

EVIDENCE-BASED CHILD AND ADOLESCENT PSYCHOSOCIAL INTERVENTIONS

This report is intended to guide practitioners, educators, youth, and families in developing appropriate plans using psychosocial interventions. It was created for the period May 2013–October 2013 using the PracticeWise Evidence-Based Services (PWEBS) Database, available at www.practicewise.com. If this is not the most current version, please check the American Academy of Pediatrics mental health Web site (www.aap.org/mentalhealth) for updates.

Problem Area	Level 1- BEST SUPPORT	Level 2- GOOD SUPPORT	Level 3- MODERATE SUPPORT	Level 4- MINIMAL SUPPORT	Level 5- NO SUPPORT
Anxious or Avoidant Behaviors	Cognitive Behavior Therapy (CBT), CBT and Medication, CBT with Parents, Education, Exposure, Modeling	Assertiveness Training, Attention, CBT for Child and Parent, Cultural Storytelling, Family Psychoeducation, Hypnosis, Relaxation, Stress Inoculation	Contingency Management, Group Therapy	Biofeedback, CBT with Parents Only, Play Therapy, Psychodynamic Therapy, Rational Emotive Therapy, Social Skills	Assessment/Monitoring, Attachment Therapy, Client Centered Therapy, Eye Movement Desensitization and Reprocessing (EMDR), Peer Pairing, Psychoeducation, Relationship Counseling, Teacher Psychoeducation
Attention and Hyperactivity Behaviors	Behavior Therapy and Medication, Biofeedback, Parent Management Training, Self-Verbalization	Contingency Management, Education, Parent Management Training (with Problem Solving, or with Teacher Psychoeducation), Physical Exercise (with or without Relaxation), Social Skills and Medication, Working Memory Training	Biofeedback and Medication	Parent Management Training and Social Skills, Relaxation, Self-Verbalization and Contingency Management, Social Skills	Attention Training, Client Centered Therapy, CBT, CBT and Anger Control, CBT and Medication, Family Therapy, Parent Coping/Stress Management, Parent Management Training and Self-Verbalization, Parent Psychoeducation, Play Therapy, Problem Solving, Psychoeducation, Self-Control Training, Self-Verbalization and Medication, Skill Development
Autism Spectrum Disorders	Intensive Behavior Therapy, Intensive Communication Training	Imitation, Parent Management Training, Peer Pairing, Physical/Social/Occupational Therapy, Social Skills	None	Cognitive Behavior Therapy, Massage, Theory of Mind Training	Auditory Integration Training, Biofeedback, Communication Skills, Contingent Responding, Eclectic Therapy, Hyperbaric Treatment, Modeling, Structured Listening
Delinquency and Disruptive Behavior	Anger Control, Assertiveness Training, CBT, Multisystemic Therapy, Parent Management Training, Parent Management Training and Problem Solving, Social Skills	Communication Skills, Contingency Management, Functional Family Therapy, Parent Management Training and CBT, Parent Management Training and Classroom Management, Problem Solving, Rational Emotive Therapy, Relaxation, Therapeutic Foster Care, Transactional Analysis	Client Centered Therapy, Family Therapy, Moral Reasoning Training, Outreach Counseling, Peer Pairing, Self-Control Training	CBT and Teacher Training; Parent Management Training, Classroom Management, and CBT; Parent Management Training and Self-Verbalization; Physical Exercise; Stress Inoculation	Behavioral Family Therapy, Catharsis, CBT with Parents, Collaborative Problem Solving, Education, Exposure, Family Empowerment and Support, Family Systems Therapy, Group Therapy (!), Imagery Training, Parent Management Training and Peer Support, Play Therapy, Psychodynamic Therapy, Self-Verbalization, Skill Development, Wraparound
Depressive or Withdrawn Behaviors	CBT, CBT and Medication, CBT with Parents, Family Therapy	Client Centered Therapy, Cognitive Behavioral Psychoeducation, Expressive Writing/Journaling/Diary, Interpersonal Therapy, Relaxation	None	Problem Solving, Self-Control Training, Self-Modeling	Life Skills, Play Therapy, Psychodynamic Therapy, Psychoeducation, Social Skills
Eating Disorders	None	CBT, Family Therapy, Family Systems Therapy	None	None	Client Centered Therapy, Education, Goal Setting
Elimination Disorders	Behavior Alert; Behavior Alert and Behavioral Training; Behavioral Training; Behavioral Training, Dietary Care, and Medical Care (with or without Biofeedback)	Behavioral Training and Dietary Care; Behavioral Training, Hypnosis, and Dietary Care; CBT	Behavior Alert and Medication	None	Assessment/Monitoring, Assessment/Monitoring and Medication, Behavioral Training and Medical Care, Biofeedback, Contingency Management, Dietary Care, Dietary Care and Medical Care, Hypnosis, Medical Care, Psychoeducation
Mania	None	Cognitive Behavioral Psychoeducation	None	None	Family-Focused Therapy, Psychoeducation
Substance Use	CBT, Community Reinforcement, Family Therapy	Assertive Continuing Care, CBT and Medication, CBT with Parents, Contingency Management, Family Systems Therapy, Functional Family Therapy, Goal Setting/Monitoring, Motivational Interviewing/Engagement (with and without CBT), Multidimensional Family Therapy, Problem Solving, Purdue Brief Family Therapy	Drug Court, Drug Court with Multisystemic Therapy and Contingency Management	Goal Setting, Psychoeducation	Assessment/Monitoring, Behavioral Family Therapy, CBT and Functional Family Therapy, Client Centered Therapy, Drug Court and Multisystemic Therapy, Drug Education, Education, Family Court, Group Therapy (!), Motivational Interviewing/Engagement with CBT and Family Therapy, Multisystemic Therapy, Parent Psychoeducation, Problem Solving, Project CARE (!)
Suicidality	None	Attachment Therapy, Counselors Care, Counselors Care and Support Training, Multisystemic Therapy, Social Support Team	None	None	Accelerated Hospitalization, Counselors Care and Anger Management
Traumatic Stress	CBT, CBT with Parents	Exposure, EMDR	None	Play Therapy, Psychodrama	Client Centered Therapy, CBT and Medication, CBT with Parents Only, Interpersonal Therapy, Psychodynamic Therapy, Psychoeducation, Relaxation

Note: Level 5 refers to treatments whose tests were unresponsive or inconclusive. The symbol (!) indicates that at least one study found negative effects on the main outcome measure. The risk of using treatments so designated should be weighed against potential benefits. This report updates and replaces the "Blue Menu" originally distributed by the Hawaii Department of Health, Child and Adolescent Mental Health Division, Evidence-Based Services Committee from 2002–2009.

Background

The American Academy of Pediatrics (AAP) “Evidence-Based Child and Adolescent Psychosocial Interventions” tool is created twice each year and posted on the AAP Web site at www.aap.org/mentalhealth, using data from the PracticeWise Evidence-Based Services Database, available at www.practicewise.com. The table is based on an ongoing review of randomized clinical psychosocial and combined treatment trials for children and adolescents with mental health needs. The contents of the table represent the treatments that best fit a patient’s characteristics, based on the primary problem (rows) and the strength of evidence behind the treatments (columns). Thus, when seeking an intervention with the best empirical support for an adolescent with depression, one might select from among cognitive behavior therapy (CBT) alone, CBT with medication, CBT with parents included, or family therapy. Each clinical trial must have been published in a peer-reviewed scientific journal, and each study is coded by 2 independent raters whose discrepancies are reviewed and resolved by a third expert judge. Prior to report development, data are subject to extensive quality analyses to identify and eliminate remaining errors, inconsistencies, or formatting problems.

Strength of Evidence Definitions

The strength of evidence classification uses a 5-level system that was originally adapted from the American Psychological Association Division 12 Task Force on the Promotion and Dissemination of Psychological Procedures.¹ These definitions can be seen in the Box on page 3. Higher strength of evidence is an indicator

of the reliability of the findings behind the treatment, not an index of the expected size of the effect. In other words, stronger evidence levels in the AAP tool typically reflect that treatment approaches have a larger number of studies behind them than those at a lower level, not that level 1 treatments would necessarily have a larger effect on patients than level 2 treatments.

Treatment Definitions

“Evidence-Based Child and Adolescent Psychosocial Interventions” uses a broad level of analysis for defining treatments, such that interventions sharing a majority of components with similar clinical strategies and theoretical underpinnings are considered to belong to a single treatment approach. For example, rather than list each CBT protocol for depression on its own, the tool handles these as a single group that collectively has achieved a particular level of scientific support. This approach focuses more on “generic” as opposed to “brand name” treatment modalities, and it also is designed to reduce the more than 500 distinct treatments that would otherwise be represented on this tool to a more practical level of analysis.

Problem Definition

The presenting problems represented in the table rows are coded using a checklist of 25 different problem areas (eg, anxious or avoidant behaviors, eating disorders, substance use). The problem area refers to the condition that a treatment explicitly targeted and for which clinical outcomes were measured. These problem areas are inclusive of diagnostic conditions (eg, all randomized trials targeting separation anxiety disorder are considered collectively within the “Anxious or Avoidant

Behaviors” row) but also include the much larger number of research trials that tested treatments but did not use diagnosis as a study entry criterion. For example, many studies use elevated scores on behavior or emotion checklists or problems such as arrests or suicide attempts to define participants. Mental health diagnoses are therefore nested under these broader categories.

History of This Tool

This tool has its origins with the Child and Adolescent Mental Health Division of the Hawaii Department of Health. Under the leadership of then-division chief Christina Donkervoet, work was commissioned starting in 1999 to review child mental health treatment outcome literature and produce reports that could serve the mental health system in selecting appropriate treatments for its youth.² Following an initial review of more than 120 randomized clinical trials,³ the division began to issue the results of these reviews in quarterly matrix reports known as the Blue Menu (named for the blue paper on which it was originally printed and distributed). This document was designed to be user-friendly and transportable, thereby making it amenable to broad and easy dissemination. As of 2010, the AAP supports the posting of the next generation of this tool. “Evidence-Based Child and Adolescent Psychosocial Interventions” now represents 668 randomized trials of psychosocial treatments for youth. PracticeWise continues to identify, review, and code new research trials and plans to continue providing updates to this tool to the AAP for the foreseeable future.

References

1. American Psychological Association Task Force on Promotion and Dissemination of Psychological Procedures, Division of Clinical Psychology. Training in and dissemination of empirically-validated psychological treatments: report and recommendations. *Clin Psychol.* 1995;48:3–23
2. Chorpita BF, Donkervoet CM. Implementation of the Felix Consent Decree in Hawaii: the implementation of the Felix Consent Decree in Hawaii. In: Steele RG, Roberts MC, eds. *Handbook of Mental Health Services for Children, Adolescents, and Families.* New York, NY: Kluwer Academic/Plenum Publishers; 2005:317–332
3. Chorpita BF, Yim LM, Donkervoet JC, et al. Toward large-scale implementation of empirically supported treatments for children: a review and observations by the Hawaii Empirical Basis to Services Task Force. *Clin Psychol Sci Pract.* 2002;9(2):165–190

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Strength of Evidence Definitions

Level 1: Best Support

- I. At least 2 randomized trials demonstrating efficacy in one or more of the following ways:
 - a. Superior to pill placebo, psychological placebo, or another treatment.
 - b. Equivalent to all other groups representing at least one level 1 or level 2 treatment in a study with adequate statistical power (30 participants per group on average) that showed significant pre-study to post-study change in the index group as well as the group(s) being tied. Ties of treatments that have previously qualified only through ties are ineligible.
- II. Experiments must be conducted with treatment manuals.
- III. Effects must have been demonstrated by at least 2 different investigator teams.

Level 2: Good Support

- I. Two experiments showing the treatment is (statistically significantly) superior to a waiting list or no-treatment control group. *Manuals, specification of sample, and independent investigators are not required.*
- OR
- II. One between-group design experiment with clear specification of group, use of manuals, and demonstrating efficacy by either
 - a. Superior to pill placebo, psychological placebo, or another treatment
 - b. Equivalent to an established treatment (See qualifying tie definition above.)

Level 3: Moderate Support

One between-group design experiment with clear specification of group and treatment approach and demonstrating efficacy by either

- a. Superior to pill placebo, psychological placebo, or another treatment
- b. Equivalent to an already established treatment in experiments with adequate statistical power (30 participants per group on average)

Level 4: Minimal Support

One experiment showing the treatment is (statistically significantly) superior to a waiting list or no-treatment control group. *Manuals, specification of sample, and independent investigators are not required.*

Level 5: No Support

The treatment has been tested in at least one study but has failed to meet criteria for levels 1 through 4.