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A Proposal to Unite Two Different Worlds of Children's Mental Health

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The thoughtful commentary by Holden and Blau (2006, this issue) highlighted some significant challenges for research and practice in child and adolescent mental health. Although we disagree with some of the commentary, we certainly do agree with three of its points: (a) A very large number of American boys and girls are at risk of, or are already experiencing, serious mental health problems, (b) the services currently provided to many of these youngsters do not do a good job of meeting their needs and preventing or resolving the problems, and (c) there is a need for more effective interventions directed at multiple levels of children's social ecology that can address complex, severe, and chronic youth problems and that can be effectively delivered in a community context. Indeed, some of us have for years stressed the need for researchers to move interventions and intervention research from university laboratory settings into family, community, school, and everyday mental health care settings, in order to create robust methods that are well-equipped for the challenges of real life. Moreover, as we argued in Weisz, Sandler, Durlak, and Anton (September 2005), "to create interventions that work well in the crucible of everyday professional use, developers should focus a very substantial portion of their adaptation and testing on precisely the kinds of individuals, interveners, and contexts for which the interventions are ultimately intended" (p. 644). This is a core principle of the deployment-focused model of treatment development and testing proposed by Weisz (2004) and is consistent with the prevention service development model proposed by Sandler et al. (2005).

There is one key question on which opinions diverge sharply: By what process shall we move from the current situation to a world in which robust interventions meet the needs of diverse youngsters who are at risk of, or already experiencing, serious mental health problems? Here we offer a proposed approach; but first we recap some points from our original article (Weisz et al., 2005) and from Holden and Blau's (2006) commentary:

- We proposed that the field be guided by a conceptual framework that views children as embedded in family, community, and culture and in which *complementary* promotion, prevention, and treatment services work together to protect and promote child mental health.
- We proposed an incremental approach building on evidence from hundreds of treatment and prevention outcome studies, conducted over 50 years and using randomized controlled trials and other scientifically sound designs (e.g., ABAB, multiple baseline).
- We noted the need for cross-disciplinary agreement on standards and procedures for reviewing intervention programs in order to provide clearer guidance to policymakers, clinicians, and consumers regarding what the evidence shows and which interventions are beneficial.
- We proposed that the strongest interventions be adapted and tested in real-world contexts, including everyday settings for children (e.g., schools, families, clinics), to achieve the best possible fit to the needs of these youngsters.

Holden and Blau (2006) disagreed with our proposals in at least three important respects:

- They argued against the use of randomized controlled trials and against what they referred to as "the use and application of evidence-based interventions driven by constrained scientific perspectives" (p. 643). As alternatives, they referred to "the process of discovery through observation and categorization" (p. 643) and the use of "incremental data from the field" (p. 643). They did not indicate how—in the absence of a scientific approach—various interventions should be evaluated to determine which ones are actually effective.
- They argued against a unified system for reviewing evidence and identifying those interventions that meet acceptable standards. It was not clear what they would propose, instead, to prevent cacophony, to assist families and providers in selecting interventions, or to prevent a system in which judgments about intervention benefit rest entirely on the claims of the intervention developers and proponents.
- They argued that rather than progressive adaptation of scientifically tested interventions, our field should rely on finding and developing interventions that emanate from work in the field.

We stress that we strongly favor efforts to find useful approaches through work in the field. An important fact, not often noted, is that some of the most potent evidence-based interventions began precisely there and developed their power through the give and take of application in home, school, community, and clinical care settings, as described in Weisz (2004). Only later were these practices described in written form, tested through research, and selected by reviewers as meeting criteria for "evidence-based" interventions. Where we disagree with Holden and Blau (2006) is not about whether useful interventions may originate in the field—indeed, we *prefer* interventions that have done so—but about the standards of evidence that should be applied to interventions before they are widely disseminated. We are concerned about what gets disseminated to vulnerable children who are in no position to assess or to choose their own interventions. We believe protecting children's mental health requires providing them with interventions that meet fair standards of evidence—evidence showing that the interventions will actually help children and their families.

It is not clear that the interventions offered as examples by Holden and Blau (2006) meet such standards, at least not yet. The authors criticized us for not citing what has been learned "from evaluations of large, federally funded demonstration projects such as the Comprehensive Community Mental Health Services for Children and Their Families Program. . . . In this systemic model, traditional interventions are combined with nontraditional service approaches to improve emotional and behavioral functioning" (p. 643). This refers to the System of

Care Initiative, disseminated through the Substance Abuse and Mental Health Services Administration (SAMHSA) at a cost of about $90 million per year. The most rigorous analyses of the system of care approach, reported by Bickman and colleagues (e.g., Bickman, 1996; Bickman, Noser, & Summerfelt, 1999), have indicated that the approach increased costs and service use substantially relative to usual services but did not improve children's clinical outcomes or everyday functioning.

The second approach advocated by Holden and Blau (2006) is wraparound services, a team-based approach to planning and coordinating formal and informal services in the community (see description in Burns, Schoenwald, Burchard, Faw, & Santos, 2000). "Incremental data from the field," Holden and Blau stated, "have suggested that this is an effective approach for addressing the needs of children with the most severe and persistent mental health problems" (p. 643). In contrast to this perspective, a recent comprehensive review (Farmer, Dorsey, & Mustillo, 2004) concluded,

> Currently, the evidence base for wraparound seems to fall on the weak side of "promising." What research exists shows positive gains. Other work, however, shows equal gains with usual care at an increased cost for wraparound. The evidence to date is concentrated in weak study designs, however. Although various researchers and authors have been involved, the publication outlets for this work have been narrow (and frequently not peer reviewed). (p. 869)

While system of care and wraparound approaches have not shown very positive outcome evidence to date, both are intuitively appealing ways of organizing and delivering interventions, and both have a remarkable record of engaging family and community support. By contrast, the evidence-based interventions discussed in our original article (Weisz et al., 2005) have significant scientific support, but most do not address the question of how multiple interventions and services should be organized, and in general these interventions have nothing like the kind of family and community acceptance achieved by systems of care and wraparound. This leads us to a proposal.

Why not combine the complementary strengths of the community-based approaches identified by Holden and Blau (2006) and the evidence-based approaches discussed in our original article (Weisz et al., 2005), rather than argue about the comparative limitations of each approach? Given that the contents of both systems of care and wraparound are free to vary with available services in the community, why not ensure that those specific services are, in fact, interventions that have been tested and shown to work? This might provide just the boost the community-based approaches need to generate beneficial effects that hold up well under scientific scrutiny. One approach could build on recent efforts at SAMHSA to encourage the use of evidence-based practices within community systems. Expanding this effort to encompass multiple empirically supported interventions, and to rigorously test program effectiveness with and without these interventions, could help to clarify whether the integration we propose carries the benefits we anticipate. It certainly seems fair to test a model in which the community-based strengths and potent delivery systems of wraparound and systems of care are united with the empirical strength of evidence-based interventions, to promote and protect mental health in children and their families.

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