VOICES FROM THE FIELD -
A View from One Applied Clinical Setting

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Service perspective

The dissemination and relevance of childhood aggression developmental research to service providers is a complex issue. We will limit our remarks to a few salient areas: "empirically supported" interventions, dissemination, risk factors, gender, the dearth of interventions and a call to address economic and social policies that exacerbate factors associated with childhood aggression.

While Earlscourt Child and Family Centre has endorsed empirically supported interventions for over two decades, we have not attempted to rigorously define "empirically supported." It is interesting to note that words like "empirically supported," "empirically validated," "proven," "evidence-based" and "promising" appear in several articles, e.g. Webster-Stratton; Domitrovich & Greenberg; and Bierman.[6,8,10] A consensus on criteria for describing interventions in this way is not self-evident. Service-providers might be understandably confused despite being prepared to embrace the merits of these kinds of interventions. By explaining their terms, researchers would provide a useful service to those in the field. We note, however, that only Domitrovich & Greenberg and Bierman raise the issue of replication and implementation.[8,10]

Should service-providers simply purchase treatment packages from a dissemination centre? Are materials sufficient without training? Earlscourt Child and Family Centre has taken the position that we will not proactively market our intervention materials (videos, manuals, parenting booklets) until our interventions meet APA criteria for well established interventions. While hundreds of our manuals were previously distributed without restrictions, we have recently limited their distribution to holders of an Earlscourt SNAP™ (Stop Now and Plan) license, and licensing is only available if a site agrees to receive training and ongoing consultation. Based on observations in replication sites we have supervised, the gap between reading a manual and program implementation can be great without sufficient training and ongoing consultation. Issues related to replication are complex; the field would benefit from researchers giving them more attention.

Several authors note various risk factors in the development of childhood aggression.[1,3,6,7,8,10] In the early 1980s, we at Earlscourt began to scrutinize our interest in

risk and protective factors for our clinical population of children with conduct disorder and ultimately came to shape our multifaceted interventions for each child and family in part based on our understanding of these factors. As a treatment aid and possible outcome measure, we developed two gender-specific risk assessment devices that bring together the developmental literature under 20 risk factors for boys (EARL-20B) and 21 risk factors for girls.[12] These devices are excellent treatment planning tools and the EARL-20B is showing some predictive validity in independent studies.[13,14]

Gender issues in early childhood development are important to address and represent a large knowledge gap. Only Keenan and Pepler mention these.[2,11] Earlscourt recently launched a gender-specific intervention for girls with severe externalizing problems given their risk of poor outcomes, such as early pregnancy and unemployment, and the lack of established interventions that address their gender-specific issues, such as body image, relational aggression and sexual development.[15] This program, known as the Earlscourt Girls Connection, is currently being stringently evaluated.

In Canada, provincial/territorial governments are responsible for providing children's mental health services. Ontario is one of the few provinces with a distinct children's mental-health sector dating back to the early 1970s. It now represents a $315-million annual expenditure typically allocated to stand-alone, community-based children's mental-health centres. Nothing of note, however, is allocated for research and none are required to deliver empirically supported interventions. Furthermore, at this level of funding, services are available to only a small fraction of those in need. While governments in Canada have endorsed certain prevention programs, they have not endorsed interventions for aggressive, school-aged children at anywhere near comparable levels.

In fact, given flat base funding for children's mental health in Ontario over the last decade, numerous government-funded programs have closed. Responding to audit recommendations for improved quality control over these expenditures, the Ontario government now requires its transfer-payment children's mental-health centres to use the Brief Child and Family Phone Interview and the Child and Adolescent Functional Assessment Scale pre- and post-treatment. This is a small quality-assurance effort with potential, but governments continue to fund theoretically diverse and unsubstantiated interventions. On the other hand, there are risks of governments funding only one or another type of intervention, severely restricting new developments in the field. Applied settings would benefit from something like a consumer's guide to recommended interventions that compared them based on similar dimensions, such as the rigour of the experimental design, effect size, treatment gains post-treatment and over time, transferability and implementation costs and requirements, such as training, certification or licensing.

Where to go from here? We suggest that researchers promote the advancement in community settings of a scientist-practitioner model of professional practice in several ways. We know from first-hand experience that stringent research designs stretch the limits of community settings and that group design studies have limited applied usefulness. Even with these and other limitations found in community settings,

researchers might provide leadership in promoting descriptions of client populations, outputs, indicators of success, single-subject designs, descriptions of moderators of outcome and follow-up. These are likely to be within the reach of community settings and have the best potential to influence the refinement of effective and efficient interventions.

Finally, we note the gap between what researchers know about factors that are associated with the development of childhood aggression, such as poverty, social housing and lack of recreational and educational opportunities, and their silence regarding Canada's economic and social policies that contribute to these factors. Children who present for treatment hungry, afraid to return to their neighbourhood and alienated from community resources will have guarded outcomes regardless of the empirical support for their treatment.

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