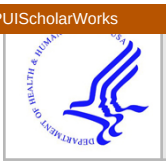

Published in final edited form as:
Am J Geriatr Psychiatry. 2010 June ; 18(6): 460–463. doi:10.1097/JGP.0b013e3181db6d9a.

Mental Health Services Research: Moving From Academia to the Community

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We and others have noted the limitations in a large body of 20th century mental health services research.[1–4] This research often focused on small, nonrepresentative, convenience samples of adults with mental illness who happened to pass through the filters that led to specialty mental health clinics at academic medical centers. This focus often seemed to disregard the larger population of older adults with mental illness in the community, including those with concomitant serious chronic health conditions. Mental health services research has now traveled beyond the limitations of a narrow focus on specialty psychiatry populations.[5,6] Through this journey, researchers initially focused on primary care where most older adults receive their health care.[7–9] However, researchers of mental health services also discovered a continually changing landscape of sites of healthcare for older adults. In addition to pursuing other sites of care, this research is increasingly targeting a broader range of patient with emotional and cognitive disorders and comorbid medical conditions.[10] The articles presented in this special issue demonstrate the broad new frontiers for innovative mental health services research. In the commentary below, we highlight three important themes that run through these articles. First, to reach older adults with mental illness, providers and researchers must go to the places where these patients are already receiving healthcare. Second, keeping pace with the new sites of care in the community requires new partnerships and new teams. Third, changes in reimbursement and definitions of value are major drivers in the change in sites of healthcare which in turn influences where mental healthcare is delivered and how its effectiveness is measured.

Medicare reform and changes in Medicaid at the State level continually reshaped the landscape of sites of care.[11,12] Important sites of care for the range of mental conditions that afflict older Americans now include the patient's home, skilled nursing facilities, hospital-based long-term care, community-based long-term care, and assisted living settings among others. Notably, the content of care for any given patient within any of these sites of care may vary as greatly as content between the different sites. For example, it is possible that home-based care could include a higher intensity of skilled nursing care for any given patient than care provided to another patient residing in a skilled nursing facility. Expanding our notions of potential sites of care for mental healthcare is important because various site of care often represent different populations of both patients and providers. Differences in

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available resources among sites dictate which treatment approaches are both feasible and effective. Different communities and different third-party payors define and regulate these sites of care differently. Home-based care is an increasingly important site of mental healthcare for older adults, because it can overcome obstacles such as difficulty with mobility, transportation, limited space, and fear of medical institutions. It may also help overcome the continuing problem of the stigma of mental illness. As demonstrated in the article by Conner et al.,[13] perceptions of stigma continue to keep people from seeking care regardless of site.

Aging in place often requires that increasing services be provided in the home, which is a greatly desired aim of the majority of older adults.[14] The content of home-based care ranges from social services alone to nutrition to assistance with daily activities to the provision of skilled nursing care. A wide range of professionals visit the home. This includes physicians and nurses as well as rehabilitation therapists, occupational therapists, social workers, and home health aides, among others. Each of these professionals represents the potential to help improve mental healthcare. Gum et al.[15] demonstrate the promise of developing partnerships with area agencies on aging and similar community-based service networks to identify older adults with barriers to access to mental healthcare. Care managers working with clients in the home might act not only as a new set of eyes and ears to improve recognition, but also make referrals or deliver psychoeducational interventions. Gellis and Bruce,[16] partnering with a home healthcare agency, demonstrate the potential of bringing behavioral interventions into the home. This intervention is especially notable in targeting clients receiving home-based care who also suffer from cardiovascular disease. Thus, these researchers expand the site of mental healthcare to the home, expand the provider base by employing clinical social workers to deliver the care, and expand the rationale for mental healthcare by highlighting the complex relationship between heart disease and depression.

The content of home-based care is variable and the aims of this care are also variable. For some patients, the aim is rehabilitation and the expectation is that home-based care will be transient. For others, home-based care is meant to serve as an alternative to institutionalization. State governments are increasingly interested in reducing the cost of institutionalization and long-term care. One strategy to reduce costs has been to provide increased services in the home. One can readily hypothesize that patients in such programs may be more similar to nursing home populations than to the group of older adults receiving home-based care or living independently in the community. Access to community-based long-term care resources would also be expected to change the spectrum of providers and treatments available in the home. Hasche et al.,[17] partnering with state government, describe the significant burden of depression among older adults receiving community-based long-term care and the potential of depression to increase the risk of institutionalization. These authors demonstrate our limited knowledge about how to tailor depressive treatment strategies to best serve this functionally impaired population. An important principle highlighted in the pooled analysis by Ell et al.[18] is that depression care can improve outcomes for older adults regardless of comorbid conditions or socioeconomic disadvantages. However, this care must be appropriately tailored to the individual and adapted to the site of care.

To reach these new sites of care with increasingly tailored interventions, new partnerships and new research and clinical teams are required. The complexity of these teams now include collaboration among nursing, social work, medicine, or rehabilitation sciences as well as collaboration between medical specialties such as primary care and psychiatry. The level of integration of these cross-disciplinary teams has been described on a continuum ranging from multidisciplinary to interdisciplinary to transdisciplinary.[19] Transdisciplinary teams are those who work jointly to "develop shared conceptual and methodologic frameworks that not only integrate but also transcend their respective disciplinary perspectives."[19] Notably, teams need not be transdisciplinary to be effective. Different teams are needed for different research questions. As suggested by Stokols et al.,[19] "cross-disciplinary collaboration should be viewed as a means for achieving the desired scientific, training, or translational aims rather than as an end in and of itself." In the realm of mental health services research, cross-disciplinary teams are viewed as essential because of the multifactorial nature of the causes and solutions for mental illness. The cross-disciplinary research teams are also reflected in clinical teams in the new team-based approaches to care for older adults. Similarly, these clinical teams are viewed as essential because of the multifactorial nature of the causes and solutions for mental illness. One consequence of expanding the list of sites or providers of care is increasing transitions in care and thereby increasing the need to facilitate communication between sites and providers. Providers co-managing the same patient are often unknown to each other even when they work within the same medical care organization. When the providers do exchange information, they may use a different lexicon or different clinical format because they come from different disciplines such as nursing, social work, or medicine. Brown et al.,[20] partnering with a visiting nurse association, report on the results of a pilot intervention to bridge such communication gaps. These investigators pilot tested a skills training intervention to improve abilities of home healthcare nurses and confidence in communicating depression-related concerns to primary care physicians.

Perhaps, a less obvious theme than the emergence of new sites and new teams among the articles of this special issue is the emergence of new outcome metrics. These metrics reflect the aims of the community and especially third-party payors. Psychiatry has a long history of searching for evidence of cost-offsets that might financially validate investments in mental healthcare. However, because of the upfront costs of implementing some of the new team-based models, stakeholders seek evidence of improved efficiency, downstream savings, and/or the ability to take the new interventions to scale. One area of important inefficiency in the care of older adults with depression is low levels of adherence to medications. Sirey et al.[21] report on the development of an individualized program to improve adherence to antidepressant therapy. The intervention shows promise in achieving an adequate dose and duration of treatment for depression through a relatively simple approach to improve patient self-management. The article by Becker et al.[22] shows the frequency of mental health conditions and dementia among Medicaid recipients with potentially preventable hospitalizations. The findings suggest that better ambulatory treatment of mental health conditions and dementia might offer not only improved patient outcomes but also cost savings by preventing these hospitalizations. The article by Gitlin et al. is intriguing because it represents an innovative approach to defining cost effectiveness

and it avoids equating value for mental healthcare with cost offsets or cost savings to the medical care system. These scientists found that their tailored activity program provided value to the family caregivers who actually provide the majority of hands-on care to older adults with dementia.[23] Partnering with assisted-living facilities, Teri et al. tackle the issue of scalability. Scalability refers to the ability to take an intervention out of the research setting and bring it to scale on a national level. Often, the capacity for scalability must be considered at the earliest design phase of the intervention and researchers often do not view this issue as part of the scientific consideration. For example, a research team might effectively train a selected group of motivated research staff but could the same training materials be effective with a national workforce of nurse's aides? Teri et al. demonstrate their team's ability to achieve treatment fidelity to a dementia training program for direct care staff.[24] Trainees included dozens of staff and leadership from eight assisted living facilities in three different states and fidelity was measured using a new comprehensive approach. These findings are relevant for a broad range of recently reported new models of care that require direct care providers to learn new skills or work in new ways.

As researchers of mental health services continue to move from academia to the community, they must continue to adapt their teams and methods to these new clinical laboratories. Working effectively in these new settings requires new partnerships with community-based service providers and new types of evidence for third-party payors. However, as a cautionary note, although the research may have moved outside of academia, the researchers typically have not. The coin of the realm within academia remains scientific productivity measured by publications and funding. Thus, part of the task of moving to the new clinical laboratories is reconciling the needs and timelines of the researcher with the needs and timelines of the community. Building cross-disciplinary research teams, partnerships with the community, new research laboratories, and new outcome metrics requires substantially more time and resources than focusing on patients who happen to make their way to academic medical centers. Investing in these new approaches is fundamental to closing the gap between knowledge and clinical practice.

Acknowledgments

This work was supported by NIMH grant P30AG024967.

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