This Month's Highlights

Focusing on Differences

Two objectives drive most research: detecting variation and identifying factors that account for it. Mental health services researchers do not have to look far to find differences. Rates of illness prevalence and treatment receipt vary, sometimes sharply. This month's lead article reports a 14-fold difference between states in the rate of stimulant treatment of children—.4% of children in Alaska and 5.1% in Delaware. Douglas C. McDonald, Ph.D., and Sarah Kuck Jalbert, M.A., M.S., also found a sixfold difference in the rate for adults (page 1079). Amanda Toler Woodward, Ph.D., analyzed data from three U.S. population surveys and found that people seeking behavioral health treatment fell into five different classes based on choice of nine provider types. Patients born before 1946 favored family physicians, although these providers also played a substantial role in treating younger Americans (page 1087). Asian Americans and Pacific Islanders (AA/PI) are a rapidly increasing U.S. population group. Little is known about their service use—a knowledge gap that is widened by researchers' tendency to combine heterogeneous subgroups into the AA/PI category. In examining four years of discharge data for psychiatric hospitalizations in Hawaii, Tentine Sentell, Ph.D., and colleagues found differences not only between AA/PI patients and white patients but also between AA/PI subgroups (page 1095). Finally, when Carl I. Cohen, M.D., and Leslie Marino, M.D., M.P.H., took a closer look at racial-ethnic differences in reported rates of psychotic symptoms, they found a shared factor—distress—that accounted for the variation (page 1103).

Psychiatrists and Integrated Care

This month's Integrated Care column describes opportunities that health care reform creates for psychiatrists—in particular, new models of integrated care. Psychiatrists, who are trained in both general medical and behavioral health care, can play leadership roles on collaborative care teams and improve patient outcomes. Lori Raney, M.D., warns psychiatrists who may not embrace these opportunities: "Failure to do so at this important juncture places psychiatrists in a precarious position with their medical colleagues, who have a gap to fill to effectively treat mental illnesses." She describes roles for psychiatrists as accessible consultants in primary care settings and as responsible monitors of general medical care in public mental health settings, along with a set of emerging principles to guide care in these settings. Psychiatrists are encouraged to seek new competencies, such as enhancing their primary care skills, learning to practice population-based medicine, using data to drive care, and honing their leadership skills (page 1076).

Sustainment of Evidence-Based Care

In large randomized controlled trials, clinicians learn to deliver innovative interventions so that researchers can test the effectiveness of these treatments. Increasingly, researchers are staying behind after the trial ends to examine sustainment—or continued use of an innovation. Lawrence A. Palinkas, Ph.D., and colleagues interviewed and held focus groups with clinicians, supervisors, and clinic directors at the end of a trial in which children received evidence-based treatments. They found evidence of sustained use of the three interventions that clinicians had been trained to deliver. However, nearly all the clinicians reported making adaptions or modifications to the treatments to meet particular clients' needs or to improve how the treatment fit with their own approach or with constraints imposed by their agency. The results provide insight into the likely sustainability of evidence-based treatments, especially those that provide little latitude for modification or adaptation (page 1110).

ACT Teams as Medical Homes?

National fidelity standards for assertive community treatment (ACT) teams have boosted their nationwide implementation. These standards charge ACT teams with addressing a broad range of clients' biopsychosocial needs, including helping them obtain general medical care. At the same time, the patient-centered medical home (PCMH) has evolved into an important service delivery model in primary care, aided by national fidelity standards for PCMH accreditation. How far away are ACT teams from functioning as PCMHs? Erik R. Vanderlip, M.D., and colleagues systematically compared standards for ACT teams and for PCMHs and found significant overlap. ACT teams have the necessary infrastructure to serve as PCMHs and with some adjustments, particularly in the supervision of general medical care, high-fidelity ACT teams could qualify as medical homes (page 1127).

Briefly Noted . . .

- A literature review found that outcomes of patients treated in acute residential settings that served as alternatives to hospitalization were equivalent to outcomes of patients treated on inpatient units (page 1140).