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RESEARCH ARTICLE

Factors Perceived as Influencing Local Health Department Involvement in Mental Health

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Introduction: Local health departments (LHDs) are potentially well positioned to implement population-based approaches to mental health promotion, but research indicates that most LHDs are not substantively engaged in activities to address mental health. Little is known about factors that influence if and how LHDs address population mental health. The objectives of this qualitative study were to (1) understand how LHD officials perceive population mental health; (2) identify factors that influence these perceptions and LHD activities to address population mental health; and (3) develop an empirically derived conceptual framework of LHD engagement in population mental health.

Methods: Twenty-one semi-structured interviews were conducted with a purposive sample of LHD officials and analyzed using thematic content analysis in 2014–2015. Transcripts were double coded, inter-rater reliability statistics were calculated, and categories with $\kappa \geq 0.60$ were retained.

Results: Respondents perceived mental health as a public health issue and expressed that it has emerged as a priority through community health needs assessment processes, such as those conducted for health department accreditation. However, most LHDs were not substantively engaged in population mental health activities because of limited resources, knowledge, data, and hesitancy to infringe upon the territory of local behavioral health agencies. LHDs and local behavioral health agencies had difficulty communicating and collaborating because of divergent perspectives and financing arrangements.

Conclusions: LHD officials are eager to embrace population mental health, but resources, training and education, and systems-level changes are needed. Contemporary reforms to the structure and financing of the U.S. health system offer opportunities to address these challenges.

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INTRODUCTION

Globally, approximately 11% of disability-adjusted life-years lost are attributable to mental illness—a proportion that increased by 38% between 1990 and 2010 and is projected to continue to rise.[1] Mental illness is common in the U.S., with a past-year prevalence of 13% among youth[2] and 19% among adults,[3] and is associated with increased risk of physical disease,[4–7] deleterious behaviors,[8–10] injuries,[11] and premature death.[12] Given the population burden of mental illness, leading public health authorities have repeatedly called for mental health to be addressed as a public health issue.[13–21]

As Cohen and Galea describe in *Population Mental Health*,[22] "Incorporating mental health into the 'mainstream' public health agenda means applying the tools and strategies of the public health field (e.g., surveillance, screening and early identification, preventive intervention, health promotion, and community action)." Local health departments (LHDs) are potentially well positioned to perform these functions[23–29] and opportunity exists for LHDs to

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integrate mental health promotion activities into mainstream practice as they are increasingly pursuing accreditation through the Public Health Accreditation Board (PHAB),[30] which recently announced that it will consider population-based mental health activities of LHDs when reviewing accreditation applications.[31] Opportunities might also be emerging as health systems reconfigure financing arrangements and LHDs redefine their roles in the Patient Protection and Affordable Care Act (ACA) implementation environment.[32–34]

However, LHD engagement in activities to address mental health is an exception—not the norm. The 2013 National Profile of Local Health Departments ("Profile Study") indicates that 44.2% of LHDs do not perform any activities to address mental health,[35] 35.3% perform activities to ensure access to mental health services for underserved populations,[36] and 16.5% engage in population-based mental illness prevention activities.[23] Analysis of 2010 Profile Study data found that a substantially smaller proportion of LHDs engaged in activities to ensure access to mental health services (32.0%) than dental (45.9%) or medical (66.0%) services.[37]

These studies suggest that barriers to LHDs addressing mental health exist, but do not shed light on the nature of these barriers, possible facilitators, or strategies that might enhance LHD involvement in population mental health. For example, it is not known whether LHD officials perceive mental health as a problem that is within their purview to address. Local behavioral health agencies (LBHAs; i.e., government entities that are financed to provide clinical mental health and addiction services) exist alongside LHDs in many jurisdictions,[38] but little is known about the extent to which LHDs and LBHAs collaborate and factors that influence these inter-organizational relationships. A compendium published in 2008 by the National Association of County and City Health Officials highlights eight examples of successful collaboration between LHDs and LBHAs, but does not elucidate barriers or account for developments related to the ACA and PHAB accreditation.[39]

The objectives of this qualitative study were to (1) understand how LHD officials perceive population mental health; (2) identify factors that influence these perceptions and LHD activities to address population mental health; and (3) develop an empirically derived conceptual framework of LHD engagement in population mental health.

METHODS

Study Sample

All LHDs that completed Module 2 of the 2013 Profile Study (N=505)[40] served as the sampling frame. The authors purposively selected LHDs to construct a geographically diverse sample of city and county LHDs that serve different size populations (Table 1). After a list of candidate LHDs was developed, the Director of each LHD was recruited to participate in an interview. One LHD official declined to participate and five did not reply to invitations. These LHD officials were replaced with officials from other LHDs with similar characteristics. When requested by the LHD official, joint interviews were conducted with multiple respondents from the LHD.

Informed by literature on population mental health[13–26] and the framework for the measurement of public health system performance of Handler et al.,[41] the authors developed a semi-structured interview guide (Figure 1). Twenty-one telephone-based interviews were then conducted in 2014–2015. As expected—given that interview respondents were highly knowledgeable about the study topic, which was narrow in focus—thematic saturation began to occur after the 12th interview.[42] Multiple LHD officials participated in six of the interviews, resulting in a total sample of 30 respondents. Each interview was approximately 45 minutes in duration, audio recorded, and transcribed.

Data Analysis

In 2015, interview transcripts were imported into NVivo 10 for analysis. First, members of the project team read the transcripts, wrote memos about themes in the data, and inductively generated preliminary coding categories. The team then met to discuss observed themes and developed a coding framework. Two coders then re-read and coded the transcripts, meeting regularly to discuss coding decisions and iteratively refine code definitions. Kappa statistics of inter-rater reliability were calculated for each thematic coding category and categories with less than "moderate agreement" ($\kappa \leq 0.60$)[43] were discarded. Concepts were then created through an iterative process using analytic techniques

Table 1. Characteristics of Interviews Conducted With LHD Officials About Population Mental Health

Interview characteristic	Number of interviews
U.S. Census region	
Northeast	4
South	4
Midwest	6
West	7
LHD population size	
≤249,999	4
250,000–499,999	1
500,000–724,999	5
750,000–999,999	4
1–1.99 million	4
≥2 million	3
Jurisdiction	
Single city	8
Single county	11
Multi-city	1
Multi-county	1
Interview dynamic	
One-on-one	15
Multiple respondents	6

LHD, local health department.