



AMERICAN  
PSYCHOLOGICAL  
ASSOCIATION

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Office of Disease Prevention  
National Institutes of Health  
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Bethesda, MD 20892

*Submitted electronically via web form*

**Comments in response to the Request for Information (RFI) on the NIH Office of the Disease Prevention Strategic Plan for Fiscal Years 2024–2028 ([NOT-OD-23-108](#))**

The American Psychological Association (APA) appreciates the opportunity to provide input to the National Institutes of Health (NIH) Request for Information (RFI) on the draft NIH Office of the Office of Disease Prevention (ODP) Strategic Plan for Fiscal Years 2024 -2028, *Prevention Research: Creating a Healthier Future for All*.

APA is the nation's largest scientific and professional nonprofit organization representing the discipline and profession of psychology, as well as more than 146,000 members and affiliates who are clinicians, researchers, educators, consultants, and students in psychological science. Our mission is to promote the advancement, communication, and application of psychological science and knowledge to benefit society and improve lives. APA offers the following comments on ODP's priorities in its draft strategic plan:

**Systematically monitor NIH investments in prevention research and the progress and results of that research.**

Prevention research can benefit individuals and society significantly, such as improved health outcomes, reduced healthcare costs, and enhanced quality of life. In addition, it can provide valuable evidence for informing public health policies and practices. However, there are still many gaps and opportunities for prevention research that need to be addressed by NIH, which has a critical role in supporting prevention research through its funding mechanisms, infrastructure, partnerships, and leadership. By identifying the most effective and cost-effective prevention strategies for different populations and settings, prevention research can help optimize the allocation of resources and improve health equity.

APA applauds ODP for the strategic plan's priority to monitor NIH's Investment in prevention research. Americans face ongoing health conditions, many are preventable, including obesity, substance misuse disorders, heart disease, and diabetes, among many others. According to the Centers for Medicare & Medicaid Services, National Health Expenditures grew 2.7 percent to \$4.3 trillion in 2021, accounting for 18.3 percent of Gross Domestic Product. Strategic investment in evidence-based prevention programs

can provide tremendous returns in monetary savings by sparing millions of people from serious diseases and conditions.

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National Health Expenditure Data. Centers for Medicare & Medicaid Services. February 17, 2023, <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet>

### Identify prevention research areas for investment or expanded effort by NIH.

The association commends ODP for its critical objective to address the inadequately funded areas of prevention research. APA agrees that this is an essential objective for the NIH-wide plan, especially mental health, which plays an essential role in the overall health of individuals and communities. It recognizes NIH's critical role in supporting prevention research through its funding mechanisms, infrastructure, partnerships, and leadership.

Working across the NIH Institutes, Centers, and Offices, and with other partners, will allow NIH to identify and support the most promising prevention research gaps. APA strongly believes it is vital to identify psychological research and mental health prevention research areas for investment, given that mental health is a crucial aspect of well-being that affects every aspect of life, from personal relationships to work productivity. In addition, the outcomes of prevention research can help reduce the burden of mental illnesses and disorders on individuals and society by supporting early intervention efforts. Further, APA is eager to see prevention research that takes a lifespan developmental approach -- a holistic approach to understanding all the physiological, cognitive, emotional, and social changes that people go through.

Another critical identified gap that needs additional investment is prevention research related to youth mental health. Accordingly, APA encourages NIH to take a population-based approach to youth mental health. It would necessitate establishing community-based infrastructure to ensure access to primary, secondary, and tertiary prevention and intervention strategies in the settings where youth naturally spend their time. Community-based infrastructure can also extend the reach of formal health and mental health services to reduce barriers to care and coordinate mental health care with other necessary services and resources.

### Social Determinants of Health

We want to share information from a forthcoming 2023 chapter to support a research agenda for primary mental health care. Kiara Alvarez and Ellen-ge Denton address community-based interventions to contribute to the mental health of youth. Responding to NIH *Request for Information (RFI): Innovative approaches to prevent mental health problems and promote mental wellness in population that experience health disparities* ([NOT-OD-23-03](#)), APA provided several examples of intervention strategies addressing social determinants of health (SDOH) that can “promote mental wellness, reduce psychological distress, and prevent the development of mental health problems in health disparity populations,” including:

- Place-based initiatives, which focus on multi-sector collaboration to address concerns in a particular neighborhood or community, provide infrastructure for primary prevention of mental health concerns. They can also include strategies to improve the interface between community resources and specialty mental health services. Community-based school initiatives are one key area where a

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place-based, youth- and family-focused approach can be expanded through funding and improved evaluation.

- Structured organizational and community-level interventions, such as the Availability, Responsiveness, and Continuity (ARC) and Communities that Care models, can guide the development of community-based infrastructure for mental health. Drop-in, low-barrier mental health and social services access models have been disseminated successfully in many countries and can form a model for a youth-focused approach to community mental health in the U.S.
- Community leadership and coalitions are key to the long-term success of establishing community infrastructure for mental health; however, they are often not given the resources to center their expertise or the expertise of parent and youth leaders.

A population-based approach to youth mental health care necessitates establishing community-based infrastructure to ensure access to primary, secondary, and tertiary prevention and intervention strategies in the settings where youth naturally spend their time. Community-based infrastructure can also extend the reach of formal health and mental health services to reduce barriers to care and coordinate mental health care with other necessary services and resources.

### Key Elements

Across conceptual models (Burgemeister et al., 2021; Jacobson, 2016; Moore & Fry, 2011), there is consensus that a population health approach to children's mental health requires a focus on strategies that are: **multi-level**, meaning they address multiple levels of a child's context and experiences, including the individual, family, and community levels; **multi-sector**, meaning they bring together a range of organizations and key partners focused on child and family well-being; **integrated across service systems**, meaning that services are coordinated and work in conjunction with each other rather than in isolation; and **integrated across prevention and intervention areas**, meaning they strive to address multiple outcomes relevant to children's well-being, rather than one issue or concern.

Specifically, the key elements of a community-based infrastructure for mental health may include the physical infrastructure of neighborhoods and service delivery locations; the social infrastructure available to parents and children; the service system infrastructure spanning education, health, and social service sectors, among others; the available community resources; and the policies and practices that govern these systems, including those established by government partners, community coalitions, and other convening groups (Bell & McKay, 2004; Ferris & Hopkins, 2015; Moore & Fry, 2011).

### Physical and social infrastructure

Place-based initiatives, which focus on multi-sector collaboration to address concerns in a particular neighborhood or community, are a key example of this community-based infrastructure. (Moore and Fry, 2011) describe the challenge as one of creating "joined-up solutions" for "joined-up problems," with action "needed on three fronts simultaneously: building more supportive communities, creating a better coordinated and more effective service system, and improving the interface between communities and services" (The Centre for Community Child Health, 2010; as cited in Moore and Fry, 2011, p. 5 v. ii).

Place-based initiatives are not new; various iterations have occurred over the past fifty years in the United States, with their funding coming from philanthropy and government initiatives (Ferris & Hopkins,

2015). Some examples include federal initiatives through which funding is disbursed to states, including Promise Neighborhoods and Promise Zones. However, despite enduring interest in place-based initiatives, challenges to evaluating their success have persisted. For example, a review of the effectiveness of place-based interventions in improving early childhood health and development found that 10 out of 11 studies reported at least one positive outcome. However, these represented only 36 percent of the total 83 outcomes reported (Burgemeister et al., 2021). Evaluations of multi-level, multi-sector initiatives that involve multiple interventions aimed at multiple outcomes (e.g., financial, educational, health) are, by definition, complex to design and carry out and are time and labor-intensive (Burgemeister et al., 2021; Ferris & Hopkins, 2015; Moore & Fry, 2011).

It is also unlikely that meaningful results can be observed in the short term, given that funding windows tend to limit the length of follow-up time (Burgemeister et al., 2021). As a result, many initiatives have typically relied on evaluating interventions at an individual level rather than showing broader outcomes for a place-based initiative. Evaluations have also focused on evaluations of smaller pilots, which are then seen as limited in their generalizability to larger-scale initiatives and other communities (Ferris & Hopkins, 2015).

Integrating formal mental health service delivery systems with community infrastructure can be an essential strategy for improving mental health service access and outcomes. Local and community-specific models for specialty mental health services that focus on reducing barriers to care and providing peer support are a promising approach to expanding community mental health infrastructure (Glisson et al., 2010; Settipani et al., 2019; Colwell et al., 2012).

For example, the ARC model addressed the lack of coordination between service sectors and youth access to services in 14 rural Appalachian communities to increase the uptake of Multisystemic Therapy (MST), an evidence-based practice. Youth receiving MST in ARC (Availability, Responsiveness, and Continuity) counties had significantly lower problem behavior scores than those receiving MST in non-ARC counties (Glisson et al., 2010), demonstrating the potential of county-level systemic interventions to improve the delivery of evidence-based mental health services. A study of ARC implementation in a midwestern city found that alignment of organizational priorities with the ARC intervention was the mechanism that resulted in improved youth outcomes within ARC agencies (Glisson et al., 2016).

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### Population Reach and Fit

APA also urges NIH to examine the following areas of prevention research: the scaling up of evidence-based programs, innovation of population-level interventions, and creating a primary system of care to promote children's mental health and well-being. Psychologists can create and evaluate novel population-level interventions that improve communities, schools, and neighborhoods as contexts for children's healthy development.

According to the National Institute of Mental Health (NIMH), the likelihood of a child experiencing a diagnosable mental health disorder by age 18 increased to 49.5 percent (U.S. DHHS, National Institute of Mental Health, 2021). APA would also like to share an area for prevention research outlined in an upcoming chapter by Ken Dodge, where he notes that "in order to improve population mental health and eliminate disparities, challenges must be overcome in bottom-up scaling of evidence-based programs (EBPs), top-down design of population-level interventions, and creation of a primary care system for children's mental health." Dodge also observes that the growing crisis in children's mental health coincides with a growing crisis in their physical health. Psychologists are well-positioned to contribute to mental health and children's overall health.

The challenge is to move beyond the delivery of psychotherapies to a small number of self-selected children toward a universal mandate to address a population crisis. This reframing allows for new conceptual models, innovative interventions, a renewed focus on prevention, and additional resources to solve a systems problem. The shift to population metrics opens new avenues for intervention that would be too expensive or time-consuming if applied only to an individual child. A bio-ecological model of child psychopathology recognizes the impact of not only the individual child and parent but also the microsystem of the school and neighborhood, the exosystem of government service agencies, and the macrosystem of cultural attitudes and norms (Bronfenbrenner & Ceci, 1994). This conceptualization suggests the potential power of community interventions, capacity-building, and public policies.

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### **Promote the use of the best available methods in prevention research and support the development of better methods.**

A forthcoming chapter by Isaac Ahuvia and Jessica Schleider addresses promising multi-level interventions or programs that combine strategies at the individual, interpersonal/organizational, community, and/or societal levels of influence to promote mental wellness, reduce psychological distress, and prevent the development of mental health problems. They ask, “What Measures Can We Use to See if Our Approach is Working?”

Mental health interventions, such as psychotherapy, are traditionally targeted towards individuals. To measure the effectiveness of these individual-level interventions, researchers have relied on self-report methods such as symptom inventories and diagnostic interviews. However, the *primary mental health care approach* requires psychologists and other providers to think beyond the impacts of our *individual-level* interventions on *individual patients’* mental health outcomes. Rigorous measurement of mental health outcomes “at scale” (i.e., at a population level) brings unique challenges and opportunities; it is also *essential* to assessing and improving efforts to promote mental health at scale.

### **Measuring Individual-Level Outcomes in Aggregate**

One conceptually straightforward way to assess the mental health levels of a population is to administer self-report measures of mental health to a sample of individuals in that population. For this approach to be practical, self-report measures must be valid and brief to minimize the burden of data collection at a large scale. A recent review (Becker-Haimes et al., 2020) provides suggestions for brief, freely available, evidence-based measures of youth mental health in the domains of overall mental health, anxiety, depression, disruptive behavior, traumatic stress, suicidality, psychosis, disordered eating, bipolar/mania, and substance use. Beyond symptom measures, data should be collected on other factors that affect individuals’ mental health, such as help-seeking, coping behaviors, and beliefs and attitudes about mental health.

While there is no shortage of instruments that can be used to measure primary mental health, little data is systematically collected at a population level. Current exceptions to this include the National Survey on Drug Use and Health, the State of Mental Health in America survey (Reinert et al., 2021), and the National Survey on LGBTQ Youth Mental Health (The Trevor Project, 2022). Whether by providing further support to these initiatives or by creating new surveys, psychologists must be supported to collect—and make publicly available—individual-level mental health outcomes at a large scale.

### **Community-Level Mental Health Outcomes**

“Community-level mental health outcomes” can refer to both the aggregated symptom levels or diagnosis rates of individuals within a community (as in the nationally administered surveys described above) and the community-wide conditions that facilitate the mental health of the individuals within them (Remington & Booske, 2011). One well-known approach for measuring the latter—the social determinants of health—is the County Health Rankings framework (Hood et al., 2016). This physical health framework assesses variables such as characteristics of the physical environment (e.g., environmental quality), social factors (e.g., community safety), economic factors (e.g., employment), access to care (and local quality of care), and health behaviors (e.g., alcohol use, diet, and exercise). A similar framework—the American Health Rankings—documents physical health outcomes by state; public health stakeholders (e.g., policymakers and public health agencies) rate these data points highly useful (Erwin et al., 2011). Measuring communities’ mental health requires a similar approach—

collecting and making available community-level information on the social and structural factors that bear on mental health.

### Evaluating the Impacts of Primary Mental Health Policies

Public policies of all kinds can positively and negatively impact primary mental health outcomes, including policies not directly aimed at impacting mental health (e.g., public assistance for families, anti-trans legislation). In addition, different best practices exist for evaluating individual-level interventions (e.g., provider-delivered therapy) and macro-level interventions (e.g., county-wide initiatives to promote healthy behaviors).

### Individual-Level Interventions

When individual-level interventions are deemed effective (e.g., in an RCT design), a natural next step for primary mental health may be to scale these interventions up. However, scale-up is not straightforward, and we should not expect interventions that work in a controlled RCT setting to work just as well at scale.

Instead, it is essential to evaluate the effectiveness of intervention scale-up (Fagan et al., 2019; Koorts et al., 2021; Zomahoun et al., 2019). Data should be collected on stakeholder engagement, buy-in, and communities' capacity to support a scaled-up intervention using a "systems approach" (McGill et al., 2021; Rutter et al., 2017). However, current reporting practices on implementation strategies are insufficient (Hooley et al., 2020).

### Macro-Level Interventions

When we aim to evaluate macro-level interventions (e.g., a county-wide initiative to promote healthy behavior), we need to use methods that allow for comparison across localities. These include the difference-in-difference framework commonly used in public health policy evaluation (Wing et al., 2018). However, these methods require access to large-scale (e.g., nationwide) datasets with geographic indicators—so long as the geographic indicator is small enough to facilitate specific measurements. For example, when data is only available at a state level, evaluating county-level interventions within a state is impossible.

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### **Promote collaborative prevention research projects and facilitate coordination of such projects across NIH and with other public and private entities.**

APA applauds this objective. Collaborative prevention research projects are essential for advancing the science of disease prevention and health promotion. The objective recognizes the challenges of such collaboration regarding coordination, communication, and dissemination of the results. It will be necessary for ODP to establish common goals and objectives among participating partners, thereby aligning the expectations and interests of stakeholders. Additionally, shared goals and objectives could facilitate the development of a coherent research plan and a clear evaluation framework. Collaborative prevention research projects would allow NIH to leverage existing resources and networks. It would also allow NIH to use resources and networks to assist in disseminating findings and recommendations to wider audiences and translate the research into practice and policy.

### **Advance tobacco regulatory and prevention science**

Tobacco use is one of the leading preventable causes of death and disease worldwide, causing more than 8 million deaths yearly (WHO). APA applauds the strategic plan's focus on tobacco regulatory and prevention science which has implications for public health and policy. Like prevention research related to mental health, this area of research faces various challenges and opportunities that require interdisciplinary collaboration and innovation. APA agrees that there continues to be a need for rigorous research and translating evidence into action.

As we know from previous research, prevention can take the form of policy-level measures, such as increased taxation of tobacco products; stricter laws (and enforcement of laws) regulating who can purchase tobacco products; how and where they can be purchased; where and when they can be used (i.e., smoke-free policies in restaurants, bars, and other places). While the U.S. Food and Drug Administration (FDA) has the authority to regulate the manufacture, marketing, and distribution of tobacco products, to do it effectively, the agency needs scientific evidence to inform its regulatory decisions and policies. ODP's interagency partnership with the FDA (Tobacco Regulatory Science Program) in collaboration with other NIH institutes and centers, federal agencies, international organizations, and academic institutes can advance high-quality prevention research that can inform tobacco regulation. APA supports the strategic plan's focus in this area, particularly a call for collecting data and evaluating policy-level actions that can contribute to the prevention of tobacco-related diseases and deaths.

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### **Promote and coordinate prevention research that addresses health disparities.**

APA applauds the strategic plan's goal to promote and coordinate prevention research addressing health disparities. To this end, the association is preparing a research agenda for primary mental health care. This information derives from a 2023 chapter written by Ashanti Brown and Isha Metzger to support the development of a research agenda on primary mental health care. The authors focus on culturally informed approaches that address underrepresented populations and reflect community values. APA agrees with their recommendation that priority should be placed on directing resources implementing mental health interventions with previously disenfranchised groups while also devoting support to rigorously evaluating if these interventions positively impact these new groups. Understanding the existing strengths and resources within the community is pivotal when thinking about "new" ways to make treatment culturally informed.

Brown and Metzger observe that mental health disparities are persistent across culturally diverse and underserved groups. The continued movement toward cultural responsiveness in mental health treatment is critical and urgently needed. With both physical and mental health, it is imperative to understand various cultures' historical and current systemic inequities that impact those individually, collectively, structurally, and multi-generationally.

Acknowledging cultural differences in response to one's therapeutic needs is also essential. An individual's culture could inform how they seek treatment, their perception of treatment (stigma), the client-clinician relationship, and linguistic barriers (Gopalkrishnan, 2018). Racism and discrimination also have a significant impact on people of color. Despite growing evidence of challenges disadvantaged populations face, including members of racial and ethnic minoritized groups, culturally responsive therapy frameworks have emerged slowly due to pushback, limited research, and funding. Additionally, although emerging, literature surrounding culturally responsive youth mental health care remains understudied.

Historically marginalized youth remain less likely to utilize and benefit from mental health services (Guo et al., 2014; La Roche, 2008; Maura & de Mamani, 2017; Price et al., 2022). In addition, significant evidence shows culturally diverse communities are more likely to resort to communal avenues (i.e., community leaders, traditional healers, community organizations) other than mental health professionals when dealing with mental distress (USDHHS, 2001). Therefore, it is necessary to leverage community leaders, organizations, values, and research approaches to facilitate access to quality, culturally adaptive services.

The need for culturally informed care is just as integral for youth's physical health as it is for their mental health concerns. Despite advances towards culturally informed care to underserved populations, overall health disparities among races are prevalent. Challenges (e.g., discrimination, historical traumas, systems of oppression, socioeconomic disadvantages) faced by marginalized youth bring attention to increased risks of stressful experiences and developing poorer physical health issues.

Diabetes rates have continued to surge among American youth, with an increase of 45% for type 1 and 95% for youth with type 2 diabetes (Lawrence et al., 2021). Race disparities for diabetes are even more prevalent, with the most significant increases being more common in youth within racial or ethnic minority groups (Lawrence et al., 2021). Similar statistical trends for additional adolescents' overall health issues (e.g., obesity, alcohol use, sexual risks) exist due to racial disparities and can be linked to social determinants of health. In addition to members of underrepresented populations' enduring health disparities (e.g., having less access to healthcare, inequities in healthcare, discrimination in healthcare provision), this challenge also highlights youth's abilities to meet and conform to evidence-based strategies inadequately.

Providing culturally informed care is challenging; it is essential to collaborate with community organizations dedicated to servicing structurally minoritized and marginalized populations to develop practice-based evidence. Community-based services are integral resources for understanding individual and communities' strengths, values, histories, family structures, systemic inequities, differences within cultures, and mistrust. For this approach to be practical and sustainable, research funding should be dedicated to underrepresented mental health services through partnerships and community-based health systems (Gopalkrishnan, 2018). This also brings attention to resource allocation for community-based participatory research (CBPR), where community leaders and members would be involved in all of the collaborative research. Community-research partnerships would allow for sustained intervention and support for solutions to address mental health disparities (Rasmus, 2019).

There continue to be gaps in the literature surrounding the efficacy and effectiveness of adaptive programs for racial and ethnic minoritized youth and families. While a number of studies have come to promising findings, there is a relative dearth of attention and funding being given to enhance further the efficacy of adaptive programs for racial/ethnic groups. Examples of this phenomenon have been prevalent within work with African American youth and families utilizing trauma-focused cognitive behavioral therapy (TF-CBT) to address cultural trauma. Cultural traumas (e.g., intergenerational trauma, racial trauma) include unique experiences of historically marginalized groups and can lead to poorer mental health (and overall health) outcomes in youth and adults. Similarly, there remains an ongoing need for research on recruiting and retaining members of underserved communities, particularly those from hidden and hard-to-reach populations.

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Thank you again for the opportunity for APA to provide input on an issue of great importance to the association. Please contact Angela Sharpe, Congressional & Federal Relations ([asharpe@apa.org](mailto:asharpe@apa.org)), if APA can partner more closely or assist in any way.

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Sincerely,



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