

PRESENTATION TO THE BOARD ON CHILDREN, YOUTH AND FAMILIES OF
THE NATIONAL RESEARCH COUNCIL AND INSTITUTE OF MEDICINE
REGARDING

PREVENTION OF MENTAL DISORDERS AND SUBSTANCE ABUSE AMONG
CHILDREN, YOUTH, AND YOUNG ADULTS: RESEARCH AND PROMISING
INTERVENTIONS

On behalf of the Society for Adolescent Medicine and the American Academy of Pediatrics. I want to express our thanks for the opportunity to be with you today as you consider this critical health issue.

Before responding to the four points you have asked us to address today, I wish very briefly to describe the two organizations I represent. The Society for Adolescent Medicine (SAM for short) has a membership of 1400 plus individuals from a variety of disciplines. Approximately 20% come from such fields as nursing, psychology, mental health, social work, public health, and the law while the remainder are physicians. SAM's mission is to improve the "physical and psychosocial health and well-being of all adolescents through advocacy, clinical care, health promotion, health service delivery, professional development, and research."

The American Academy of Pediatrics (the Academy or AAP for short) is comprised of 60,000 pediatricians; its mission is to obtain optimal physical, mental, and social health and well-being for infants, children, adolescents, and young adults.

Now let me respond to your queries...

Does your organization have a position on mental health promotion or prevention of mental health disorders or substance abuse among children, youth, and young adults?

SAM is developing a position paper on adolescents and substance abuse. The first draft of this paper will be presented to the Board of Directors in the fall of 2007. SAM has several policy statements in print and posted on our website (<http://www.adolescenthealth.org/PositionPapers.htm>) that address both substance abuse and mental health. One is a position paper on Access to Health Care for Adolescents and Young Adults that addresses issues of health insurance, provision of comprehensive and coordinated care (including mental health and substance abuse services), safety net providers and programs, quality of care, affordability, compensation for providers, availability of trained and experienced providers, visibility and flexibility of adolescent oriented services, and confidentiality. A second paper details the Society's vision for Clinical Preventive Services for Adolescents, including such issues as the rationale for providing preventive services, use of evidence based-guidelines to guide care, and issues in implementing such services. Other position papers that may be

pertinent to the work of this Committee include statements on: Financing Mental Health Services for Adolescents, Homeless and Runaway Youth; Incarcerated Youth; and School-Based Health Clinics.

The AAP also has numerous policy statements that address the prevention and treatment of mental health and substance abuse and is in the process of developing several more. I will highlight three briefly. First is the Academy's Task Force on Mental Health (TFOMH). This task force was appointed by the Board of Directors in 2004 to develop an evidence-based framework for how pediatricians should address mental health issues in the primary care setting. The AAP defines mental health as including behavioral, neurodevelopmental, psychiatric, psychological, emotional, and substance abuse issues. The TFOMH is charged with developing clinical decision-making support and tools to assist primary care pediatricians in addressing mental health and substance abuse concerns in their practices. Currently, the TFOMH has developed two algorithms to guide clinicians in the early identification of mental health issues; engage families in seeking help; provide early intervention; assess children and families who experience ongoing symptoms or functional impairment; and provide care and monitor progress through collaboration with families, and as needed with mental health and substance abuse specialty providers.

A second initiative is the Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents. Originally developed by the Maternal and Child Health Bureau, this effort is now housed at the Academy. The third edition, with an accompanying toolkit, will be released in the fall of 2007. Bright Futures has extensive material pertaining to the promotion of child and adolescent well-being including prevention efforts and early identification of problems. A companion piece, Bright Futures in Practice: Mental Health, will be revised in the next few years. Both rely on evidence based guidelines.

The third effort is the AAP's evidence based practice guidelines and tool kit for the identification and management of children and adolescents with attention-deficit hyperactivity disorders. Finally, the AAP is considering endorsement of Columbia University's evidence based Guidelines for Adolescent Depression in Primary Care (GLAD-PC).

What role do evidence-based practices and other relevant research play in your efforts?

As I hope is evident from some of the preceding material, evidence based-practice and relevant research is at the heart of what both organizations do, to the extent that the evidence base is there. Both organizations try to base their position statements and structure their clinical practice guidelines according to the best available evidence and research. The Society for Adolescent Medicine views a major part of its mission as developing and disseminating the very

evidence base to which you refer. Many of the members of the Society are actively engaged in research regarding the unique health needs of adolescents and young adults and research presentations are an important component of the Society's annual meeting. One critical issue for SAM is that adolescents are neither big children nor little adults and consequently evidence based guidelines and research must be specifically focused on this unique population and not simply derived or extrapolated from guidelines or research developed for children or adults.

How are evidence-based practices best translated to your field or service system?

For both organizations, evidence based practices are best translated through a combination of dissemination of critical research and the development, dissemination, and implementation of clinical guidelines. As demonstrated by the work of the Academy's Task Force on Mental Health, implementation is greatly facilitated - though by no means assured - through development of toolkits that practitioners can incorporate into their practices. These toolkits can include screening tools and/or guidelines such as those developed by the AAP regarding the evaluation and management of children and adolescents with ADHD. Other examples, as highlighted in SAM's position paper on Clinical Preventive Services for Adolescents, would be the American Medical Association's Guidelines for Adolescent Preventive Services, which included a defined schedule for preventive services as well as validated health screening questionnaires.

What are the biggest barriers to the adoption of evidence-based practices?

For those of us specifically concerned with the health and well-being of adolescents, one of the biggest barriers has been, until recently, the paucity of evidence-based research for addressing prevention of mental health and substance abuse disorders among adolescents, especially in clinical settings. Many practices and recommendations were based on what worked for children or for adults, an approach we now know is inadequate. Hence an evidence based approach cannot be the sole criterion to determine if promising approaches should be implemented or reimbursed although they clearly need to be evaluated.

Other barriers are those that I am certain are quite familiar to the members of the committee. These include lack of provider skills, time, systems, money and technology (as outlined in SAM's position paper on Clinical Preventive Services for Adolescents).

Skills: many practitioners lack the skills to apply evidence based guidelines. In medical schools and pediatric residency programs, teaching about prevention must compete with an ever expanding basic science knowledge base, including that fueled by exploration of the human genome and its application to clinical

care. Many of us who are charged with teaching about adolescent health and disseminating relevant research are concerned because the number of individuals who are choosing this area of medicine is not keeping pace with the need.

Time: Prevention takes time, as does assessment and counseling of children, youth, and families at risk for mental health and/or substance abuse disorders. But time is something most clinicians do not have much of, with office visits now lasting 5-10 minutes for acute problems and, for the lucky practitioner, 15-20 minutes for a comprehensive assessment. To some extent, time pressures can be alleviated by changes in systems of care and through incorporation of on-line pre-visit or in office computerized assessments or screening tools. But since many validated screening tools are proprietary, this approach may be limited. Furthermore, technologies to support this approach are still in early development and must be affordable if care systems are to adopt them.

Money: Money, or rather compensation, is a very significant issue. No matter how extensive the knowledge base, no matter how readily available are state of the art tools based on sound scientific evidence, clinicians will not or cannot address prevention issues if they cannot get reimbursed adequately. In some settings, such as an HMO, reimbursement for prevention may not be an issue, but for most clinicians, it is. Reimbursement for preventive services is inadequate if reimbursed at all. This is a particular problem for those who focus on adolescent care exclusively, as they cannot buffer longer, more costly adolescent preventive service visits by simultaneously scheduling quick visits for a weight or post-ear infection check.

Another barrier is the paucity of qualified mental health and substance abuse providers; screening or identification does little good if referral sources are inadequate. Furthermore the substance abuse and mental health systems often do not communicate with each other, leaving a primary care provider caught between the two systems when dealing with a child or adolescent with both types of problems.

For those of us who focus on adolescent health and well being, the shortage of qualified adolescent focused providers and systems is even more acute. The adolescent's desire for confidentiality and his/her inability to pay for or access services complicates the situation even further. That is one reason why SAM supports school-based health centers, especially for urban and disadvantaged youth. And all of these issues are magnified for out of school, homeless, and street youth.

Finally, even if we can successfully incorporate evidence based guidelines into our systems of care, we must still convince parents and teenagers of the need for and value of such services.

Thank you for your attention.

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American Academy of Pediatrics and the Society for Adolescent Medicine

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