Children and Adolescents in the mental health system represent clinically complex cases with high rates of behavior problems, diverse mental health disorders, criminal behavior, and other “at risk” behaviors (e.g., school truancy, family conflict, etc.). Because of the family’s important role in the initiation and escalation of adolescent problem behaviors, family-based interventions have been of great interest to treatment researchers and community practitioners (Rowe & Liddle, 2003; Stanton & Todd, 1982). The results of a decade of systematic studies and a number of qualitative and quantitative research reviews leaves little doubt that family-based treatment approaches can engage adolescents and families in treatment and significantly reduce adolescent problem behaviors (Liddle & Dakof, 1995; Stanton & Shadish, 1997; Sexton, Alexander, & Mease, 2003; Waldron, 1997).

Despite these promising findings, a significant gap exists in translating family evidence-based treatments (EBT) into community settings. The emerging evidence suggests that even though evidence-based family treatments may be effective in research trials they don’t always translate to programs into community settings under less controlled non-clinical trial study conditions (more clinically realistic) with children, adolescents and their families (Hoagwood, et al., 1995; Rowe & Liddle, 2003; Sexton & Alexander, 2002). In a sobering finding, Henggeler (2007) found that effects are consistently lower for EBTs implemented in real life clinical settings compared to laboratory settings and that those reductions were on the order of 50% lower. Similarly, Weisz, Jenson-Doss and Hawley (2006) found that when EBT and usual care (UC) treatments were similar in intensity, therapist training, setting and other characteristics, the superiority of the EBT on client outcomes diminished. The question is why? It may be that because even when evidence-based treatments are specific in regard to the mechanisms of change, the complexities of clients, therapists, and the methods to measure and monitor, adapt and successfully replicate the practice the practice are yet to be understood.

Two issues seem to emerge as most salient explanation for the lack of successful translation of evidence based treatments (EBT) into community settings and as some of the most important challenges in the field of children and adolescent mental health services.

(1) Client/Therapist Diversity.

Client and therapist diversity are important factors that moderate the impact the outcomes of family based EBT. In a clinical setting client diversity is represented by the nature and severity of clinical problems, the family and community relational contexts, as well as culture, race and ethnicity of the clients (among other factors). Work has been
done to understand the range of client problems for which family focused EBT are effective (Sexton et al, 2003). However, little work has been done regarding the effectiveness of evidence-based interventions for culturally and racially diverse youth, families, and communities. Given the well-documented disparity in mental health and juvenile justice, cultural sensitivity and applicability is becoming one of the most important implementation issues in juvenile justice and child and adolescent mental health systems. A recent meta-analysis (Wilson, Lipsey, & Soydan, 2007) found that for the studies included in the analysis, no significant differences across cultural/ethnic groups. They authors concluded that mainstream treatments for youth in juvenile justice were effective and that there was no difference in effectiveness across youth/family cultural group. Unfortunately, it is unclear whether specific evidence-based treatments were represented in the meta-analysis and if so, the magnitude of that effect.

Examination of the role of client diversity will help advance the development of treatment intervention programs, improve their acceptability to diverse community and thus, have a greater chance of successfully serving the diverse client population often found in child and adolescent mental health settings. In addition, systematically studying client diversity will may help add systematic evidence to the personal, political, and scientific issues surrounding the implementation of evidence based interventions and help guide the enhancement and adaptation of EBP to make them more culturally sensitive. Finally, understanding the role of client diversity will help further our understanding of the interaction between diversity and core clinical change mechanisms of therapeutic change.

(2) Successful replication of treatment models in community settings.

A major challenge in the mental health community is the replication of family focused evidence-based treatments in community-based settings (Henggeler, et al., 2002, 1997). Current research supports importance of treatment adherence and therapist competence as key reasons that efficacious treatments may fail in community-based settings (Henggeler, et al. 1997; Hogue, et al., 1996; Sexton, & Alexander, 2002; Waltz, et al. 1993). Studies of adherence in family based intervention programs have demonstrated that for efficacious programs to achieve success in community settings, the programs must be consistently delivered in a manner that adheres to the models’ specifications (Barnoski, 2004; Sexton, Sydnor, & Turner, 2003). Studies suggest that therapist adherence to a clinical intervention model does seem to be related to adolescent re-offense rate and incarceration (Barnoski, 2004; Henggeler, et al., 1997; Schoenwald et al., 2000). Follow-up studies also demonstrated that therapist adherence predicts improvements in family relations and reductions in youth recidivism rates (Henggeler, et al., 1999; Schoenwald, Henggeler, Brondino, & Rowland, 2000).

The issue of model specific adherence is, however, more complex. It seems that adherence to a specified model of treatment maybe necessary for some outcomes but that strictly following an EBT protocol does not ensure improved clinical outcomes. For example, Morgenstern, et al. (2001) found no difference in clinical outcome when comparing clients whose therapists rigidly adhered to the EBT vs. clients whose therapists flexibly implemented the given
program. This suggests that strict fidelity to this particular EBT did not automatically enhance clinical practice outcomes. Henggeler and colleagues found that while various aspects of adherence affect key outcomes, no global relationship between adherence and outcomes could be found (Henggeler et al., 1997; Henggeler, Pickrel, & Brondino, 1999). Finally, both Hogue et al (2008) and Barber et al. (2006) found that a curvilinear relationship may exist between therapist model adherence and clinical outcomes. These studies suggest that while therapist model specific adherence may be important, we are far from understanding its role in the mechanisms of clinical change.

The literature treatment adherence literature also suggests that we have yet to discover the most effective ways to promote, monitor, and improve treatment adherence in clinical settings. If evidence-based treatments are to translate in community settings we also need to better understand the specific methods to monitor treatment adherence and the specific level and type of information necessary for therapists in community based programs replicate models and produce positive outcomes. A number of questions have emerged regard. Is therapist model adherence enough? Are there clinical processes that also should be monitored and understood through therapy? What is the role of symptom change and the intensity of problematic events in the process of therapy?

We also know little about the methods for monitoring and using model specific, clinical process, and client problem information. Particularly promising are the efforts to use computer technology to monitor and feedback back both clinical process outcomes (Bickman and colleagues) and model specific adherence (Sexton & Alexander, 2004). These tools may be useful in monitoring the ongoing relationship between client symptoms, model adherence, and other clinical processes (e. g. therapeutic alliance) increase model adherence and promote clinical adaptations necessary to improve model adherence and improve community-based outcomes. Using computer technology these methods not only monitor but feedback information in a “real time” manner so that it is immediately available to clinicians. Finally, monitoring systems like these have the potential to further our theoretical understanding of the mechanisms of clinical change by modeling “timelines” of therapy (Kazdin, 2008). Despite these efforts, we still don’t know what type of information, in what format, in what frequency, and at what frequency information may best be monitored and provided as feedback.