AMERICAN PSYCHOLOGICAL ASSOCIATION

MOVING PSYCHOLOGICAL SCIENCE TOWARD A POPULATION HEALTH APPROACH:

IMPROVING THE POPULATION MENTAL HEALTH AND WELL BEING OF OUR CHILDREN

TRANSCRIPT

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Ken Dodge, PhD: Psychological scientists and mental health professionals can be proud of the many evidence-based therapies they have developed to address children's mental health disorders, cognitive therapy for depression, parent management training or conduct disorder, social cognitive skills training for peer relations problems, and the list goes on. Unfortunately, these efforts have not yet led to improvements in the overall level of mental health and well-being in our population. We have not yet moved the needle on children's mental health in our nation.

Meanwhile, a child's mental health crisis is growing. The likelihood a child will experience a diagnosable psychiatric disorder by age 19 has grown to 49.5%. Firearms mortality, mostly from suicide and homicide, has become the leading cause of death in our young people. Drug overdose has become the third leading cause of death. This crisis has been accelerated during the COVID years, but it started a decade ago.

In spite of our nation's wealth, compared with other developed nations, our families and children are not bearing well. The United States ranks 35th out of the 38 nations in the OECD in maternal mortality rates. Child mortality rates are just as appalling. It always has not been this way. Over the last 30 years, the United States has fallen behind the rest of the developed world in child mortality, most of which is caused by behaviors that are preventable. Even more egregious are the disparities in children's well-being across race, ethnic, and income groups.

The left side of this graph shows that mortality for Black children is over twice as high as for non-Hispanic white children, and the right-side graph shows that low-income children come to kindergarten less well prepared than do non-low-income children, and Black children are more than three times as likely as white children to be reported to Child Protective Services for child abuse. The status quo of mental health and well-being treatment is not succeeding.

A decade ago, the prescient Alan Kazdin declared, and I quote, "Despite advances, mental health professionals are not likely to reduce the prevalence incidence and burden of mental illness without a major shift in intervention research and clinical practice." That call for a revolutionary transformation inspired the American Psychological Association to host the summit of population health science attended by several hundred persons on September 12, 2023.

I'm Ken Dodge, a psychologist at Duke University, and one of the attendees at that summit. I'm wearing my festive shirt today because I am downright giddy about what transpired at the summit and the transformation that is occurring. Our challenge is to move beyond the delivery of science psychotherapies to a small number of self-selected families and toward a universal mandate to address a population crisis.

Although daunting, this reframing affords us opportunities for new conceptual models, innovative interventions, a renewed focus on prevention, and additional resources to solve a system's problem. We start with reformulating the goals and metrics we would use to evaluate impact. Rather than settling for a good outcome for a small number of families who seek out therapies, we must measure the mental health of the entire population at regular intervals, just like we measure the economy, and we must apply two sets of metrics, one for the population as a whole and one to assess disparities in mental health across race, ethnic, income, geographic and cultural groups.

Our two goals become the improvement of quantified population mental health and well-being and the elimination of group disparities in these figures. As we develop ways to measure the mental health of our population, we will develop a more comprehensive strategy to reach our goals. At the summit, we identified three components of a comprehensive plan to achieve population mental health, and we began to craft the scientific and policy agenda for next steps.

The first component is a bottom-up approach. We must scale up our available evidence-based interventions to reach all persons in need. Unfortunately, mixed success has been reported in the literature. When evidence-based interventions are scaled-up in community settings, typically, the implementation is incomplete.

There's a scale-up penalty and impact that occurs when an intervention is disseminated to whole community. We must bring our implementation science to bear as we collaborate with community leaders to identify scale-up strategies. One challenge in scaling is how to reach the full population in need, fewer than 5% of children could benefit from services actually receive them.

We need to develop better marketing tools, but we also need to improve the goodness-of-fit with families, culture, and circumstances so that families can participate and will want to participate. Talk therapies that assume a middle-class comfort level and availability during daytime working hours will not scale. COVID forced expanded modalities, including virtual meetings and social media. We need to continue these innovations and also test their efficacy. While trying to reach the full population, successful scaling requires maintenance of high fidelity to the interventions manualized protocol.

Often, scaling brings larger caseloads, poor quality supervision, lack of monitoring and performance, and few incentives for high quality. We need better business models for high-quality scaling. The challenge is not just reach, we need to adapt interventions that had been developed with one cultural group to become effective with a broader range of cultural groups in a community. The goal of maintaining fidelity to a protocol often bumps up against the goal of adaptation to a local culture. How do we appropriately adapt to a new group while still following a protocol?

What if required is a more clearly articulated theory of which elements of a therapy are essential to success and which can be adapted without loss of impact, or perhaps even improvement in impact? The eminent John Weisz has suggested that to shrink the gap between a university-developed intervention and its at-scale version, we must make a major shift toward creating and testing interventions in real-world settings at large scale from the very beginning. We must be cautious about developing interventions that can never scale.

To succeed in creating scalable interventions, we must think about the endpoint at the outset. We can do so by starting with new partnerships among scientists, therapists, and community leaders. I learned this important point while working with the Fast Track Intervention to prevent serious violence in high-risk children. My colleagues and I used developmental science and all our

resources to create a 10-year-long intervention that cost $58,000 per high-risk child. Our randomized control trial proved that the intervention successfully prevented adult externalizing, psychopathology, and did so with a positive rate of return on this large financial investment.

However, when it came to dissemination, we learned that communities cannot afford the initial investment or will not prioritize allocation of funds for a group of outcast children. Even with better strategies for bottom-up design of scaling interventions, participants at the summit realized that no amount of scaling will adequately move the needle on our population's mental health. We should not count on intervention with individual families to solve a societal problem. I realized this point when I was a clinical psychologist consulting with families in the Head Start Program.

I recall meeting with a mother who wanted to be the best for her young child but was denied access to the best resources. I found myself teaching her skills of how to identify the best childcare program in her community, how to be first in line for enrolling when there were too few openings, and how to convince her employer to allow her to take a few hours away from work to stand in line. As a psychologist working with a single family, I had to figure out how to help the family cope with the community's inadequacies and even the community's racism and sexism.

Not everyone can be first in line for a limited set of resources. This approach can only go so far in moving the population needle. We realize the second component of a comprehensive strategy, a top-down approach at the population level. I get very excited about this idea because we can innovate community-level intervention possibilities well beyond the kin of the individual therapist.

In addition to teaching a parent how to be first in line for a limited opportunity, we need to make high-quality opportunities available to every family. Some community-level interventions can be implemented at a modest per-child cost, even if the total community cost seems large. With the fast-track intervention, we delivered curricula and social-emotional learning and emotional regulation to individual children at a high per-child cost. Mark Greenberg and others have create a classroom curricula to address the same skills at a much lower per-child cost.

Top-down approaches organize themselves into three strategies, innovate community-level interventions, build community capacity and resources, and adopt better public policies. Let's start with community-level interventions. These are aimed at changing the context in which children develop. The PBIS system, that is Positive Behavioral Interventions and Supports is a school-wide approach to creating a learning environment that supports the development of these skills through reform in managing behavior and discipline problems. Neighborhood-level interventions such as increasing green spaces with babysitting co-ops may lower family stress and improve children's mental health. Television, social media, and new technologies afford delivery of interventions to a broader community.

Government agencies could make service application forms easier to complete for families. They could make services more accessible to low-income families by locating them in housing projects or school, and they could employ more culturally competent service providers. Public service announcements and community practices could change attitudes about mental health and reduce stigma associated with seeking services. I've worked on an intervention with families of newborn infants called Family Connects.

If you are a parent, you know that almost every family giving birth experiences stress, anxiety, and has unmet needs. Whether these needs are for material goods, such as a crib or for psychological support to counter postpartum depression, substance abuse, domestic violence, or simply anxiety about period date, but parents rarely ask for the help they need. One of the most important elements

of Family Connects is our paradoxical message to parents that the way to be competent is to learn how to ask for help. We need cultural change to make it more acceptable, even a positive indicator to ask for help. Again, though, we cannot put all of the onus on individual families,

A top-down approach includes building community capacity to deliver high-quality interventions in many ways by increasing the compensation level for service providers, by supporting cross-training and training of lay providers, by funding schools at higher levels and by allocating resources for evidence-based efforts such as pre-kindergarten, and high-quality childcare. We need to forge public-private partnerships to fund worthy interventions in a fair and effective way.

One example is the state of Oregon's legislatively supported policy to finance the Family Connects program. The scaled-up statewide implementation is financed with equal shares by the federal Medicaid program, state taxpayer allocation, and private health insurance that mandates coverage of Family Connects.

Beyond dollars, we need to adopt laws and policies that have been proven to support family mental health and well-being. Did you know that the United States is the only developed nation in the world that does not guarantee paid leave from employment to be a parent? Half of all workers in the United States do not even qualify for unpaid leave with having a child. We need employers to become more family-friendly through predictable and flexible work schedules. We need to reform Child Protective Services so that its forensic function is distinct from its clinical function. We need to reform how police respond to a domestic violence call. We need to outlaw corporal punishment of children in school.

Furthermore, rather than continue in an arbitrary or politically motivated way to generate policies, we need to have child development science drive the creation and testing of top-down approaches. We need to have systematic policy analysis and economics drive the calculation of benefit-cost ratios and implementation.

The third component of a comprehensive strategy is systems change. A major reason the mental health needs of children and families have been neglected is that the United States has never created a universal system of mental healthcare families. We might contrast the lack of a childhood mental health system with comparatively well-functioning systems in other sectors, including healthcare, education, and elder care.

Even if not perfect, these sectors do have systems and several features in common. First, they reach universally. One need not be in need, already sick, or diagnosed with a disorder to receive an annual checkup or preventive services at regular intervals. A general practitioner provides global advice, such as wear a bike helmet, avoid sugary drinks, screens for more serious concerns and disorders, intervenes briefly, if possible and preventively, and connects a person with specialized diagnostic and therapeutic resources tailored for that individual through a network of service agencies. The care across these specialized resources is coordinated through an ongoing electronic case record that facilitates cross-provider communication and documents the history of needs and services.

In contrast, for Children's Mental Health, families are on their own to recognize their needs, identifies which services they need, buying those services in the community, and figure out how to access those services. Sadly, this lack of a system means few families get their needs met. Historically, disenfranchised families are even less likely to be in a good old boys' network to access precious services, and so disparities grow.

Communities have begun to recognize the need for more comprehensive reach and screening and provision of early intervention. As an example, the Healthy Steps Program embeds a child development specialist in a pediatric practice to attend to families' psychological needs as they arise. Another approach is Triple P, the positive parenting program, which reaches universally through a coordinated set of tiered interventions to lower the rate of child conduct problems in a community. The family checkup is another program with universal reach to identify family needs that provide brief intervention to address children's behavior problems.

Family Connects is a systems approach to supporting families at birth by attempting to reach every family giving birth in a community through one to several home visits by trained public health nurses who support the family, identify their family-specific postpartum needs, provide brief interventions, and connect families with community resources to address their needs. Implementation studies show community-wide reach can be over 80% with health fidelity. Replicated randomized controlled trials demonstrate positive impact on improving mother's mental health and reducing child protective services investigations for abuse by over one-third.

These systems-level approaches hold the promise of a new era that could be called primary care for children's mental health. As this new era begins, we can identify highest priority tasks that face scientists, practitioners, and policymakers over the next decade. I will close by highlighting three, measurement, valuation, and accountability. First, measurement. You'll notice how the annual population level, academic achievement test score reports get public attention to dominate change in local education. Have you noticed how periodic reports of population, unemployment rates motivate political leaders to prioritize solutions?

These reports provide not only a current status when tracked across time, they tell us whether we're moving in the desired direction so we can evaluate impact and change course as needed. Imagine an annual report of our children's mental health based on administrative records coupled with surveys of representative samples. Did you know that the nation of Bhutan publishes an empirically based Gross National Happiness Index? Population-level measurement of children's mental health and well-being, including disaggregation by important race, ethnic, and income groups, emerged as a high priority at the APA Summit.

A second priority is evaluation. Developmental science must be the basis for intervention. Scientists and community leaders must collaborate to design these interventions. These efforts must be based not solely on political interests, but must be empirically driven.

Scientific rigor has been the hallmark of evidence-based programs, and the same rigor will be required in evaluating community-level interventions. Evaluation will be enhanced through the creation of integrated data systems that track every child across development. Administrative records afford relatively inexpensive evaluation trials. We need to convince public officials to randomize entire communities, perhaps by using lotteries to roll out funding first to some communities and then to more communities over time.

Finally, a major driver of innovation and evaluation will be public accountability with children's mental health. Really having an evidence-based program in a community is no longer sufficient. Communities must be held accountable for population levels of children's mental health and for disparities in mental health across groups. Only when these metrics are put into place and publicly reported will policymakers be held accountable to make the reforms that are necessary to bring a system of primary mental healthcare to our communities. Get yourself a festive shirt. Join the movement. Thanks for listening.