

**C013022 ABSTRACT:** This is an introductory article in a special issue of Data Matters that discusses concerns being addressed by leading researchers in the field. The authors state that research on the effectiveness of clinical treatments, service modalities and preventative interventions continues to grow at a rapid rate; however, there continues to be a significant gap between what works and what is practiced in the field. The articles touches on what constitutes evidence, whose evidence is it, and will funding follow the evidence base?

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## To Be or Not To Be... Evidence-Based?

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This is the question confronting providers, families, payers, policy makers, researchers, and advocates in the field of children's mental health. Evidence-based practice is an emerging concept and reflects a nationwide effort to build quality and accountability in health and behavioral health care service delivery. Underlying this concept is (1) the fundamental belief that children with emotional and behavioral disorders should be able to count on receiving care that meets their needs and is based on the best scientific knowledge available, and (2) the fundamental concern that for many of these children, the care that is delivered is not effective care. Some have identified this movement to evidence-based practice as the new "revolution" in health care that focuses on assessment and accountability (Kiesler, 2000). While there is much reason for optimism and hope in this movement towards evidence-based practice in children's mental health, there is also reason for much concern and caution. Some of these concerns and challenges are presented below.

**Moving from Science to Service**  
 All too frequently, children and their families receive care that is based

on outdated practices and narrowly defined outcomes as opposed to care that is based on increasing evidence of effectiveness and a wider spectrum of desired functional and quality of life outcomes. The field continues to rely on practices that have little supporting evidence or, at worst, have poor outcomes. The care that is often provided is based on "that's what we've always done" rather than on an emerging evidence-base for "what works." Research on the effectiveness of clinical treatments, service modalities and preventive interventions continues to grow at a rapid rate. This research has spurred new excitement and hope for making a difference in the lives of these children. However, there continues to be a significant gap between what we know works and what is practiced in the field.

Changing practice is a formidable task that occurs at a painstakingly slow pace, often requiring not only changes in practice behaviors, but restructuring programs and allocating an infusion of upfront resources. In addition, implementation of new practices can be especially difficult in an environment of shrinking state and local budgets and competing priorities. Implementation often involves significant organizational change, provider re-training and changes in public and private reimbursement. Clearly, a challenge is to promote the effective dissemination and

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implementation of proven interventions, the task often described as moving “science to services.”

**Practice-based Evidence or From Service to Science**

Evidence-based practices are not available for all problems and needs and, even when available, do not necessarily work uniformly across all families and communities. Many communities and provider organizations have developed innovative strategies and “promising practices” that lack a systematically developed evidence base. In particular, services targeting ethnic and racial minority communities have often developed culturally-driven practices or have incorporated cultural adaptations to existing evidence-based practices to better serve their children and families, however, they may lack the capacity and resources for research and evaluation. The evidence base needs to be developed for these services and their communities. If we limit the building of the evidence base to a one-way “science to services” approach, we risk stifling innovation and recognition of potential practice-based evidence.

**What Constitutes Evidence?**

In the field of children’s mental health, “evidence base” refers to scientifically obtained knowledge about the prevalence, incidence or risks for mental disorders or about the impact of treatments or services on these problems (Burns and Hoagwood, 2002). It denotes quality, robustness and accountability. But establishing the criteria for what constitutes an evidence-based practice varies among different child-serving systems and provider groups. Different levels of

evidence, based on the rigor of the research design (for example, number of controlled studies, randomization of participants in studies, number of single-case studies, etc.) have been put forth by various research organizations and public policy programs. These range from “evidence-based” practice grounded in systematic randomized clinical trials, to “evidence-informed” practice based on meta-analyses of existing research studies, to “evidence-suggested” practice based on consensus groups

we must continue to proceed with the best existing knowledge, expert consensus, and experience.

**And Whose Evidence Is It?**

Concerns have been raised that much of the research on practice and service in children’s mental health has occurred in academic laboratory-type settings with children who display a single, well-circumscribed disorder. The intent of designing research studies in this manner is to prevent the intrusion of “confounding” variables. However, these variables often reflect real-life situations and need to be incorporated into the examination of effective practice. Failure to attend to these variables, which affect the conditions of practice, may diminish the relevance of this research. These practices may work only in a controlled research setting, not in real-

life clinic settings. Additionally, children often present with complex disorders that do not easily fall into a single diagnostic category. For example, co-occurring disorders, whether a combination of emotional disorders or emotional and substance abuse disorders,

are becoming increasingly prevalent. Children with these disorders are particularly challenging to a research endeavor that traditionally isolates a condition in order to determine diagnostic-specific treatments. And finally, much of this research does not include racially and ethnically diverse populations, so the generalizability of these evidence-based practices remains to be determined.

**Family Choice**

In the last decade, a strong family movement has highlighted the positive impact of family involvement and family choice in the treatment planning and decision making for their children with serious emotional



and expert opinion (Evans, 2003). Similarly, many national efforts and provider systems have constructed their own criteria and cataloguing of evidence-based practices. These represent critical efforts to identify services that produce positive outcomes for youth and warrant the expenditure of shrinking fiscal and human resources. However, the multiple efforts and criteria for identification of evidence-based practices raise potential confusion and dilemmas for practitioners, policy makers, families and consumers. More clarity is needed to ensure informed decision-making. And, as we await the findings from practice-based research,

disorders. Major advocacy and provider groups endorse families as partners in planning. The field is no longer concerned with whether to involve families, but how best to do this. With the movement to evidence-based practice, how does this affect the role of families in decisions regarding treatment and intervention? How will the strength of science-based practices be integrated with family choice? Families often present first-hand evidence of what works for their child in the context of their family and community and concerns have been raised that this "evidence" will be minimized in favor of "scientific evidence." At the least, families should be informed of evidence-based practices. But beyond this, families need to also have a role in actively shaping and evaluating practice. While families want to know what works and what practices are effective, they also need to have a voice in determining what practices, services and supports address their needs and should be the focus of research endeavors. For example, while researchers may focus on the effectiveness of psychotherapy, families may prioritize building the evidence base for effective respite care services.

### The Fit with Systems of Care

Questions have been raised about the compatibility of evidence-based practice and systems of care. Some concerns have been expressed that the movement to evidence-based practice will supersede or displace the systems of care approach. A system of care approach and evidence-based practice are not competing efforts but complementary. Systems of care focus on improving access, developing a broad array of services and ensuring coordination; it provides the context for evidence-based practices. The system of care provides the service delivery vehicle for clinical treatment and support services and neither the system nor the practice alone is likely

to yield positive results for children and their families (English, 2002). It is these two concepts working in tandem that provide the hope for improved access and quality of care. Thus, the movement toward evidence-based practice converges well with a system of care approach.

### Will Funding Follow the Evidence Base?

In 1998, approximately \$11.75 billion was spent for mental health services for children in the specialty mental health and general health sectors alone. This represents a three-fold increase since 1986 (Sturm, et al., 2001). It also raises the question of how these dollars are being spent. Given a continued reliance on traditional services that lack a strong evidence base, are we utilizing resources for effective practices? Historically, large amounts of federal and state dollars were spent to pay for more restrictive and less effective services. As the evidence increases to identify "what works", policy must address both the selection and funding of the most effective services. An important caveat in the funding picture is that we still need to learn more about the generalizability of the current evidence to children with complex disorders and children from diverse communities. Conversely, we need to be careful not to de-fund or under fund services and supports that are promising but lack the evidence base or to fund only a single component of an evidence-based multimodal service. For example, where pharmacological interventions are adjunctive to psychosocial therapies, some payment models fund only the medication component of the treatment, reducing costs but ignoring fidelity to the evidence-based intervention.

### Overview of Data Matters #6

With the increasing momentum of evidence-based practices, a broad

array of stakeholders is contributing to the discussions and debates on this topic. We are excited about this issue of *Data Matters* which provides a forum for the perspectives of these diverse stakeholders. The articles in this issue discuss issues being addressed by leading researchers in the field, cataloguing of practices by different child-serving systems, family accolades and cautions regarding evidence-based practices, challenges in working with providers as the "consumers" of these practices, state and local community efforts to implement evidence-based practices, and implementing an evidence-based practice in systems of care. While the voices are variously supportive or cautious, all share in common the desire for high quality, effective services to improve the lives of children with emotional and behavioral disorders. We are pleased to bring you this issue and hope you find it informative. ♦

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