



Data Trends

Summaries of research on mental health services for children and adolescents and their families

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Source: Chorpita, B. F., Yim, L. M., Donkervoet, J. C., Arensdorf, A., Amundsen, M. J., McGee, C., Serrano, A., Yates, A., Burns, J. A., & Morelli, P. (2002). Toward large-scale implementation of empirically supported treatments for children: A review and observations by the Hawaii Empirical Basis to Services Task Force, *Clinical Psychology*, 9(2), 165-190, and commentaries by: Henggeler, S., et al. (191-194); Bickman, L. (195-199); Hogan, M. F. (200-203); Gonzales, J. J., et al. (204-209); Hoagwood, K. (210-213); Kendall, P. C. (214-216); Roberts, M. C. (217-219); Jackson, Y. (220-222); Jensen, P. S. (223-224), and; Hawley et al. (225-230).

The State of Hawaii has undertaken a major effort to identify children's mental health services that have strong empirical support, and that might be implemented more broadly in Hawaii. This effort, by Bruce Chorpita and his colleagues, is the foundation piece for this series of articles, which collectively makes an important contribution to the discussion in the children's mental health field about evidence-based interventions.

The Hawaii Task Force, created by state legislation, included administrators, clinicians, and researchers from various disciplines, as well as parents. The Task Force reviewed 115 scholarly articles and rated treatment outcomes according to criteria established by the American Psychological Association (APA). While the APA-identified treatments that were: 1) Well Established/Efficacious, and 2) Probably Efficacious, the Hawaii Task Force added the categories of: 3) Possibly Efficacious 4) Unsupported, and 5) Possibly Harmful. The Task Force did not review psychopharmacological treatments, nor did it review articles in which treatments were classified by location as opposed to their procedures (i.e., treatment in residential treatment centers or therapeutic foster care or schools). Further, articles researching comorbidity and multi-modal treatments (with the exception of multi-systemic therapy) were not reviewed.

The journal *Clinical Psychology* provides an important service to the field by inviting 10 different individuals to comment on the lead article by Chorpita et al. While each commentator lauded the work of the Task Force—and especially its multidisciplinary nature—each also added to the current discussion over what constitutes an efficacious treatment and how to implement such treatments at the clinical level in real world settings. One of the major challenges identified by the commentators has to do with the limited research base currently available on effective services (treatment applied under real world conditions) as opposed to the much larger research base on efficacious treatments (treatment applied under special conditions, such as in a special lab, with volunteer subjects instead of real clients, or with unusually well-trained clinicians). A related challenge is the complexity of large scale implementation of interventions, even when effectiveness data are available. Hoagwood, for example, indicates that “the progression from effective treatments to their implementation and dissemination into real world practice settings is through largely uncharted scientific territory” (p. 212). She points out that until variables relevant to this progression at multiple levels are better understood, “a healthy skepticism about the relevance of evidence-based treatments is warranted” (p. 212).

Several themes emerged from the articles of the commentators that are germane to the current state of mental health services, and services research.

Practitioners: Historically, practitioners have been reluctant to use manualized treatments and are not expected to receive empirically supported treatments at the implementation level very well. However, inclusion of practitioners at every stage of treatment design and implementation may help offset this reluctance, especially when practitioner needs vary from location to location. Henggeler suggests that clinicians are likely to respond positively to empirically supported treatments when those treatments are: (a) clearly superior to current treatments, (b) not too different from current treatments, (c) simple rather than complicated, (d) can be tried out in stages or temporarily, and (e) have visible outcomes. Kendall, Roberts, Gonzales et al. and Jackson each argue that a “collegial demeanor” and working relationship between researchers and practitioners will prove beneficial at all stages of research, but especially at the implementation stage. This insight also recalls Henggeler's discussion of organizational characteristics that help move implementation along (i. e., an organization is more likely to adopt innovations when representatives from all levels of the organization are included in the change process).

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Journals: Commentators also expressed concern over the role of scholarly journals with regard to standardization, data collection, and implementation. First, data collection could be more uniform if journals—and authors—were to standardize more rigorously the reporting of certain demographic data (e.g., ethnicity). Jensen suggests that journals actively include “guidelines that journal editors might recommend be used when manuscripts concerning the efficacy of a given intervention are submitted” (p. 224). Second, unspoken scholarly and journalistic parameters may hinder data collection. For example, Chorpita et al., created the Unsupported and Possibly Harmful categories in the event that they came across studies with poor or questionable outcomes. They did not come across any of these studies, not because such treatments do not exist, but because they remain unpublished. However, Hawley et al. write that “such information is extremely important to clinicians and families” (p. 226). Third, journals can move implementation efforts forward by including articles that are relevant to real-world settings. Quoting Greer, Gonzales et al. suggests that “only infrequently do scientific articles speak directly to the realities of practice...not only is similarity of the cases to one’s own patients missing, but the specifics of implementation are often missing as well” (p. 208).

Multidisciplinary collaboration: An overwhelming interest in the collaborative process was voiced by these commentators, from questions about the qualifications of the collaborators, to how disputes were settled, to a genuine interest in whether organizational dynamics might hinder the collaborative process. Regardless, commentators suggested that implementation efforts would benefit from involving practicing clinicians “at the very start of such processes, at the point of conceptualizing the questions, especially those about barriers and solutions to treatment feasibility” (Gonzales et al., p. 208).

Measurement: Questions about measurement were wide ranging, from the specific to the theoretical. Specific concerns included Jackson’s probing commentary about the relative lack of data on culture, acculturation, and ethnicity, and Hogan’s concern over rigid parameters used to denote childhood development (i.e., through chronological age only). Hoagwood’s concerns were more theoretical; she advocated for a revisiting of certain constructs that are based on artificial distinctions (i.e., single/multiple diagnoses, prevention/intervention, location-based/procedure-based treatments). Furthermore, Hoagwood suggests that some constructs, such as functionality, are still not conceptually clear. In particular, she questioned the utility of using a diagnosis to determine what kind of treatment a child ought to receive. For example, she reports that it has been shown that there is poor agreement between the diagnosis a researcher would give a child (based on the DISC) and the diagnosis a clinician would give the same child. Therefore, when treatment is driven by diagnosis, it may be possible to assign the wrong treatment to a child due to an erroneous diagnosis. She writes, “The problem is the way in which science is carved out into linguistic categories and then takes on an independent existence as funding streams and administrative bureaucracies harden these categories into insular entities” (p. 211). This comment bears a remarkable resemblance to Bickman’s charge that diagnostic categories encourage “silos of intervention” (p. 196), when intervention treatments are based on a singular diagnosis. Other commentators raised similar reservations about diagnosis-driven treatment.

Another area of concern had to do with factors not currently measured but which, commentators argue, ought to be. For example, Bickman would like to see therapeutic alliance as a measurable factor, and Jackson welcomes the measurement of cultural and acculturation factors. Finally, commentators were in agreement that comorbidity, psychopharmacological treatments, multi-modal treatments, and location-based treatments need to be included in future reviews of the literature.

This set of articles provides readers with both a sense of urgency and caution over the next steps toward implementation of empirically-based interventions. This is of course a tricky place to be: we must both look backwards at our research while continuing to move forward toward implementation. Yet each time we look either way, we learn more and we question more. Perhaps Danish philosopher Søren Kierkegaard understood this problem when he wrote: “It is quite true what philosophy says: that life must be understood backwards. But then one forgets the other principle: that it must be lived forwards. Which principle, the more one thinks it through, ends exactly with the thought that temporal life can never properly be understood precisely because I can at no instant find complete rest in which to adopt the position: backwards.”