

Tenth in  
a series of  
Technical  
Reports

## Prevention Approaches for State Mental Health Authorities

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**POSITION STATEMENT ON THE INTEGRATION OF PUBLIC HEALTH  
PROMOTION AND PREVENTION STRATEGIES  
IN PUBLIC MENTAL HEALTH**

Prevention science has demonstrated that prevention practices can *reduce risk factors and enhance protective factors*. Further, these interventions represent a *cost-effective use of resources* relative to more expensive, treatment-based approaches.

Public health promotion and prevention are *best practices* for increasing positive functioning and resilience, decreasing the risk of developing mental illness, and facilitating recovery. These practices have been underemphasized and underutilized in the public mental health sector.

The members of the National Association of State Mental Health Program Directors (NASMHPD) believe individuals of all ages are entitled to lives of optimal mental health and well-being.

To achieve this goal, members of NASMHPD will lead public mental health systems in the development of policies and practices for the:

- Promotion of positive mental health,
- Earliest possible* identification and intervention in mental health problems,
- Reduction of the incidence of mental illness and suicide,
- Prevention of disability due to mental illness and co-occurring conditions, and
- Prevention of conditions commonly associated with mental illness including medical illness, substance abuse and trauma.

NASMHPD members are, therefore, committed to:

- Educating health professionals and the general public about the importance of mental health promotion and mental illness prevention practices,
- Adopting proven promotion and prevention strategies, and incorporating them into the State mental health plan.
- Supporting new initiatives with appropriate policies and dedicated resources.

NASMHPD members further commit to sustaining and improving performance in promotion and prevention activities, while meeting the demands of serving a public mental health population, by:

- Monitoring program implementation,
- Evaluating program outcomes and effectiveness, and
- Conducting surveillance of population-level indicators.

State Mental Health authorities must work with consumers, families and their advocates and providers and develop new partnerships to be successful in these efforts.

## REPORT PREPARATION

This report is the 10<sup>th</sup> in a continuing series of reports initiated by the Medical Directors Council of the National Association of State Mental Health Program Directors (NASMHPD) and developed in collaboration with NASMHPD leadership. The purpose of these reports is to provide information and assistance to state mental health directors on emerging clinical and service system issues.

“Prevention Approaches for State Mental Health Authorities” was developed through a pre-meeting conference call and discussions at a Medical Directors’ meeting in Honolulu, Hawaii, from February 17 – 18, 2004. The purpose of this report is to demonstrate the application of public health prevention strategies to the public mental health sector.

Information for this report was gathered from presentations and commentary from meeting participants, prevention literature distributed prior to the meeting, and materials distributed at the meeting. A list of meeting participants is included as Appendix A.

Alan Q. Radke, M.D., M..P.H., (Editor), Maile Burke, M.P.A., (Technical Writer), and Sarah Callahan, M.H.S.A., (Conference Facilitator) prepared an initial draft of this report that was distributed to all meeting participants. Subsequent drafts were distributed to the Editorial Review Board of the Medical Directors’ Council and at the Commissioner’s June 2004 meeting. Final approval for this report is pending. The report does not necessarily reflect the views of the NASMHPD membership

## **I. BEGINNING THE CONVERSATION**

### **New thinking for practitioners in mental health field**

The idea of applying public health principles to mental illness, especially in severe mental illness, and promoting good mental health was the foundation of discussions that took place at the National Association of State Mental Health Program Directors' (NASMHPD) Medical Directors' Council meeting in Honolulu, Hawaii, on February 17th and 18th, 2004.

The Council recognized the necessity of utilizing public health promotion and prevention practices in the development and delivery of the services provided by a public mental health system to increase positive functioning and resilience and decrease the risk of developing mental illness and facilitate recovery. These strategies are predicated on the belief that mental health is essential to overall health and well-being.

Mental health promotion and prevention activities complement treatment and have as their goal the earliest possible detection of mental health problems across the lifespan through routine comprehensive screening and assessment and coordination of services among a broad range of disciplines. For those already in the public mental health system, promotion and prevention interventions can prevent further disability.

In a time of increasingly limited resources, the case for prevention becomes even more compelling. Prevention science has demonstrated that prevention practices can reduce risk factors and enhance protective factors. Further, these interventions are a cost effective use of resources relative to more expensive, treatment-based approaches. By not utilizing prevention and promotion approaches, we waste both human and financial capital.

### **Introduction to Promotion and Prevention**

The World Health Organization (WHO) report on Prevention and Promotion in Mental Health (2002), defined health promotion as “the process of enabling people to increase control over, and to improve their health.” Strategies for mental health promotion relate to improving the quality of life and the potential for health, rather than the amelioration of symptoms and deficits.<sup>1</sup>

Hodgson et al.'s literature review of effective mental health promotion (cited in the WHO's report), defined mental health promotion as “the enhancement of the capacity of individuals, families, groups or communities to strengthen or support positive emotional, cognitive and related experiences.” In the same WHO report, the Commonwealth Department of Health and Aged Care in Canberra is cited, defining health promotion as “any action taken to maximize mental health and well being among populations and individuals.”<sup>2</sup>

Prevention activities are generally directed against risk factors and are implemented at specific periods before the onset of a problem or disorder. Once a problem or disorder has developed, however, preventive interventions are still useful to reduce the severity, course, duration, and disability associated with the problem.

Primary prevention efforts can be “Universal,” targeting the general population; “Selective,” targeting individuals at higher risk for developing mental disorders/problems; and “Indicated,” targeting persons at high-risk for mental disorders. Secondary prevention involves reducing the prevalence of illness or all specific treatment-related strategies. Tertiary prevention involves interventions that reduce disability and prevent relapses of the illness and includes all forms of rehabilitation.

It has been thought that specific interventions are needed to prevent specific behaviors. However, because multiple problem behaviors that relate to mental health at some level have been found to have common causes, a single intervention can have effects on multiple behaviors.

“Problems are related to each other, and can be represented with an underlying ‘super latent variable’. By focusing on the common distal causes of multiple behaviors, a broader range of behaviors can be influenced. This stepping back, to look at the very distal causes of behavior, can be applied to causes in the broad socio-cultural environment, the more focused social context in which individuals live, and at the individual level as well.”<sup>3</sup>

Early interventions address the more proximal causes of behavior and change knowledge, improve decision-making or increase social skills. These interventions also have a wide influence on various types of behaviors. And, as an intervention can influence multiple behaviors, so can they prevent multiple *negative behaviors* and enhance multiple *positive behaviors*.

The implications of understanding and applying the idea of intervening in common causes of multiple outcomes are immense both financially and programmatically. For State Mental Health Authorities needing to justify budget requests and allocate resources effectively, direct and indirect cost savings associated with prevention have, and can be, substantiated. Four examples of the type of data that can illustrate the cost impact of prevention include:

outcomes of efforts to reduce suicide, which included an \$11.8 billion savings in medical care in Canada and a \$25 billion savings in direct and indirect costs;

the billing data collected on 24,000 individuals with self inflicted injuries in New York, which showed \$202 million dollars was spent for treatment;

New York Medicaid program data from 2002, on 259,000 individuals showing high inpatient utilization by 3,000 or 1%, with this 1% capturing 14% of the dollars – an average cost per person of \$86,000 a year as compared to 600,000 individuals served in public mental health system at a cost of \$12,000 per person per year; and

Cost data from the Rochester Project Link Program, which proactively treated chemically dependent individuals with serious mental illness who were being released from jail, that showed \$2.2 million spent for approximately 46 individuals.<sup>4</sup>

Integrated program models are necessary to develop, implement, and evaluate the types of comprehensive programs that influence multiple behaviors. New and improved partnerships with professionals across a wide range of disciplines, to include classrooms, schools, clinics and the greater community, will ensure the greatest success in these efforts.

With limited resources and based on what research shows, comprehensive programs that focus on the antecedents of behaviors and utilize broader partnerships will enable individuals and communities to address a number of different issues more efficiently. Developing more ‘peer support’ and self help among primary consumers of mental health care and their families, and increasing utilization of ‘natural’ support systems that already exist in communities (service clubs, health clubs, churches) can also have a great effect at very little cost. A well-integrated program will have positive outcomes for public mental health budgets, providers, and consumers.

## **Challenges**

The perspectives of the fields of public health and mental health are different. Prevention requires new thinking, a new language, and a new set of skills for professionals and paraprofessionals in the field of mental health. When advocating for the use of promotion and prevention strategies in public mental health, the State Mental Health Authority will have to overcome issues similar to those faced by Public Health practitioners when encouraging healthy behaviors to prevent illness and disease.

These challenges include unfamiliarity and confusion about the public health/prevention conceptual model, fear that existing or new resources will go somewhere else other than our traditionally served populations, lack of a workforce skilled in both mental health issues and prevention issues, lack of a dedicated funding stream, and limited research and evidence regarding the effectiveness of interventions, especially in adults.

The mental health field is based on a medical model, which treats illness rather than preventing it. For example, State eligibility criteria require a particular diagnosis to receive services. However it typically treats the sick and waits for those at risk for mental health problems to develop further disability before receiving assistance. This approach is costly, in terms of both human and financial capital.

A public health approach seeks to promote health and to prevent ill health or further disability due to an existing mental illness in the general population. This broader view is based on evidence that when more prevention is undertaken, less people will reach a point where they need increased and more expensive care.

Barriers to incorporating public health practices in the mental health field can be overcome through education of professionals and paraprofessionals about health promotion concepts and prevention science, and increased conversation and collaboration between the two fields.

Rather than being competing values, health promotion, illness prevention, and treatment should be seen as positions on a continuum of public (mental) health services that should be made

available to society. Once this vision is accepted, maintaining the infrastructure required to provide this continuum becomes the new work of those involved in public (mental) health. Prevention is also a difficult hard concept to sell to lawmakers, who generally want instant results and a quick fix, and may be unwilling to wait long enough for prevention strategies to prove themselves. Further, most State Mental Health Authorities will not have individuals who have benefited from prevention services to assist in advocacy, in the way they might if advocating for treatment.

Evidence-based research can provide the basis for advocacy, together with examples of success with prevention in the maternal and child health field and tobacco prevention. A well-known personality or ‘champion’ can also be sought to increase attention to the cause. Together, these will provide support for the State Mental Health Authority in their efforts to fund and incorporate prevention strategies in public mental health system.

In *Achieving the Promise: Transforming Mental health Care In America*, President Bush’s New Freedom Commission addresses prevention and health promotion. Goal 4 speaks to early mental health screening, assessment and referral, as selected prevention. Goal 5.1 recommends acceleration of research to promote recovery and resilience.<sup>5</sup>

### **The Recovery Model**

The President’s New Freedom Commission Report refers to recovery as the process in which people are able to live, work, learn and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms.<sup>6</sup>

In New York State, recovery is ‘gaining control over one’s life in the context of the personal, social, and economic losses that may result from the experience of psychiatric disability. This continuing, non-linear, highly individual process is based on hope and leads to healing and growth.’ In adults, this means living at home in their community, working or engaging in meaningful activities, and socializing or being engaged with others in the community. For children it means living at home, being in school, having friends and staying out of trouble.<sup>7</sup>

Group participants agreed that Recovery should not be seen as being asymptomatic or ‘not diagnosable’, but as a process within which the individual is an active participant in society with a meaningful role that they choose and define. Stigma is recognized as a barrier to the principles of recovery.

### **Does Recovery fit in Prevention?**

The idea that recovery from mental illness is possible is an important concept that has gained recognition in the past quarter century. But does it fit in the field of Prevention?

Recovery finds its place in the public health model in the context of Secondary and Tertiary prevention, where activities are focused on preventing further disability and rehabilitating disability that has occurred. In these activities, the goal of recovery is critically important.



Prevention and Recovery can be seen not as competing or disparate values, but as equally important processes on the continuum of care provided by a public mental health system. Recovery is also highly consistent with the health promotion since it focuses on increasing healthy adaptive functioning rather than treatment of an illness or deficit state.

The recovery model may not fit when looking at promotion and prevention activities with young children, especially those at risk for severe mental illness. Two contrasting examples are autism and attachment disorders. It is not currently known whether autism can be prevented, and there is considerable controversy about whether it can be 'recovered from', but there is prevention science that addresses attachment disorders in children. A focus on building resiliency, or an ability to 'rebound' from trauma or threats to normal development, and preventing co-morbidities from accumulating is indicated for this population. Elements needed for recovery include education, engagement, and self help.

Knowledge is power and being empowered is a critical part of recovery. Knowledge about one's illness and its treatment and its effects and side effects need to be transferred from various fields of practice and providers of care to recipients of care and their families.

Such knowledge can be shared verbally or transferred through dissemination of existing, available educational resources from sources like the National Institutes of Health. Tool kits and compilations or summaries could also be created to provide an abbreviated, more user-friendly means for recipients and their families to be actively involved in seeking and managing care.

Providers need to not only transfer knowledge, but also engage in conversation with recipients of care and their families. This entails taking an 'asking stance' toward clients and their families, asking if they understand what is being shared and what their questions, concerns, fears, and needs might be.

Recipients of care and their families must also be encouraged to take a more active role in the processes of education and engagement. Providing clients with a checklist of questions to ask their provider about their condition, care, or the medications they are being prescribed could facilitate this. A simple tool such as this can provide the impetus for the type of deeper and continued interactive discussion between provider and recipient that is critical not only to effective care, but also to the process of recovery.

Providers should be more available to consumers and their families in terms of office hours and scheduling; this is an important element of recovery. A clinic or provider with 9-5 hours may not be easily accessible to consumers. Additionally, it can be difficult for a person in recovery to wait to be seen six or seven weeks down the road when being rescheduled for a missed appointment.

Empowerment through self help is another element which is critical to the process of recovery. There is a National-level toolkit for 'illness' self-management, but what is needed is a 'wellness' self-management model and toolkit, which would instruct on how to promote wellness for oneself and others. This type of toolkit could be integrated into the continuum of care and used in selected, indicated and universal promotion and prevention strategies.

Enabling a client and their family to become educated partners in treatment not only facilitates recovery, but it also is a health promotion and illness prevention approach in and of itself. These suggested elements will help to ensure that recipients of care and their families can be more active participants in not only mental health care and management, but also in the process of recovery.

<sup>1</sup> World Health Organization (2001). Prevention and Promotion in Mental Health. World Health Organization's Meeting on Evidence for Prevention and Promotion in Mental Health: Conceptual and Measurement Issues. (p.8). Geneva: World Health Organization.

<sup>2</sup> Ibid.

<sup>3</sup> Flay, Brian (2003) Positive Youth Development for the Improvement of Multiple Behaviors, Character, Mental Health and Academic Achievement. Prevention Approaches for State Mental health Authorities. Medical Directors' Council of the National Association of State Mental Health Program Directors' meeting, Honolulu, Hawaii.

<sup>4</sup> Carpinello, Sharon (2003). Medical Directors Council meeting. National Association of State Mental Health Program Directors.

<sup>5</sup> New Freedom Commission on Mental Health (2003). Achieving the Promise: Transforming Mental Health Care in America. Executive Summary. U.S. Department of Health and Human Services Pub. No. SMA-03-3831.

<sup>6</sup> Ibid.

<sup>7</sup> Carpinello, Sharon (2003) Medical Directors Council meeting. National Association of State Mental Health Program Directors

## **II. IMPLICATIONS FOR APPLICATION IN A PUBLIC MENTAL HEALTH SYSTEM**

### **Continuum of Care: Promotion, Prevention, Treatment, Recovery**

The Mental Health field has largely been driven by a service or treatment orientation, based on diagnosis. For prevention and promotion activities to be accepted, professionals and para-professionals in the field must first learn to 'think prevention.'

This necessitates looking beyond who is already in the system of care to the greater population and promoting care on a broader continuum beginning with health promotion and illness prevention, including treatment, and supporting the process of recovery throughout.

This broader view opens doors to an increased number of options with respect to partners, care and financing.

### **Better Coordination Among Stakeholders in the New Continuum of Care**

Those in the public mental health system need to go "upstream" to enlist the help of others in learning how to construct a gate that will prevent people from falling into the river and then *construct it*, instead of continuing to just find new and better ways of fishing people out "downstream."

State Mental Health Authorities need to link with consumers and their advocates, public health and private practitioners and others in the public mental health system, including State, Community and Acute Care Hospitals, to begin the conversation about Prevention with the goal of community wide acceptance of health promotion and prevention as effective processes for improving mental health and the services of a public mental health system.

Once partners have embraced the concepts of promotion and prevention, issues of utilization and identification of existing and new resources for mental health promotion and prevention will need to be discussed. Again, central to these discussions must be an acknowledgement that what is needed is not making the current system better, but retooling and doing things differently and more efficiently. This ‘collaborative engagement’ will need to include articulated, and perhaps more formal, agreements together with changes in policy.

## **Best practices**

Science supports promotion and prevention practices. Only evidence-based prevention and promotion practices should be used. These practices are established by adhering to a strict set of criteria, which speak to the practice’s or program’s efficacy and effectiveness<sup>1</sup>

Efficacy criteria establish to whether a program/intervention does more good than harm when delivered under optimum conditions, generally a controlled environment. Direct causal statements can be made under these conditions. However, will this program or intervention have the same effect in the ‘real world’ under less than ideal conditions?

Effectiveness criteria indicate whether the program/intervention does more good than harm when delivered in the ‘real world.’ While direct causal statements may not be able to be made when implementing programs or interventions under these conditions, one can assume that if the program or intervention is implemented with adequate fidelity to the model, a similar effect will occur ‘in natural settings.’

The following recommendations on standards that should be applied for accepting evidence of efficacy and effectiveness of promotion and/or prevention programs were developed by the Society for Prevention Research (SPR)<sup>2</sup>.

### Standards for Efficacy

1. Specificity of Efficacy Statement  
“Program X is efficacious for producing Y outcomes for Z population.”
2. Intervention Description and Outcomes  
There should be an adequate program or policy description at a level that would allow others to implement/replicate it. The stated public health or behavioral outcome(s) of the intervention must be measures and there must be at least one long-term follow-up. Valid measures of the targeted behavior must be used and reliability of measures must be available.
3. Clarity of Causal Inference  
The design allows unambiguous causal statements, and must have at least one comparison condition that does not receive the tested intervention. The assignment to conditions can include random assignment, repeated time-series designs, regression-discontinuity designs and matched control designs w/demonstrated pretest equivalence and without self selection.
4. Generalizability of Findings

The sample is defined – the report must specify what/who the sample is and how it was obtained.

#### 5. Precision of Outcomes

Statistical analysis allows a causal relationship to be unambiguously established. There must be statistically significant effects. Practical significance, in terms of public health impact, must be demonstrated. Significant effects are shown for at least one long-term follow-up and consistent findings are required from at least two different high-quality studies.

### Standards for Effectiveness

#### 1. Effectiveness under Real World Conditions

Where implementation and participation of a target audience may vary, all criteria for efficacy stand and the following are added.

#### 2. Program Description & Outcomes

Manuals and, if appropriate, training and technical support must be readily available. A clear theory of causal mechanisms and a clear statement of “for whom” and “under what condition?” must be present. Level of exposure should be measured (integrity and level of implementation/delivery of intervention and acceptance / compliance/ adherence/involvement of target audience and subgroups of interest in the intervention activities.)

#### 3. Clarity of Causal Inference

The same standards as stated for efficacy apply, although challenges are greater. Randomization is still the best approach.

#### 4. Generalizability of Findings

The sample must be representative of the target population, and the degree to which findings are generalizable should be evaluated.

#### 5. Precision of Outcome

Evaluation reports should show some evidence of practical importance and consistent findings are required from at least three different high-quality studies/replications that meet all of the above criteria and each of which has adequate statistical power.

Further criteria for broad dissemination include the ability of the intervention/program to “Go to Scale” or to be readily available to a broad audience. Clear cost information must also be readily available and there must be clear knowledge about the sustainability of the program once implemented. Finally, monitoring and evaluation tools must be available to providers.<sup>3</sup>

### Lists of Best Practices

There are various lists of specific promotion and prevention programs that have been compiled for use. As cited by Nancy J. Davis, Ed.D, in “The Promotion of Mental Health and the Prevention of Mental and Behavioral Disorders: Surely the Time Is Right.”<sup>4</sup>

Mrazek, P.J., & Haggerty, R.J., Eds. (1994). *Reducing Risks for Mental Disorders: Frontiers for Preventive Intervention Research*. Washington, DC: National Academy Press

Olds, D., Robinson, J., Song, N., Little, C., & Hill, P. (August 1999). *Reducing Risks for Mental Disorders During the First Five Years of Life: A Review of Preventive Interventions*. A report prepared for the Center for Mental Health Services, Rockville, MD.

Greenberg, M.T., Domitrovich, C., & Baumbarger, B. (July 1999b). *Preventing Mental Disorders in School-Age Children: A Review of the Effectiveness of Prevention Programs*. A report prepared for the Center for Mental Health Services, Rockville, MD.

Mrazek, P.J. (1998). *Preventing Mental Health and Substance Abuse Problems in Managed Health Care Settings*. Alexandria, VA: National Mental Health Association.

Dorfman, S.L. (October 1999). *Preventive Interventions for Mental Health and Substance Abuse Under Managed Care*. A report prepared for the Offices of Managed Care of the Center for Mental Health Services and the Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration, Rockville, MD.

Are there principles that assure that a particular practice will have positive outcome? Is the best practice culturally adaptive, recovery focused, and amenable to resource differences?

### Fidelity versus Flexibility

As in any field, standards for prevention research and program implementation are necessary. Furthermore, the public health model views illness prevention and health promotion as being a community action that must have grass roots support.

On the other hand, do strict criteria deter creativity? Does fidelity inhibit the ability of different communities, serving diverse populations, to implement appropriate promotion and prevention programs? One size does not fit all.

Reasonable fidelity can produce good outcomes. Individualization, or variability in design and implementation, are possible to meet local needs and address very specific concerns. A strong evaluation component addressing the variations being made and analyzing the relationship between implementation and outcomes, however, will be critical to understanding whether the program as implemented “worked.”

Generally, the greater the fidelity to the model, the larger the effect will be. Fidelity measures can, therefore, be seen and used as controls for outcomes that were not expected.

It is recognized that any comprehensive promotion or prevention technique or program needs to be “community based” or individualized to the demographics, needs and resources of the community.

For the State Mental Health Authority, using a scientific basis to decide where to put resources is critically important. The good news is that there are a number of programs with good science behind them which are readily available.

For those charged with implementing programs in their communities, the good news is that adjustment of the model for variations in populations is possible, again with adequate evaluation of variations and an analysis of the relationship between implementation and outcomes.

The good news for the individual consumer, who has very specific needs and wants, is that more individualized care is available. Through a ‘blended model’ of care, a menu of services that might be effective for them now becomes available, supplementing treatment currently provided based on clinical diagnosis.

### **Sustainability and Quality Improvement as part of the Prevention Strategy**

Continuous Quality Improvement (CQI) of prevention efforts at the program level and the individual practitioner level is necessary.

Providers are encouraged to take a step back and ask themselves why people are coming to their door and to think about what they can do as individuals, and with local partners, to prevent people from needing treatment. By engaging in this type of personal, in depth quality assurance, and sharing information with partners and systems, the concept of CQI can be used as a tool in mental health promotion and prevention activities.

The State Mental Health Authority can also encourage CQI by promulgating requirements for these types of activities at the practitioner level and implementing more performance based contracting. Is a product being produced that is worth funding?

What is being advocated is not ‘managed care’ but ‘care management.’ Consumers and their advocates, the State Mental Health authority and providers together must agree that what is needed are effective, efficient ways to develop and implement promotion and prevention strategies that have reasonable outcomes and are sustainable. They then must hold themselves and each other accountable.

Non-monetary support, such as technical assistance, can also greatly affect sustainability. For instance, a State taking over implementation of a Federally-initiated demonstration project might need technical assistance to ensure that an adequate evaluation component is incorporated into the project.

### **Interface Issues**

The importance of screening for co-occurring conditions and linkage with integrated treatment strategies/services needs to be emphasized. The goal of our collective efforts should be the education of all disciplines in such a way that they accept and actively support prevention as the best way to serve the entire population, many of whom have more than one condition.

### **Substance Abuse/Mental Health**

The overlap between those with substance abuse and mental health disorders is well known. Each group suffering from a behavioral health condition is comprised of a significant portion of

the other's population. Research in risk and protective factors in children has shown a core group of risk factors for early onset of substance abuse, conduct disorders, and early onset of delinquency.

What is important about this from a prevention standpoint is that the order of occurrence of these medical or psychiatric diagnosis is irrelevant. Rather than focusing on the 'order' of behaviors or the diagnosis, focusing on ameliorating *any* risk factors will have positive effects on both mental health and substance use.

It has been shown that children who are at risk because of family conditions, for instance having a mother with substance abuse and/or mental health problems, are less likely to become involved in any treatment system. As we look at co-occurring conditions, it is extremely important to look at not only risk factors, but also at the domains in which they occur. By involving the family and broader community in the prevention process it may be easier to make a difference. The implications of not intervening when these risk factors are present will be felt in the mental health, substance abuse and juvenile justice systems.

### Physical Health / Mental Health

Physical health problems have been tied to the rising costs of mental health care, making the linkage between the two critically important.

There is a long history of medical providers, particularly primary care providers, not being trained to recognize or screen for early signs of trauma or mental illness. Those in the field of mental health, likewise, are not trained to screen for physical health symptoms and do not feel it is their responsibility to do so.

Individual consumers do not expect providers to be "cross-trained", and it may take all they have to seek care from one system, let alone to question their provider about referrals for their 'other' problems. Unfortunately, consumers do rely on the fragmented 'system' to facilitate access to comprehensive care.

An individual's presenting complaint may not be the only problem he/she has. Adequate screening and coordination with behavioral health and physical health systems is necessary so that wherever a person enters, they are linked to the appropriate care. Each discipline needs to be educated enough to screen for early signs of physical and mental health problems. Each discipline needs to converse and connect with others on behalf of the consumer, so that consumers are truly linked to the care provided by a person or system, and not just 'referred.'

Implied in these relationships is the understanding that collaboration, and not separation, is being promoted and that working together means better outcomes for the both the professional and the individual consumer of care.

### Co-Occurring Mortality and Morbidity



Individuals with mental illness have higher rates of physical disorders and die earlier than the general population based on epidemiological studies in countries with national case registries (mortality rates of 1 ½ - 2 ½ times that of the general population.)<sup>5</sup>

Some physical disorders are due to side effects from medications. For instance, antidepressant medication can cause weight gain, cardiovascular problems and diabetes. Other factors to consider include lifestyle issues relating to diet, exercise, and access to medical care. Those with mental disorders have higher rates of suicide, accidents, and death from homicide as well as from natural causes or disease, including blood borne diseases like Hepatitis and HIV/AIDS. With a co-occurring substance abuse, smoking as self-medication is seen and smokers in general have higher rates of depression.

To reduce mortality and morbidity in populations with mental illness, better integrated primary care and mental health care is critical. Reducing the stigma associated with mental illness is important in this area, to increase the comfort level and understanding of those in the primary care arena in helping individuals with mental illness. Prevention among consumers, focusing on wellness and recovery, self-managing illness through education, monitoring of diet and exercise, and early use of primary care, are also necessary.

While there is not a large amount of evidence-based practice in this area, risk factors have been identified and a link between mortality, morbidity and mental illness has been established.

Greater collaboration among those in the fields of medicine, mental health and substance abuse is needed and begins with acknowledgement of the interface issues mentioned here. Their participation as partners is critical to the process of reducing morbidity and mortality in those with mental illness

### Consumers

Interface is an important issue for consumers, as historically treatment is ‘done to’ them, without any real dialogue or engagement as a partner. Consumers of mental health care want a provider to be accountable to them and to produce some outcome which they have a part in determining. Outcomes that consumers often want are different from those the ‘system’ uses to evaluate itself.

Consumers want stable housing, access to transportation, a job or meaningful activity, friends or a natural support system, and a relationship with a significant other. The public mental health system evaluates itself on measures like length of community tenure, reduction in psycho-pathology, skills development and consumer satisfaction. More effort needs to be placed on evaluating and reporting outcomes that consumers want and changing the locus of treatment to them, rather than higher levels of care.

We begin to change the locus of care from an office based, provider-based system to one that is consumer centered by reallocating resources to educate and engage consumers in the treatment and management of self, symptom and environment. We ask providers, through their education and expertise, to act as consultants and to engage the consumer in assuming greater responsibility for the direction and outcomes of his/her care.

Going beyond the relationship between provider and consumer, or system and consumer, is necessary, however. Treatment, and the relationship between provider and consumer, is imbedded in the larger context of community and society. We can improve individual practices of providers or clinics, but we must also change the way our 'culture' views mental illness and help seeking behavior.

Children as consumers need a more complex perspective. Families, and the Education, Juvenile Justice and Welfare systems and other stakeholders must speak for a child in the ways suggested above.

### **Cultural competency**

Addressing cultural competency is important, as it is another opportunity for the mental health professional to become attuned to and responsive to real issues faced by culturally diverse populations. Certain cultural and ethnic minority groups share a greater proportion of the burden of mental illness.

The single most important variable in the successful treatment of mental illness is the relationship between the service provider and the consumer.

Cultural competency requires awareness by providers of the cultural differences between themselves and their patients. This awareness is gained by engaging in meaningful dialogue about the patient's background, becoming educated about that culture, and perceiving and treating the client as an individual, despite personal feelings or assumptions about individuals from that culture.

The concept of 'cultural difference' does not just imply those differences between a dominant culture and a minority culture. It includes physical differences, as in the blind and deaf communities, and even unique differences as defined by individuals in their own personal context. It has been seen in peer groups of those with serious mental illness that the culture of 'birth' becomes less important as they relate to each other around a culture of mental illness or a particular treatment.

Greater attention must be given to how we individualize approaches in prevention and promotion to adequately address all these differences. The fact is, we can only know how culture affects a person and which particular culture has the greatest effect on them at any given time, when we take the time to ask. Acknowledging differences and accepting tension among cultures is part of a learning experience that can lead to greater understanding and a common ground from which effective work can begin.

Culturally sensitive promotion and prevention practices must go beyond linguistic differences and adequately address the context or construct of the text for the particular culture. Culturally sensitive treatment services may be ones that are selected from a 'menu' of services offered by a provider, based on the individual's needs, wants and culture.

Finally, it is important to recognize that the values and practices of indigenous people often incorporate Western concepts of health promotion and disease prevention, just in different ways and with different terms. Respect, acceptance and integration of these indigenous practices should be foremost in our minds when developing, implementing and evaluating promotion and prevention activities in our diverse communities.

This may include a greater appreciation and acceptance of the informal delivery systems that have existed and worked in cultures for many years by more flexible program and funding requirements. It could mean greater acceptance of the differences in priorities and policies of certain cultures as compared to their western counterparts. It does mean paying attention to what the particular cultural community defines and identifies as appropriate and important to them at a given point in time.

The way in which a promotion or prevention approach might be implemented in one culture could be different than how it would be implemented in another. However, often the value or belief, on which the intervention is based, is commonly held. For instance, all may accept that molesting young children is unacceptable. The approach on how to prevent that will likely differ in different communities and cultures, as the way issues are explained and discussed needs to be personalized.

While there may be no single health promotion or illness prevention activity that will cross all cultures, we do know that Universal prevention does result in some reduction and prevention in the general population and, further, that this impact in some cases will be felt by those in the highest risk group. Though developing culturally sensitive interventions/programs may be easiest at the Indicated and Selective levels of prevention, what we know about the effects of Universal prevention supports its use as an effective strategy.

### **Building Capacity**

Ongoing training of professionals and para-professionals and monitoring and evaluation of prevention programs and their outcomes are critical for sustaining prevention programs in communities.

Prevention requires new thinking, a new language, and a new set of skills. Wellness self-management is a key in promotion and prevention. It is a newer concept, in practice, in the field of mental health.

The interplay of existing and needed resources, including personnel, to support the infrastructure of this new continuum of care leads to an understanding of the importance of training and cross training for those involved in the provision of services.

We must develop processes to ensure that mental health professionals and para professionals receive adequate and ongoing education and training in the field of prevention. This training and education should be academic as well as on-the-job.

## **Growing Our Own**

Integrating Prevention into professional curricula, licensing exams, trainings and certifications for those in the mental health field will help to ensure a more competent workforce. However, staff turnover in the public mental health system means training of personnel responsible for implementing promotion and prevention programs must be ongoing

As consumers enter the system of care through many doors, *all* disciplines providing care need to increase knowledge and understanding of prevention concepts, to be able to screen thoroughly for early signs of illness and to link the consumer appropriately and *personally* with other care professionals. This includes social workers, nurses, and school counselors as well as primary care physicians.

Without such education, for example, screening in the hands of the poorly trained could result in more case findings, inaccurate labeling of individuals, referrals to inappropriate care and even commitment to a lifetime of care in a public mental health system. We do not want to create more disability than we prevent.

Ongoing training of professionals and para-professionals is also needed in program monitoring and evaluation. It is critically important to know whether a program is being delivered with reasonable fidelity and whether good outcomes are being produced. Whether publicly or privately funded, good outcomes about effectiveness are necessary to sustain programs and are often the bottom line.

<sup>1</sup> Flay, B.R. Efficacy and effectiveness trials (and other phases of research) in the development of health promotion programs. *Preventive Medicine*, 15, 451-474, 1986.

<sup>2</sup> Though multiple standards exist, the SPR created their own because the nature of interventions can vary greatly and a standard randomized clinical trial is not always appropriate for evaluation. SPR sought to accommodate various kinds of interventions when selecting their criteria.

<sup>3</sup> Flay, B.R., Biglan, A., Boruch, R.F., Castro, F.g., Gottfredson, D., Kellam, S., Moscicki, E., Schinke, S., Valentine, J., and Jr. P. (2004) *Standards of evidence: Criteria for efficacy, effectiveness and dissemination*. Washington, DC: The Society of Prevention Research.

<sup>4</sup> Davis, Nancy J. The Promotion of Mental Health and the Prevention of Mental and Behavioral Disorders: Surely the Time is Right. *International Journal of Emergency Mental Health*, 4:1 22.

<sup>5</sup> Brown, S. (1997) Excess Mortality in Schizophrenia: A meta-analysis. *British Journal of Psychiatry*, 171:502-508.

### **III. SPECIAL POPULATIONS<sup>1</sup>**

#### **Prenatal & Early childhood**

From the standpoint of prevention, the preschool period is extremely critical. Early intervention has multiple meanings, but it directs our attention to early childhood for a variety of reasons. First, it is the least likely part of life to be understood by the traditional mental health system. Second, it is a period when cascading life events can quickly lead to significant risk building for the individual. Third, given what has been scientifically proven about the efficacy of early intervention, it is the appropriate place to start.

In early development, the broader, more distal causes or factors effecting behavior, including families, schools, and community, are critically important and must be addressed or changed to ensure success and sustainability of promotion and prevention efforts. These same factors can lead to early detection and treatment.

A summary of empirically validated prevention programs for young children (0-8 years) that are designed to prevent later development of substance abuse, violence, delinquency are cited in “Nipping Early Risk Factors in the Bud.” by Carolyn Webster-Stratton and Ted Taylor.<sup>2</sup> By program type and/or name:

Parent and family focused interventions include: Home Visiting, Structural Family Therapy, Living with Children, Helping the Noncompliant Child, Parent-Child Interaction Therapy, Synthesis training, Enhanced family treatment, Positive Parenting Program, Incredible Years Parenting Program, Community-based program, DARE to be You, and Focus on Families.

Child-Focused Interventions include: Problem-solving curriculum, Incredible Years Dinosaur Program, Peer Coping Skills Training and Earls court Social Skills Program

Classroom-Focused Interventions: ICPS, High Scope Perry Preschool Project, Contingencies for Learning Academic and Social Skills, Program for Academic Survival Skills, Good

Behavior Game, Promoting Alternative Thinking Strategies, Second Step Child Development Project.

Multifocused Interventions: First Step, Montreal Program, Fast Track, Linking the Interests of Family and Teacher, Seattle Social Development Project, Incredible Years Teacher Training.

As cited in “Community Planning to Foster Resilience in Children” Chapter 18: Resilience-Building Prevention Programs that Work: A Federal Perspective (in progress), Top 21 Evidence-Based Family-Focused Programs include:<sup>3</sup>

For Infants and Toddlers: Nurse Family Partnerships, Parent Child Development Center Programs

For Preschoolers and School-aged Children: The Incredible Years, Helping the Noncompliant Child, Soar: Skills, Opportunities, and Recognition, Preventive Treatment Program, Parent Management Training, Linking the Interests of Families and Teachers, Dare to BE You, Fast Track, Parent-Child Interaction Therapy, Strengthening Families, First Steps to Success

## **Youth**

A holistic approach that looks at the needs of individuals across the life span, acknowledging many risk and protective factors that need to be employed to foster well being and the prevention of problem behaviors, is needed. This approach needs to focus on prevention of greater disability, the risk of youth suicide, and recovery and on consumer-directed services and illness self-management.

We can promote the mental health of young children by improving and expanding school and community mental health programs as well as mental health screening for children entering the child welfare and juvenile justice systems. Transition-age youth also benefit greatly when connected to job opportunities.

For those already in the public mental health system, addressing their needs in transition, as they move from the juvenile service system to the adult system, includes providing the kind of support that will prevent the youth from spending a lifetime in the public mental health system.

More communication among providers of service is necessary to discuss the specific needs of youth, improve networking, and provide better-coordinated services.

As cited in “Community Planning to Foster Resilience in Children” , Top Evidence-Based Family-Focused Programs for this group include<sup>4</sup>:

For Pre-Adolescents and young Adolescents: Preparing for the Drug Free Years, Brief Strategic Family Therapy, Strengthening Families for Parents and youth, Adolescent Transitions Program

For Older Adolescents: Mutlisystemic Therapy, Functional Family Therapy, Multi-dimensional Treatment Foster Care, Creating Lasting Family Connections

New lists of validated prevention programs are being developed. An example of a recently validated programs is Helping Adolescents at Risk: Prevention of multiple problem behaviors.<sup>5</sup>

### **Older Persons**

The fastest growing segment of those committing suicide are males over the age of 85. Suicide in this population is not an impulsive thought, but an organized, motivated action seen as problem solving. The elderly often experience the dual problem of vital losses and a decreased capacity to deal with those losses.

Appropriate and promising prevention strategies for older adults must include an understanding of the specialized risk factors for suicide. These include being an older white or Asian male, living alone, being recently widowed or divorced, being diagnosed with depression, or experiencing functional decline, bereavement, or a change in job or functional professionalism.

The barriers to successful intervention with this population include the stigma about seeking mental health treatment, the lack of knowledge about geriatric mental health issues, and the non-recognition of depression and suicidal ideation on the part of care providers and the older person themselves. Issues complicating these barriers include the lack of transportation, in home mental health services, and affordable housing for the elderly, the inadequacy of managed care coverage, the inability of Medicaid and Medicare reimbursement to support community based mental health and the lack of political will for reform.

Prevention in this area includes increasing the awareness of providers and consumers about the problem of depression in older people and the effectiveness of pharmacological and cognitive, behavioral treatment for depression. Equipping primary care physicians with data systems or algorithms for use in screening, to pick up the sometimes subtle symptoms and risk factors in older adults, could help in early detection. Telemedicine could increase their access to and collaboration with a relatively small supply of geriatric psychiatrists for consultation. It necessitates nontraditional approaches that increase independent living, provide access to services from community, social, volunteer and religious organizations, and equip people to deal more effectively with retirement and bereavement issues.

Finally, a culture valuing independence and productivity is not likely to hold the older person in high esteem. We must reduce ageism in our country and the stigma attached to 'getting old.'

<sup>1</sup> The time allotted to presentations and commentary on promotion and prevention in special populations was insufficient. This meeting allowed issues of concern to be highlighted and provides a starting point for the type of in depth review and discussion warranted.

<sup>2</sup> Webster-Stratton, C., and Taylor, Ted. Nipping Early Risk Factors in the Bud: Preventing Substance Abuse, Delinquency and Violence in Adolescence Through Interventions Targeted at Young Children (0-8 Years) Prevention Science, 2:3 173.

<sup>3</sup> Clauss-Ehlers, C., & Weist, M. (Eds., in progress). Community planning to foster resilience in children. New York: Kluwer Academic/Plenum Publishers.

<sup>4</sup> Webster-Stratton, C., and Taylor, Ted. Nipping Early Risk Factors in the Bud: Preventing Substance Abuse, Delinquency and Violence in Adolescence Through Interventions Targeted at Young Children (0-8 Years), 173.

<sup>5</sup> Biglan, A., Brennan, P.A., Foster, S.L., Holder, H., et al. (2004). Helping adolescents at risk: Prevention of multiple problem behaviors. New York: The Guilford Press.

#### **IV. RECOMMENDATIONS**

These recommendations, offered by meeting participants to specific groups and individuals, come with an overarching theme: that Mental Health promotion and prevention activities be employed within a developmental framework, or across the lifespan, with priority given to the earliest possible detection of mental health problems.

#### **STATE MENTAL HEALTH AUTHORITIES**

Develop policies that promote recovery and wellness.

Ensure adequate monitoring and evaluation of mental health promotion and illness prevention programs.

Develop and/or improve the State's surveillance systems with regard to prevention in mental health.

Develop partnerships with Public Health to develop health promotion and illness prevention initiatives in mental health.

Work with State Medicaid Directors as partners in Prevention, engaging them in cost/benefit analysis with respect to prevention programs.

Develop plan to educate and train Primary Care Physicians in mental health screening, assessment, and referral.

Convene stakeholders in the State (County partners, Community hospitals, Community mental health centers) to create a plan for health promotion and illness prevention in mental health.

Work with NASMHPD to develop State legislative initiatives for grants to communities that require partnerships with state agencies (Departments of Health and Human Services).



Work with family members of consumers of the public mental health system as a “high risk” group for mental health problems.

## **NASHMPD**

Issue Paper or Fact Sheet on “Prevention 101”

Define what is preventable, and what we should no longer accept – i.e. suicide, some early childhood developmental problems, sexual assault of vulnerable populations

Revisit the World Health Organization’s 2001 document on prevention

Educate regarding the facts that Prevention has solid science foundation and present information on evidence-based practices.

Convene National meeting of National level stakeholders on Health Promotion and Prevention to include Co-Morbidity

Researchers, Office of Juvenile Justice and Delinquency Prevention, SAMHSA, Centers for Disease Control & Prevention, National Prevention Network, Schools, Casey Foundation, NACSMHA, First Responders, Fed Families, SPR, American Association of Retired Persons, NCOA, ASA, National Institutes of Health, Children’s Defense Fund, Public Health Nursing affiliate of ASTHO, National Association of Social Workers, NAMI

Convene meeting of technical groups and consumers to evaluate how to communicate and how to market the concept of prevention and promotion.

Provide funding for States to convene State stakeholders around the issue of Prevention in Mental Health

### Work with Federal partners

Demonstrate a collaborative model around prevention.

Work with Centers for Disease Control & Prevention in regards to Healthy America 2010.

Dialogue with SAMHSA about including Prevention in Mental Health as part of the next Healthy People / Healthy America publication.

Get Center for Mental Health Services to provide funding for prevention through resources set aside in the block grant.

Work to develop Federal legislative initiatives for grants to communities that require partnerships (with Public Health, Substance Abuse, and/or others.)

Develop strategy to link SAMHSA and HRSA for funding prevention in mental health.

Advocate for prevention being a mandatory part of the new comprehensive State mental health plans.

#### Work with Professional and Advocacy Associations

Address stigma and its ramifications.

Endorse NASMHPD Children Youth and Family Division's prevention efforts.

Work with the National Governor's Association to get Prevention and Promotion included in the mental health component of their State Health plans.

Propose a joint application for funding around prevention, bridging mental health and public health, with the Association of State and Territorial Health Officers.

Begin a dialogue with the National Alliance for the Mentally Ill and the Mental Health Association about the value of prevention in promoting mental health.

#### **NASHMPD MEDICAL DIRECTORS' COUNCIL**

Work with American Psychiatric Association to develop nosologies (DSM V) that are developmentally and culturally appropriate and consumer and practitioner friendly to utilize.

Include Prevention & Promotion as a key session at a Best Practices Symposium.

Collaborate with NAC/SMHA to promote the use of advance directives or wrap-around plans and illness management and recovery as prevention strategies.

#### **NASMHPD RESEARCH INSTITUTE**

Convene a group of mental health researchers to discuss prevention as a mental health strategy.

Present environment scan of states' Promotion and Prevention programs/activities to the Medical Directors' Council.

Request resources from National Institutes of Mental Health to help identify key risk and protective factors with regard to mental health that require ongoing research.

Provide technical assistance to States to develop and include a strong outcomes component in all prevention research and programs initiated.

## **NATIONAL TECHNICAL ASSISTANCE CENTER**

NETI Training on health promotion and prevention in mental health

Provide technical assistance to peer groups regarding the concept of prevention.

Provide a menu of efficacious/effective health promotion and prevention programs.

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## **Specific Recommended Prevention Initiatives**

### **Addendum to Prevention Approaches for State Mental Health Authorities**

**October 2004**

#### Introduction

As part of the review and discussion process leading to final acceptance and endorsement of this technical report the Medical Director's Council felt that the technical report made such a compelling argument for the need for prompt action in the area of prevention that SMHA should proceed with some specific programs immediately. In considering these additional recommendations it should be understood that they did not arise during the usual review of evidence and expert panel discussions that produced the Tenth Technical Report "Prevention Approaches for SMHA". Rather the council as a whole recommends these specific initiatives for SMHA initial prevention efforts.

Suicide Prevention and Early Intervention in Psychosis are recommended for the highest priority due to their having the best supporting evidence and the best potential for making a real difference in large numbers of community members. Five additional lower priority options are also presented. While they have less evidence for efficacy they may fit well with the goals and opportunities of particular individual SMHA.

#### Recommendations

##### I Suicide Prevention

The Medical Director's Council recommends that all SMHA's be actively involved in Early Psychosis Intervention activities for the following reasons:

It is a major cause of death among persons served by SMHA

There are a variety of evidence based suicide prevention interventions available to take action on including screening, gate keeper training, crisis centers and hotlines, restriction of lethal means, media education, post intervention, and school based suicide awareness curriculums

Since suicide is also a major cause of death for non-severely mentally ill persons it is an opportunity to broaden and deepen the constituency of SMHA.

Suicide is an easily understood issue in public discussion and its prevention routinely draws broad and deep support with the general public

The federal government has been strongly supporting suicide prevention activities since 1998 an increasing amount of funding through the federal government are becoming available.

Due to federal advocacy approximately half of the states have developed suicide prevention plans. These plans often in collaboration with their state public health authority.

The following resource websites are recommended for use in developing suicide prevention initiatives.

The Surgeon General's Call to Action

[www.surgeongeneral.gov/library/calltoaction/calltoaction.htm](http://www.surgeongeneral.gov/library/calltoaction/calltoaction.htm)

The National Strategy for Suicide Prevention Website

[www.mentalhealth.org/suicideprevention](http://www.mentalhealth.org/suicideprevention)

The Suicide Prevention Resource Center

[www.SPRC.org](http://www.SPRC.org)

## II Early Psychosis Intervention

The Medical Director's Council recommends that all SMHA's be actively involved in Early Psychosis Intervention activities for the following reasons:

Studies have shown that a longer Duration of Untreated Psychosis (DUP) worsens outcomes (Edwards and McGorry, 2002; Woods et al. 2003, McGlashan, 1999)

New screening instruments make it increasingly feasible to identify persons in the pre-psychosis phase who could benefit from early detection programs (for example, McGorry et al. 2003; Miller and McGlashan 2000; Miller et al. 2002)

Model early detection and treatment programs have been developed in several countries in addition to the US. These countries include, Australia, Norway, Canada and England.

These programs open the door to treatment for persons at a high risk of psychosis, thereby increasing the efficacy of and accessibility to psychosis treatments currently available.

Increasing evidence indicates that early detection programs produce positive outcomes for clients (McGlashan, 2003; Davidson and McGlashan 1997).

The following resource websites are recommended for use in developing Early Psychosis Initiatives:

International Early Psychosis Association

<http://www.iepa.org.au>

Early Psychosis Prevention and Intervention Centre (EPPIC), Australia

<http://www.eppic.org.au>

Personal Assessment and Crisis Evaluation (PACE) Clinic

<http://www.pace-clinic.org>

Prevention and Early Intervention Program for Psychosis (PEPP)

<http://www.Pepp.ca/index.html>

### III Lower Priorities for State Mental Health Authority Prevention Activities

The following are recommended as lower priority than suicide prevention or early psychosis intervention due to having a less robust evidence base, impacting a smaller number of people, effecting a shorter duration of life span or a narrower probably base of public support and enthusiasm. They should be considered in states that have made good progress in suicide and early psychosis recommendations or where they are a particularly good fit with the local state circumstance.

#### A Universal or Whole Population Opportunities

##### 1. Depression Screening and Referral

Depression is very common and often under-diagnosed. Many easy to use screening tools are available. It is easy to implement at community events and is part of other health care activities. Effective treatments are readily available both within the primary care and the mental health sector.

##### 2. Post Partum Depression

Post Partum Depression while less common than Depression in general can generate more public support due to its impact on children. Screening tools are widely available as are effective treatments.

#### B. Selected Interventions for Prevention Activities in Populations Already Served by SMHA

##### 1. Prevention of Substance Abuse in Persons with Severe Mental Illness

Approximately half of persons with severe mental illness will experience problems with substance abuse or dependence at some point during their life making them a particularly appropriate population for substance abuse prevention activities. Substance abuse prevention interventions are well developed and a wide range of resource materials are available from SAMHSA through the Center for Substance Abuse Treatment. The resource materials are easily adaptable to SMI populations. Prevention of substance abuse in persons with severe mental illness should be an essential part of any state mental health authorities approach to co-occurring disorders.

##### 2. Preventing Medical Illness and Premature Death in Persons with Severe Mental Illness.

Persons with severe mental illness live an average of ten years less than the general population. There are many existing prevention activities that are readily adaptable to the SMI population including routine preventive

care schedules, dietary counseling, and facilitation and monitoring of primary care.

3. Prevention of Traumatization in Severe Mental Illness

Various studies report between 60%–80% of persons with severe mental illness experience trauma at some point during their life. As a high risk group they are particularly appropriate for prevention efforts to reduce both initial trauma and retraumatization.