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Editorial

Editorial: 3rd Special Issue on behavior change, health, and health disparities

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ABSTRACT

This Special Issue of Preventive Medicine (PM) is the 3rd that we have organized on behavior change, health, and health disparities. This is a topic of critical importance to improving U.S. population health. There is broad scientific consensus that personal behaviors such as cigarette smoking, other substance abuse, and physical inactivity/obesity are among the most important modifiable causes of chronic disease and its adverse impacts on population health. Hence, effectively promoting health-related behavior change needs to be a key component of health care research and policy. There is also broad recognition that while these problems extend throughout the population, they disproportionately impact economically disadvantaged populations and other vulnerable populations and represent a major contributor to health disparities. Thus, behavior change represents an essential step in curtailing health disparities, which receives special attention in this 3rd Special Issue. We also devote considerable space to the longstanding challenges of reducing cigarette smoking and use of other tobacco and nicotine delivery products in vulnerable populations, obesity, and for the first time food insecurity. Across each of these topics we include contributions from highly accomplished policymakers and scientists to acquaint readers with recent accomplishments as well as remaining knowledge gaps and challenges.

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1. Introduction

This Special Issue of Preventive Medicine (PM) is the 3rd in a series that focuses on behavior change, health, and health disparities. The first Special Issue appeared in November 2014 (<mailto:http://www.sciencedirect.com/science/journal/00917435/68/supp/C>) and the 2nd in November 2015 (<http://www.sciencedirect.com/science/journal/00917435/80>). Contributors to these Special Issues are selected from among participants in the Annual Conference on Behavior Change, Health, and Health Disparities that is organized by the Vermont Center on Behavior and Health (VCBH), a National Institutes of Health (NIH) and Food and Drug Administration (FDA) supported biomedical research center located at the University of Vermont (<http://www.uvm.edu/medicine/behaviorandhealth/>). This select subset of conferees was invited to contribute to this Special Issue because of their exemplary scholarship and outstanding conference presentations. Each contribution underwent thorough peer-review overseen by the Editor-in-Chief in coordination with the Guest Editor. Below I comment briefly on the rationale for organizing these annual conferences and associated publications as well as how the excellent contributions to this 3rd Special Issue advance knowledge in this important area of biomedical research.

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2. Behavior change, health, and health disparities

As discussed in the Introductions to the two prior special issues (Higgins, 2014; Higgins, 2015), U.S. population health ranks near the bottom compared to other developed countries despite spending orders of magnitude more on healthcare than any other country. When health experts examine the reasons for this relatively poor state of U.S. population health, there is widespread agreement that unhealthy personal behavior patterns (e.g., cigarette smoking and other substance abuse, physical inactivity and poor food choices, non-adherence with medical prevention and treatment regimens) are the largest contributor to this problem. There is also consensus that reducing the prevalence of these behavior patterns (i.e., behavior change), and associated chronic health conditions, offers the greatest opportunity for improving U.S. population health (Institute of Medicine, 2013; Schroeder, 2007). Because these risk behaviors and associated chronic diseases are overrepresented in economically disadvantaged and other more vulnerable population subgroups, they are also recognized to be direct contributors to the growing problem of health disparities in the U.S. and other developed countries. Perhaps not surprisingly considering this state of affairs, the NIH has made behavior change a cross-institutes priority (NIH Common Fund, 2013). In brief, there is growing recognition of the need to advance scientific understanding and more effective management of chronic health conditions where personal behavior is a proximal cause (e.g.,

cardiovascular disease, obesity, site-specific cancers, substance use disorders, type-2 diabetes).

The VCBH, its annual conference, and this series of Special Issues of PM on behavior change, health, and health disparities were established to address this need. More specifically, the mission of the VCBH is to support and grow biomedical research examining relationships between unhealthy behavior patterns and risk for chronic disease and premature health. We prioritize research that uses the principles and methods of behavioral economics and behavioral pharmacology to (a) delineate underlying behavioral processes involved in risk for unhealthy behavior and (b) develop more effective behavior-change interventions. Considerable effort is also devoted to the essential task of characterizing health-related behavior patterns, associated risk factors, and adverse health impacts in vulnerable populations. Each of those priorities is well represented in the contributions to this 3rd Special Issue.

3. Importance of addressing health disparities

The lead article in this Special Issue is from Steven A. Schroeder, MD, a national expert on behavior change, health, and health disparities (Schroeder, 2016—in this issue). Schroeder provides an update on the current standing of U.S. population health relative to other developed countries compared to where it stood at the time of his seminal Shattuck Lecture on this topic (Schroeder, 2007) (also see Higgins, 2014 on this topic). Overall, the news is not good in that the gap has grown larger. At first blush that is surprising in light of the considerable progress that has been made in the U.S. relative to other developed countries in reducing prevalence of cigarette smoking and other tobacco consumption (Higgins, 2014). However, as Schroeder notes, there is a considerable time lag between changes in cigarette smoking and the realization of associated health impacts, which is likely a factor at play here. However, Schroeder also underscores how those gains in reducing U.S. tobacco consumption were unevenly distributed across the population. That is, they were disproportionately seen among the more affluent, and have changed relatively little among more vulnerable populations, including those who are economically disadvantaged, have psychiatric conditions, sexual minorities, and other socially marginalized segments of the U.S. population. These subgroups are also disproportionately impacted by other behavior and health problems (e.g., obesity, unwanted pregnancies, other substance use disorders) that collectively account for a considerable portion of the growing problem of health disparities. The overarching message of Schroeder's essay is that reducing health disparities is key to improving U.S. population health and its relative standing in the international community. We at the VCBH concur wholeheartedly with that assessment, which is reflected in the other invited contributions to this Special Issue, including an entire section devoted to the use of tobacco and nicotine delivery products in vulnerable populations.

4. Leveraging behavioral science

Consistent with the VCBH mission, we prioritized contributions that explicitly underscore the application of principles and methods of behavioral science to advancing knowledge on vulnerability to unhealthy behavior patterns and improving the efficacy and reach of behavior change interventions.

4.1. Behavioral economics

The discipline of behavioral economics is making innovative and substantive contributions to this emerging area of behavior and health research. Bickel and colleagues contributed an essay (Bickel et al., 2016—in this issue) outlining five defining dimensions of this approach to studying health behaviors: (1) provides novel *conceptual systems* to inform scientific understanding of health behaviors; (2) *translates* scientific understanding into practical and effective behavior-change

interventions; (3) leverages varied aspects of behavior *change* beyond increases or decreases in frequency; (4) recognizes and exploits *trans-disease* processes and interventions; and (5) leverages *technology* in efforts to maximize efficacy, cost effectiveness, and reach. These are offered as helpful guideposts in defining this emerging area of research. While not unique to behavioral economics, these dimensions in combination represent an approach that is having broad reach and considerable efficacy in the area of health-related behavior change in the U.S. and internationally as the contributions to this Special Issue and elsewhere demonstrate.

In the area of substance use disorders, Murphy and Dennhardt (2016—in this issue) offer a behavioral economic conceptual analysis of processes underpinning vulnerability to alcohol and drug misuse among young adults. They also underscore the need for lower intensity and less expensive behavioral economic interventions that can be made available to college students and other young adults whose substance misuse is not sufficiently severe to warrant formal treatment but nevertheless places them at risk for academic failure, accidents, sexual misconduct, etc. In short, they provide a conceptually strong, empirically sound approach to understanding and reducing substance misuse among young adults.

Turning to those with more severe substance use disorders, Tidey (2016—in this issue) provides a brief and insightful review of the potential for a behavioral economic approach to improve efforts to decrease cigarette smoking among those with severe mental illness. She outlines novel ways that behavioral economic strategies might be combined with efficacious medications (e.g., varenicline) to reduce smoking in this highly difficult-to-treat population. Included among the behavioral economic strategies mentioned as possible candidates for combining with varenicline is contingency management (i.e., financial incentives). Exploring that combination seems very promising. Indeed, a rigorous trial examining the efficacy and cost-effectiveness of a long-term (i.e., maintenance) incentives plus medication intervention for smoking abstinence among those with serious mental illness seems long overdue.

Davis and colleagues (Davis et al., 2016—in this issue) provide the third in a programmatic series of reviews on the efficacy of contingency management in the form of vouchers exchangeable for retail items or other monetary reinforcers for treating substance use disorders (also see Higgins et al., 2011; Lussier et al., 2006). Collapsing across the three reviews in the area of addictions, 177 controlled studies on the use of voucher-based CM with substance users have been reported, with 155 (88%) of those studies supporting efficacy. That is an enormous record of empirical support. Unique to this most recent review is that approximately one-third of the studies that conducted follow-up assessments after incentives were discontinued reported continuing benefit from the incentives.

As has been discussed previously in this series (Higgins, 2014), planning and programming for maintenance of longer-term outcomes with incentives and other behavior-change interventions is an important priority that has not received the research attention that it merits. Leahey et al. (2016—in this issue) provide an important demonstration of how financial incentives and peer- or professional-provided social reinforcement can be combined to sustain weight loss in a 10-month maintenance intervention. As Silverman and colleagues have demonstrated with illicit drug abuse, incentives-based interventions can be highly efficacious maintenance interventions (Silverman et al., 2012). Looking forward, there is good reason to believe that such longer-term maintenance interventions are going to be a necessary component to sustaining health-related behavior change. The health-care system has long recognized that need regarding pharmacological treatments of chronic health conditions. I see no reason to anticipate something different for behavioral interventions. Cost-effectiveness will be an important arbiter of how that all plays out and will become an ever more important element of health-related behavior change research.

Silverman and colleagues contribute a commentary advocating for using the highly efficacious incentives-based Therapeutic Workplace

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