

The U.S. Preventive Services Task Force's
Opportunity to Pursue a New Strategy
for Behavioral Health



Nathaniel Z. Counts, JD,¹ J. David Hawkins, PhD,² Diana H. Fishbein, PhD³

On August 30, 2018, the U.S. Preventive Services Task Force (USPSTF) released its final research plan on Interventions to Prevent Illicit and Nonmedical Drug Use in Children, Adolescents, and Young Adults, an update of a 2014 recommendation on the same topic. Although USPSTF found insufficient evidence to recommend an intervention in 2014,¹ this 2018 update offers USPSTF an opportunity to review new evidence as well as to consider a new overall strategy for preventing substance use and mental health conditions.

The need for a new prevention strategy has never been greater, as drug overdose and suicide deaths rates continue to rise in the U.S.^{2,3} In part, these increases may be explained by the shared socioeconomic risk factors that lead to addiction, mental health conditions, and suicide, including childhood adversity, changing social and economic dynamics of adulthood, and lack of necessary supports in aging.⁴ Although some of these risk factors lie outside the reach of the clinical preventive services studied by USPSTF, key upstream determinants of behavioral health can be modified by clinical intervention, and USPSTF can develop a coordinated strategy to effectively manage and address these determinants across the population.

For example, in the 2016 report on Facing Addiction in America, the U.S. Surgeon General identified 42 tested and effective programs and policies for preventing substance use initiation, misuse, abuse, and addiction.⁵ Many of these interventions exert effects beyond solely preventing substance use, targeting critical determinants of a child's healthy cognitive, affective, and behavioral development, including the family and community context in which they develop.⁶ By building on core developmental needs, such as healthy attachment to a caring adult or appropriate emotional regulation and coping in the face of reasonable stressors, these interventions also prevent or mitigate other health conditions, such as depression, suicidality, obesity, unwanted pregnancy and sexually transmitted infections, child maltreatment, and even some types of

injuries.⁷ Some of these interventions are also cost saving from a healthcare perspective, and many of them are cost saving from a societal perspective.⁸ If effectively applied across a population, these interventions could help stem the tide of the current overdose and suicide epidemic while addressing the underlying risk factors contributing to poor behavioral health outcomes in the U.S.

To build on the opportunity presented by USPSTF topic update, leading advocacy organizations, including Mental Health America, Faces and Voices of Recovery, the Addiction Policy Forum, the Coalition for the Promotion of Behavioral Health, and the National Prevention Science Coalition, collaborated with experts from the research community to recommend that USPSTF adopt a new strategy for prevention in behavioral health by modifying its topic review process in three ways: (1) segmenting reviews by developmental periods; (2) focusing on cross-cutting prevention in behavioral health; and (3) creating a process to coordinate universal and selective prevention strategies for a topic area.

First, USPSTF should segment its review of interventions by developmental periods, such as prenatal, infancy, early to late childhood, and adolescence. Although effective substance use preventive interventions for any given age range share common elements, they differ in meaningful ways across developmental periods. A review of all interventions that prevent substance use, regardless of the age at which the interventions are delivered, would produce a high degree of heterogeneity and complicate USPSTF's ability to issue a

From ¹Mental Health America, Alexandria, Virginia; ²University of Washington School of Social Work, Seattle, Washington; and ³Pennsylvania State University College of Health and Human Development, State College, Pennsylvania

Address correspondence to: Nathaniel Z. Counts, JD, Mental Health America, 500 Montgomery St., Suite 820, Alexandria VA 22314. E-mail: ncounts@mentalhealthamerica.net.

0749-3797/\$36.00

<https://doi.org/10.1016/j.amepre.2018.10.011>

clear recommendation for the topic area.⁹ By segmenting interventions by the developmental period they target, USPSTF's review would likely offer more definitive evidence for issuing a specific clinical recommendation for that age range. For interventions that target ages earlier than pre-adolescence, the primary outcomes considered in the review will likely need to be the modifiable predictors or precursors of later substance use initiation, such as externalizing problems early, rather than actual prevention of substance use¹⁰; few studies have followed children longitudinally for a long enough duration to demonstrate effects directly on substance use. Studies that find an effect on an outcome earlier in development that is a demonstrated and significant mediator of later substance use should be included in a review of substance use prevention to capture these upstream interventions. USPSTF's 2014 review did not segment interventions by developmental stage and as a result, some of the opportunities to prevent substance use earlier in the life course were not fully considered in their recommendation.

Second, USPSTF should expand the topic under consideration from Interventions to Prevent Illicit and Non-medical Drug Use in Children, Adolescents, and Young Adults to Interventions to Prevent Behavioral Health Conditions Including Illicit Drug and Nonmedical Drug Use in Children, Adolescents, and Young Adults, in support of a more cross-cutting focus. As noted above, many of the interventions that USPSTF will likely identify in a review of the evidence at each developmental stage will demonstrate effects across multiple health conditions.¹¹ Although this change may initially only appear to have a superficial impact on the topic name, it can signal a change in USPSTF's approach to adding and updating topics related to behavioral health. To the extent that the present review leads to a recommendation of an intervention that is effective in preventing conditions in another USPSTF topic area, such as depression, obesity, or sexually transmitted infections, this can change USPSTF's approach in those areas. Instead of reviewing the entirety of the literature, USPSTF can focus these future reviews on interventions that address unique aspects of the condition, such as counseling on contraceptive use for sexually transmitted infections, to build on the existing recommendation for preventing multiple conditions. This strategy would leverage the opportunity for a single intervention to be effective in more than one topic area, minimizing overlap and potentially reducing the burden for USPSTF in reviewing the evidence and for providers in delivering the interventions. By taking a cross-cutting and developmental perspective rather than condition-specific perspective, USPSTF can increase the parsimony of the

review system and justify larger investments in preventive interventions with greater salience for public health.

Adopting a developmental perspective also necessitates the inclusion of alcohol and tobacco in the definition of substance use, as interventions that promote healthy development and prevent youth alcohol and tobacco use initiation also prevent initiation of other substance use.¹² By including alcohol and tobacco with other substances as required primary outcomes, USPSTF can ensure that it has access to the full body of evidence in considering recommendations.

Third, USPSTF should create a framework for coordinating universal and selective prevention strategies across development. Universal prevention equally applies an intervention across a whole population (e.g., a school or community) to reduce disease burden, whereas selective prevention targets interventions to the members of the population that demonstrate elevated risk—often after screening. For substance use, USPSTF is currently in the process of updating recommendations for both universal and selective strategies, but in other topic areas, such as depression, USPSTF takes only a single approach. For interventions that promote behavioral health at any developmental period, the evidence will likely be divided between universal and selective preventive strategies. Combining universal and selective strategies in a single review would make it challenging to issue a clear and appropriate recommendation for a specific developmental period, and reviewing one strategy without considering the other could miss critical opportunities to prevent chronic conditions. With a systematic framework for coordinating universal and selective strategies at each developmental period, USPSTF would be better positioned to ensure that recommendations most effectively apply the available evidence to improve public health.

The three changes proposed to USPSTF recommendation process will better leverage the emerging body of prevention science to achieve USPSTF's goal of reducing the public health burden of preventable diseases and disorders. To illustrate how this proposed framework might be applied in practice, examples of topics and interventions that USPSTF may recommend under the framework are available in [Table 1](#), drawn from the evidence-based intervention registry, The Blueprints for Healthy Youth Development.¹³ Although many of the greatest opportunities for addressing the suicide and overdose epidemics originate outside of clinical care, including increasing access to meaningful employment or reducing adverse experiences (e.g., trauma) in childhood, this USPSTF topic update in tandem with a new coordinated strategy could be a critical step toward achieving an inflection point for behavioral health in the U.S.

Table 1. Example USPSTF Topics and Recommendations in a Developmental Framework

Developmental period/ Possible intervention	Universal or selective	Possible outcomes
Early adolescence		
Guiding Good Choices	Universal	Substance use, externalizing behaviors, depression
Strengthening Families 10–14	Universal	Substance use, externalizing behaviors, internalizing problems
Families Unidas	Selective	Substance use, risky sexual behaviors, externalizing
Early childhood		
Triple P System	Universal and selective	Child maltreatment, psychosocial distress
Incredible Years—Parent Training Program	Selective	Externalizing behaviors, internalizing problems
Infancy		
Family Foundations	Universal	Externalizing behaviors, internalizing problems

Source: Blueprints for Healthy Youth Development, University of Colorado Boulder. USPSTF, U.S. Preventive Services Task Force.

ACKNOWLEDGMENTS

All authors contributed to the conceptualization of the paper. Mr. Counts performed the primary drafting, and Dr. Hawkins and Dr. Fishbein offered substantive revisions. No financial disclosures were reported by the authors of this paper.

REFERENCES

1. Patnode CD, O'Connor E, Rowland M, Burda BU, Perdue LA, Whitlock EP. Primary care behavioral interventions to prevent or reduce illicit drug use and nonmedical pharmaceutical use in children and adolescents: a systematic evidence review for the U.S. Preventive Services Task Force. *Ann Intern Med.* 2014;160(9):612–620. <https://doi.org/10.7326/M13-2064>.
2. Rudd RA. Increases in drug and opioid-involved overdose deaths—United States, 2010–2015. *MMWR Morb Mortal Wkly Rep.* 2016;65(50–51):1445–1452. <https://doi.org/10.15585/mmwr.mm655051e1>.
3. Stone DM, Simon TR, Fowler KA, et al. Vital signs: trends in state suicide rates—United States, 1999–2016 and circumstances contributing to suicide—27 states, 2015. *MMWR Morb Mortal Wkly Rep.* 2018;67(22):617–624. <https://doi.org/10.15585/mmwr.mm6722a1>.
4. Dasgupta N, Beletsky L, Ciccarone D. Opioid crisis: no easy fix to its social and economic determinants. *Am J Public Health.* 2018;108(2):182–186. <https://doi.org/10.2105/AJPH.2017.304187>.
5. HHS. Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health. Washington, DC: HHS, 2016.
6. Leslie LK, Mehus CJ, Hawkins JD, et al. Primary health care: potential home for family-focused preventive interventions. *Am J Prev Med.* 2016;51(4):S106–S118. <https://doi.org/10.1016/j.amepre.2016.05.014>.
7. Counts NZ, Halfon N, Kelleher KJ, et al. Redesigning provider payments to reduce long-term costs by promoting healthy development. *NAM Perspectives.* Published April 20, 2018. <https://doi.org/10.31478/201804b>.
8. Benefit-Cost Results. Washington State Institute for Public Policy. www.wsipp.wa.gov/BenefitCost. Published December 2017. Accessed October 10, 2018.
9. Van Ryzin MJ, Roseth CJ, Fosco GM, Lee YK, Chen IC. A component-centered meta-analysis of family-based prevention programs for adolescent substance use. *Clin Psychol Rev.* 2016;45:72–80. <https://doi.org/10.1016/j.cpr.2016.03.007>.
10. Dodge KA, Malone PS, Lansford JE, Miller S, Pettit GS, Bates JE. A dynamic cascade model of the development of substance-use onset. *Monogr Soc Res Child Devent.* 2009;74(3):vii–119.
11. Catalano RF, Fagan AA, Gavin LE, et al. Worldwide application of prevention science in adolescent health. *Lancet.* 2012;379(9826):1653–1664. [https://doi.org/10.1016/S0140-6736\(12\)60238-4](https://doi.org/10.1016/S0140-6736(12)60238-4).
12. Schwartz SJ, Phelps E, Lerner JV, et al. Promotion as prevention: positive youth development as protective against tobacco, alcohol, illicit drug, and sex initiation. *Appl Dev Sci.* 2010;14(4):197–211. <https://doi.org/10.1080/10888691.2010.516186>.
13. The Blueprints for Healthy Youth Development. University of Colorado Boulder. www.blueprintsprograms.com/search-results. Accessed June 6, 2018.