



This report is intended to guide practitioners, educators, youth, and families in developing appropriate plans using psychosocial interventions. It was created for the period October 2020 – March 2021 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 (AAP) mental health Web site (www.aap.org/mentalhealth) for updates.

Please note that this chart represents an independent analysis by PracticeWise and should not be construed as endorsement by the AAP. For an explanation of PracticeWise determination of evidence/level, please see below or visit www.practicewise.com/aap.

Evidence-Based Child and Adolescent Psychosocial Interventions

| 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 | Attention Training, Cognitive Behavior Therapy (CBT), CBT and Medication, CBT for Child and for Parent, CBT with Parents, Education, Exposure, Modeling | Assertiveness Training, Attention, Biofeedback, CBT and Expression, CBT and Parent Management Training (PMT), CBT with Parents Only, Cultural Storytelling, Family Psychoeducation, Hypnosis, Mindfulness, Relaxation, Stress Inoculation | Contingency Management (CM), Group Therapy | Behavioral Activation and Exposure, Play Therapy, PMT, Psychodynamic Therapy, Rational Emotive Therapy, Social Skills | Assessment/Monitoring, Attachment Therapy, Attention Training and Exposure, Client Centered Therapy, Eye Movement Desensitization and Reprocessing (EMDR), Peer Pairing, Problem Solving, Psychoeducation, Relationship Counseling, Teacher Psychoeducation |
| Autism Spectrum Disorders | CBT, Intensive Behavioral Treatment, Intensive Communication Training, Joint Attention/Empathetic & Emotional Engagement, PMT, Social Skills | Family Psychoeducation, Imitation, Peer Pairing, PMT and Medication, Theory of Mind Training | None | Massage, Peer Pairing and Modeling, Play Therapy | Attention Training, Biofeedback, Client Centered Therapy, Cognitive Flexibility Training, Communication Skills, Contingent Responding, Eclectic Therapy, Executive Functioning Training, Fine Motor Training, Modeling, Parent Psychoeducation, Physical/Social/Occupational Therapy, Sensory Integration Training, Social Skills and Peer Pairing, Structured Listening, Working Memory Training |
| Delinquency and Disruptive Behavior | Anger Control, Assertiveness Training, CBT, CM, Motivational Interviewing (MI)/Engagement, Multisystemic Therapy, PMT, PMT and Problem Solving, Problem Solving, Social Skills, Therapeutic Foster Care | CBT and PMT, CBT and Teacher Training, Communication Skills, Cooperative Problem Solving, Family Therapy, Functional Family Therapy, Mindfulness, PMT and Classroom Management, PMT and Medication, PMT and Social Skills, Rational Emotive Therapy, Relaxation, Self Control Training, Transactional Analysis | Client Centered Therapy, Moral Reasoning Training, Outreach Counseling, Peer Pairing | CBT and Teacher Psychoeducation, Exposure, Parent Psychoeducation, Physical Exercise, PMT and Classroom Management and CBT, PMT and Self-Verbalization, Stress Inoculation | Behavioral Family Therapy, Catharsis, CBT with Parents, Education, Family Empowerment and Support, Family Systems Therapy, Group Therapy, Imagery Training, MI/Engagement and CBT, Play Therapy, PMT and Peer Support, Psychodynamic Therapy, Psychoeducation, Self Verbalization, Skill Development, Wraparound |
| Depressive or Withdrawn Behaviors | CBT, CBT and Medication, CBT with Parents, Client Centered Therapy, Family Therapy | Attention Training, Cognitive Behavioral Psychoeducation, Expression, Interpersonal Therapy, MI/Engagement, MI/Engagement and CBT, Physical Exercise, Problem Solving, Relaxation | None | Behavioral Activation, Mindfulness, Self Control Training, Self Modeling, Social Skills | Attention, CBT and Anger Control, CBT and Behavioral Sleep Intervention, CBT and PMT, Goal Setting, Life Skills, Play Therapy, PMT, PMT and Emotion Regulation, Psychodynamic Therapy, Psychoeducation |
| Eating Disorders | CBT, Family-Focused Therapy, Physical Exercise and Dietary Care and Behavioral Feedback | CBT for Child and for Parent, Family Systems Therapy, Family Therapy with Parents Only | Family Therapy and Usual Care | Physical Exercise and Dietary Care | Behavioral Training and Dietary Care, CBT with Parents, Client Centered Therapy, Dietary Care, Education, Family Therapy, Family Therapy with Parent Consultant, Goal Setting, Psychoeducation, Yoga |

| Problem Area | Level 1- BEST SUPPORT | Level 2- GOOD SUPPORT | Level 3- MODERATE SUPPORT | Level 4- MINIMAL SUPPORT | Level 5- NO SUPPORT |
|------------------------------|---|--|---|---|---|
| Elimination Disorders | Behavior Alert, Behavior Alert and Behavioral Training, Behavioral Training, Behavioral Training and Biofeedback and Dietary Care and Medical Care, Behavioral Training and Dietary Care and Medical Care | Behavioral Training and Dietary Care, Behavioral Training and Hypnosis and Dietary Care, CBT | Behavior Alert and Medication, Behavioral Training and Medical Care | None | Assessment/Monitoring, Assessment/Monitoring and Medication, Behavioral Training and Medical Care and Play Therapy, Biofeedback, CM, Dietary Care, Dietary Care and Medical Care, Hypnosis, Medical Care, Psychoeducation |
| Mania | None | CBT for Child and for Parent, Cognitive Behavioral Psychoeducation | None | None | Cognitive Behavioral Psychoeducation and Dietary Care, Dialectical Behavior Therapy and Medication, Family-Focused Therapy, Psychoeducation |
| Substance Use | CBT, Community Reinforcement, CM, Family Therapy, MI/Engagement | Assertive Continuing Care, CBT and CM, Case Management, CBT and Medication, CBT with Parents, Family Systems Therapy, Functional Family Therapy, Goal Setting, Goal Setting/Monitoring, MI/Engagement and CBT, MI/Engagement and CBT and CM, MI/Engagement and Expression, Multidimensional Family Therapy, Problem Solving, Purdue Brief Family Therapy | CBT and Family Therapy, Drug Court, Drug Court and Multisystemic Therapy and CM, Eclectic Therapy | PMT, Psychoeducation | Advice/Encouragement, Assessment/Monitoring, Behavioral Family Therapy, CBT and Community Information Campaign, Client Centered Therapy, CM and Behavioral Family Therapy, CM and Parent Psychoeducation, Drug Court and Multisystemic Therapy, Drug Education, Education, Family Court, Feedback, Group Therapy, Mindfulness, MI/Engagement and CBT and CM and PMT, MI/Engagement and CBT and Family Therapy, Multisystemic Therapy, Parent Psychoeducation, Therapeutic Vocational Training |
| Suicidality | None | Attachment Therapy, CBT with Parents, Counselors Care, Counselors Care and Support Training, Interpersonal Therapy, Multisystemic Therapy, Parent Coping/Stress Management, Psychodynamic Therapy, Social Support | None | CBT | Accelerated Hospitalization, Case Management, Client Centered Therapy, Communication Skills, Counselors Care and Anger Management, Family Therapy, Psychoeducation |
| Traumatic Stress | CBT, CBT with Parents, EMDR, Exposure | Therapeutic Foster Care | None | CBT and Expression, Play Therapy, Relaxation and Expression | Advice/Encouragement, Client Centered Therapy, CBT and Medication, CBT with Parents Only, Education, Expressive Play, Interpersonal Therapy, Problem Solving, Psychodynamic Therapy, Psychoeducation, Relaxation, Structured Listening |

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Note: CBT = Cognitive Behavior Therapy; Contingency Management = CM; EMDR = Eye Movement Desensitization and Reprocessing; MI = Motivational Interviewing; PMT = Parent Management Training; Level 5 refers to treatments whose tests were unresponsive or inconclusive. 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.

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate. Original document included as part of Addressing Mental Health Concerns in Primary Care: A Clinician’s Toolkit. Copyright © 2010 American Academy of Pediatrics. All Rights Reserved. The American Academy of Pediatrics does not review or endorse any modifications made to this document and in no event shall the AAP be liable for any such changes

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, client centered therapy, 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 below. 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.

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 (e.g., 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 (e.g., 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 over 1,100 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

See more on the PracticeWise [publications page](#).

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.