Expanding the Toolkit or Changing the Paradigm: Are We Ready for a Public Health Approach to Mental Health?

Marc S. Atkins[1] and Stacy L. Frazier[1]
[1]University of Illinois at Chicago

Abstract

Kazdin and Blase aptly describe the enormous mental health burden facing our nation and suggest several ways to reform the workforce, setting, and content of services to address this long-standing unmet need. We propose that current health care reform legislation and associated advances in service delivery provide a unique and timely opportunity for a paradigm shift in mental health research, practice, and training to support services that are comprehensive, readily accessible, and relevant to a broad range of mental health needs and capacities. Using the recent public health initiative to contain the H1N1 virus for comparison, and informed by a long-standing and extensive literature documenting the need for a public health model for mental health, we describe the rationale for a three-tiered public mental health model, illustrated with examples from ongoing research, to minimize universal risk for mental health difficulties via capacity building in natural settings; reduce onset and severity of symptoms by prioritizing high-risk groups via screening and services for targeted populations; and reduce psychiatric impairment among individuals with more intensive needs via individual, family, and group interventions. New priorities for clinical science to support a public health approach are proposed.

Keywords

public health, policy, treatment

In March 2009, the World Health Organization (WHO) received reports of deaths in Mexico from a new strain of influenza virus, labeled H1N1 but known generically as Swine Flu. By June, the virus had spread to several countries, including the U.S., which reported incidences in all states and territories. Public health officials braced for the worst. Facing the possibility of a worldwide epidemic, the WHO declared a pandemic alert and initiated a public health response with three interrelated goals: an intensive intervention to isolate and treat infected patients with antiviral drug therapy, a targeted intervention for at-risk populations (e.g., elderly, pregnant woman, young children) for immediate distribution of the newly developed vaccine, and a universal public health campaign to limit the spread of infection through proper hygiene (e.g., hand-washing, coughing into elbow). With these efforts, nearly 80 million people in 77 countries received the vaccine and a worldwide epidemic was averted. Although not without problems (World Health Organization, 2011), this was the largest and most successful public health response to an emerging crisis in over 40 years.

As we reviewed the Kazdin and Blase article, we reflected on lessons learned from the international public health community's coordination of a multilevel intervention to avert a worldwide epidemic. Notably, necessary reactive measures

(e.g., isolate those already infected) were combined with voluntary proactive measures (e.g., promote proper hygiene) to limit the spread of infection. In contrast, consider the response (or lack thereof) of the mental health community to the enormous mental health burden facing our nation, aptly described by Kazdin and Blase and widely acknowledged for decades as highlighted in the historic Surgeon General's report of mental health published at the turn of the millennium. As Dr. Satcher notes in his preface, "Even more than other areas of health and medicine, the mental health field is plagued by disparities in the availability of and access to its services . . . viewed readily through the lenses of racial and cultural diversity, age, . . . gender . . . (and) a person's financial status" (U.S. Public Health Service, 2000).

We commend Kazdin and Blase for raising the urgency of these issues among the clinical science community, but we are concerned that their recommendations, though often innovative, may serve to increase the toolkit rather than transform the paradigm. Similarly, although we greatly appreciate their call

Corresponding Author:
Marc S. Atkins, University of Illinois at Chicago, Institute for Juvenile Research (MC 747), 1747 W. Roosevelt Rd., Chicago, IL 60608
E-mail: atkins@uic.edu

for the integration of prevention and intervention, we suggest, as others have before, that the problems are so long standing, so vast, and so unresponsive to current methods and models that a new comprehensive approach that utilizes levers of change at multiple levels is required. In particular, there will be no resolution of the nation's unmet mental health needs without recognition of the social determinants of health (Wilkinson & Marmot, 2003) and the synergy that is created by distinct but complementary efforts along the continuum from prevention to intervention.

We also note that, in another way, the timing of the Kazdin and Blase article could not be more propitious given current innovations in health care and recently enacted health care reform legislation. As reviewed by Frank (2011), the *Patient Protection and Affordable Care Act* includes three primary levers of change: parity for mental health services as fully integrated with other health services, specific provisions for funding mental health promotion and prevention services, and the inclusion of community mental health centers in the definition of a "health home" (cf., Alakeson, Frank, & Katz, 2010). In addition, the WHO recently issued a fact sheet on mental health that could become a driver of mental health policy, research, and practice and, we suggest, promote a reordering of priorities for clinical science (World Health Organization, 2010). Most notably, WHO emphasizes "intersectoral strategies" that deemphasize mental disorders to focus on "mainstreaming mental health promotion into policies and programmes in government and business sectors." Nationally and internationally, the balance is tipping in favor of a paradigm shift towards comprehensive models to alleviate mental health suffering,

The compelling case for a public health framework—and a three-tiered approach in particular—to address the persistent barriers to accessible and effective mental health services has been made before: in the Surgeon General's (2000) report, with further detail and emphasis in the recent Institute of Medicine's report on prevention of youth mental health disorders (Institute of Medicine, 2009), and most recently and succinctly by Stiffman, Stelk, Evans, and Atkins (2010). All of these reports recognize that a shift towards the efficient and effective implementation of a coordinated and comprehensive three-tiered approach to mental health will involve many challenges, including a reallocation of resources (e.g., Kelleher, 2010), a retooling of the workforce (Schoenwald, Ringeisen, Hoagwood, Evans, & Atkins, 2010), and a broader reconceptualization of mental health promotion that includes healthy functioning across domains (e.g., cognitive, social, physical) and settings (e.g., home, school, work; M. Atkins, Hoagwood, Kutash, & Seidman, 2010). Our goal in this commentary is not to reiterate these already well-articulated justifications for a public health approach to mental health. Instead, we hope to extend this vision by describing components of a three-tiered approach to mental health, including specific examples from our own work, as much to show the urgent need for additional research as to illustrate opportunities for change.

Universal

We have elsewhere proposed a model for mental health promotion at the universal level that enhances the natural synergy between community settings and mental health (Cappella, Frazier, Atkins, Schoenwald, & Glisson, 2008; Frazier, Cappella, & Atkins, 2007). Shifting prevention to natural settings (e.g., schools, park districts, community centers) makes sense for two primary reasons. First, mental health promotion already lies at the heart of most natural settings, whose goals, routines, and activities are inherently designed to foster skills building, positive relationships, and healthy functioning. Second, there is an extensive empirical literature to suggest that front-line staff often struggle to provide high-quality services or meet the extensive needs of youth or families in their care (e.g., Larson & Walker, 2010; Pianta, Belsky, Houts, & Morrison, 2007). Borrowing from an organizational perspective, we propose that supporting a natural setting means strengthening organizational capacity to achieve its mission and goals by supporting staff to effectively implement its core technology (i.e., deliver high quality service) so that consumers of that service derive the most benefit out of their participation in that setting. By example, we have been pursuing a program of research in collaboration with the Chicago Park District that examines the capacity of recreational afterschool and summer programs to promote children's mental health in urban, poor communities (Frazier et al., 2007).

To illustrate, extensive empirical data suggest that afterschool programs can play a critical role in children's psychosocial development, especially for children living in communities of concentrated urban poverty (Durlak, Mahoney, Bohnert, & Parente, 2010). Despite their potential, however, program impact is often compromised by the extensive mental health needs of children and the pervasive poverty in which they live. Hence, we are pursuing two concurrent pathways. First, we are examining the feasibility and impact of community mental health agency consultation to recreation staff around academic enrichment, coaching behaviors, activity engagement, and behavior management (Frazier, Chacko, Van Gessel, Boyle, & Pelham, in press). Second, we are working with lead administrators to examine and expand their organizational capacity to offer systematic training, professional development, and comprehensive support to their recreation leaders and physical instructors. Both efforts converge around the goal of improving service delivery and outcomes for youth participating in out-of-school time programs.

Targeted

As is true for any public health problem, universal interventions are necessary but not sufficient to address the enormous mental health burden facing our nation. They will produce far less impact by themselves than if they are implemented as part of a comprehensive model, with unique but synergistic efforts at each level of intervention. When implemented successfully,

universal interventions would reduce the risk for mental health problems and limit the numbers of individuals who enter this level of need. It follows, then, that targeted interventions would prioritize care for high-risk groups via indicated outreach, screenings, and services. Examples of high-risk groups might include children of parents with mental illness, families living in poverty, or individuals exhibiting subclinical symptoms or early evidence of impaired functioning. Targeted interventions can be integrated into both community and clinical settings, as illustrated in our earlier example. However, perhaps unlike natural settings that are designed for entire communities, targeted interventions may be more readily incorporated into settings such as primary care offices, emergency rooms, and social service agencies inherently committed to identifying and reducing risky behaviors via health screenings, community outreach, psycho-education activities, and early intervention.

The consultation of mental health providers to afterschool staff noted above is one example of integrating universal and targeted interventions. As another example of a targeted intervention with universal components, we are studying a Medicaid fee-for-service, school-based mental health model for urban, low-income children and families that is guided by empirical evidence for schooling as critical for children's social and emotional adjustment and by evidence for the direct and indirect benefits of academic achievement for children's mental health (Cappella et al., 2008). In a series of iterative studies, we have identified teacher-referred children in early elementary grades exhibiting disruptive behaviors that impair classroom functioning and interfere with academic progress. Community mental health providers, parent advocates, and peer-identified teacher key opinion leaders (M.S. Atkins et al., 2008) together receive training and supervision in the implementation of evidence-based tools for the key empirical classroom and home predictors of children's learning. This ongoing work links universal (classroom-wide) and targeted (services for high need youth) levels to redefine mental health goals, mobilize natural and indigenous resources, and capitalize on the inherent capacity of natural settings to promote children's healthy development (M. Atkins et al., 2006; M. Atkins et al., 2011).

Intensive

As noted by Kazdin and Blase, current rates of mental illness diagnoses in our country exceed the availability of mental health providers, resulting in an enormous mental health burden. The infusion of resources at universal and targeted levels of intervention is designed to reduce the prevalence of mental health disorders, thus reducing the number of individuals exhibiting clinical symptoms or more severe functional impairment. In turn, our nation's limited pool of mental health providers would be at liberty to serve the smaller subset of individuals whose intensive mental health needs warrant more extensive treatment. For example, returning to the afterschool and school-based work noted earlier, we anticipate the need for more intensive services in classrooms and homes, as new findings indicate personal characteristics and settings that are unresponsive to the service model. Indeed, it is at this level of the pyramid—this end of the continuum from prevention to intervention—that Kazdin and Blase's innovative recommendations for new psychotherapy tools are most relevant and most ripe for close empirical examination.

It is also worth noting that trends would predict that the highest rates of unmet mental health need at this tier still would emerge from targeted groups at highest risk, thereby justifying the need to allocate resources for early intervention. Hence, to meet the needs at this most intensive level, we need to follow a variety of paths that extend beyond the most traditional clinical research and practice models, as Kazdin and Blase note quite clearly.

However, early efforts to move efficacious treatments from university-based clinical trials into community care settings revealed the extensive challenges associated with implementation. As highlighted with some frequency in the literature (e.g., Weiss, Doss, & Hawley, 2005), the longstanding science-to-service gap in large part emanates from the fact that most evidence-based treatments have been developed with samples of patients and providers whose characteristics fail to represent those in routine care settings.

Fortunately, the last decade has given rise to several new areas of research, each helping to close the research to practice gap. For example, transportability studies emphasize training, supervision, fidelity, and feedback mechanisms to examine what it will take to achieve outcomes that approach those reported in efficacy studies (Schoenwald & Hoagwood, 2001). Alternatively, Hoagwood and colleagues proposed the clinic–community intervention development model, which includes eight steps that begin with intervention development and end with dissemination and sustainability. Unique to this model is its emphasis on starting and ending in community settings with the providers and consumers for whom the interventions are intended (Hoagwood, Burns, & Weisz, 2002). Most recently, Chorpita and colleagues introduced a "common elements" approach to service delivery, responding to the limited time and opportunity in community settings for clinician training and supervision in evidence-based interventions (Chorpita, Deleiden, & Weisz, 2005). They identified 30 core intervention components that have high impact and broad relevance (e.g., differential attention, relaxation training social problem-solving), and packaged them in a website designed specifically for community-based service providers (Chorpita, Becker, & Deleiden, 2007). This approach is currently being implemented nationally with ongoing evaluation and appears to have great promise to bring evidenced-based practice to scale.

Final Thoughts

The long-standing mental health burden facing our nation is too vast and too impervious to change to be resolved by the

fragmented approach that exists today. We thank Kazdin and Blase for highlighting the enormity and urgency of the problem for the clinical science community, though we suggest that a primary focus on revising psychotherapy, however innovative, addresses a relatively small proportion of the problem. As we have described, there is strong consensus that only a comprehensive and integrated public health model can adequately address the pervasive societal problems that underlie our country's mental health needs. Recent innovations in health care reform and newly enacted legislation provide a unique and timely opportunity to advance comprehensive models of mental health practice.

The ongoing programs of research we have presented are attempting to meet the need for new models of mental health service delivery. We offer them to augment the recommendations by Kazdin and Blase, to address the limitations of traditional psychotherapy, and to counter the tendency of our field to Balkanize prevention and intervention. Our field continues to allocate the most time and resources to the intensive tier of intervention (i.e., evidence-based treatments), whereas a public health approach suggests that we would have more success if comparable effort were allocated to coordinated care. We acknowledge that none of the models or examples is without limitation or immune from criticism and all are in need of further research and development. In fact, that is our very point in highlighting them for this commentary. The clinical science community has much to offer in clinical acumen and research expertise. In addition, interdisciplinary research with basic science, social science, and clinical allies will strengthen and speed the development of effective strategies to alleviate our nation's mental health burden. To that end, we urge the clinical science community to heed the long-standing call for a public health approach to mental health service delivery and, in particular, to prioritize a more equitable distribution of resources across the continuum from prevention to intervention.

Declaration of Conflicting Interests

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