The Time Is Now: Creating a Public Policy Action Agenda on Preventing Mental Illnesses

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The Twenty-third Annual Rosalynn Carter Symposium on Mental Health Policy

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Contents

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a family member who was affected unless they were being moved out of Central State Hospital. They wanted to be sure there was going to be assistance. Then when Jimmy was elected, he established the Governor's Commission to Improve Services for the Mentally and Emotionally Handicapped.

Beverly has been there all these years supporting me in everything that I have done. She is one of the most wonderful people I have had the pleasure to meet. She has worked tirelessly to focus

Keynote Panel: Adverse Childhood Experiences Study

Vincent Felitti, M.D.
Co-principal Investigator

The very idea that mental illness can be prevented is quite bold an idea and recent, really within the past century. We increasingly recognize that early life events, including often-unrecognized traumas, have dramatic and long-lasting effects on the neural and biological systems involved in well-being, psychopathology, biomedical disease, and social function. My intent is to illustrate that concept by providing you details of a large, ongoing study that involves over 17,000 middle-class Americans and the collaboration of two organizations.

The Adverse Childhood Experiences (ACE) study is an outgrowth of repeated, counterintuitive observations made while operating a weight-loss program. The program uses the technique of supplemented fasting, which allows nonsurgical weight reduction of approximately 300 pounds per year. Unexpectedly, our weight program had a high dropout rate, limited almost exclusively to patients successfully losing weight.

Exploring the reasons underlying the high prevalence of patients inexplicably fleeing their own success ultimately led us to recognize that certain of the more intractable public health problems, like obesity, were also unconscious, or occasionally conscious, solutions to problems dating back to the earliest years, but hidden by time, shame, secrecy, and social taboos against exploring certain areas of life experience. We saw that what appeared to be the problem often was an attempted solution by the person involved. This is, of course, a major public health paradox: The problem is also a solution.

What appeared to be the problem often was an attempted solution by the person involved.

In the course of this work, it became evident that traumatic life experiences during childhood and adolescence were far more common than generally recognized, were complexly interrelated, and were associated in a strong and proportionate manner to outcomes

important to medical practice, public health, and the social fabric of the nation. In the context of everyday medical practice, we came to recognize that the earliest years of infancy and childhood are not lost but, like a child's footprints in wet cement, are often lifelong.

Questions & Answers

Q Paul Fink: How do you think we can get every physician in America to take an abuse history, which I think would be the first step toward the implementation of prevention?

A This calls for a paradigm shift in primary care medical practice: to move from the current symptom reactive style practice to one that is more comprehensive.

The information is completely overwhelming in terms of the scope; people do not want to believe that the scope of this problem is so big. The policy solution is to get out of the silos and everybody share a piece of the problems that result from impaired childhood development.

Q Enid Hunkeler: Did you ever look at what accounted for experiences later on that might give us the seeds to solutions to understand why, among people who had these same difficulties in childhood, some went one way and others went another way?

A The general topic is resiliency. We measured what children experienced growing up in their households, which is a 684.001 in d.341 -1.182ed whalls y(d.341 -1.182,)-25(some) mea24(wentaw24(is)-25t)-24(might-25TJT*[(res]TJ-3.307 -1T*[( )-24(sor(anc)-2)]TJ-3iences)ldren)-24ho . Wchildfo

depression. Our approach provides teaching about depression and how to get treatment, combined with encouraging resilience in children in the areas of friendship, activities, and understanding, and helping families remember the positives in their histories and problem solve for the future. The central tenet of our work has been that parents with depression are parents first. Care needs to be oriented to helping them be effective parents despite depression.

We have delivered these interventions primarily in our long-term trials in group discussions or in a family talk intervention. A clinician works with parents to get a history and do some teaching. The clinician also sees the children, sits with the parents until they are ready to run a family meeting with the children,o run f24(meetinamily)2cgroup

In this country, we have also emphasized actively assisting patients to break down barriers and get access and the need for systems reform. Perhaps most importantly, our work was a long-term commitment to families. This involved asking what they wanted, helping them get it, staying with them, and changing as their needs changed. There are many systems in which effective treatment for parents with depression, and a focus on parenting, could yield large results. Illnesses change over time, risks become different, and systems that make a long-term commitment to follow people not only are much more likely to succeed but, in fact, are taking on the problem in a preventive way.

The central tenet of our work has been that parents with depression are parents first.

Staff must have adequate time and space to learn new methods and to employ them. A systemswide approach is necessary since working in any one sector will miss a large number of depressed people. Having a flexible array of strategies makes the most sense, starting with a public health campaign, relatively simple maneuvers, and doing more intensive interventions, either for families in need or for those who are particularly difficult to reach or, perhaps, for families who are high utilizers of services. It also makes sense to have a coordinated campaign so that there is a synergy among different parts. Ready access to treatment is essential, as is heightening awareness in clinicians of all disciplines. Most of the cases of depression, if they present in the health sector at all, will present to internists or pediatricians.

Surveillance is another important issue. If we kept track of depression in caregivers and parents, we would do much more about it. Very often, depression is used as the tracer condition to see how an overall system is performing in terms of mental health. If we ask adults with depression if they have children and how the children are doing, we would find out a great deal.

One needs a stepwise approach in doing programs to understand the needs of families and to develop the resources for a large-scale program. I am partial to a master trainer strategy, which has been used very effectively in a number of programs. Monitoring and flexibly changing strategies over time are other key elements.

My experiences and the experiences in Europe might guide the formation of systemswide programs. Parental depression requires a family approach, so by working on this problem, perhaps we could think about how to develop systems of family-centered care in general. Treatment and effective parenting for parents are prevention for the next generation. We do not need delivery systems for a single intervention; we need delivery systems for a wide range of interventions.

Mary Dozier, Ph.D.
Professor, Department of Psychology, University of Delaware

I want to tell you about an intervention that we developed for babies in foster care and their families. We modified this also for babies who stay with parents who have neglected them, and we are now looking at the effectiveness of that with birth parents. But what I will be telling you about is the intervention for foster parents specifically.

Infants and toddlers are biologically prepared to depend upon a caregiver. When they enter foster care, they usually have experienced neglect, almost always experiencing a disruption in care with their caregivers. The caregiving system has fundamentally failed here. Over the last 10 to 15 years, we looked at the ways in which children cope with these challenges and how we can help them and their caregivers cope more effectively.

Young children entering foster care, or children who have experienced adversity, very much need nurturing care, but there are often two things that get in their way. One is that they tend to push away somebody who is available. This would not be horrible if the person kept being available and the child learned that they would be. But, we found through contingency analysis that even a young baby has an effect on the caregiver so much that the caregiver gives back

in kind to the child what is elicited. If the child acts like the parent does not need him, that parent turns away, assuming that the child does not need the parent. We help caregivers learn that the child needs you even though he is giving you all the signals that he does not.

The second obstacle to nurturing care is that some caregivers are not naturally nurturing. For the most part, our kids do okay in homes where there aren't a lot of risks. But, children who have experienced early adversity need this nurturing care, and they need a caregiver who can provide

Carolyn Webster-Stratton, Ph.D.
Professor of Family and Child Nursing, Research Affiliate, Center of Human Development and Disability, University of Washington; Principal Investigator, Incredible Years

Aggressive and disruptive behavior problems in children start early and, for some, escalate in intensity. From 1988 to 1997, arrests for children under age 13 increased 165 percent for drug abuse, 76 percent for weapons violations, and 54 percent for aggravated assault. In a recent national study, 46 percent of kindergarten teachers reported that half their students lacked the self-regulatory skills to function productively. And, 5 to 8 percent of children are diagnosed with oppositional defiant disorder (ODD) or conduct disorder (CD), the primary reason for referrals to mental health agencies for children.

Why Treat Aggressive Behavior Problems in Young Children?

Emotional regulation and social competence are powerful predictors of school success even after controlling for variations in cognitive abilities. Children with disruptive and aggressive behavior are at high risk for underachievement, school dropout, delinquency, violence, and substance abuse. The most chronic offenders in adolescence have been shown to start their aggressive behavior as young as age 3.

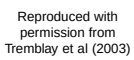

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Figure 2. Normal Trajectories of Physical Aggression

Normal Trajectories of Physical Aggression

Each line in Figure 2 represents frequency of aggression in a subset of the population. Clearly, there are individual differences in the amount of aggression exhibited by children. The top line is of most concern because it does not decline. These trajectories have been shown in studies worldwide. (Graph reprinted with permission from Tremblay.)

Several risk factors exist for oppositional and aggressive behavior problems, including child biological risk factors, family risk factors, and school risk factors. There is not any one risk marker of disadvantage but, rather, the more family and environmental risk factors the child is exposed to, the greater the likelihood of poor outcomes.

Why Intervene Early?

Early intervention has a greater chance of preventing later academic and social problems because it prevents the cascading of cumulating risk factors. At early ages (3 to 8 years), behavior is more malleable, and it is the optimal period to use alternatives to physical aggression. Treatment of antisocial behavior in adolescence is more difficult and more costly. Prevention of early aggression, and the subsequent diversion of one high-risk child from a life of crime, results in 60 to 80 fewer crimes and cost benefits of $1.7 to $2.3 million per child.

The Problem

Less than 10 percent of young children with aggressive behavior problems actually receive treatment; even fewer ever receive an evidence-based treatment. Teachers typically have not been trained in classroom management skills or a curriculum focused on social-emotional and problem-solving skills.

The Solution

The Incredible Years (IY) is one example of a set of intervention programs researched over the past 25 years. Its short-term objectives include preventing and reducing aggression and behavior problems and promoting social, emotional, and academic competence in young children. Its long-term objective: to prevent delinquency, substance abuse, and violence in adolescence.

Research Outcomes

Research conducted shows the effectiveness of the Incredible Years programs in two prevention settings (Head Start and schools with high percentages of free lunches) and as a treatment program for children with ODD, CD, and ADHD.

IY Prevention Studies — Head Start

Of the Head Start children in the intervention condition (IY teacher training), 91 percent showed at least a 30 percent drop in behavior problems in the classroom at the end of the school year, compared with 57 percent of children in the regular Head Start classrooms. Sixty-nine percent of Head Start children in the abnormal social competence range at baseline (beginning of school year) moved into the normal range at the end of the school year,

IY Treatment Studies for Children Diagnosed with ODD, CD

Posttreatment, 83 percent of children who had had IY child treatment plus IY teacher classroom management training showed a minimum of 30 percent reduction of aggressive1ion of

Questions & Answers

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Questions & Answers

Q Rosa Gil: In terms of early prevention, to what degree do these models and initiatives involve immigrant communities?

A We have done a lot of work with new immigrant families, and we do them with all of the groups together. New immigrants come with interpreters whom we train. We may have a group going on in Amharic, Arabic, Chinese, Vietnamese — all in the same group, and they cannot speak to each other. They come in thinking they are very different and end up discovering that they are dealing with so many of the same issues. They become empowered as a group. The beauty about doing it around schools is that they are often at those same schools, and, so, you start building around the schools as a network.

Q How should you be implementing your work so that we compress the 17-year gap between the development of

Dinner Address

Terry Cline, Ph.D.
Administrator, Substance Abuse and Mental Health Services Administration

I learned the hard way about the importance of public policy over 20 years ago on the streets of Cambridge, Somerville, and Boston, Mass. As a new clinical psychologist, I delivered family-based services in low-income housing developments, going into people's homes to provide family therapy. Walking to those appointments, I would think about all the people I walked by that I did not have time to help and that there must be some way that we can make mental health and substance abuse services available to more people. I struggled with that thought then as a staff psychologist and now as administrator of the Substance Abuse and Mental Health Services Administration (SAMHSA).

I love looking at trends, at data. It is important not to see just where we are but where we have been and where we hope to go. Looking at the mental health services delivery system, we have made indisputable progress. As a nation, I believe we have come a long way in widening the circle of opportunities that were promised in the Declaration of Independence. Throughout our nation's history, this promise has been broken for certain people. Certain groups have been left out and these individuals include people with mental illness.

Over 40 years ago, the Kennedy administration signed into law the Mental Retardation Facilities and Community Mental Health Center Construction Act. The focus was on buildings at that time, less so on services. Although the act accomplished many things, I believe its most important accomplishment was uprooting the notion that those with mental illnesses were irreparably damaged.

Reform is not enough to achieve the promise of a recovery-oriented system of care; indeed, a total transformation is required.

Prior to that act, the focus was based largely on lessening the burden to society. The act changed that perspective.

Over a decade later, the Carter Commission carried forward the belief that not only were people with mental illnesses not irreparably damaged, it offered the prospect that recovery was possible with improved care. The commission called out the plight of the underserved, the burden of stigma, the human cost associated with continuing to operate within a fragmented system of care. It called out funding patterns, bureaucratic entanglements, and organizational boundaries, which created a disjointed, uncoordinated approach between behavioral health, primary health, and human service systems.

In 2003, President Bush created the New Freedom Commission on Mental Health to push to the forefront mental illness issues. That commission's findings built upon the understanding that, today, recovery is not the exception; it really is the expectation people with mental illness have, that possibility for recovery.

Reform is not enough to achieve the promise of a recovery-oriented system of care; indeed, a total transformation is required. Over these decades, tremendous progress has been made:

We have gone from over 500,000 Americans institutionalized in private psychiatric hospitals in the 1960s to about 50,000 today.

Research findings have produced lifesaving treatments, and, through service demonstration programs, best practices and evidence-based practices have emerged.

Consumer and family movements have flourished.

Yet we have failed to move the knowledge into everyday practice and into the hands of every person in America. To complicate this national challenge, we do not have the funding we need to accomplish what we know needs to be done.

So, in addition to making certain that we do what we know needs to be done, we need to make sure the limited resources available are used as effectively and efficiently as possible. We also need to be much smarter about moving knowledge into practice. Former U.S. Surgeon General David Satcher said, "The difference between knowing and doing can be fatal."

Current Status

We have more than 32,000 suicides in the United States every single year. We have as many as 700,000 Americans who are homeless on any given night, and an estimated 20 to 25 percent of these individuals have a serious mental illness. One-half of this subgroup also has an alcohol and or drug problem. Studies indicate that between 16 and 50 percent of all incarcerated individuals have mental illnesses.

Part of the transformation process involves shifting our attention in front of the onset of illness.

Half of all people with mental health problems go without treatment.

Where is that profound sense of urgency and outrage about people with a serious mental illness dying, on average, 25 years earlier than the general population? With all of our reports in hand we cannot blame ignorance for inaction. How do we get ahead of the curve?

Part of the transformation process involves shifting our attention in front of the onset of illness. It requires us to focus on promoting mental health and advancing prevention efforts to reduce the incidence and prevalence of mental illness. Part of the solution is in adopting a public health approach, lessening and, in many instances, negating the need for services. Yet, how do we create and design public policy around preventing mental illnesses and promoting mental health? I believe the answers include early intervention and integration of services and the applications of screening.

Integration of Services

There is plenty of debate around the value of integration.

What is the value of making connections across disciplines and in creating a larger context for the care of the whole person?

What is the value for primary care practitioners and behavioral health providers to look beyond their individual disciplines and integrate historically independent and isolated disciplines?

What is the value in better connecting the scientific community with the broader public?

The value is the achievable goal that mental health and freedom from substance abuse are viewed as fundamental to overall health and well-being and that mental and substance use disorders are treated with the same urgency as any other health condition. Behavioral health is inextricably linked to overall physical health, and integration is not only valuable, it is necessary.

A wealth of research studies, commission reports, surveys, and cumulative data analyses demonstrate that untreated addiction and mental illnesses impact lives in the social segment, in the workplace, with the family unit, in community settings, in primary emergency care settings, at schools, and in other settings.

When behavioral health problems go untreated, the consequences can be devastating, and costs are shifted to other sectors of our health and human service delivery systems. In 2004, almost one in four stays in U.S. community hospitals for patients 18 and older involve mental health disorders or substance-abuse-

Questions & Answers

Q Carl Bell: What do you think about using a business model to disseminate the evidence that we have to move science into service?

A There are many opportunities between the substance abuse and mental health fields. There is what is called the blending initiative, collaboration between the National Institutes of Health, SAMHSA, and National Association of State Alcohol Drug Directors. They have created a forum that pushes science into the field because the states and the communities are where there is action.

Q Christine Castles:What is recovery? How do you measure it, and how do you know when you see it? I believe I can recover as much as the larger society will allow me to recover.

A National outcome measures cover 10 domains: symptom reduction, stable housing and employment, social connectedness, decreased contact with the criminal justice system, and perceptions of care. We need to be able to articulate that to our funders. If a person is to recover, the larger society needs to include them and allow them the full privileges and full access to what it is like to be a human being in our country with all of those attendant privileges.

Q Charles Ray: What shifts in programs and/or funding are going to back up your speech?

A Let me give you two small examples of how I think we can help move this ball down the field. The Federal Executive Steering Committee on Mental Health came out of the President's New Freedom Commission and has participants representing nine different Cabinet-level agencies. They are focused on five primary areas. One is the integration of

Questions & Answers

behavioral health and primary health; another is an appropriations bill that includes about 7.5 million dollars for mental health promotion.

Q I don't know how you deal with mental health or addiction unless you deal with housing. How do you plan to integrate what resources you bring to the U.S. Department of Urban Development (HUD) housing agenda?

A Part of that is with the Federal Executive Steering Committee on Mental Health where HUD is very active in those conversations. Out of all the domains that we could have chosen for national outcome measures, one of those is housing. Aware that that is an important indicator, all of the states will be collecting that data. I agree: If you do not know where you are going to be sleeping tonight, or if your family is going to be in the car or out on the street, you cannot be focused on your recovery.

Q What are the different agencies' efforts to treat returning soldiers?

A SAMHSA is doing all that it can to partner with the U.S. Department of Veterans Affairs and the Department of Defense. We have also worked out arrangements with the National Guard around substance abuse and prevention services.

Q Eric Goplerud: What can SAMHSA do to bring together the stovepipes of substance abuse prevention, mental health promotion, and substance use treatment?

A We are starting to provide some of that integration through the Federal Executive Steering Committee on Mental Health, which has focused primarily on mental health services. The point where that is happening is actually with our returning vets. There was a time to have separate identities so that these fields could stand on their own without being consumed or absorbed by the other one. This is the same concern I hear now: Mental health will get swallowed by public health. Mental health is strong, and, in combination with substance abuse, it is even stronger. There is no risk that it will lose its identity and purpose as part of public health.

Panel 11: Prevention Programs for Adolescents

Larke Huang, Ph.D.
Moderator, Senior Adviser on Children to the Administrator of SAMHSA

This is a very exciting time for prevention work with adolescents. There is an increasing focus on prevention of mental health disorders — at the individual, family, and community level — and on promotion of mental health, with a compelling body of research to support these interventions. The positive youth development movement has provided important foundational research for understanding what is necessary to ensure that youth are on a positive trajectory. We have emerging research showing links between promotion of social-emotional competence in students and improved academic outcomes and research on after-school programs showing that adding a social-emotional component results in better academic achievement. As we go forward, it is important that we craft an approach that focuses on systemic, population-based prevention as well as on individual and family prevention interventions.

Poverty puts youth at risk for poor outcomes as youth in poverty are at greater risk for experiencing behavioral or emotional problems. We know that increasing family income, especially among poor families, boosts cognitive and social outcomes. Economic hardship influences youth development, in large measure through their parents: through parents' investment in their children, the stress they experience in raising them and in making ends meet, and their behaviors toward their children. Understanding this path has important policy and program implications for prevention of mental disorders among youth and promotion of healthy youth functioning. Thus, we need a comprehensive package of interventions to reduce child poverty and increase family investments in youth.

Many of our mental health and substance use disorders are preventable. While we do not have a national call to action or a "war on mental disorders," we do know many of the risk and protective factors for disorders, and we know these can be effectively addressed in prevention efforts.

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About a year ago, the Morehouse School of Medicine received funding from the Department of Health and Human Services to develop a regional coordinating center for rebuilding the health infrastructure in the post-Katrina area. Even though I am the principal investigator of that project, most of the leading work has been done by Drs. Dominic Mack and Tom Kim, especially in the area of telepsychiatry.

Let me back up a bit. As someone who had the opportunity to be around for the release of the first Surgeon General's Report on Mental Health, I find much of what is happening now quite interesting as well as challenging. In that first report, we defined mental health as "the successful performance of mental functions, such that one could be productive in his or her day-to-day activities and could develop and maintain positive relationships with other people." We also said that mental health was "the ability to adapt to change in one's environment and to deal with adversity." I was in office, of course, during the time of the Oklahoma City Federal Building bombing and worked closely with the fire department and police officers for a year after that. In Oklahoma City, the firefighters had gone through a training program before the bombing of the federal building and were much better prepared than the police. We saw dramatic differences in the following year in terms of how firefighters were able to cope with their experiences, compared with police officers. So the idea of training to prepare for disasters is very important.

Support

Students should experience meaningful connections with adults, have strong bonds to the school, have positive peer relationships with prosocial peers, and feel that support is available and effective.

Social-Emotional Learning

Students should have strong social and emotional capacities and feel that their fellow students are socially responsible and capable. This includes emotional intelligence and cultural competence and the ability to be responsible and persistent, work cooperatively, and contribute to their school and community.

Authentic Challenge

Students should feel challenged. It is not enough to say that we have high standards. Are they meaningful to me? Do I feel a strong motivation to realize them? Do I see school as connected to my goals, that there are rigorous opportunities to learn, and that they are for me, not just for someone who looks different?

Why are these conditions for learning important for educators concerned with academic achievement? I would suggest that there are two reasons. One comes out of basic research my colleagues at the American Institutes for Research did regarding the basic conditions for learning. They identified how important are the neurological and physiological abilities of students to attend to learning, including the ability to concentrate and use short- and long-term memory. The second comes from the important work in developmental psychology of Lev Vigosky regarding the zone of proximal development — the difference between what a learner can achieve with or without social support. Teachers work with many students at the same time. How can they understand how to support every student, every moment of time, when they deal with 20, 30, or even 40 or more kids? You need strong conditions for learning where distractions are minimized (e.g., where students can manage their emotions) and where the motivations for learning are enhanced (e.g., where students feel connected to teachers). The conditions for learning enhance students' ability to attend and the teachers' ability to be in the zone of proximal development for all students all the time.

The conditions for learning are important

and who are socially and economically disadvantaged. More students of color attend dropout factories where 60 percent of the students, starting in ninth grade, fail to graduate. This is not just about bad teaching, though that is not an unimportant issue. It is also about school environments that are unhealthy for teachers and students.

Let me give you an example of how the conditions for learning were addressed. There was a readiness to do things in the Chicago public school system because, in spite of a decade of school reform, the district was still not succeeding fully. The Consortium on Chicago School Research demonstrated that things got better in those schools where there were both high levels of student support and academic focus. Under a new CEO, there was an interest in using performance management in order to push things — a good business motto — and an interest in creating metrics for the proposed performance management system that would help make Chicago schools safe and supportive. As we worked with them, they had four questions:

1. Are there things that one can measure? If so, what are they?
2. Can one measure them reliably and validly?
3. Can one measure them efficiently so they do not lose much instructional time?
4. Can the metrics be actionable?

A distinguished expert panel came to a quick consensus around the first two questions and identified the four conditions of learning. Then, we conducted 22 different focus groups with students, teachers, and parents and held cognitive labs to make sure that the questions were interpreted in the way that we intended them. We developed and piloted a 59-item survey that normally could be completed in less than 15 minutes and then administered it citywide to essentially all high school students. Then, we produced a high-quality, eight-page score report that gave people not only the overall data but also disaggregated data and helped them understand what they can do with it. During the second year, we extended the surveys to elementary schools and developed a Web-based tool, linked to school reports, that helps schools identify appropriate evidence-based strategies and programs.

Implementing the survey has started to change behavior in Chicago schools. For example, if I am a principal, I may worry whether or not I am listed as the least safe school in Chicago. However, if I want to do something, I have some support for identifying resources. Equally important, it has started to change the discourse of educators. One of the things the CEO is asking principals is, "Why don't the kids in your school feel supported?" When supervisors bring principals together, they now ask, "What are you doing about these data?" They still ask about academics, but now they ask about the conditions for learning as well.

In conclusion, there are three major recommendations or action steps that should be taken to create emotionally safe and supportive schools that promote students' positive social, emotional, and academic learning:

1. Ensure that stakeholders understand the importance of the social and emotional conditions for learning.
2. Help districts and states develop the capacity to assess and monitor the social and emotional conditions for learning.
3. Provide schools and communities with effective tools and strategies to improve the social and emotional conditions for learning.

Paulette Running Wolf, Ph.D.
Running Wolf & Associates; Acting Executive Director, First Nations Behavioral Health Association

My name is Kistimaki, which means "Bead Woman," and I think that describes what we do as professionals — putting pieces of programs, interventions, and resources together to make safe and beautiful homes and communities for our families. I am here to represent the First Nations Behavioral Health Association and have been asked to present American Indian Life Skills Curriculum on behalf of Teresa LaFromboise, the creator of American Indian Life Skills.

In 1987, the Zuni pueblo contacted Teresa and asked for help to develop an intervention to address their rapidly rising suicide rates. It took over two years to involve community spiritual leaders, community members, and tribal leaders to put this intervention together that was clearly grounded in cultural values and world belief systems. It was a very effective intervention.

The Zuni Life Skills was a really exciting thing for Indian country because we had never had something specific to a community, and I think that is critical. But, after evaluating the project, it was believed that many of the cultural nuances of the Zuni intervention could be adapted to create a similar intervention for other tribes.

A modified version of the Zuni Life Skills was field-tested at the Sequoia High School in the Cherokee Nation of Tahlequah, Okla. Students in this school represent approximately 20 tribes. Like the Zuni version, this intervention incorporated three days of well-being indicators that are specific to tribal groups: helping each other, group belonging, and spiritual belief systems and practices.

Unlike the Zuni version, the metaphors and behavioral incidents described in the intervention represent the diverse beliefs of diverse tribes of intertribal nations. Underlying this work was the assumption that many tribes, and especially more traditional tribes, would be reluctant to share valued, deep-structured cultural information. Universal American Indian values and behaviors could be incorporated into a social cognitive intervention that would appeal to tribal youth and community members and parents. The Sequoia High School 20-year suicide rate underwent a complete reversal, with zero completions reported since American Indian Life Skills was recorded in the late 1980s.

The primary issue that we are all concerned about is how do we get these interventions selected? We have multiple interventions that communities can pick from, but how do you get them to that point and who does that?

In response to the Red Lake incident, SAMHSA (thanks to Dr. Anne Mathews - Younes) contracted with Kauffman & Associates to provide resources to the highest risk tribal communities to implement the Native Aspirations project. The process included two existing interventions (also developed specifically for Native communities), which have been used successfully. One is the Community Readiness model (developed by the Tri-Ethnic Center) and the other was an intervention, whose

development was supported years ago by SAMHSA, called the Gathering of Native Americans (GONA) to identify and address intergenerational trauma. The next step after the GONA was, "What now?" Realizing where some of our problems were coming from, communities that were having these GONAs were excited, but, typically, nothing happened afterward!

We paired that GONA with a community mobilization piece and restructured it to allow opportunities for community members at the height of their excitement and understanding to volunteer to participate in community mobilization and planning. Really crucial was the fact that it was not just community members involved in this process, it was school personnel, local tribal colleges, law enforcement — all of those silo structures that were not working together. If you go to a native community and ask about their resource and referral system, you are going to get a blank look. We have our systems, but they do not make sense in a traditional setting.

We also do not take much notice of the tribal communities' fear of research and evaluation, which has a real choke hold.

Part of that contract was doing a regional training for American Indian Life Skills, and it was exciting to see parents, tribal members, and social service providers leave this training ready to go out with their plan. Our criteria for participation included working in teams of two from each program, willingness to take the training home and immediately implement it, and agreeing to participate in ongoing technical assistance and consultation.

We also do not take much notice of the tribal communities' fear of research and evaluation, which has a real choke hold. We need to address the myth that if a program is being evaluated, then there is no need to keep evaluating it. We can provide training certification via tribal community colleges, which builds local resources, and we need to design ways of involving families, such as a companion training for parents.

As part of the Native Aspirations process, we also promoted a concept called clinical coordination teams. Key professionals who were trusted in the community, as well as tribal members and spiritual leaders, came together, and we provided them with a review of available evidence-based interventions (EBIs) that have been used in native communities and in the mainstream. Almost without exception, all communities chose American Indian Life Skills, and a few that thought they could afford it sometime in the future also chose Project Venture.

We need to acknowledge that a key feature during the initial process of getting interventions out to communities is having community power brokers involved. Because of intergenerational trauma (I know what your family did to my family 40 years ago), it is really important to build those collaborative relationships between parents and families and agencies and resources.

There is a tendency to utilize interventions off the shelf, in a cookbook approach. That is not doing us any favors, yet we look the other way. We need to address that issue, and we need to allow the door to remain open for creative approaches that do not have evidence bases because many tribal communities rely on their own culture-based interventions. One value and belief that I think we all share is that we are all in the "process of becoming." The challenge is to remain true to our purpose and direction in terms of EBI selection and EBI development, while keeping that door open and making opportunities for new interventions to provide services.

Questions & Answers

Q Frank Berry: There are evidence-based practices that work for kids with serious emotional disturbance. How do we start before that, with the grand model being inoculation?

A I think the inoculation is giving children a sense of power, a sense of control, transforming children's learned helplessness into learned helpfulness. If you can take children who are hurt — because hurt children hurt other children — have them take that hurt energy and sublimate it, transform it, that is the inoculation.

Q Donna Marsh: What other things would you suggest that would be important to convey to communities as they look at adopting and implementing practices successfully?

A Other than relationship building and the community's readiness to take on different aspects of the vision, we need to have youth and family members at the table. It is so important to have enough voices at the table and to treat each other respectfully. We get into a battle over funding, and my way is better than your way. If we can put those things aside and focus on what is best, not just from my perspective but from the collective perspective of the community, then you will get ownership.

You must have leadership that is able to manage diversity and get them focused on a shared vision. Also, study business to figure out how to get people to do what you want them to do. If you can appeal to and get to that community and say what is in this for you, you can actually get everybody going in the same direction.

Q Carol Coussons de Reyes: How do I address cultural competency within our system?

A Readiness is an issue. We all know what is right and wrong, but we rarely take it a little bit deeper than that. We are full of fears about being different from each other. Figuring out a strategy about making a comfort level and providing the opportunity for that comfort level to develop are probably the first steps.

Everybody needs social fabric, social skills, self-esteem, a way to minimize their trauma. They need adult protective shields and monitoring; they need access to technology that is modern and new, whether it is biomedical or psychosocial. They need connectedness. How you do that in a particular culture is culturally specific; it is not either/or, it is both.

Comment: Ellen Whitman

We have all talked about local communities, tribal communities. When you are populating your tables, do not forget about county governments. Counties provide about $20 billion in mental health care, and there is a lot of innovative work going on at the county levels. Seventy percent of the American population lives in states that have county-based public mental health systems. So when you are putting together your collaboratives, remember that there are enumerable resources, expertise, caring people, and some funding on the table from county government.

There are four national ethnic behavioral health associations, and each has been, within their own communities, identifying practices that may not have scientifically grounded evidence but have a lot of long-term evidence. We are missing a whole set of interventions that have been working within our culturally diverse communities that we are trying also to bring to the foreground to say that these practices are culturally and community-grown, that we need to also take a look at these and not have them totally supplanted by our database of evidence-based interventions that are not necessarily built on these populations. We really need both.

Panel 111: Prevention for Adults and

We are going to focus on prevention for adults and older adults and will add specific conversations around three other prevention programs:

- preventing suicide among older people when treating geriatric depression in a primary care setting;
- a screening and intervention program for people with alcohol and other drug issues; and
- a group-based psychological intervention for people who are unemployed, helping them with job-seeking skills and with trying to avoid depression.

Martha L. Bruce, Ph.D., M.P.H
Professor of Sociology in Psychiatry at Weill Medical College

None of these interventions occur in formal mental health treatment settings, and each places a high value on both coordination and integration. While we will certainly describe our interventions, we are really hoping to also focus our time on two other key aspects:

- why we believe that each of these intervention programs is ready to go "prime time"; and
- what the policy barriers are to the widespread dissemination, implementation, and sustainability of these programs.

clinician to help improve the treatment. We usually call this person a depression care manager. Depression care managers help educate people, activate them, encourage them, and help people engage in their treatment and in life again.

PROSPECT Intervention: Component 3

When things are not going well, there ought to be a way of collaborating among the care manager, the physician or the treating physician, and the mental health specialist.

The IMPACT Trial is a similar trial, slightly different in the research design, but the intervention was essentially the same: helping people get consistent treatment, good care management, and a collaboration among a specialist, when needed, a physician, and the care manager.

In both trials, the outcomes were remarkably similar. The people who were getting the interventions, be it IMPACT or PROSPECT, did better, and they got better sooner. Sooner is really important when you are dealing with depression, because every day you are not better, you are suffering and your family is suffering.

Right now there are two big barriers. Cost is the obvious barrier. Who is going to pay for all of this? I think there are a couple of ways to think about it. It is easy to think of each intervention in a box, in which case it is probably hard to find someone to pay for the "whole box." But, we can also think about the major components of the interventions.

If we think about what happens in care management, we could step back and say, well, who and what setting is best-equipped to conduct care management functions? It may be that, in a solo practice, these are very simple things that a physician could or would want to learn. Medicare has added CPT code that allows reimbursement for central elements of care management.

A primary care practice can organize itself also by having the functions of care management, either for depression alone or for a range of chronic medical conditions, be the responsibility of a single care management. The structure of care management that you see in primary health care does not work in home health care.

There is one other big barrier. Science has taught us that it is possible to screen and care for depression in elderly primary care and other patients. But we need the will to do it. One of the major barriers to caring for depression in seniors is stigma related to ageism. It is easy to look at an old person who is depressed — maybe her husband died or she lost a friend, maybe she has failing health or mobility — and say, she is old, what do you expect? Frankly, I expect that you do not have to have that response. Most older people can do well, so let us help the people who are having problems do well as well.

Eric Goplerud, Ph.D.
Director, Ensuring Solutions to Alcohol Problems, George Washington University Medical Center

Five fairly typical case presentations:

- 55-year-old male admitted to the hospital for acute pancreatitis
- 23-year-old male traumatically injured in a car crash and admitted to the ER into a trauma center
- 45-year-old woman comes into a community health center for gastritis, acid reflux, and mild wheezing of asthma
- 19-year-old woman comes to the community health clinic to check about possible sexually transmitted diseases
- 37-year-old male seriously depressed with suicidal ideation comes to a community mental health center for service

What do these people have in common?

First, they are coming into contact with our health care system. They are likely to have alcohol or drug use that contributes to or complicates their treatment, and, likely, they are never asked about and never intervened for that condition. Had they received counseling as short

I am going to describe the successful activity of a wildly diverse, interorganizational, intergovernmental, interdisciplinary group that got together and said the only way we are going to move SBI into the mainstream of American medicine is to get mainstream medicine paid to provide the services. Initially, the loose group of SBI advocates developed a proposal to CMS (Center for Medicare and Medicaid Services) to get new Medicaid reimbursement codes, called HCPCS codes, that will cover screening and brief intervention in general medical settings. That was accomplished, and in Jan. 1, 2007, two new HCPCS codes were made available by CMS for SBI. But is there a single

Laws in 32 states allow insurance companies to deny payment for people who were under the influence of alcohol when they were injured. This creates an incredible disincentive for hospitals to screen when a physician may order a $25 blood alcohol test and the hospital gets socked with a $250,000 uncollected bill for putting a person's intestines back inside. Insurers are permitted to deny the medical bill, simply because the patient may have a positive blood alcohol level at admission.

If the health care field could implement all of these things — training, accreditation, removing restrictive laws — will SBI happen? Probably not. Physicians and other health professionals are much more likely to do things that they get paid to do and not do things for which they do not get paid. The real way to move screening and brief intervention into prime time is to provide carrots: Pay physicians and pay health care providers to do screening and brief intervention.

health care provider time, Medicare also provides a facility reimbursement rate that pays for the lights, pencils, computers, and receptionists for every administration of SBI in a facility.

We not only have the science, the training, and the tools, we have got the payment mechanism. Is this going to work? We hope so. This ought to be something that community mental health organizations and behavioral health care providers jump all over, because this is going to help our clients with mental illnesses who have substance use problems to get SBI services at the point that they come into contact with the health care system.

Richard Price, Ph.D.

Professor of Psychology and Business Administration, University of Michigan; Director, Michigan Prevention Research Center; Principal Investigator, Prevent Depression During Unemployment – JOBS Project

First, I want to talk a little bit about adult working life, where most of us spend most of our time, and the intervention that we developed called the JOBS intervention. Then, I want to point to the arena of work as a key social field for prevention and rehabilitation in adulthood and in later life.

Work fills most of our waking time and adult life, but it also spills over into family life. It is important for us to remember that jobs are packages of [illegible]

community health centers, labor union halls. And it reduces the need and the cost for mental health services for those people. Data from a number of cost and benefit analyses suggest that even just the increased tax revenue associated with re-employment means that the JOBS program pays for itself in approximately seven months of re-employment. That does not include the cost savings associated with increased utilization of health and mental health services.

There are now dozens, perhaps nearly 100, of programs over the last 25 or 30 years that have shown they can have a positive impact, and there are a number of other promising programs on the way. If we have such a good prevention science base across the whole life span, why are they not operating in all of our communities?dé

Questions & Answers

Q Ken Thompson: Are we doing things at the health public policy level that would address things that will drive a lot of the mental health issues that we see?

A The biggest obstacle to screening, early intervention, and much of what we have talked about here is our fundamental and societal belief in individualism. We talk community, we talk collaborative, but we act as individuals. That leads to things like codification of laws about the sanctity of the family, reluctance of people to intervene even if they know that there is domestic violence in the house down the street, reluctance of parents to seek help for kids because they might be judged as lacking in some way, and reluctance of individuals to seek help for the same reason.

Professionals in the health and mental health fields sometimes forget that housing, work, education, community, and property taxes all drive health and mental health outcomes. There are some things we know deeply. We know a lot about well-being; we know a lot about families; we know a lot about mental health. We can recognize those implications, but we ought to stay at home enough to make sure it happens in our own community.

Q Marie Dyak: The way we see pharmaceutical ads, are we going to see an awareness campaign?

A When I spoke to a packed audience of about 300 physicians with the American Society of Addiction Medicine about reimbursement for screening and brief intervention, not only do they understand CPT but they said, well, I only get $24 for doing this. If I use a different code, I get $64. What is the incentive?

Part of it is also figuring out who are you marketing to. We will be marketing this information to several different groups: billing and coding people, office managers, the nurse supervisors in emergency rooms, clinicians, and the health plans and Medicaid.

One pharmaceutical manufacturer said what we need in the substance use field is a Prozac moment. What we need is a transition from substance abuse treatment to something that is done in a 28-day program or in Alcoholics Anonymous. We need that direct-to-consumer advertising that says this is good practice. If your doctor has not asked you about your alcohol use, tell him.

Q Ken Martinez: Sometimes, in our research practice and policy we tend to try to apply generic evidence-based practices to all cultures. What cautions do we need to be careful about in doing that?

A We tend to think about culture as cultural differences, as insurmountable, mysterious. We forget about the common ground. I do know that trusting partnerships are possible, and most of what we do could never happen without them. So rather than imagine that we could appreciate those differences, we try to build partnerships where the colleagues, in whatever settings they are, are equally empowered and can teach us a great deal.

Q Chris Metzler: Have you looked at Medicare issues and how we can improve that major program and have it trickle down to the rest?

A The State Children's Health Insurance Program legislation that went through the House had two very important things that the health care field generally missed, although Mental Health America did not miss it. The first was eliminating the discriminatory statute around coverage of mental and substance use disorders. The second, which was really groundbreaking, is the Medicare Mental Health Modernization Act of 2007, which, basically, was parity coverage for Medicare. We not only got it in the bill, but we had a majority of the House vote in favor of it.

There is activity around performance

One of the Carter Center Mental Health Program's strategic goals focuses on

Biographies

William R. Beardslee, M.D.

William R. Beardslee is academic chairman of the Department of Psychiatry at Children's Hospital in Boston and Gardner Monks Professor of Child Psychiatry at Harvard Medical School. He received his bachelor of arts degree from Haverford College and his medical degree from Case Western Reserve University. He trained in general psychiatry at Massachusetts General Hospital and in child psychiatry and psychiatric research at Children's Hospital in Boston and has a longstanding research interest in the development of children at risk because of severe parental mental illness. He is especially interested in the protective effects of self-understanding in enabling youngsters and adults to cope with adversity and has studied self-understanding in civil-rights workers, survivors of cancer, and children of parents with affective disorders.

Carl C. Bell, M.D.

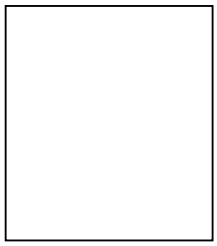
Carl C. Bell is president and chief executive officer of the Community Mental Health Council, a comprehensive community mental health center in Chicago. He is also principal investigator of a National Institute of Mental Health grant: Using Chicago HIV Prevention and Adolescent Mental Health Project to Prevent Youth HIV Risk in a South African Township. At the University of Illinois at Chicago, Bell serves as director of public and community psychiatry, clinical professor of psychiatry and public health, and co-director of the UIC Interdisciplinary Violence Prevention Research Center. During his 35-year career, Bell has published more than 350 articles and books on mental health and has been a guest on "Nightline," "CBS Sunday Morning," "The News Hour with Jim Lehrer," and "Today."

Martha L. Bruce, Ph.D., M.P.H.

Martha L. Bruce is professor of sociology in psychiatry at Weill Medical College of Cornell University and in the clinical epidemiology program at the Graduate School of Medical Sciences and associate vice chair for research in the Department of Psychiatry. A sociologist and psychiatric epidemiologist, Bruce conducts community-based services research aimed at improving access to quality mental health among vulnerable older adults suffering from depression. She has been the principal investigator of an award funded by the National Institute of Mental Health that works in partnership with community-based agencies to develop research aimed at improving the treatment and outcomes of depression in elderly patients receiving home health services.

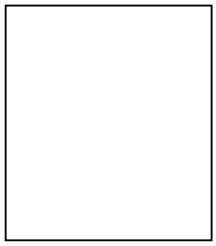
Terry Cline, Ph.D.

Terry Cline is administrator of the Substance Abuse and Mental Health Services Administration (SAMHSA), the U.S. agency responsible for improving the accountability, capacity, and effectiveness of the nation's substance abuse prevention, addictions treatment, and mental health service delivery systems. Throughout his career, Cline has worked to ensure individual and family needs are the driving force for the prevention, treatment, and recovery support services delivered. Prior to his appointment at SAMHSA, Cline served as Oklahoma's secretary of health. At the same time, he served as Oklahoma's commissioner of the Department of Mental Health and Substance Abuse Services. In these positions, he actively participated in and supported the creation of grassroots coalitions to improve the health status of local communities.



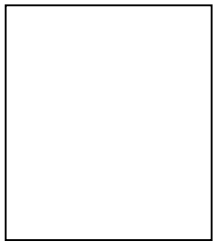
Mary Dozier, Ph.D.

Mary Dozier received her Ph.D. in clinical psychology from Duke University in 1983 and completed an internship and postdoctoral fellowship at St. Elizabeth's Hospital in Washington, D.C. After her first position at Trinity University in Texas, Dozier moved to the University of Delaware, where she is now. She was promoted to professor at the University of Delaware in 2003 and was named Amy E. Dupont Chair of Child Development in 2004. For the last 15 years, Dozier has studied challenges faced by young children in the child welfare system. In work funded by the National Institute of Mental Health, she has developed an intervention to enhance relationships between children and their caregivers.



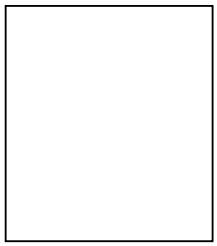
Vincent J. Felitti, M.D.

Vincent J. Felitti, is co-principal investigator of the Adverse Childhood Experiences (ACE) Study, ongoing collaborative research between Kaiser Permanente and the U.S. Centers for Disease Control and Prevention. A 1962 graduate of Johns Hopkins Medical School, Felitti is an internist who started as an infectious disease physician in 1968 at Kaiser Permanente in San Diego and then founded the Department of Preventive Medicine in 1975; he served as chief of preventive medicine until 2001. Under Felitti's leadership over the years, the department provided comprehensive, biopsychosocial medical evaluation to assess the health risks and disease burden of more than 1 million adults.



Gregory L. Fricchione, M.D.

Gregory Fricchione has been at Harvard Medical School since 1993 when he was appointed an associate professor of psychiatry and director of the Medical Psychiatry Service at Brigham and Women's Hospital. Since July 2002, he has been associate chief of psychiatry at Massachusetts General Hospital and director of the Division of Psychiatry and Medicine. In 2000, while on leave of absence, he joined The Carter Center to work with former First Lady Rosalynn Carter on public and international mental health issues and policy. Fricchione received his medical degree from New York University School of Medicine in 1978. He is board certified in psychiatry and has added qualifications in psychosomatic medicine and geriatric psychiatry.



Eric Goplerud, Ph.D.

Goplerud is a research professor, Department of Health Policy, at the George Washington University School of Public Health and Health Services. His policy and research interests include improving access to alcohol screening and treatment, integrating primary health and behavioral health care services, measuring performance in managed behavioral health, and improving quality in public and private behavioral health care. Currently, he is principal investigator for contracts and grants with the Pew Charitable Trusts, Robert Wood Johnson Foundation, Substance Abuse and Mental Health Services Administration, U.S. Postal Service, National Highway Traffic Administration, Centers for Disease Control and Prevention, National Institute on Alcohol Abuse and Alcoholism, and National Institute on Drug Abuse.

Larke Nahme Huang, Ph.D.

Larke Nahme Huang, a licensed clinical-community psychologist, is senior adviser on children to the administrator of the U.S. Substance Abuse and Mental Health Services Administration. She is also the agency lead on cultural competence and eliminating disparities. For the past 25 years, Huang has worked at the interface of practice, research, and policy. She has been a community mental health practitioner, a faculty member at the University of California–Berkeley and Georgetown University, and a research director at the American Institutes for Research. She has worked with states and communities to build systems of care for children with serious emotional and behavioral disorders.

Gail P. Hutchings, M.P.A.

Gail P. Hutchings is founding president and chief executive officer of the Behavioral Health Policy Collaborative, a private consulting firm located in Alexandria, Va., whose clients are public and private organizations dedicated to improving mental health and substance abuse systems, services, and outcomes. Until late 2005, Hutchings was chief of staff of the U.S. Substance Abuse and Mental Health Services Administration. While with SAMHSA, she served in a variety of other senior roles including acting deputy administrator, acting director of the Center for Mental Health Services, and senior adviser to the administrator. She was responsible for major policy initiatives including alternate commissioner on the President's New Freedom Commission on Mental Health.

Jane Knitzer, Ed.D.

Jane Knitzer is executive director of the National Center for Children in Poverty, which promotes research-informed policy to improve the lives of low-income children and families. She is also clinical professor of population and family health at the Mailman School of Public Health at Columbia University. As a psychologist, Knitzer has focused her research on improving public policies related to children's mental health, child welfare, and early childhood. Her work on mental health includes the groundbreaking policy report "Unclaimed Children: The Failure of Public Responsibility to Children and Adolescents in Need of Mental Health Services." Most recently, Knitzer has called attention to the importance of addressing social and emotional issues in young children.

David Osher, Ph.D.

David Osher is managing research scientist at the American Institutes for Research (AIR), where he leads centers and projects that focus on educational equity, the conditions for learning, and school- and communitywide interventions for youth with mental health disorders and their families. Osher is principal investigator of four centers that support major national initiatives and receive support from the federal government. He also is principal investigator of the What Works Clearinghouse review of character education and of AIR's initiatives that study the conditions of learning and help states, school districts, and schools collect and use survey data on the conditions for learning for school improvement.

Richard H. Price, Ph.D.

Richard H. Price is Barger Family Professor and director of the Interdisciplinary Program in Organizational Studies, professor of psychology, and research professor at the Institute for Social Research at the University of Michigan. He is co-founder of the Rackham Interdisciplinary Committee on Organizational Studies and also has served as associate vice president for research at Michigan. Price is a fellow of the American Psychological Association, the American Psychological Society, and the Society for the Psychological Study of Social Issues. His research focuses on innovation and leadership in the organization of work and its impact on health and productivity.

Paulette Running Wolf, Ph.D.

An enrolled Blackfeet tribal member, Paulette Running Wolf is a counseling psychologist with more than 20 years of experience in American Indian program development, research, and evaluation in education, community mental health, and social services. Running Wolf has provided community mobilization and planning services in more than 30 tribal communities nationally and is committed to the improvement of behavioral health services in tribal communities. She is currently a board member and acting executive director of the First Nations Behavioral Health Association. Running Wolf has successfully impof3l2bmlf 25(ucation1i1ng)

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