Developing interventions in child and adolescent mental health services: Do we really know what works for whom?

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A recent Cochrane Review of psychological therapies and antidepressants for depression in children and adolescents concludes ‘on the basis of the available evidence, we do not know whether psychological therapy, antidepressant medication or a combination of the two is most effective to treat depressive disorders in children and adolescents’ (Cox et al., 2014). This candid conclusion is made despite evidence from 11 randomised controlled trials (RCTs) involving 1307 participants being included in the review. The differing and at times contradictory results of these trials made it impossible to state with certainty which treatment option was most effective.

Conclusions such as this in the scientific literature are refreshingly honest in presenting a clear picture to clinicians that even in relatively well-researched areas such as adolescent depression evidence is uncertain. This lack of evidence is not unusual in Child Mental Health. Indeed, the second edition of the classic text ‘What Works for Whom? A Critical Review of Treatments for Children and Adolescents’ identifies whole areas of child mental such as psychosis, child maltreatment and Asperger syndrome where interventions have hardly been researched at all and across the field as a whole it is noted, ‘we know very little about the long term effects of the treatments we discuss in this book’ (Fonagy et al., 2015a, p. 7). From a practitioner perspective, Wren (2015) writes,

In a few areas, we have some modest research evidence and some consensus about how to proceed therapeutically (e.g. some form of exposure is probably required in treating anxiety). But in most areas, we have very limited certainty about the value of the research evidence and little agreement about how best to proceed. As clinicians, we operate in the zone of complexity where we must go forward on a trial and error basis, conscious of our fallibility, where creativity and innovation are required to develop new understandings of how to act (understandings in time to be duly explored in systematic research). . . To both safeguard our credibility, and strengthen the quest for greater understanding, we need to acknowledge the limits of our knowledge. (p. 28)

When faced with a patient and dilemmas regarding treatment, we are therefore often working in the dark, we frequently do not know, the ‘evidence’ is not available to tell us what course of action to take. How might this situation be improved so there are fewer gaps in our understanding of what works for whom and greater alignment between research and the needs of patients and clinicians? There are a number of issues that need to be addressed ranging from greater investment in intervention research to developing more personalised treatments that take into account clinical heterogeneity and patient preference.

First, a key issue is research funding. A recent review of research funding in the United Kingdom undertaken by the Mental Health Charity MQ (2015) notes that the vast majority of research funding...
in mental health is directed towards underpinning research which is aimed at understanding biological, psychological and socioeconomic processes and research that looks at the risk or cause of development of mental ill health. Considerably less funding goes directly towards the development of treatments and therapeutic interventions research. The situation is compounded in Child Mental Health which is itself relatively underfunded. The charity argues for greater investment in research on psychological treatments and highlights that some psychological treatments receive a greater proportion of total current funding than others, for example, 27.55% of UK Mental Health Research funding was allocated to cognitive behaviour therapy as compared to 1.96% allocated to psychodynamic psychotherapy. The problem of under-evaluated psychological treatments, such as systemic and psychodynamic psychotherapy, which are often in widespread use in Child Mental Health Settings needs to be urgently addressed if we are aiming for fewer gaps in our understanding of what treatments are likely to benefit some children in particular circumstances (Fonagy et al., 2015b).

In addition, initiatives such as the James Lind Alliance (n.d.; www.lindalliance.org/) help in ensuring that those who fund health research are aware of what matters to both patients and clinicians. Patients, carers and clinicians are brought together and invited to prioritise ‘unanswered questions’ about the effects of treatments that they agree are most important. The overall aim is to change the way in which research funding is granted with a view to raising awareness of research questions which are of direct relevance to patients and clinicians.

Second, the way research is itself is conducted has increasingly become the focus of attention. It is now accepted that in fields such as surgery or psychotherapy where the intervention is generally complex and multi-dimensional and influenced by the skills and expertise of the practitioner as well as the setting in which the intervention is delivered, care must be taken to ensure that these factors are accounted for in interpreting the results of any RCT (Kennedy, 2009). This applies to most interventions in Child Mental Health which are generally multi-dimensional, complex and influenced by a myriad of contextual factors. This has led to a greater focus on common factors that may be influencing outcome across a range of treatment modalities and a move a move away from a focus on ‘brand name’ therapies. In August 2012, the American Psychological Association approved the resolution ‘Recognition of Psychotherapy Effectiveness’, which states,

> Comparisons of different forms of psychotherapy most often result in relatively nonsignificant difference, and contextual and relationship factors often mediate or moderate outcomes. These findings suggest that (1) most valid and structured psychotherapies are roughly equivalent in effectiveness and (2) patient and therapist characteristics, which are not usually captured by a patient’s diagnosis or by the therapist’s use of a specific psychotherapy, affect the results. (APA, 2012)

Hence, researchers are increasingly interested in investigating the processes behind treatment effects (Green, 2015). Trials should not just answer the question of whether a treatment worked, but how it worked. National Institute of Mental Health (NIMH) have recently introduced a requirement that all their trials must include a specified mechanism target in their trial design (Green, 2015).

Third, this shift in focus in how research is conducted has led to a developing interest in evaluating ‘modular’ approaches to treatment whereby the emphasis is on treating specific presenting problems rather than a focus on single diagnostic categories (Weisz et al., 2012). This takes into account the clinical heterogeneity found within diagnostic categories and paves the way for a more personalised approach to treatment. Alongside this, initiatives to involve patients more in collaborative decisions regarding treatments has potential to ensure that patient preferences are incorporated into personalised approaches (Edbrooke-Childs et al., 2015).

Fourth, it is important to recognise that psychosocial treatments in general, including those designated as evidence based, are not immune from vested interests more commonly associated
with pharmacological treatments. This can potentially hamper further development in the field. Designating an intervention as ‘Evidenced-Based’ can lead to a commercialisation of training materials and manuals with developers pushing to ‘franchise’ the intervention leading to a restriction in access and importantly ‘the potential to bring about a developmental arrest or a kind of ossification of a therapy’ (Fonagy et al., 2015a, p. 14).

Finally, we may need to accept that even with further developments there will inevitably be limits to what intervention science can tell us. Archie Cochrane (1972), the founding father of evidence-based medicine, recognised this when he wrote, ‘I believe cure is rare while the need for care is widespread, and that the pursuit of cure at all costs may restrict the supply of care’ (p. 7). Or as Wren (2015) advises practitioners working in contemporary Child and Adolescent Mental Health Services,

If we feel cast down by the thought that intervention science has delivered very modest findings, we should remind ourselves that that our immense and extraordinary task is attending to and trying to heal the pain and uncertainties of living – within the limits of our particular, constraining, cultural world – helping people struggle to maintain self-belief, trust in others, interpersonal understanding and communication, tolerance of pain, fear and disappointment (capacities that may have never properly taken shape, or have faltered). (p. 31)

References