD, depression); b) by intervention (medication, psychotherapy, multimodal/systemic), and c) by setting types (primary care, child welfare, juvenile justice, specialty mental health, education). Such a careful examination by relevant stakeholders (researchers, practitioners, consumers, and policy-makers) could prove useful in elucidating where the research-translation gaps are most pronounced, as well as in identifying “low-hanging fruit” where fairly rapid progress might be made in situations where a given disorder, treatment modality, or setting is poised for change.

In the case of ADHD, some progress has been made in the stimulant treatment of ADHD, but even here, debates continue among professional groups and relevant stakeholders. Possible simple metrics might include a) the percent of children receiving essential components of EB care or overall EB care procedures for a given condition; b) the average proportion of clinicians applying specific EBPs for given disorders within specific settings or disciplines; or c) the number or proportion of children suffering from severe impairment from their mental health problems due to lack of implementation of quality care.

2. Link Incentives to Feedback-and Outcomes-based performance, Application of EBPs by Health Care Systems, and Focusing on Management of Populations rather than Individuals. In considering economic or incentive-based solutions for application of EBPs, we first note that we are unaware few child mental health studies that have demonstrated that a presumed EBP was/is more cost-effective (in terms if CER/ICER) than a non-EBP approach. In one of the few studies of its kind, the NIMH MTA study demonstrated that high quality medication management methods (an EBP) yielded substantially better …

TO BE ADDED: ADDITIONAL SUMMARIES OF THE LIT HERE, E.G. THE MST CEA ANALYSES, FAST-TRACK, WEBSTER-STRATTON, CEAs, ETC>?

These studies offer some modest hope for optimism that implementation of EBPs might in fact be cost-effective, under some conditions. Having such information that informs us to positive cost savings would be useful. However, we suggest that other, as yet unstudied (in child mental health) considerations might be considered as useful means of increasing the application of child-focused EBPs. COMMENT FROM KH: You might cite Heckman’s work here which uses economic analyses from early intervention studies.
First, a significant difference between current and needed new business/financial models is the emphasis on caring for a panel or population of patients over time and settings regardless of their “visit” status. This reframing of the targets for a revised healthcare system sets in motion a range of different administrative structures, service arrays, staffing patterns, etc. Current models of service delivery focuses on caring for individual patients during a specific visit and within a particular type of site such as inpatient, residential, day treatment or clinic. In contrast, new models must support population management strategies that include early identification, standardized assessments, decision support, ongoing monitoring and structuring care around long term interactions in settings that support the patient and family in the care process….also known as the “chronic care model” (Wagner et al., 1992) and the “medical home.”

In the U.S., evidence for improvements in specialty care using population methods and regional planning is mounting, though it remains limited with respect to mental health services, and uncertain to its impact on ultimate costs. Nonetheless, faced with increasingly complex treatment practices for the most severe patients, limited numbers of pediatric subspecialists, long wait times, lack of outcomes data and inappropriate care in many locations, pediatric critical care, transplant, trauma services and burn services have developed increasingly sophisticated regional delivery systems with reductions in mortality and costs, published outcomes and standards, and a credentialing system. Other subspecialists not associated with major surgical procedures or events are also moving to similar models of regional organization with credentialing of centers, publication of outcomes and monitoring of patients over time and across settings, including cystic fibrosis, sickle cell disease, and IBD.

Like these other disciplines before regional coordination was implemented, child mental health service delivery is complicated by extremely limited access to the most highly trained specialists, a rapidly expanding armamentarium of complex treatments, little to no tracking of patients over time and across settings, and no monitoring of outcomes. The rapid expansion of electronic health records, regional and insurer data warehouses and informatics applications for communicating with patients in real time means that mental health professionals may need to coordinate communication efforts with regional efforts in the near future for reimbursement and quality of care. CBA and CER studies of these reorganizational strategies, and their ultimate effect on EBP deployment is uncertain.

Monitoring of accountability and clinical actions are dependent on expert systems derived from computer and industrial design sciences. Although some industries monitor individual workers, most advanced systems monitor overall system outcomes and use rapid cycle improvement processes of various types to improve quality. What is especially important for monitoring is when individual practices or outcomes vary across sites or reflect different determinants. Thus, overall monitoring of patients across settings and time as well as monitoring of individual visits are likely to lead to improving mental health care for child and adolescents, with resulting effects on costs and cost-effectiveness analyses.
While most discussions of digital technology in medical care focus on the electronic health record, the uses of other types of digital technology may have greater implications for improving mental health services and their costs. These technologies can be divided into those that provide patient and family engagement with their care, and medical systems to those that provide decision support for the clinician and practice (some technologies do both). For example, computerized psychosocial screening and assessment in pediatric waiting rooms can facilitate physician recognition and correct diagnosis of these patients. Logistical challenges frequently prevent such psychosocial screening from occurring. Front office staff members often lack the time to distribute and score paper questionnaires, and primary care providers have competing clinical responsibilities during brief visits with patients (Stevens et al., 2008). Touchpad computers in the waiting room or at-home screening prior to office visits with secure wireless connections can help overcome these logistical challenges.

Obvious means of helping bring out the types of changes outlined above are performance-based contracting, pay-for-performance, payment structures tied to capitation models, and specific incentives or grants building in new information systems and consumer engagement tools. In a competitive market driven by outcomes tied to performance, such improvements over time should also become increasingly implemented because they make good business sense.

One of the major problems related to the failure to tie economic incentives and consequences to clinical outcomes is that these two perspectives may diverge. When they do, policy makers face a key challenge. A program may be advantageous for society yet not for the health care payer. In that case, the policy maker must find a way to bring the payer’s incentives into line with the social good. For example, better mental health services for troubled youth may increase spending on mental health services. However, those expenditures may reduce costs in the juvenile justice system. The key issue, therefore, for the policy maker is to find a way to transfer funds from the juvenile justice to the mental health system.

As one means of addressing this problem within states or counties, joining of monies into a risk pool to manage a population that straddles special education, juvenile justice, child welfare, and health care systems may be necessary. DOES ANYONE HAVE SOME GOOD IDEAS HERE, TRADITIONAL SYSTEM OF CARE, ETC. WITH GOOD DATA OR MODELS? COMMENT FROM KH: This has been the premise of the Milwaukee Wrap-around initiative, which has won the Innovations in American Government award for its economic viability: http://www.systemofcarealumni.org

3. Wider Understanding, Promotion, and Application of Effective Dissemination Models, Especially Sustainable Business Models. Successful business models for closing the research-practice gap should be identified, evaluated, and further disseminated if appropriate. For example, the business “case histories” of current dissemination efforts such as MST, Inc., Coping Cat, Webster-Stratton approaches, Botvin’s LifeSkills program, Triple PPP America, should be transcribed, published, and made available to researchers and potential business organizations interested in closing the research practice gap.

Areas of traditional pediatric medicine should be examined, to determine if there are have been effective strategies for closing the research-practice gap in relatively common disorders, such as pediatric obesity and asthma. These relatively common conditions often initially managed in primary care might provide good models for EBP implementation strategies with common conditions such as ADHD, LD, and depressive
disorders. Less common or more severe problem areas, such as bipolar disorder, autism, or schizophrenia might require regional models developed for the more rare pediatric illnesses, such as sickle cell disease, cystic fibrosis. Quite different business models seem likely for common (ADHD, depression) vs. rare (JBD, schizophrenia) illnesses.

Another strategy might involve a workshop for investigators and potential business partners about opportunities within the SBIR program, and how it might focus specifically on effective business models. Similarly, models such as that employed by the REACH Institute might be further studied and promoted, if found effective. The REACH Institute was founded to close the research translation gap by accelerating the acceptance and effective use of proven interventions that foster children’s emotional and behavioral health. REACH uses a 4-step process that attempts to reduce the time that it takes for state-of-art science to reach local communities by: 1) quickly and proactively identifying and validating the highest-quality scientific findings; 2) working with the researchers and treatment developers to adapt these new interventions with appropriate tools to make them family- and child-friendly; 3) quickly disseminating and implementing these proven interventions, and 4) empowering local communities to sustain this change process through ongoing access to REACH training materials and technical assistance. Without catalysts for each of these steps, the overall process can take years, apparent from business case histories of current models for deployment such as MST and others. (WE NEED BUSINESS CASE HISTORIES!)

Relatedly, we suspect that the operating business models within many of our current clinical settings, if tasked to implement new EBP interventions would not be viable. For example, currently across most treatment settings, child mental health services are treated much like a commodity that can be purchased with little to no attention to quality and outcomes. Often, high quality programs can only be sustained with grant funds, thus rendering the business case for dissemination a non-sequitor. Legacy business and health care organizations, such as hospitals that consider mental health as a necessary (and evil) commodity unlinked to quality and outcomes, will tend to bargain for the cheapest possible service, particularly when much more expensive issues are at stake, such as cardiac by-pass surgeries. New organizations must be created whose primary emphasis is on quality and outcomes, focused on realigning the setting’s regulations, values, philosophy, operating characteristics, and financial incentives to ensure that the specific needs of clients are addressed with high quality, AND with an efficient business model with all the necessary organizational and IT efficiencies needed for a model healthcare system with the right values, tying clinical practices and procedures to feedback and outcomes. Successful business examples from other areas of medicine must be identified, and the characteristics of these successful models outlined for possible replication. Medicare Accountable Healthcare Organizations with sharing of incentives between providers and plans have demonstrated some promising improvements among small groups of elderly with chronic illnesses. Motivated plans and provider groups linked by outcome and performance goals might yield similar results for children and adolescents with mental disorders.

Of note, a group of researchers, overlapping in part with the attendees of this CAMHS conference, have met over a series of conference calls and face-to-face meetings during the past 18 months to identify the characteristics, principles, and procedures of a system that could deliver high quality mental health services within an efficient business model (Collaborative Approaches to Children’s Health [CATCH] Services). Such a system would attempt to align service quality parameters with business, organizational,
and personnel incentives, as an efficient means of ensuring that state-of-art research is routine applied with clinical settings.

4. Develop a strategic plan for redesign of the children’s mental health services, taking context and public health approaches into account for the optimal design and delivery of quality services. One overriding criticism of current treatment is their failure to consider context in the design of treatment services. Current intervention models have largely focus on the individual child or family without considering other settings within which children spend most of their time. Nearly all ignore indigenous resources in the community that may be effective and cost-effective in promoting growth and prosocial development. As an alternative (or realignment of) the current system of mental health services, a public health framework requires that children’s adaptive functioning be promoted within key ecological settings, promoting sustainable program goals and processes by: 1) focusing on competencies, 2) identifying and supporting indigenous resources, and, 3) integrating prevention and intervention programs within the natural setting.

One major implication of an ecological model guiding mental health services is to expand the notion of the mental health workforce from a limited number of trained professionals seeing patients in traditional clinic settings to incorporate the range of persons and settings important to children’s development. For example, in schools, an extensive literature has established the benefits of successful schooling to children’s social and emotional adjustment (Roeser et al., 1999; Spencer et al., 1993). However, no consensus exists regarding effective educational reform models, nor how mental health should be incorporated into these models, nor given the current funding structures for schools, how such models might be paid for.

A second implication of nesting services within settings is the identification and support of indigenous resources within these settings as agents of change. This step follows logically from the prioritizing goals and is important both to ensure the sustainability of program goals and processes as well as to reconcile the workforce imbalance relative to regional disparities and the high need for services. The identification of indigenous resources involves both the selection of primary change agents and those factors involved in the successful performance of their roles.

A natural extension from prevention to intervention could emerge with prevention being defined by programs to enhance natural setting goals, and intervention defined by programs directed to factors that interfere with positive adaptation to settings. Thus, nesting mental health services within settings such as schools and after-school programs might act to reduce the need for more intensive services, and increase the precision and efficiency of intensive service models.

The knowledgeable development of such a strategic plan will require additional mental health services research that proposes targets for change and by collaborating with educators to implement and evaluate these changes (Cappella et al., 2008). To that end, the form or structure of settings would guide services, suggesting dramatic changes to current priorities (see Frazier et al., 2007 for an example for after school programs).

The Future:

Although the transition from a clinician-patient model to a public health approach will be complex, lengthy, and require cultural change, other steps, such as the
development of a research-practice gap metric can proceed fairly immediately with the appropriate stakeholder consumers, scientists, and policy-makers. Our second recommendation, changing of incentives to support approaches more consistent with application of EBPs, is underway on several fronts in pediatrics, where the standard of the field is increasingly to assume responsibility for panels of patients, including their mental health care for conditions such as ADHD (“carved-in” vs. “carved-out”) with disease management and medical home models.

Our third recommendation, the wider promotion and application of effective business dissemination models, appears readily achievable, and might be the focus on scholarly paper or book of case studies. Within business schools, the case study method is considered perhaps the essential approach to teaching persons how to deal with the many interlocking complexities of making an effective and sustainable business out of disseminating a useful product. Business school case studies are often characterized by truly useful, much needed products that fail in the marketplace, not because they were a proven (“evidence-based”) concept, but because of all of the later details required to sustain a viable business dissemination.

For our fourth recommendation, the larger question is how to get from here (i.e. a clinician-patient-focused model) to there (i.e. a public mental health model). Studies that have examined diffusion of innovation in other fields have determined that program response, or more precisely the degree to which programs are adopted within a setting, are often a function of social interactional networks, and social network theory has several implications for new models of mental health care programs.

A Strategic Plan Embedded with Newly Emerging Federal Initiatives. Because the culture and structure of current service delivery systems support the status quo, new public health models will require strong incentives, disruptive technologies, financial reform and innovative leaders to create a culture that will allow alternative programs to take root. While daunting, we note that successful strategies have been developed and deployed within the US to reduce teenage pregnancy by 50% over the last decade; such dramatic changes appear in fact to be possible, if supported at the highest levels, and if based on sound behavioral change and communication science, theory, and practice (Jaccard et al., 2009). Thus, an overall strategic plan, much like the War on Cancer and the War on Tobacco needs to be developed, and understood as unfolding over time. This obviously needs to be a part of the overall strategic approaches to other health care areas, such as in the recent incentives of the new administration to develop and evaluate new electronic medical records and informatics tools, funding of comparative effectiveness studies.

Other fields of science, such as engineering, and social policy may help in identifying how cultural and technical change has occurred. Effective expert systems that manage complex health or social problems have attributes that allow them to function across settings and time for individuals and groups that are served. These attributes can be divided into those that are generic system strengths or characteristics and those that are specific content strengths or characteristics necessary for practice in a field such as child mental healthcare.

Clinical, Policy, and Research Priorities:
New methods and systems will require the close alignment of clinical practices with research and evaluation, all tied to carefully deployed changed to policy. We mention these briefly below.
MORE TO BE ADDED…

* Development and Studies of Benchmarks and Gap Indicators Across Disorders, Populations, Systems, and Service Types

* Studies of Client and Family Activation: Patient and family participation in therapy or treatment is one of, if not, the best predictor of successful outcomes of interventions. However, success in engaging patients and families in routine services remains elusive with most community mental health settings experiencing high rates of dropouts at each phase of treatment. Support for family activation and engagement in service planning is being garnered from national family support, education and advocacy organizations. For example, the National Alliance for the Mentally Ill has recently issued a new guide for families, called “Choosing the Right Treatment: What Families Need to Know about Evidence-based Practices” (Gruttadaro, Burns & Duckworth, 2007). The attention by family-based organizations to delivery of effective research-based services and to active involvement of families in mental healthcare delivery foreshadows a new opportunity for restructuring the child and adolescent mental health system. Studies of active family involvement, informed choice, and use of research-informed strategies signals a new stance on the roles of families in a re-structured system.

* Legal Challenges: Current U.S. anti-monopoly policies targeting provider collusion on prices and contracting set limits on the scope of cooperation among mental health providers. Establishing specific boundaries and opportunities within which regional services may be delivered will be essential. Initial efforts should be focused on contracting among coordinated provider groups and sharing of patient information that has traditionally been seen as highly concerning.

* Establishing standards and criteria: New treatments and assessment tools will require leaders in child mental health to establish minimum ranges of standards for types of services, fidelity or quality of care, and access to services for key conditions. For example, guidelines may delineate that Level II Centers provide cognitive-behavioral therapy or interpersonal psychotherapy for depression in both group and individual settings while Level I Centers might be required to provide these plus one of these depression treatment for youth with depression and comorbid drug use.

* Credentialing providers and centers: Professionals in all fields routinely engage in the evaluation and credentialing of professionals. Expanding such efforts to credentialing systems that meet standards of access, service, quality and outcomes will be important. Such efforts are already underway in many aspects of mental health, but have not fully penetrated the practice of specific EBPs. More importantly, focusing less on guild-specific credentialing or individual performance but more on team success and outcomes should be a natural evolution of the other changes here are introduced.

* Developing and validating outcomes monitoring systems and transparency: Publishing and benchmarking routine outcomes of treatment across centers is an accepted practice in a growing number of disciplines and should be an essential part of child mental healthcare, with appropriate case mix adjustment to accommodate for the evident differences in population and panel levels of factors (poverty, education, prior exposure to trauma, etc) affecting disease risk, course, and treatment response. Transparency will
allow poorly performing institutions to be identified, and high quality institutions to be imitated.

* Studies can and should address all of the above issues, to include organization of care; guidelines for appropriate referral; transition to building a rational tiered system of care from a starting point of fragmentation; benchmarking outcomes with appropriate adjustments; studying “model” community/city/healthcare systems willing to serve as natural laboratories for testing these new approaches
REFERENCES


