Second Opinions

More research

Thank you for your September 1997 article, "Including children in research signals new era," by Luann Zanzola, bringing news of the new era in child health care research to the attention of the pediatrics communities. The Agency for Health Care Policy and Research (AHCPR), a sister agency of the National Institutes of Health (NIH), published a policy on the inclusion of children in health services research in the May 9, 1997, NIH guide. Our policy also was stimulated by the joint NIH-AAP workshop in June 1996, in which AHCPR participated. Interested individuals can find the policy on AHCPR's Web site www.ahcpr.gov.

Like NIH, AHCPR believes that when there is a sound, scientific rationale for including children in health services research, investigators should be expected to do so, unless there is a strong overriding reason that justifies their exclusion from the studies. Under AHCPR's new policy, applicants for AHCPR funding will be expected to address this issue in their applications.

At AHCPR, children's health services research addresses important topics of organization and delivery of care, health insurance and expenditures, outcomes and effectiveness, use of new technology for clinical and patient education purposes, and quality of care for children. New starts in 1996 addressed such issues as patterns and outcomes of referral and care for children on Medicaid, validity of patient and provider reports of adolescent services, cost-effectiveness of asthma guidelines, development and implementation of computer-based guidelines on neonatal jaundice, and design and assessment of an instrument to measure child health status.

In June 1997, AHCPR issued a request for applications for research on the effectiveness of mental health and substance abuse treatments in general health sector settings (e.g., emergency rooms, pediatricians' and other primary care providers' offices). Our new evidence-based practice centers, which, under contract to AHCPR, will develop and disseminate "evidence reports" on topics of importance in everyday practice, have child health expertise, and will address child health topics.

AHCPR has a strong commitment to improving the capacity of health services researchers to do research on the delivery of health care to children, particularly in real-world clinical settings, and is working with the health services community to build the necessary infrastructure (AHCPR, Child Health Services: Building a Research Agenda Pub. No. 97-R005, April 1997; AHCPR, Research on Children's Health New Starts Pub. No. 97-R057, May 23, 1997; Forrest, GB, Simpson, LA, Clancy, CM. Child Health Services Research, JAMA June 11, 1991, Vol. 277, No. 22: 1787-1793). We are pleased that pediatricians in clinical practice are collaborating increasingly with the research community to conduct child health care research that is more immediately useful in day-to-day clinical practice, but we are painfully aware that better incentives for child health care research and researchers may be needed to answer the breadth of unanswered questions in child health.

AHCPR recognizes, as does NIH, that the development and implementation of policies for inclusion of children will require adjustments in administrative mechanisms and, importantly, education and preparation of the scientific community, parents, institutional review boards, initial review groups, advisory bodies and program staff. AHCPR is working collaboratively with NIH and the health services research community to further develop and implement our policies concurrently.

For more information on AHCPR's policy, contact Patricia Thompson, Ph.D., Office of Scientific Affairs, (301) 594-1437, ext. 1607; e-mail pthompson@ahcpr.gov.

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Another view

In his article entitled "Expert debunks top 10 myths about teens" (July 1997), Mr. Mike A. Males makes several points worthy of consideration, particularly his desire to redirect policy and racism. Additional resources and interagency collaboration are needed to determine how child abuse and domestic violence, whether witnessed or directly experienced, influence youth violence.

Mr. Males makes a valid point regarding the dilemma of exaggerating the problem of youth violence in order to garner media and public attention. This process can only stigmatize young people and might have a negative effect on their integration into the community. And, as Mr. Males notes, exaggerating youth violence may remove the spotlight from adults and the influence their violent behavior has on adolescents.

We disagree, however, with several specific points Mr. Males presents.

First, a careful review of statistics does not lead to the conclusion that violent injuries among youths are problems that should be "de-emphasized in most cases." For example, in his argument against the myth of schools as "cauldrons of drugs and violence," Mr. Males cites only the relatively low number of homicides that occur on school grounds. But murder rates alone do not define a violent environment. In a nationally representative sample, 10 percent of students admitted to carrying a weapon on school property during the preceding 30 days, 8 percent were threatened or injured with a weapon, 35 percent of students had property stolen or deliberately damaged during the 12 months prior to the study, and nearly 5 percent reported that they missed a day of school during the preceding 30 days because they felt unsafe in school or when traveling to or from school.