

Preface

Evidence-Based Practice, Part I:  
Research Update



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*Guest Editors*

We welcomed a timely invitation last year from the leadership of the *Child and Adolescent Psychiatric Clinics of North America* to develop an issue on evidence-based practice in child mental health care. We were informed that it would be published around the 5-year anniversary of the 1999 release of the Surgeon General's Report on Mental Health, which was the first comprehensive presentation of the evidence for mental health care containing impressive findings about the potential to improve mental health care in this country. To some extent—and to the surprise of those of us involved in reviewing the evidence for child treatment (ourselves included)—a more promising picture than expected emerged of the potential to treat children and adolescents effectively. Moreover, the findings were not dissimilar to those for adults who have mental disorders.

We believe that the time is ripe for a reassessment and update of the evidence. A convergence of three social and scientific movements lends support to the timeliness of this endeavor: research priority-setting by federal agencies targeted at strengthening the evidence base; a range of both federal and state policy initiatives on the application of evidence to practice and policy; and increasing demand by advocates to improve both access and quality of mental health care for children. All of these developments share a common theme: pay attention to proven practices and put them into place. This convergence of efforts has led to a significant expansion of new findings about effective treatments for youth and efforts to incorporate such findings into clinical care.

One issue of *Child and Adolescent Psychiatric Clinics of North America* was planned to examine two questions: (1) What is the current state of the evidence?; and (2) What is the potential to move evidence into practice? The intent was to broaden the discussion beyond a description of discrete studies in the context of the contributions and challenges that research-based findings could make toward improving policy and practice. Papers were invited around these two major themes. Authors responded enthusiastically, such that two issues were required to accommodate their contributions. The content divided naturally into “Part One: Evidence Update” and “Part Two: Effecting Change.” Part Two will be released in the Spring of 2005.

Part One provides an update on the status of recent studies examining the impact of specific treatment approaches (medication, psychosocial, and community-based services) on child and family outcomes. The scientific reviews consist primarily of studies utilizing a randomized clinical trial design conducted across a wide range of clinical conditions and treatment modalities. In the tradition of evidence-based medicine defined in the first article, the five papers that follow update the evidence base and offer youth, families, and clinicians an array of clinical interventions from which to select.

In Part Two, the voices and views of stakeholders about evidence-based practice, most critically those of family members and clinical practitioners, are echoed in several papers, along with theoretical and empirical data about attitudinal factors related to changing practitioner practice. Models for training clinicians and for dissemination of evidence-based medicine offer encouragement that evidence-based interventions stand a good chance of becoming available and succeeding in real-world clinical practice. The dissemination approach currently being tested for adult interventions described in this issue recognizes the necessity of addressing multiple stakeholder preferences (eg, consumer, clinician, administrator, policymaker), and incorporating formal training, ongoing consultation and supervision, and fidelity and outcome monitoring into the model. The challenges are complex, thus multipronged approaches and strategies need to be applied intensively to support dissemination and implementation efforts. What has also become clear is that multiple requirements at policy and organizational levels (eg, availability of resources for training, reimbursement, a climate open to change, and readiness for specific interventions) are essential prerequisites to change.

Since the release of the Surgeon General’s Report on Mental Health, a number of developments in child mental health have sparked special initiatives to disseminate and implement evidence-based practice. There has been time to digest the Surgeon General’s and subsequent reports and to consider requirements for dissemination. These developments range from further contributions to the evidence, to early development of user-friendly training materials, and even reimbursement tied to evidence-based practice. Dissemination initiatives supported by states, the federal government, and foundations are springing forth across the country, and others are forthcoming, especially some that give priority to reimbursement for evidence-based practices. At the same time that such an

evolutionary—or revolutionary—process is underway to replace usual care with evidence-based care, it is already being challenged. A warning from the National Mental Health Association in May 2004 may indicate that evidence-based practice has become suspect (“evidence-based medicine may be used to contain costs and limit access to treatment” [www.nmha.org]). The articles in these issues also communicate diversity among viewpoints regarding the criteria for defining the evidence base and caution about moving forward too quickly. Nonetheless, as Kazdin comments in his article in this issue, “For any clinician in practice, it would be difficult to justify using a non-EBT as the first line of attack if there is an available EBT.”

These articles document significant progress over the past 5 years, and they offer guidance about future directions:

- Achieving consensus about appropriate and effective clinical practice;
- Obtaining critical stakeholder (including policymaker) support for implementation of evidence-based practice;
- Integrating the relevant training and clinical tools into graduate and continuing education; and
- Creating a better balance in treatment development research between science and real-world clinical needs, including research approaches to intervention dissemination.

In conclusion, the critical question seems to be whether or not the field has the confidence, forbearance, and strategic capability to effectively move the current evidence, albeit incomplete and steadily emerging, into practice. We appreciate the high quality papers contributed by the authors and hope that these two issues of the *Child and Adolescent Psychiatric Clinics of North America* will be instrumental in stimulating further debate and a creative dialectic about these issues to benefit the mental health of children and families.

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