

PERSPECTIVES

State-of-the-Art Challenges for Mental Health Services Research

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Abstract

Background: Research-based, state-of-the-art services for people with serious mental disorders would consist of demonstrably effective treatments, organized synergistically, and financed in ways that create incentives to provide such treatment. While research exists in these domains of treatment, organization and financing, this research base contains significant gaps, and what is known frequently neither informs policy making nor enters practice.

Review: The NIMH services-research portfolio has identified successful patient-level and system-level interventions for people with serious mental disorders, but much of this research has yet to make its way into practice. Similarly, while we have made progress in asking 'what is good care?', we have much less information about the answers to 'what constitutes an adequate try?'. Writing a prescription for an efficacious medication does not constitute an adequate trial of that medication. Similarly, offering people boring psychosocial rehabilitation programs does not constitute an adequate try of promoting recovery via rehabilitation services, but what does? Defining what constitutes an adequate try can be a way of allocating scarce resources or it can be a polite way of defining when a system gets to give up on someone. As state governments move to contract with managed care entities for services for Medicaid beneficiaries, one of the great contracting challenges is defining and monitoring the provision of what constitutes an adequate try.

Discussion: To obtain better value for our health care expenditures, we need to find ways to get what we know works into practice, whether we are contracting for services or deciding which clinical therapies to pursue. For example, problem-oriented family therapy has been shown to improve clinical outcomes for people with schizophrenia, yet such interventions are rare in practice. We also need to pay more attention to the quality of the clinical care actually being delivered—not what was prescribed, nor what the clinician was trained in, nor what the job description was, but

what actually is occurring. Figuring out how to contract for and disseminate efficacious treatments so that they occur and are effective in real-world settings is critically important yet is a largely unexplored area of services research. We need to answer both 'what is good care?' and 'how do we get it to happen?'.
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Introduction

People with serious mental disorders (SMDs) are faced with complex challenges, and they present complex challenges to their service systems, families and communities. As services researchers endeavoring to provide policy-relevant information, we just need to figure out the following.

- (i) What treatments work (in the real world)?
- (ii) How should they be organized?
- (iii) How do financing mechanisms influence outcomes?

Clearly, the devil is in the details. Every state mental health commissioner, consumer advocacy group and managed behavioral health care organization in the country wants answers to these questions. Let us look at what we as mental health services researchers are providing in the way of information to inform policy making. This is another way of saying: let us examine some of the substantial return to date on NIMH's and other's services research portfolios, and let us also identify areas that are crying out for further development.

Getting research findings into practice

We know from epidemiological data that most people with SMDs have multiple impairments.^{1–3} In addition to SMD, they may have substance use disorders, medical comorbidities, the aftermath of trauma, poverty—the list goes on. Services data indicate that, for people with multiple disorders, it is difficult to access care to meet their diverse needs, often because needed services are provided by different entities. These diverse needs are integrated within the client, and if the services to meet those needs are integrated within

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the staff providing the services, outcomes improve.⁴ For people who are dually diagnosed with SMD and substance abuse, having the same clinical staff treat the substance abuse and the mental illness improves outcomes.⁴ We are not just talking about integration at the level of the agency or the program, we are talking about training our front line service providers—be they BA level case managers, consumers on the team, psychiatrists etc—all front-line staff, to deliver high quality substance abuse treatment and mental health care.

From the Robert Wood Johnson (RWJ) Program on Chronic Mental Illness,⁵ we learned that integrating services at the organization level does not necessarily translate into integrating services at the service-delivery level. That demonstration assumed, as most studies of organization and financing assume, that people provide good care, but, as we have learned from the Schizophrenia Patient Outcomes Research Project (PORT)⁶ and elsewhere, the quality of care typically is deficient. Therefore, while treatment recommendations are crucial, we need to figure out much more about how to get practice guidelines into practice.

We continue to make progress with respect to identifying effective interventions. Now, how do we roll these interventions out? For example, involving families in long-term psycho-education programs decreases relapse and rehospitalization rates over 18–24 months.⁷ What training, supervisory and financing processes get us to those outcomes? We know that the quality of the clinical care matters, now what do we do about it? How do we change practice at the level of the client and direct service provider? What gets the bottle of the more efficacious medication into a client's hand, and what determines whether the client takes it? What prompts clinicians to engage clients and their families in problem-oriented family therapy? As one who has been funded to roll out new interventions within a public mental health system, I have been humbled by how hard it is to change practice. It is one thing to implement family therapy as part of a trial using clinicians who volunteer to be part of the study, and quite another to change the practice of line staff who already feel that they are doing a good job with their current practices, or would be if they just had more time, thank you very much for your interesting talks.

If we want better value for our health care dollars, it is critically important to find ways to get what we know works into practice, be it when we contract for services or when we decide how to spend our clinical time. In both the public and in the private sector, we need to pay more attention to the quality of the care actually being delivered—not what is prescribed, not what was in the training, not what is in the job description, but what actually is occurring. And, even more importantly, we have to enhance our service-research efforts to include examinations of ways to get research findings into practice. Figuring out how to disseminate efficacious treatments so that they occur and are effective in real-world settings is critically important yet is a largely unexplored area of services research. Call it technology transfer, shared decision making, training and implementation—we have not even evolved a common

language yet in this area, much less ways of quantifying what are the keys to successful real-world implementations of efficacious treatments, but we need to identify both 'what is good care?' and 'how do we get it to happen?'.

To return to family therapy as an example, the PORT study⁶ found that mental health clinic personnel perceive several barriers to the implementation of family psycho-education, including lack of resources (both time and money) as well as some skepticism about the availability of families and the capacity of the model to produce the outcomes suggested in the research. However PORT dissemination efforts suggested that with the support of the leadership, a modest amount of technical assistance and training can lead to the successful implementation of family psycho-education in agencies in which the staff believe that the model is consistent with their philosophy and mode of delivering treatment.⁸ Kim Mueser and Bob Drake from the New Hampshire–Dartmouth Psychiatric Research Center have been working with us in the public mental health system in Connecticut to increase the amount and quality of family therapy occurring at demonstration sites in Connecticut. We routinely hear the following conjectures as to what the barriers to providing family therapy include: (i) professionals do not yet have skills and training for working with families; (ii) case managers routinely underestimate the amount of contact people with SMDs have with their families; (iii) many clinicians are trained within a psychodynamic framework and do not have the teaching skills to train families to improve problem-solving skills; (iv) we do not know how to create incentives to stimulate clinicians to work with families; (v) often, the clinicians are nearer the client's age than the rest of the family's, hence it is understandable that they may bring to this work some of their own baggage about dealing with families, and (vi) given that family work is usually an addition to clinicians' work loads, we need to show the payoff of such work. These conjectures sorely need data to accept or refute them. Meanwhile, work with families languishes.

What is an adequate try?

An important corollary to asking 'what is good care?' is asking 'what constitutes an adequate try?', and this is the case for the full spectrum of interventions, whether we are talking about psychosocial interventions or medication effectiveness. Translating drug efficacy studies into information on real-world drug effectiveness means defining a drug's action to include the influences of the client and the mental health care system. While loss of neuroleptic efficacy accounts for roughly 60% of rehospitalization costs for people with schizophrenia, the other 40% is attributable to noncompliance due to largely unspecified factors such as client preferences because of uncomfortable side effects, hurdles to accessing and taking a medication, lack of appropriate medication education, and so forth.⁹

Clearly, simply writing a prescription for an efficacious medication does not constitute an adequate try. In the course of research on services for people with SMD, we must

constantly try to disentangle the confounding of limitations which are imposed because of the illness with limitations imposed by inadequate services or inadequate application of services. While it is up to pharmaceutical researchers to provide information or alternatives to deal with the 60% of the variance having to do with efficacy, it is up to service researchers to figure out how to use these agents optimally.

Similarly, referring people to voc-rehab systems that take forever or offering them boring psychosocial rehab programs does not constitute an adequate try. In the housing area, we have learned that helping someone obtain housing is not enough—we have to help with preventing housing loss.¹⁰

Service research has demonstrated that assertive community treatment (ACT) teams typically reduce the amount of time spent in hospitals and improve residential stability.^{10–13,7} ACT teams do not cure schizophrenia; they afford people a more stable disability. These beneficial outcomes are seen when the ACT model is implemented, and are less apparent in programs which are less faithful to the model with respect to components such as a shared caseload, high staff:client ratio, medication management as a team function and assertive, *in vivo* contacts.¹⁴ Services research also suggests beneficial effects of integrating substance abuse treatment and vocational support within the ACT model.⁷ Hence, the bar has been raised with respect to answering the question of ‘what constitutes an adequate try?’, and, as the bar is raised, we need to know what it costs different players to achieve those adequate tries.

Apportioning investments

Defining what constitutes an adequate try can be a polite way of defining when a system gets to reduce its investment or give up on someone. For example, when does a payer or an insurer or a managed care organization get to say ‘this level of functional disability is as good as can be expected; no further care is medically necessary?’ Private sector contracts with managed care companies commonly exclude payment for custodial care. People determined to need custodial care are deemed the responsibility of the state system rather than the employer’s benefit plan. The standards for what constitutes an adequate try for a client under such a plan can be lower than what would be considered an adequate try in many state mental health systems. For example, it would be extremely unusual for a beneficiary under a private sector managed care contract to have access to an assertive community treatment team. As states move to contract with managed care entities for services for Medicaid beneficiaries, one of the great contracting challenges is defining and monitoring the provision of what constitutes an adequate try. This revolution is upon us, and it may eclipse deinstitutionalization in its promise and its perils.

All of the challenges and payoffs of services research are brought to a head when striking a deal with someone else (such as a managed care organization) to do what we (as public-sector payers, taxpayers or employers’ benefits administrators) found too cumbersome, expensive or difficult

to do ourselves. When crafting the contracts for such carve-outs, we can insist that particular structures (e.g., ACT teams) be in place, but any focus on structure rather than on outcomes runs the risk of accomplishing the equivalent of mandating the providing of more hospital beds than we need and diverting resources from other ends. Services research has also shown us that mandating care has a way of watering down care.

Summary

The breadth of research on services for people with SMD is enormous and growing daily. While the payoffs are also accumulating, there remain huge gaps between what we have learned about what constitutes good care and what occurs in routine practice settings. As payment arrangements and service settings change (whether in response to research findings, political exigencies or other factors), we need to find new real-world partners, such as state payers and managed care organizations, to keep our work relevant to the entities charged with planning and providing services, and we need to engage these partners so that we can keep figuring out what works, with whom, and how to make sure that those are the services that get delivered.

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