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EDITORIAL

The Ethically Questionable Lack of Research Evaluation of What We Deliver in the Child and Youth Mental Health Service System

"We will try and fit in some research evaluation of what we are providing if and when there is breathing space from the more pressing delivery of clinical services", in effect, research evaluation is nice but optional. This, I would argue, is the too often encountered stance of child mental health policy makers, administrators and clinicians. Underlying this stance is presumably a belief that a substantial proportion of our clinical interventions and services result in more benefit than harm, an assumption that is thin on evidence. Rather, most of what is delivered is likely a mixture of some positive effects, some nil effects and some negative effects. What proportion falls into each of these categories is unknown.

Depending on their belief state, some may argue it is unethical to proceed with the delivery of a given intervention or service that has yet to be rigorously evaluated, while others convinced of its effectiveness find it unethical not to proceed. One of the challenges in our field, however, is that it is not always obvious whether a service is helpful, harmful or ineffective. As Leonard Bickman reflects, "…one of the paradoxical problems with our mental health services is that they are not visibly harmful … Ineffective mental health services do not usually produce dramatic negative outcomes" (p. 437, Bickman, 2008). This contrasts with other fields of medicine where identifiable patterns of benefit and harm may be more clearly discernable from examination, sometimes, of even naturalistic data without statistical analysis. An historical and dramatic example is Ignaz Semmelweis' identification of physician behaviour contributing to "childbed fever" (puerperal infections) through physicians and trainees going directly from autopsy work to attend deliveries without intervening handwashing (Noakes, Borresen, Hew-Butler et al., 2008).

It has been proposed that a clinical decision to withhold access to a given intervention for the purposes of research, in particular through the use of a randomized controlled trial (RCT), should be guided by the ethical principal of clinical equipoise, i.e., a situation in which consensus, among the community of experts, has not been reached as to the superiority of one proposed arm of a clinical trial over the other (Freedman, 1987). One wonders about "consensus" in the "community of experts" in the diverse field of child mental health. However, this conundrum may be moot, as others have proposed that the notion of clinical equipoise is flawed, unhelpfully blurring ethical principles for duty of care in health services with that of health research (Miller & Brody, 2003)[1]. This does not dismiss the need to grapple with ethical principles, however, it may, rather, call into greater question the lack of scrutiny of health service provision outside of research trials. Miller & Brody (2003) flag that health services are generally much less regulated than research trials, despite potential risks from novel and variable treatment delivered as part of routine clinical services. What balance should then be sought between health service delivery and research evaluation in the child and youth mental intervention field?

This challenge can in part be addressed by increasingly building in thoughtful and rigorous research designs into existing real-world service delivery or in formats that inform such delivery. In this pursuit, hats off to Tobon, Zipursky, Streiner et al. whose article in this issue describes their implementation of a rigorous research evaluation design (i.e., an RCT) to examine the impact of adding in a supplemental pre-treatment motivational enhancement to an emotional regulation intervention within community settings. Despite acknowledged limitations, this contribution provides meaningful ideas on methodological approaches and clinical content that researchers and clinicians should consider. Imagine if such an approach was routinely built into our service efforts rather than representing a rare exception.

We also recognize the importance of using different methodological designs to better understand existing clinical and service phenomena. This includes qualitative methodological designs such as the approach taken in the study by Speranzini, Goodarzi, Casselman, & Pringsheim also in this issue, in which they examined pediatricians' perspectives on managing child disruptive and aggressive behaviours in clinical practice. We look forward to receiving more qualitative and quantitative submissions examining child mental health service issues with the use of increasingly rigorous

methods. The prospective contributor is reminded to review published criteria to guide assessment of the rigour of their study through use of the EQUATOR checklists (http://www.equator-network.org/) for various methodological designs as noted in the author instructions for the Journal.

I would also like to flag a couple of new endeavours in this issue. First, we are excited to bring you a new column highlighting a challenging clinical scenario. One of our Associate Editors, Dr. Dean Elbe, pitched a not uncommon clinical challenge to three Canadian experts to elicit how they might approach the psychopharmacological management of AJ's clinical presentation. We welcome your feedback on this format as we plan to periodically include other clinical scenarios with invited responses in future issues.

Second, another one of our Associate Editors, Dr. Peter Braunberger, is helping to guide the Journal in taking tentative steps to develop a new section we are calling Arts & Literature and Nature (ALAN). Please see a call to readers for contributions under that section in this issue. To whet your appetite, we solicited internal contributions from our editorial team as to a few recommended movies with child and youth mental health themes. We look forward to your contributions!

Finally, we bring you the second installment of Recommended Academic Reading. This time we tapped our Editorial Board for recommendations which resulted in an interesting mix of important recent papers in our field that we hope you will consider reading. Thanks to Drs. Kathy Bennett, Jennifer Crosbie, and Amanda Newton.

John D. McLennan
Editor

Footnote

1. The reader is cautioned as to this editor's limited comprehension of the nuances of the philosophical arguments for and against clinical equipoise.

References

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