Child and Adolescent Mental Health Services: Issues and Solutions: The Research-Practice Translation Gap

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Problem Statement: Failure to apply recent research findings 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. And in the child mental health area, in the well-studied area of ADHD based on data from the NIMH MTA Study, fewer than 16% of community-treated children received appropriate medication care, using even a marginal standard of 8 hours/day of medication coverage, treatment for 80% of the year, and total daily doses of > 15mg (in methylphenidate equivalents) (MTA Cooperative Group, in preparation), resulting in substantial differences in treatment outcomes between well-treated and inadequately treated children at 14 and 24 months post-randomization (MTA Cooperative Group, 2004).

State of the literature: 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, or provider disciplines, or clinical populations. Arguably, the best-studied area in child mental health services is stimulant medication treatment of ADHD, where treatment standards have been developed by multiple professional organizations and NCQA. For example, In the NCQA validation study across 6 health plans for its ADHD diagnosis initiation quality indicator, applying the 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, respectively. For continuing ADHD patients (not newly initiated treatment), continuation and maintenance follow-up visit (at least two additional visits) rates averaged 14 percent (commercial) and 16 percent (Medicaid). 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%. Little evidence of change was noted across the years 2005-2007. Although treatment guidelines now exist for adolescent depression for both primary care and specialty mental health, HEDIS measures have not been developed or applied for adolescent depression, much less for any other area of child mental health diagnosis and treatment services.

In other areas of medicine where the research translation gap has been more thoroughly examined (e.g., cancer, diabetes), 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 user needs, the intervention was not designed to be self-sustaining, intervention specificity to a particular setting, not modularized or customizable, etc.); 2) problems with studies’ research designs (e.g., not relevant or representative, failure to evaluate cost, reach, setting adoption, implementation, maintenance, and/or sustainability); 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.).

Potential Solutions: Four strategies that may help close the research-practice gap in child mental health services are briefly discussed. First, 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.

Second, a generally accepted metric for the research-translation gap must be developed, agreed upon by key stakeholders, and applied, across disorder, treatment types, and settings. 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 metrics might include a) the percent of children receiving minimally adequate component of care or overall care for a given condition; b) the average number of years that a given intervention lags widespread application, 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.

Third, successful models for closing the research-practice gap should be identified, evaluated, and further disseminated if appropriate. For example, 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 an innovative 4-step process that greatly reduces the time that it takes for state-of-art science to reach local communities: 1) identifying and validating the highest-quality scientific findings; 2) Adapting 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 the catalyst of the REACH Institute, each of these steps often takes years. Through exclusive partnerships with leading scientists across the US, REACH trains local educational and health care professionals in the latest and most effective therapeutic interventions developed by respected NIH-funded researchers.

Fourth and last, the problems with current settings that are tasked to implement new interventions should not be understated. Currently across most treatment settings, child mental health services are treated much like a commodity that can be purchased with little-no attention to quality and outcomes. New organizations must be created with primary emphasis 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, within an efficient business model. Successful business examples from other areas of medicine must be identified, and the characteristics of these successful models outlined for possible replication. 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 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.
REFERENCES


BACKGROUND FACTS

* 41 million uninsured Americans exhibit consistently worse clinical outcomes than the insured, and are at increased risk for dying prematurely (Institute of Medicine, 2002; Institute of Medicine, 2003a)

* The lag between the discovery of more effective forms of treatment and their incorporation into routine patient care averages 17 years (Balas, 2001; Institute of Medicine, 2003b)

* 18,000 Americans die each year from heart attacks because they did not receive preventive medications, although they were eligible for them (Chassin, 1997; Institute of Medicine, 2003a)

* Medical errors kill more people per year than breast cancer, AIDS, or motor vehicle accidents (Institute of Medicine, 2000; Centers for Disease Control and Prevention; National Center for Health Statistics: Preliminary Data for 1998, 1999)

* More than 50% of patients with diabetes, hypertension, tobacco addiction, hyperlipidemia, congestive heart failure, asthma, depression and chronic atrial fibrillation are currently managed inadequately (Institute of Medicine, 2003c; Clark et al., 2000; Joint National Committee on Prevention, 1997; Legorreta et al., 2000; McBride et al., 1998; Ni et al., 1998; Perez-Stable and Fuentes-Afflick, 1998; Samsa et al., 2000; Young et al., 2001)