



## Review

## Addressing the treatment gap: A key challenge for extending evidence-based psychosocial interventions



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## ABSTRACT

Remarkable progress has been made in developing psychosocial interventions for a broad range of psychiatric disorders for children, adolescents, and adults. In addition many efforts are well underway to address the research–practice gap, which refers to the dissemination evidence-based treatments from controlled settings to clinical care. The present article focuses on the treatment gap, which refers to the discrepancy in the proportion of the population in need of services and the proportion that actually receives them. Currently, in the United States (and worldwide), the vast majority of individuals in need of mental health services receive no treatment. Although there are many reasons, the dominant model of delivering psychosocial interventions in both research and clinical practice makes it difficult to scale treatment to reach the large swaths of individuals in need. That model includes one-to-one, in person treatment, with a trained mental health professional, and provided in clinical setting (e.g., clinic, private practice office, health-care facility). The article discusses the development of delivery models that would permit reaching more individuals in need, highlights criteria for developing such models, and illustrates novel models already available. The article proposes that our next challenge is to reach individuals in need with the many excellent interventions we have developed but through a diversified set of delivery models.

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The development of evidence-based psychosocial interventions (EBPIs) is truly a remarkable advance. As is well known, EBPIs refer to interventions that have been evaluated in randomized controlled clinical trials, where treatments, client samples, and outcomes have been well specified, and where the effects have been replicated by an independent research team.<sup>1</sup> A current priority is to disseminate

treatment from research to clinical practice or addressing research–practice gap. Extending interventions from research to practice is a critical step in the process of improving mental health care. Another step is extending treatments in ways that go well beyond clinical practice and to reach the large number of people in need of clinical care but who are not receiving services. Disseminating EBPIs to clinical practice alone will not necessarily address this latter need.

The article discusses the development of delivery models that would permit reaching more individuals in need, highlights criteria for developing such models, and illustrates novel models already available. The overall thesis is that a key challenge in the coming years is to develop interventions that can have broad impact on reducing the burdens of mental illness by ensuring that treatment reaches unserved individuals. Examples of how this can be achieved are drawn from multiple disciplines that can help extend interventions with an evidence base.

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<sup>1</sup> The criteria for delineating treatments considered to have empirical support have evolved over time and among different countries, states and provinces within a country, professional organizations, and public and private agencies (e.g., Chambless & Ollendick, 2001; Charman & Barkham, 2005; Tolin, McKay, Forman, Klonsky, & Thombs, 2015). The terminology has varied too as illustrated by empirically supported treatments, empirically validated treatments, evidence-based psychotherapies, evidence-based practice, and others (e.g., American Psychological Association, 2006; Goodheart, Kazdin, & Sternberg, 2006). The differences among criteria and meanings among the terms are not pivotal to the focus of this article. In addition, this term has adopted the broad term that emphasizes evidence-based psychosocial interventions. Interventions is used rather than treatments because many of the models that can improve mental health and decrease mental disorders are well outside what would normally be called treatment.

## 1. Treatment gap

### 1.1. Overview of the problem

The treatment gap refers to the difference in the proportion of people who have disorders or a particular disorder (prevalence) and the proportion of those individuals who actually receive care (Kohn, Saxena, Levav, & Saraceno, 2004; Patel, Maj et al., 2010). In the context of mental health, considerable evidence has addressed each component of the gap to outline the nature of the problem (Andrade et al., 2014; Becker & Kleinman, 2013; Merikangas et al., 2011; Steel et al., 2014; Whiteford et al., 2013). In the United States, millions of children, adolescents, and adults experience significant mental health problems and receive no help whatsoever. For example, from reports of the National Comorbidity Study, we have learned that 26% of the US population meet criteria for a psychiatric disorder within the past 12 months (Kessler et al., 1994; Kessler, Chiu, et al., 2005). This increases to 46% of the population over the course of life (Kessler, Berglund et al., 2005). For ease of computation consider that approximately 25% of the US population experience a psychiatric disorder during a given year and 50% in their lifetime. From a US population of approximately 320 million, this translates to 80 million and 160 million people, respectively. Important to add is that the estimates may be conservative; some disorders (e.g., schizophrenia) as well as subsyndromal (subclinical) disorders often are omitted from surveys of prevalence.

Separate lines of research have addressed the extent to which individuals in need of services actually receive them. In the US, approximately 70% in need of services do not receive any services (Kessler, Demler et al., 2005). Ethnic minority groups (e.g., African, Hispanic, and Native Americans) have much less access to care than do European Americans (e.g., McGuire & Miranda, 2008). For example, African Americans are less likely to have access to services than are European Americans (12.5 vs. 25.4%), and Hispanic Americans are less likely to have adequate care than are European Americans (10.7 versus 22.7%; Wells, Klap, Koike, & Sherbourne, 2001). The lack of available services for most people and systematic disparities among those services underlie the importance of delivering services in ways that can reach many more people as well as target special groups.

The problem of high prevalence rates and a gap in the proportion who receives treatment has been studied internationally. The World Health Organization ([WHO] [Mental Health Survey Consortium, 2004](#)) provided extensive data on the treatment gap from surveys of over 60,000 adults in 14 countries in the Americas, Europe, Middle East, Africa, and Asia. The proportion of respondents who received treatment for emotional or substance-use disorders during the previous 12 months ranged from a low of 0.8% (Nigeria) to a high of 15.3% (United States). These percentages refer to those who received treatment among those in need. These numbers convey that the vast majority 99.2% and 84.7%, respectively (by subtracting the above percentages from 100%) of individuals in need did not receive treatment. The general finding is that most people with a diagnosable psychiatric condition do not receive treatment.

Among the small minority of individuals who receive services what exactly do they receive? In the WHO study, “receiving services” was based on asking respondents if they ever saw any contact from a long list of caregivers either as an outpatient or inpatient for problems with emotions, nerves, mental health, or use of alcohol or drugs. Included were mental health professionals (e.g., psychiatrist, psychologist), general medical or other professionals (e.g., general practitioner, occupational therapist), religious counselors (e.g., minister, sheikh), and traditional healers (e.g., herbalist, spiritualist). The list varied among countries depending on local

circumstances where types of healers may vary. The precise service provided by these individuals was not identified. Also, the duration of the intervention was not known, but receiving services required at least one contact. Thus when we say that 15% of individuals received treatment, information is ambiguous and could be one contact with someone who has had no training in mental health.

In the US, the National Comorbidity Survey-Replication study also has provided data on who receives treatment as well as some further information about the nature of that treatment (Wang, Lane et al., 2005). Over 9000 individuals with psychiatric disorders answered questions about their treatment that included who the service provider was (e.g., psychiatric, family physical, social worker, spiritual advisor and others) and the type of treatment they received (e.g., self-help group, medication, hospital admission). Minimally adequate treatment was defined as receiving an intervention (e.g., medication, psychotherapy) that followed evidence-based guidelines for the specific disorder and included multiple contacts (rather than only one visit). For individuals with a psychiatric disorder, 21.5% received treatment from a mental health specialist; 41.7% received treatment if this is expanded to include contact with any health-care person, in addition to those trained in mental health. For individuals who did not meet criteria for disorder (subsyndromal disorder), 4.4% received treatment from a mental health specialist and 10.1% received treatment if this is expanded to include any contact. Overall, across the entire sample, only 32.7% were classified as receiving at least minimally adequate treatment. The investigators concluded that only one third of treatments provided met minimal standards of adequacy based on evidence-based treatment guidelines.

Other conclusions were noted from this survey. First, treatments were used that have unclear benefits. For example, the complementary and alternative treatments accounted for 31.3% of all mental health visits despite the absence of evidence attesting to their effectiveness. Second, most services and mental health visits were consumed by individuals without meeting the criteria for disorders. Because the cut point for a diagnosis (clinical, subclinical) is difficult to defend and because more disorders are conceived as on a spectrum, “subclinical” may well be in need of or profit from treatment. It does mean that those with greater severity of dysfunction may not be consuming most of the available services.

### 1.2. General comments

Key points summarize the state of the treatment gap. First, most individuals with mental disorders do not receive treatment and that applies to the US and other countries. There is no single summary percentage one can provide because of variation among studies in: the disorders that are included (e.g., subsyndromal disorders, substance use and abuse, personality disorders), in what “counts” as treatment, and the list of who is included as potential service providers (e.g., mental health professional, religious leader), and ethnicity, culture, and country of the sample. And yet, through it all it is clear that we are not providing treatment to the large majority of people in need of services.

Second, when treatment is provided, it includes a variety of interventions administered by mental health professionals, health-care professionals in other areas (e.g., general practitioners), and by others (e.g., religious leaders, healers). This care usually refers to some contact. Yet that contact is not necessarily formalized psychological treatment or medication.

Third and related, EBPIs are used infrequently for mental disorders for the proportionately few individuals who receive care. Epidemiological surveys have not been designed to probe in depth precisely what the interventions are, how long they are administered, and whether the persons administering the treatment are

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