Module 7: Mental Health

Part 3: Stigma, Resilience, Best Practices, and Next Steps

So, it's generally accepted that there are two different types of stigma. Stigma is understood to be public and self. Public stigma has to do with stereotypes, prejudice, discrimination that people have around mental illness based on these ideas of what it means to be a person with mental illness. Self stigma is what happens when somebody has internalized those public views and discriminates against themselves, limits themselves, thinks about themselves in such a way that it prevents them from being fully participating members of society.

Now the good news is there was some research done a few years ago that suggested that stigma towards mental health services has reduced over time, meaning that compared to 20 years ago, today people are much more likely to say, "I would attend services for mental health problems. I would be public about that, and I would refer my friends for mental health services as well." This attitude, this perception, suggests that stereotypes of people with mental illness as weak or incompetent, prejudices against it such as, "You are a bad person" and discrimination such as, "I'm afraid I'm going to lose my employment" or "People won't like me," that these things are much less widely held as they were before. This is a good thing.

Now resilience. Resilience is a concept that has developed over the past 30 years. The study of resilience focuses on one particular subset of processes associated with human development. Those processes that enhance the experience of well-being among individuals who face significant adversity. Resilience is both the capacity of individuals to navigate their way to the psychological, social, cultural, and physical resources that sustain their wellbeing and their capacity to individually and collectively to negotiate for these resources to be provided and experienced in culturally meaningful ways.

So what this means is that it's not about having a person, let's say a child, who is somehow strong and has a positive outlook in life simply because they are in a very disadvantaged situation. Resilience is not just an individual experience. It is also a social and an environmental experience. Policies should consider ways to improve the social and cultural systems in order to improve youth outcomes, including mental health. For example, changing Welfare-to-Work policies to reduce parent's time away from children can improve parent-child relationships, thereby mitigate some of the effects of poverty on youth outcomes.

Another example is that if you have a child with a psychiatric illness that's in school, you could ask the child, "Wow, how is it that you're able to do so well in school?" and think about that as resilience on an individual level. But you could also say, "What structures are in place in this school that allow for this child to get what he or she needs and experience that in a culturally meaningful way to contribute to his or her success despite significant adversity?"

What treatments work for children? Well, as of August 2014, the Substance Abuse and Mental Health Services Administration, SAMHSA, their National Registry of Evidence-based Programs and Practices, NREPP, listed 91 evidence-based practices for children and adolescents ages 0 to 18. A review of these interventions suggested that most of them were cognitive and behavioral in basis, meaning that they addressed changing thoughts and changing behaviors.
They addressed a variety of disorders. Everything from autism, Asperger's, attention deficit, suicide risk, depression, all the way to other issues such as school truancy, pregnancy prevention, and those sorts of things. The modalities included individual, family, and group, such as classroom-based treatments.

So what are the next steps? Well, we have 91 empirically-based treatments. We have a lot of information about what works, what leads to youth resilience. We understand that there's a decrease in stigma. There are policies in place that are trying to merge the physical and the mental healthcare. What do we need to do next?

The first thing is we need to enforce mental health parity. We need to make sure that folks that are paying for services are paying for mental health services to the same extent that they're paying for physical health services. We need to coordinate mental health and

general health care. So it's not enough to say, "Oh, you're coming in with a physical ailment. We're not going to talk about depression, anxiety, suicide risk, or trauma." We need to address those also because we know that they are integrated.

We need to determine which treatments work best for which symptom clusters and personalities. The treatments that have been identified on the NREPP list are what we consider broad and general, in that they'll say, "These work for kids with depression." But as we know, there are many different symptoms which make up the diagnosis of major depressive disorder. The question is what treatments are out there, and I suspect many have yet to be developed, that treat some cluster of symptoms for depressed youth better than other clusters of symptoms for depressed youth.

We also need to improve dissemination of these empirically supported treatments into the community. There is approximately an 18-year gap between scientific discovery around intervention and the time at which it is used in the community. If you have a child that is at risk for killing himself, 18 years is way too long to wait for that empirically-supported treatment to get into the hands of the provider that you're looking at right now. Next steps include using technology such as podcasts and professional networks to both disseminate these empirically supported treatments as well as to improve fidelity of treatment delivery and adherence to the treatments.

And finally, to improve the integration of universal, selective, and targeted interventions in schools and primary care. What this means is that we need to have broad-based screening. We also need to be able to say, "These kids are at risk for problems," and we need to address the kids who are actually exhibiting the emotional and behavioral problems in the schools and the primary care settings.

I'm Jonathan Singer. Thank you so much.