JOURNAL
OF THE CANADIAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY / DE L'ACADÉMIE CANADIENNE DE PSYCHIATRIE DE L'ENFANT ET DE L'ADOLESCENT

BRIEF COMMUNICATION

# Listening to Bickman: Findings from Child Mental Health Services Research

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Psychiatry has become quite attuned to *Listening to Prozac* (Kramer, 1993) and writings on other psychotropic medications. The marked expansion of psychotropic medication use in children and adolescents (e.g., Pringsheim, Lam, & Patton, 2011) suggests that this attunement extends to child psychiatry. Our subspecialty, however, seems less attentive to work and findings coming from child mental health services research, despite its critical relevance to our field and day-to-day clinical work. What should be particularly influential is the body of work produced by Dr. Leonard Bickman and colleagues. While Bickman and his research group are not alone in critically and rigorously evaluating child mental health services, he and his group stand out as consistently and repeatedly challenging conventional wisdom including recent additions to his provocative "Myths about Mental Health Services" (Bickman, 2013). However, there appears to be poor awareness of this work or, if known, a failure to incorporate its findings into deliberations on the reform of child mental health services in Canada.

The repeated and appealing call to knock down our service silos and in their place construct a system of care for child mental health has been heard for years. The oft cited system of care document by Stroul and Friedman (1994) continues to provide a guiding framework for contemporary service reform recommendations in child mental health. While such frameworks have a number of common sense and desirable elements, there appears to be little attention to empirical research work on these elements and the resulting systems of care. This contrasts to our almost automatic consideration, at least in a cursory manner, of empirical work when deciding upon the use of a given psychotropic medication for children and adolescents with mental health needs.

Bickman and colleagues have published findings from a series of empirical studies which examine important elements of the system of care model for child mental health services. The Fort Bragg Evaluation Project has been one of the largest and most controversial works. Using a quasi-experimental design, this study contrasted children from military families receiving services for mental health problems in a model system of care with those receiving services from traditional service arrangements within the state of North Carolina. Those children in the model system of care received more services and their parents reported more satisfaction compared to those in the traditional treatment system, however, clinical and functional outcomes for children were no better despite higher costs of the model system (Bickman, 1996). Subsequent examination of outcomes out to five years confirmed the lack of clinical differences over time (Bickman, Lambert, Andrade, & Penaloza, 2000). While a positive framing can point to the increased access and continuity of care achieved, one of the intervention aims, the resulting failure to improve outcomes is then even more concerning given that a hypothesized mechanism for improved outcomes is increased access and continuity of care. A subsequent study employed an experimental design contrasting children receiving care within a model system of care versus services from a traditional service arrangement but this time within the public community mental health sector within Stark County in the state of Ohio. The pattern of results mirrored those from Fort Bragg such that child outcomes were no better for those in the model system of care despite higher service receipt and higher costs (Bickman, Noser, & Summerfelt, 1999). Another of Bickman's studies examined a particularly popular component of systems of care, i.e., wrap-around (Bickman, Smith, Lambert, & de Andrade, 2003). Using a quasi-experimental

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Submitted: May 12, 2014; Accepted: September 3, 2014

design, those in the wrap around intervention arm did indeed receive more wrap around services and experienced less discontinuity in service receipt, however, again, there was no evidence of better outcomes of children in the model system (Bickman et al., 2003). Despite these patterns of findings, systems of care initiatives in Canada are pursued with seeming little to no evaluation and with little pause to consider the distinct possibility that anticipated outcomes will be unrealized.

A leading hypothesis proposed to explain the surprising negative findings from this series of studies is that intervention components, employed within the above studied system of care models, may not have been evidence-based or effective (e.g., Bickman, Heflinger, Lambert, & Summerfelt, 1996); the notion being that the integration of ineffective services is not likely to result in improved outcomes. This is consistent with other bodies of work that have raised questions as to the effectiveness of typical services provided in the child mental health sector and the proposition that this may in part be a function of the lack of employment of evidence-based interventions (e.g., Weisz & Jensen, 2001). The increasing call for implementation of evidence-based interventions within community child mental health practices might then be seen as an important response to the above pattern of findings which might allow the promised gains from systems of care to be realized.

However, many cracks have opened up in the attempt to improve child mental health outcomes through dissemination of evidence-based interventions. Some of the challenges in this movement include: (i) what appears to be co-opting of the label "evidence-based" by clinicians and managers to describe what they are providing regardless of the extent to which it is evidence-based; (ii) lack of fidelity in the delivery of original components of empirically-supported interventions; and, (iii) questions as to the fit of packaged evidence-based interventions to clinical scenarios in typical practice, etc. An additional challenge to this movement is the provocative implications from the findings that a modular delivery of elements of empirically-supported interventions outperformed standard packaged empirically-supported interventions, with the latter not outperforming treatment as usual (Weisz et al., 2012). These and other findings further flame debates about fidelity vs flexibility within the evidence-based movement. An important, and possibly essential, response to this conundrum is the call for the implementation of measurement feedback systems within child mental health services, with the proposition that child mental health services will not improve without such implementation (Bickman, 2008).

Bickman and colleagues again help us out by providing empirical findings from a study implemented within the messy real-world of child mental health services. In this experimental design, the "only" intervention entailed the clinician receiving systematic weekly feedback (from clinician, parent and youth symptom ratings) throughout the child's treatment in contrast to the comparison group in which the clinician did not received such feedback until 90 days post treatment initiation. Findings included youth improving faster in the intervention group and a finding, from post-hoc analysis, that better outcomes were obtained by youth treated by clinicians who more frequently accessed the feedback (Bickman, Kelly, Breda, de Andrade, & Rimer, 2011). While replication is certainly required, this approach and these findings, along with the previous work on systems of care, have important implications as to directions to consider in our attempts to improve child mental health services in Canada…if we are listening.

## Acknowledgements/Conflicts of Interest:

The author has no financial relationships to disclose.

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