



National Association of State Mental Health Program Directors

**Reducing the Burden of Mental Illness:**  
The Role of Preventive Activities and Public Health  
Strategies

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## About NASMHPD

The National Association of State Mental Health Program Directors (NASMHPD) is home to the only member organization representing state executives responsible for the \$37 billion public behavioral health service delivery system serving nearly 7 million people annually in all 50 states, 4 territories, and the District of Columbia.

NASMHPD serves as the national representative and advocate for state behavioral health agencies and their directors and supports effective stewardship of state mental health systems. NASMHPD informs its members on current and emerging public policy issues, educates on research findings and best practices, provides consultation and technical assistance, collaborates with key stakeholders and facilitates state-to-state sharing of new approaches and information on improving care for people with serious mental illnesses.

## Preface

This issue paper on the role of preventive activities and public health promotion in reducing the burden of behavioral health disorders is the third in a series of eight briefs under the auspices of the NASMHPD on implementation issues associated with the Affordable Care Act.

We hope this report will provide further guidance to SAMHSA and State Behavioral Health Authorities (SBHAs) on the roles that state agencies can play in promoting positive mental health, preventing the development of mental health problems, and reducing the impact of mental illness by utilizing a public health approach. These efforts may be assisted in part through various opportunities made possible under the Affordable Care Act and in the rapidly changing health care service delivery environment.

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## Executive Summary

Mental health and mental illness can be influenced by multiple determinants, including genetics and biology, but also by numerous social and environmental factors. For example, social determinants of health—including income, stressful circumstances and life events such as trauma, early childhood experiences, social exclusion, occupation, education level, sanitation, social support, stigma, discrimination (e.g., racism), and lack of access to health resources—can influence mental health and mental illness.

In turn, mental health and mental illness may influence physical health and biologic functioning. Positive mental health—positive emotions and evaluations of life—are associated with better endocrine function, and better immune response. Higher levels of purpose in life, personal growth, and positive relations have been linked with lower cardiovascular risk.

Social determinants may have positive or negative consequences. For example, an intact family provides a strong, protective social network. Other protective factors include religion and spirituality, social support, and social participation. On the other hand, a lack of infrastructure in poor urban neighborhoods often leads to communities that are disenfranchised and social networks that are frayed.

Public health interventions can create major improvements in the mental health of our society. To be effective, it is essential that the public health system clearly define population disparities, set goals for improvement, focus on community-based research, and educate the community about the effects of social determinants of health on mental health and mental illness. The interaction of the three elements—social determinants of health, health outcomes, and public health interventions—can yield central insights for maintaining positive mental health and fostering improvement for populations who have a mental illness.

The Affordable Care Act (ACA) includes four primary levers of change: coverage for previously uninsured persons which helps to decrease disparities in access to care, thereby improving overall wellbeing; parity for mental health with other health care; funding for preventive and promotional programs and services that can have a positive impact on mental health; and the integration of public health prevention and promotion programs into what have traditionally been programs to address physical health. The case for a public health framework to address the persistent barriers to accessible and effective mental health services using this multi-tiered approach is compelling. However, a shift towards the efficient and effective implementation of a coordinated and comprehensive approach to mental health will involve many challenges, including a reallocation of resources, a retooling of the workforce, and a broader reconceptualization of mental health promotion that includes healthy functioning (cognitive, social, and physical) across multiple domains and settings (home, school, work).

This report identifies relevant components of a public health framework and the positive impact that a preventive approach can have on improving the mental health of the

population. Provisions of the ACA which states can leverage to implement or increase promotion and prevention-related activities to foster mental health are highlighted, along with examples of models and activities that states might consider in their efforts to improve wellbeing and reduce the impact of mental illness.

## I. Introduction

In 1999, the Office of the U.S. Surgeon General released its first report on mental health, calling for the full integration of mental health care into the nation's public health system. The Surgeon General's report urged a broad public health approach, including clinical diagnosis and treatment of mental illness, as well as surveillance, research, and promotion of mental health. The report concluded that mental illnesses are among the most prevalent and costly conditions in the United States and that effective treatments can reduce their prevalence and their adverse effects on other health conditions. In the years since, mental health promotion, the prevention of mental illness, and actions to reduce the severity and impact of mental illness, have all been increasingly recognized by the public health community as critical to good physical health.

Approximately 18 percent of Americans 18 years of age or older—42.5 million adults—suffer from a diagnosable mental disorder in any given year.<sup>i</sup> Forty-six percent of U.S. adults will experience some mental disorder during the course of their lifetime.<sup>ii</sup> The estimated lifetime prevalence of mental illness among the U.S. adult population is 31.2 percent for anxiety disorders, 25 percent for impulse-control disorders, 21.4 percent for mood disorders, and 15 percent for substance use disorders.<sup>iii</sup> Depression is among the leading global causes of life-years lived with a disability.<sup>iv</sup>

Mental health and mental illness can be influenced by multiple determinants, including genetics and biology and their interactions with social and environmental factors. For example, social determinants of health—including income, stressful circumstances and life events such as trauma, early childhood experiences, social exclusion, occupation, education level, sanitation, social support, stigma, discrimination (e.g., racism), and lack of access to health resources—can influence mental health and mental illness.

In turn, mental health and mental illness may influence physical health and biologic functioning. Positive mental health—positive emotions and evaluations of life—are associated with better endocrine function (i.e., lower levels of cortisol, epinephrine, and norepinephrine), and better immune response (i.e., higher antibody production and greater resistance to illness). Higher levels of purpose in life, personal growth, and positive relations have been linked with lower cardiovascular risk including lower glycosylated hemoglobin, lower weight, lower waist to hip ratios, and higher good or HDL cholesterol.

The interconnections of injury, chronic disease and its risk factors, and mental illness are striking. Injury rates for both unintentional (e.g., motor vehicle injuries) and intentional (e.g., homicide) injuries are 2 to 4<sup>v</sup> times and 7 times higher,<sup>vi</sup> respectively, among people

with a history of mental illness than for the overall population. Tobacco use among people diagnosed with a mental illness is twice as high as in the overall population.<sup>vii</sup>

Mental illness and chronic disease are frequently associated; the incidence, course, and outcomes of each are affected by the presence of the other. In addition, there is extensive evidence of a causal connection between mental illness and chronic diseases such as cardiovascular disease, diabetes, obesity, asthma, arthritis, epilepsy, and cancer. The National Arthritis Action Plan<sup>viii</sup> identifies the need to “define the impact of coping, depression, and other emotional responses [on] arthritis.”

In addition, there is a reciprocal relationship between chronic disease self-management and mental health. Self-efficacy, goal-setting, and problem-solving enable self-management behaviors, and these components are dependent on mental health. Conversely, self-management behaviors that enhance health, such as physical activity and stress reduction, can improve mental health status and quality of life.

However, the absence of mental illness does not necessarily mean the presence of mental health. Growing research supports the view that mental health and mental illness are independent but related dimensions. Findings suggest that well-being has its own biomarkers, contrasted with those associated with ill-being, but more studies are required.

Mental health generally refers to “the successful performance of mental function, resulting in productive activities, fulfilling relationships, and the ability to adapt to change and adversity.”<sup>ix</sup> Mental health can also be characterized as the presence of positive affect (e.g., optimism, cheerfulness, and interest), absence of negative affect, and satisfaction with life.<sup>x</sup> These domains are commonly referred to as “well-being.”

Mental illness is “characterized by alterations in thinking, mood, or behavior associated with distress or impaired functioning,”<sup>xi</sup> and includes diseases with classic psychiatric diagnoses, such as depression, bipolar disorder, and schizophrenia.

It is important to note that *all* individuals—including those with a mental illness—can benefit from efforts to promote well-being and life satisfaction, and hence mental health promotion strategies can be employed to benefit the full population.<sup>xii</sup>

Higher levels of interpersonal well-being and purpose in life are also linked with lower inflammatory factors (e.g., interleukin 6), as well as brain function—asymmetric activation of the prefrontal cortex, as well as reduced amygdala activation to aversive stimuli, accompanied by greater activation of the ventral anterior cingulate cortex.

## **II. The Burden of Mental Illness**

People from disadvantaged populations who have diagnosed disorders often face problems accessing medical care. The influence of these diagnosed disorders may also operate in more advantaged groups, but limited English language proficiency, limited

medical literacy, geographic inaccessibility, and lack of medical insurance are all more common among immigrants, minority populations, and people in rural areas. Additional social determinants may include housing status, income, education, stigma and discrimination, access to resources, stress, physical environment, and institutionalization.

Social determinants may have positive or negative consequences. For example, an intact family provides a strong, protective social network. Other protective factors include religion and spirituality, social support, and social participation. On the other hand, a lack of infrastructure in poor urban neighborhoods often leads to communities that are disenfranchised and social networks that are frayed.

Poor health outcomes increase in the presence of multiple negative social determinants, and mental illness often occurs concurrently with chronic diseases. For example, among American Indians, the presence of trauma, stress, and depression increases the risk for diabetes. Individuals concurrently suffering from depression and diabetes more often fail to seek treatment, leading to reduced blood glucose control, and increased risk for heart disease, respiratory disorders, and pain. Lack of insurance, limited health literacy, stigma, and cultural beliefs also may prevent individuals from seeking help, screening, and health assessment.

### **The Role of Public Health Interventions**

Public health interventions can create major improvements in fostering mental health and reducing the burden of mental illness. To be effective, it is essential that the public health system clearly define population disparities, set goals for improvement, focus on community-based research, and educate the community about the effects of social determinants of health on mental health and mental illness. The interaction of the three elements—social determinants of health, health outcomes, and public health interventions—can yield central insights for maintaining mental health and improvement for all populations who have a mental illness.

## **III. Preventive Activities Related to the Onset, Progression, and Negative Impacts of Mental Illness**

There are different ways to categorize preventive measures. A commonly-utilized framework within public health relates to the goals of a practice according to “stages of disease,” with a continuum across primary, secondary, and tertiary prevention. Primary prevention efforts may be further delineated by the level of risk of the targeted population, at the universal, selective, and indicated levels. These categories are discussed below.

### *Primary Prevention*

Primary prevention consists of those activities that take place prior to the onset of a disorder. It is predicated on the identification of modifiable risk and protective factors,

with strategies to minimize the former and enhance the latter. Risk factors for mental health problems include, for instance, child maltreatment, chronic poverty, and social exclusion. Whereas nurturing environments, opportunities for pro-social engagement in one's surroundings, and the development of social and emotional skills that support self-regulation and executive function are all examples of protective factors. Within the realm of primary prevention, the Institute of Medicine highlights three levels of intervention based on the level of risk of the target population<sup>xiii</sup>. *Universal* prevention strategies are those that are aimed at general population groups without regard to risk (e.g., programs implemented in a full classroom to enhance social and emotional skills development). *Selective* prevention programs are those that target individuals that have elevated risks (e.g., a program to enhance resilience for children whose parents are recently divorced, or programs to strengthen parenting practices for families at risk for child maltreatment). Finally, *indicated* prevention activities are those that serve individuals in which early indicators of a problem are present, yet the person does not yet meet criteria for a disorder (e.g., programs targeting youth with early substance use and aggressive behavior).

Because primary prevention practices take place across diverse settings (e.g., schools, homes, daycare centers, community serve centers), funding to support these activities often comes from a wide range of sources. An example of a primary prevention intervention type that now receives support via program funding under the ACA is home visitation for pre- and post-natal parents. Programs of this model type operate at the selective level of prevention, and they have shown success in improving maternal and child health, reducing maltreatment, promoting healthy parent child bonding, enhancing positive social and emotional development of the child, and improving school readiness.

### *Secondary Prevention*

Secondary prevention aims to reduce the progression of a disorder, typically through screening and early identification.<sup>xiv</sup> By identifying problems very early on, individuals can be offered services and supports to address their needs, which may help to reduce more rapid or severe progression of an illness. As more primary care providers are encouraged to screen for potential behavioral health problems, greater numbers of individuals can be provided with timely care that will help to reduce, on a national level, the collective impact of such disorders. The ACA's extension of health coverage to previously uninsured individuals—as well as its strong emphasis on screening and early intervention—enhances opportunities for secondary prevention practices.

### *Tertiary Prevention*

Tertiary prevention focuses on improving functioning, minimizing the impact of an illness, and helping to prevent or delay further complications.<sup>xv</sup> Outreach, coordinated care, and linkages to services and supports can help persons with mental illness to be more fully and successfully engaged in their communities and can enhance positive functioning in the different areas of their lives. Broader access to care, and the emphasis



on care coordination and integrated health homes under the ACA, will create opportunities for improved mental health in this regard.

#### IV. Public Health Strategies

Public health programs are applications of interventions in the field. The public health approach to addressing mental health and mental illness includes policies and programs to advance surveillance, epidemiology, prevention research, communication, education, and systems changes. Public health surveillance provides data about the burden of disease, risk factors, and the effects of specific interventions. Epidemiology is an essential tool for examining the influences on disease and health in populations and supporting research for new scientific insights and policy development. Prevention research develops and evaluates interventions to improve health, including mental health. Public communication and education for health professionals help to disseminate evidence-based information about the results of epidemiologic and prevention research. The success of public health policies and programs in improving health must be periodically assessed and regularly re-evaluated.

Integration of mental health and chronic disease public health programs is a challenging but essential task in protecting the health of Americans. The synergistic integration of activities for mental health and public health is more effective than siloed efforts by mental health stakeholders alone. Especially in times of limited resources, partnerships can capitalize on existing public health programs, developing new ideas to expand the impact of smaller budgets.

For instance, the SAMHSA/Health Resources and Services Administration's (HRSA) Center for Integrated Health Solutions offers a [Toolkit for Mental Health Providers](#)<sup>xvi</sup> on its [website](#) for achieving tobacco cessation among persons with mental illness. The toolkit was developed for a broad continuum of mental health providers, all of whom recognize that tobacco cessation is a key component of many individuals' recovery and a priority issue for every health provider—direct providers, as well as administrators and behavioral health organizations. Many of the materials in the toolkit are appropriate for primary care and substance use treatment providers as well as mental health providers. The Toolkit was developed by the University of Colorado Denver, Department of Psychiatry, Behavioral Health and Wellness Program, with support from the Smoking Cessation Leadership Center at the University of California San Francisco. Funding to develop the Toolkit was provided with proceeds from the Colorado Tobacco Tax through a grant with the Tobacco Disparities Initiatives of the State Tobacco Education and Prevention Partnership (STEPP), Colorado Department of Public Health and Environment.

Nationally and internationally, the balance is tipping in favor of a paradigm shift towards comprehensive models to alleviate mental health suffering. The World Health Organization (WHO) recently issued a fact sheet on mental health that could become a driver of mental health policy, research, and practice, and which suggests promoting a reordering of priorities for clinical science. Most notably, WHO emphasizes

“intersectoral strategies” that deemphasize mental health disorders to focus on “mainstreaming mental health promotion into policies and programs in government and business sectors.”<sup>xvii</sup>

The Affordable Care Act (ACA) includes four primary levers of change: coverage for previously uninsured persons which helps to decrease disparities in access to care, thereby improving overall wellbeing; parity for mental health with other health care; certain funding provisions for promotive/preventive programs and services that can have a positive impact on mental health; and the integration of public health prevention and promotion programs into what have traditionally been programs to address physical health. The case for a public health framework to address the persistent barriers to accessible and effective mental health services using this multi-tiered approach is compelling. However, a shift towards the efficient and effective implementation of a coordinated and comprehensive approach to mental health will involve many challenges, including a reallocation of resources, a retooling of the workforce, and a broader reconceptualization of mental health promotion that includes healthy functioning (cognitive, social, and physical) across multiple domains and settings (home, school, work).

### **Addressing Multiple Levels of Risk and Need**

Within a public health framework, there would ideally be a seamless continuum of promotion, prevention, treatment, and recovery services and supports to collectively address the range of needs within a community, thereby improving the mental and physical wellbeing of the population as a whole. When implemented successfully, universal interventions should reduce the risk for mental illness and limit the numbers of individuals who enter a higher level of need. However, as is true for any public health intervention, universal interventions alone may still be insufficient to address the overall mental health burden facing our nation. Such efforts can have a far greater impact if they are implemented as part of a comprehensive model, integrated into both community and clinical settings, with unique but synergistic efforts at each level of intervention that targets the interventions, prioritizing care for high-risk groups.

Some mental health policy observers have proposed a model for mental health promotion at a broad-based level to enhance the natural synergy between community settings and mental health. Shifting a focus to community settings such as schools, park districts, and community centers makes sense for two primary reasons. First, mental health promotion—with goals, routines, and activities inherently designed to foster skills building, positive relationships, and healthy functioning—already lies at the heart of most community settings. Second, supporting a community setting permits the use and strengthening of existing organizational capacity to effectively deliver high quality service so that individuals derive the most benefit from participation.

To illustrate, extensive empirical data suggest that after-school programs can play a critical role in children's psycho-social development, especially for children living in communities of concentrated urban poverty. Despite their potential, however, program

impact is often compromised by the extensive mental health needs of children and the pervasive poverty in which they live. Hence, some groups are pursuing concurrent pathways by examining the feasibility and impact of community mental health agency consultation to recreation staff around academic enrichment, coaching behaviors, activity engagement, and behavior management. Others are working with lead administrators to examine and expand their organizational capacity to offer systematic training, professional development, and comprehensive support to recreation leaders and physical education instructors. Both efforts support the goal of improving service delivery and outcomes for youth participating in out-of-school time programs.

Because young people spend a substantial amount of time each day in school settings, this environment is conducive to the implementation of multiple types of programs and activities that can collectively improve child wellbeing. Classroom models to enhance problem-solving abilities and self-regulation can strengthen the emotional health of all children at a universal level. For children with more elevated risk, there are certain multi-tiered models that involve work with children in schools to foster skills development combined with work with families to strengthen positive parenting and family dynamics. Many schools partner with parent groups, advocacy and service organizations, and other community partners to coordinate diverse services and supports. Consultation services by mental health providers to teachers and afterschool staff can improve understanding of children's mental health needs. A school mental health center can offer opportunities for screening, early identification, and referral or provision of services which will improve access to timely care while also "normalizing" mental health in a manner which reduces stigma, thereby increasing the likelihood of better outcomes. These collective efforts to mobilize resources and capitalize on the inherent capacity of natural settings to promote the healthy development of children can create population-level improvements over time.

Similarly, targeted interventions for adults might be just as effectively incorporated into settings such as primary care offices, emergency rooms, and social service agencies inherently committed to identifying and reducing risky behaviors via health screenings, community outreach, psycho-education activities, and early intervention.

There are also interesting opportunities for the blending of treatment and prevention activities by offering holistic supports to families in which the parent of minor-aged children is managing a mental illness. For example, a psycho-education model for families with a depressed parent that is designed to help to promote a better understanding of the illness has been shown to improve family communication and reduce risks for depression in adolescents, thereby benefiting the family unit as a whole<sup>xviii</sup>.

Current rates of mental illness diagnoses in our country exceed the capacity of the mental health provider system. The infusion of preventive activities at different levels of intervention within the broader continuum should reduce the prevalence of mental health disorders, thus reducing the number of individuals exhibiting clinical symptoms or more severe functional impairment. The nation's limited pool of mental health providers would

then be at liberty to serve the smaller subset of individuals whose intensive mental health needs warrant more extensive treatment.

## **V. Communication, Education, and Implementation**

Developing a scientific foundation for integrating the promotion of positive mental health and the prevention of the onset or progression of mental illness within our public health systems is essential but will not, by itself, drive change. Public communication and the education of health professionals will be needed to encourage the use of new knowledge and technologies. Other audiences must include policy makers, health insurers, and decision makers in the public health and mental health systems.

### **Social Marketing Campaigns**

Communication strategies such as social marketing can be used to target key audiences, including individuals with or at risk for mental illness or the families of individuals with mental illness. Social marketing campaigns can convey: the importance of mental health to whole health; strategies for enhancing resilience and protective factors; and letting the public know that mental illness can become chronic if untreated and that it can affect the course of other chronic diseases. Social marketing campaigns also can help to reduce the stigma of mental illness and encourage diverse sectors to get involved in activities to promote positive mental health.

Social marketing plans should be community-focused and include strategies to reach hard-to-reach populations such as rural or incarcerated populations, out-of-school youth, and racial and ethnic minorities.

### **Education of the Health Care and Mental Health Care Workforce**

The training needs of the public health, mental health, and health care provider workforces (as well as other professionals such as school teachers likely to encounter mental health issues) require collaborative identification and development. These professionals need to be made aware of the signs, symptoms, and treatability of common mental disorders and their relevance to physical health, which can foster earlier identification and support. They also should be trained to recognize the importance of preventive measures and strategies for mental health promotion.

## **VI. The Need for a Dynamic Portfolio of Strategies**

Most policy leaders have focused on treatment—specifically psychotherapy—because of the attention psychotherapists receive in research, practice, and clinical training. However, the prevention and treatment agendas must always be treated as complementary, and it is essential that they be integrated. Theory and principles that underlie current interventions, as well as the techniques that derive from them, might

have variations applicable to both prevention and treatment. Many of the delivery methods (e.g., use of the Internet, parent-to-parent delivery) may be shared as well.

Reducing the burden of mental illness first depends on avoiding onset, or limiting the severity of onset and, by doing so, reducing incidence and the need for more intensive treatment. Prevention is therefore pivotal, and a portfolio of preventive interventions with various models of delivery is needed for multiple venues and contexts. That portfolio should include preventive interventions that vary in their reach, costs, and required effort. The assembly of any portfolio of interventions must begin with a conceptualization of who ought to be reached in the population, what outcomes are sought, and what interventions are likely to produce successful outcomes for each of the various population groups.

### **Assessment**

Assessment is crucial in developing a portfolio of effective interventions. The goal of reducing the burden of mental illness must begin with an effective national assessment of the mental health of the nation. A comprehensive assessment must provide ongoing information for tracking trends in mental illness, its burden over time across cohorts, and the existence of social influences that might affect the baseline.

Many observers have articulated the importance of a national database on mental illness that provides a baseline to better establish the extent of the burden and whether there are changes in that burden over time. A national database also helps to engage multiple disciplines (e.g., education, sociology, social policy) and provides opportunities to generate and test hypotheses about economic and social influences that might be understood and possibly harnessed to improve mental health. There is no single discipline or modality of intervention that can claim the range of factors that might impact mental health. Natural factors, from climate and pollution to natural disasters, and human factors are all known to have a deleterious impact on both physical and mental health.

There are a few models in place to monitor mental health changes over time. SAMHSA's annual nationwide National Survey on Drug Use and Health (NSDUH) provides national and state-level data on the use of tobacco, alcohol, illicit drugs (including non-medical use of prescription drugs) and mental health in the United States, utilizing interviews with 70,000 randomly selected individuals. State and federal government agencies, private organizations, individual researchers, and the public use the data collected through NSDUH. State and local health agencies use NSDUH data to estimate the need for treatment facilities. The White House Office of National Drug Control Policy and the U.S. Department of Justice use the information to support prevention programs and monitor drug control strategies. The Partnership at Drugfree.org (formerly The Partnership for a Drug-Free America) uses NSDUH data to design media advertising campaigns for the prevention of substance use and abuse. The National Institute on Drug Abuse (NIDA) develops uses the date to help determine which populations and types of drug use should be the target of research programs. The U.S. Department of Education uses the data to inform drug use prevention and education programs and provide

educational materials for teachers and administrators. The U.S. Department of Transportation uses NSDUH data on driving after alcohol and illicit drug use to develop prevention programs and materials on impaired driving.

In addition, the National Institute of Mental Health's National Comorbidity Survey (NCS), which samples the mental health status of thousands of adults and youths, provides data on incidence and prevalence and encompasses several countries through the auspices of the World Health Organization. Another example is the Monitoring the Future Survey funded by the National Institute on Drug Abuse, which assesses behaviors, attitudes, and values of American secondary school students. The latter project began in 1975 and has provided data on drug, alcohol, and cigarette use nationwide for approximately 50,000 8th, 10th, and 12th grade students annually.

Although it currently does so only on a very limited basis, assessing the impact of childhood behavioral disorders on mortality, the Institute for Health Metrics and Evaluation (IHME) at the University of Washington could also serve this purpose in a more significant way. The IHME focuses specifically on evaluating data on health indicators, including the prevalence of major diseases and effectiveness of health programs. Adding a more robust collection of mental health and major psychological sources of impairment would be a natural extension of this effort, given that mechanisms for rigorous evaluation are already in place for obtaining the requisite data.

### **Measuring Treatment Approaches**

Outcome measures are important in psychosocial intervention. However, some measures should also focus on characteristics of the treatment delivery model. Assessment must include the characteristics of treatment, such as what groups in need can be reached, and when developmentally, and in what setting the intervention can be delivered. Other critical dimensions, such as the reach of the intervention (the scale of application and when the intervention can be applied), and the degree of "therapeutic effort" (required dosage and degree of restrictions placed on the client), are also no less important than outcome measures.

The value of a treatment is not necessarily in its effect on individual patient outcomes but also in where that intervention fits within broader efforts to help reduce the burden of mental illness across all populations. Cost will always be an important factor in building a portfolio of public health interventions for mental health. Measuring the characteristics of treatment delivery requires the use of cost-benefit analyses that measure the cost of the intervention against the outcomes it produces to determine its overall utility.

## **VII. Collaborating With Other Disciplines: Brief Illustrations**

Collaboration in the sciences has increased to the point that collaborative work or team science often exerts greater impact than the work of individual investigators. Reducing the burden of mental illness requires collaborating with other disciplines, in part because



of the complexity and range of influences to be considered under different social and economic conditions and cultural contexts. While mental health professionals in psychology, psychiatry, clinical social work have historically collaborated with each other to provide treatment services, collaborations to develop effective preventive health approaches must encompass additional disciplines and strategies that are beyond traditional practice.

The reader may wish to consider the following interdisciplinary approaches and how they might contribute.

### **Diet and Nutrition**

Studies of diet and nutrition continue to involve increasingly sophisticated lines of empirical research (e.g., alternative medicine, cellular microbiology of nutrition). Assessments of critical mechanisms (e.g., the conversion of diet to minerals to neurotransmitters, and cell trafficking and transport) in a more fine-grained fashion have changed the nature of dietary research. It would seem that diet, nutrition, vitamins, and minerals affect critical psychological processes and could be harnessed to influence mental health and illness. The ability of changes in diet to reach large populations could make a nutritional approach an excellent addition to a portfolio of models of delivery for preventing the onset, or mitigating the impact, of mental illness.

There are many intriguing leads already. For example, pesticides in one's diet (e.g., especially on fresh and frozen fruit) have been implicated in the onset of attention-deficit/hyperactivity disorder. And a randomized and placebo controlled trial has suggested fatty acid supplements could have therapeutic effects on psychoses. While diet may not provide a simple answer, nutrition might well be a potential element in broader prevention efforts. The determinant in all cases should be evidence and adherence to the goal rather than allegiance to a profession or a restricted model of treatment delivery.

Of course, one would want strong evidence with regard to risk factors, etiology, and treatment. The credibility of approaches to utilizing diet in the etiology and treatment of psychological and psychiatric dysfunction has suffered as a result of faddish diets, quick cures for desperate parents and clients, and, at best, checkered evidence. Diet "cures" are readily available on the Internet for conditions as diverse as attention-deficit/hyperactivity disorder, autism, and dyslexia, despite the absence of evidence and multiple empirical challenges.

### **Epidemiology and Public Health**

The two linked disciplines of epidemiology and public health are obvious partners because they focus on the distribution of dysfunction or disease, the factors involved in risk and prevention, and population-based interventions. Among the common features of epidemiology and public health are an interest in evaluating the factors that predict onset of disease and can be used to identify groups at risk, the development and testing of

intervention strategies, and the goal of implementing policy for widespread adoption where possible. Drawing on that orientation is critical to the mental health profession.

As an example, the federal Office of Disease Prevention and Health Promotion has delineated a national goal: Healthy People 2020 ([www.healthypeople.gov/](http://www.healthypeople.gov/)). This initiative sets national objectives for promoting health and preventing disease, drawing on what has been learned from health research during the last decade, and uses that as a basis for setting priorities. The public sector and various stakeholders have helped to craft a 10-year policy to promote health. The Centers for Disease Control and Prevention takes a similar population-based approach to preventing illness and improving quality of life ([www.cdc.gov/](http://www.cdc.gov/)). These initiatives also recognize the disparities in health-care delivery and those who are not served.

However, population-based interventions alone will not be sufficient. Many individuals in need are missed by public health interventions, many who do receive the intervention may not respond, and many who respond may not respond significantly. The effectiveness of public-health approaches, which often consist solely of providing information to the public, can be improved through psychological science, drawing on theory and research on message framing, social norming, and focusing illusion to optimize changes in attitudes, behaviors, decision making, and subjective experience.

There is a need and place for an intense individual focus in a portfolio of intervention models. However, a public-health perspective sensitizes mental health providers to the need to ascertain which interventions warrant greater influence than what is done through one-on-one psychological therapy. For instance, public-health (population) perspectives are currently being encouraged in addressing family interventions for parenting and domestic violence.

Mental health professionals must also identify interventions that are effective and can be provided on a greater scale to communities and large consumer groups. Advances in technology have helped facilitate ever-growing extensions of psychological interventions to the public at large. A very costly intervention can be identified (e.g., individual, weekly, in-person psychotherapy) as one that should only be applied on a small scale to only a very select few.

## **VIII. Examples of Mental Health Promotion Best Practices for Older Adult Populations**

### **Agency Partners with American Indian Tribes**

The Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) developed working agreements with several American Indian tribes to bring Elder Wrap-Around Case Management services to their elders; agreements differed with each tribe. In one program, the SAMHSA-funded Targeted Capacity Expansion project offered wraparound planning and case management as long as tribal agencies



delivered behavioral health care. By responding to immediate needs first, such as replacing broken windows, case managers gained the trust of older adults before addressing behavioral health issues. As relationships intensified, staff was able to address the potential fear and stigma associated with behavioral health treatment programs.

### **Alcohol and Drug Council Engages Older African Americans**

The Houston Council on Alcohol and Drugs partners with aging and health organizations under the Wellderly Program.<sup>xix</sup> The Wellderly program offers presentations and workshops for older adults and service providers, and it uses the screening, brief intervention, and referral to treatment (SBIRT) model adapted for older adults who may be misusing or abusing alcohol, prescription medication, or other substances. The program focuses on at-risk older adult populations, including African Americans and individuals in senior independent living communities, many of whom are at risk due to social isolation for depression, complex medical problems, and substance abuse.

### **Community Center Addresses Depression in Older Latinos**

Un Nuevo Amanecer (A New Dawn), a program offered by Centro de la Comunidad Unida/United Community Center in Milwaukee, Wisconsin and funded by SAMHSA, brings together aging and behavioral health agencies to successfully reach and engage older Latinos with symptoms of depression.<sup>xx</sup> The program focuses on cultural heritage to strengthen personal development.

The program overcame participants' initial reluctance to engage by offering group activities in the community center. These outreach activities focused on emotional wellness—emphasizing behavioral health as a part of wellness—to overcome the stigma among older Latinos surrounding mental health treatment and address the unique needs of the population it serves.

### **Healthy IDEAS Program Engages Depressed Older Asian Immigrants**

Stigma makes it difficult to discuss depression with many older Asian adults. Healthy IDEAS for Asian Immigrant Seniors has been adapted by a collaborative of Los Angeles agencies working with the developers of the original Healthy IDEAS program.<sup>xxi</sup> The integration of Healthy IDEAS into existing care management systems makes the program a good fit for social service agencies working with Cambodian, Chinese, Japanese, and Korean communities.

For Japanese clients who seem particularly resistant to the word “depression,” screening questions are reordered to gain acceptance of the tool. With Cambodian adults, group discussions focus on health concepts. These and other older immigrants from Korea and China are shown how to take steps to reduce their depressive symptoms through behavior activation, a major component of the Healthy IDEAS program.<sup>xxii</sup>

## **IX. Prevention and Public Health Strategies for Children’s Mental Health**

In recent years, the call for a new way of addressing children’s mental health in the United States has grown stronger. A case can be made for changing the current approach to children’s mental health, and specifically, for implementing a public health approach to children’s mental health. Hope for this new approach is inspired by successful examples of public health efforts in the area of children’s physical health and intellectual development, increased recognition of the positive impact of System of Care values, and a developing understanding of the ways healthy environments can enhance children’s development. These examples have illustrated how a population-focused approach emphasizing optimal growth and well-being can be successfully integrated into American society.

Other innovations, such as nurse visitation programs for first-time mothers and social skills development programs, provide excellent examples of effective public health interventions for children’s mental health, even though they may not be labeled as mental health interventions.

## **X. Gathering the Data to Implement a Prevention and Public Health Approach to Children’s Mental Health**

Successful innovation requires the use of data to help set priorities, inform plans, make decisions about interventions, advocate for community change, and sustain interventions. The data-gathering process can be divided into four parts: (1) determining what to assess; (2) identifying data sources and data collection strategies; (3) collecting the data; and (4) analyzing and interpreting the data to inform decisions about interventions.

### **Determining What to Assess**

Before beginning implementation, innovators should gather information that helps them understand the needs of the population of focus—in this case, the current condition of the mental health of children—the context within which an intervention is or will be offered, and what infrastructure exists to support the pursuit of optimal mental health among children. Collecting demographic information on family socio-economic status, race and ethnic identification, age, and geographic location allows the data to be disaggregated, a step critical to understanding the nuances between and within populations of focus, and helping to identify what adaptations and modifications in delivery systems may be necessary.

While many communities and states collect population level data on mental health disorders, a new “Intervening Model” includes a focus on positive mental health outcomes. However, incorporating positive mental health outcomes and determinants in data collection may require a shift in methods and tools used because the science of measuring positive mental health and its determinants lags behind the measurement of

mental health problems. Innovators will want to use the best knowledge available to identify outcomes and determinants that inform an understanding of the population of interest and the social and physical environmental factors shaping children’s mental health.

In addition to understanding the mental health status of the population and the determinants that impact it, an assessment of current resources and community assets, and child-serving delivery systems and sectors is important in establishing the need for intervention efforts. Questions should include:

- What are the diversity issues within the community and the service and support systems that most impact the mental health of children?
- Who needs to be engaged as a partner in efforts? What are the existing relationships?
- What are the current funding opportunities and challenges?

## **XI. Examples of Initiatives that Support the Behavioral Health of Young People**

### **Maryland Early Childhood Mental Health Consultation Project**

Maryland’s Early Childhood Mental Health Steering Committee was established in 1990 and chaired by representatives of the state departments of Health and Mental Hygiene and Education. It included families, state and local child serving agencies, early childhood providers, and advocates. Starting with a clear commitment not to establish a new “service system” to deliver early childhood mental health services and supports, the Steering Committee identified where young children were spending time and attempted to bring appropriate services—from prevention to treatment—to them.

The Steering Committee used excess state budget funds to pilot two three-year behavioral consultation programs—one in Baltimore City and one on Maryland’s Eastern Shore. The Early Childhood Mental Health Consultation Project was designed to improve the ability of early care and education program staff, as well as families, to address mental health problems (particularly behavioral problems) in children ages birth to five years, enabling them to avoid expulsion from their preschool or daycare programs. Ninety percent of children at risk of expulsion were maintained in their placements.

On-going data collection was also required as a part of the project. The data from the project was subsequently used to advocate in the Maryland legislature for policy and funding for statewide implementation. Legislators cited the data as the reason for their support for a statewide program.

### **Mental Health Awareness Campaign—National Promotion/Prevention/Reclaiming Social Marketing Effort**

The National Mental Health Awareness Campaign is a nationwide nonpartisan public education campaign that was launched as part of the 1999 White House Conference on Mental Health. The campaign has a two-pronged goal: to encourage people to identify, discuss, and seek help for mental health problems and to create a more accepting environment for them to do so. Since the program's inception, millions of people have been educated through a speaker's bureau, public service announcements, Town Hall Meetings, media outreach, and printed materials. The speaker's bureau partners with schools to fight stigma, nurture the mental health of all students, and reduce the risk of suicide.

### **Re-Claiming Futures**

An innovative Robert Wood Johnson-funded initiative in Portland, Oregon and nine other sites, the Reclaiming Futures Program, examined ways in which youth involved with juvenile drug use or delinquency could reclaim health while also addressing their substance abuse issues. A national evaluation, published in 2010,<sup>xxiii</sup> focused on each community's ability to implement the objectives of the initiative but did not assess the behavioral impact on youth of any particular intervention or treatment technique. Rather, the evaluation aimed to document the development and evolution of Reclaiming Futures in each community and the lessons learned from this experience. The outcomes tracked by the national evaluation team focused on the processes, policies, leadership dynamics, and personal relationships hypothesized to produce positive system change.

Researchers tracked whether and how the service systems in each Reclaiming Futures community changed and whether they changed as intended. Positive changes were reported in all 10 Reclaiming Futures communities regarding treatment delivery and effectiveness, cooperation, and information-sharing among youth service providers, and family involvement in youth care.

In Portland, a collaboration involving the Native American Youth and Family Center (NAYA Family Center), the National Indian Child Welfare Association, and the Research and Training Center on Family Support and Children's Mental Health documented the effectiveness of NAYA's services for Native American children and youth with and without diagnoses. Participatory definitions of health were used to encourage young adults to achieve success in all domains. Areas of success included the development of healthy relationships, personal capacities, balance, and healthy lifestyle choices. Positive outcomes were further defined as including: "knowing lots of people, honoring boundaries, being OK with your body and looking good, finding constructive ways to solve problems, walking in both worlds," and more. Specific reclaiming activities included healing circles, housing and employment programs, and life-skill supports and services designed to assist youth participants in achieving independent living.

### **Illinois Framework for a Coordinated Mental Health System**

The Illinois Framework for a Coordinated Mental Health System for Children Ages 0 –18 (Figure 1, below) illustrates how prevention, early intervention, and treatment systems

can be layered to address the varying needs of all children in the community. It allows distinct “systems” to work together in a manner that can be shared to provide collaboration among the many partners and initiatives.

The three spheres in the Illinois framework work together to create a coordinated system. The **Prevention** sphere includes broad strategies to promote healthy social and emotional development in all children. Prevention is characterized by population-specific education and awareness, consultation with mental health experts, and curricula on social and emotional development. The next sphere, **Early Intervention**, addresses a subset of the total children’s population. Early intervention can be viewed as a support and linkage system to assist children and families in skill-building and crisis support. It is a link between prevention and treatment systems and uses more specific, short-term strategies for detection and response. Finally, the **Treatment** sphere includes an array of services and supports for access to care.

***Framework for a Coordinated Mental Health System  
in Illinois for Children Ages 0-18***

**Prevention**

***Coordinated Systems for Promoting Healthy Social and  
Emotional Development in Children***

Public education and awareness  
Mental health consultation with providers  
Voluntary home visits  
Parent education and support services  
Social and emotional development programs and curricula for community services and schools

**Early Intervention**

***Coordinated Systems for Early Detection, Identification,  
and Response to Mental Health Needs***

Mental health consultation with providers  
Student support services  
Early identification, assessment, referral, and follow-up  
Short-term counseling and support groups  
Skills-building classes (e.g., problem-solving, anger management)  
Ongoing and crisis support

**Treatment**

***Coordinated Systems of Care for Providing Comprehensive  
Treatment and Family Supports***

Therapy and support groups  
Comprehensive assessment, diagnostic, and referral services  
Hospitalization and inpatient mental health treatment services  
Respite and other support services for families  
Drug treatment

**XII. Roles for State Behavioral Health Agencies (SBHAs) in  
Developing and implementing Effective Mental Health  
Promotion, Wellness and Prevention Activities**

**The Changing Healthcare Landscape**

Creating strong bi-directional linkages between preventive services and primary and behavioral healthcare services is a critical step in achieving improved patient outcomes. Historically, health promotion and prevention research and services have been under-funded. However, funding has been made available under the ACA for states to focus

more on preventive activities that benefit behavioral health outcomes, along with the integration of community-based programs and primary and specialty care. The Federal government is placing a heavy focus on health promotion and prevention activities at the community and state levels. Health care purchasers and payers are placing an emphasis on health promotion and prevention activities at the community and state level.

For instance, under the ACA, a state Medicaid program can receive extra federal funding if it chooses to cover the preventive services recommended by the U.S. Preventive Services Task Force (USPSTF). The USPSTF is an independent panel of experts in primary care and prevention that systematically reviews the evidence of effectiveness of clinical preventive services and develops recommendations for their use. One such preventive service recommended by the USPSTF is the screening of adults for depression in clinical practices that have systems in place to assure accurate diagnosis, effective treatment, and follow-up. Also included is the implementation of Screening, Brief Intervention, Referral and Treatment (SBIRT) for alcohol misuse.

An Interagency Council has been created at the Federal level to promote health and wellness policies. The Council consists of representatives of Federal agencies that interact with health and safety policy, including the departments of Health and Human Services, Agriculture, Education, Labor, and Transportation. The Council is charged with establishing a national prevention and health promotion strategy and developing interagency working relationships to implement the strategy. The Council is required to report annually to Congress on its health promotion activities and progress in meeting the goals of a national strategy that include identifying behavioral health best practices.

These and similar activities are supported by the Prevention and Public Health Investment Fund created under the ACA to provide a sustained investment in prevention and public health programs to improve health and help restrain the rate of growth in private- and public-sector healthcare costs. These new prevention efforts will help to promote behavioral health related prevention and screening, as well as physical wellness and prevention.

### **Specific ACA Provisions Focused on Prevention and Promotion**

Section 2951 of the ACA created the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program, now being administered by the Health Resources and Services Administration (HRSA) and the Administration for Children and Families (ACF), which allows collaboration and partnership at the federal, state, tribal, and community levels to improve health and development outcomes for at-risk children through evidence-based home visiting programs. The MIECHV program includes grants to states and six jurisdictions to develop statewide home visiting programs.

The MIECHV program is designed to: (1) strengthen and improve the programs and activities carried out the Social Security Act; (2) improve coordination of services for at-risk communities; and (3) identify and provide comprehensive services to improve outcomes for families who reside in at-risk communities. It is offered on a voluntary basis



to pregnant women, expectant fathers, or parents and primary caregivers of children, birth to kindergarten entry. Home visits target one or more of the benchmark and participant outcomes in the ACA, including:

- Improvement in maternal, infant, and child health;
- prevention of child injuries, child abuse, or maltreatment, and reduction of emergency department visits;
- improvement in school readiness and child academic achievement;
- improvement in parenting skills;
- reduction in crime or domestic violence;
- improvement in family economic self-sufficiency; and
- improvement in coordination and referrals for other community resources and supports.<sup>xxiv</sup>

Additionally, there is a Tribal MIECHV program administered through the Office of Child Care in ACF which supports the implementation of high-quality, culturally-relevant, evidence-based home visiting programs in American Indian and Alaskan Native communities.

Section 4004 of the ACA mandates that the Secretary of Health and Human Services (HHS) provide for planning and implementation for a national public-private partnership to undertake a prevention and health promotion outreach and education campaign designed to increase public awareness about how to encourage healthy behaviors and prevent disease across the lifespan. As a part of that effort, the Secretary has conducted an ongoing national media campaign on health promotion and disease prevention focusing on nutrition, physical activity, mental health, and smoking cessation using science-based social research. That campaign includes a web-based portal, [www.HealthyPeople.gov](http://www.HealthyPeople.gov), that provides informational guidelines on health promotion and disease prevention to healthcare providers and the public, as well as a personalized prevention plan tool for individuals to determine their disease risks and obtain tailored guidance on health promotion and disease prevention. In addition, the Secretary provides guidance and relevant information to States and health care providers regarding preventive services and services to combat obesity that are available to Medicaid enrollees, including obesity screening and counseling for children and adults.

Section 4108 of the ACA, authorizes Federal grants to states that implement widely-available, easily accessible, and evidence-based programs of incentives for Medicaid enrollees who adopt healthy behaviors. The programs must be comprehensive and uniquely suited to address the needs of Medicaid eligible beneficiaries and must have demonstrated success in helping individuals lower or control cholesterol and/or blood pressure, lose weight, quit smoking and/or manage or prevent diabetes. They may also address comorbidities, such as depression, traditionally associated with these conditions. States that receive the grants are required to conduct a public outreach and education campaign to educate Medicaid enrollees regarding the availability and coverage of those preventive services.



The ACA also requires, under §4104, that screening and preventive services and an annual physical examination be provided to Medicare enrollees free of cost, and that preventive and wellness services be provided, under the §1302(b) essential health benefits provisions, to Medicaid alternative benefit plan enrollees free of cost-sharing. In addition, §4106 of the ACA created a Medicaid State Plan option for traditional Medicaid enrollees to expand diagnostic, screening, preventive and rehabilitation services to include: (1) any clinical preventive service recommended with a grade of A or B by the U.S. Preventive Services Task Force; and (2) with respect to adults, immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) and their administration. States that elect to cover these additional services and vaccines under the traditional Medicaid State Plan without cost to the beneficiary are eligible to receive an increased Federal medical assistance matching percentage (FMAP) of one percentage point for the services.

Section 4101 of the ACA creates a grant program for school-based health centers. Grant awards may prioritize communities that have previously evidenced barriers to primary health care and mental health and substance abuse disorder prevention services for children and adolescents.

Section 4102 of the ACA mandates the creation of a five-year oral healthcare prevention public education campaign at CDC, focused on preventive measures and targeted to key populations, including children, the elderly, individuals with disabilities, and Native American populations, as well as pregnant women. The new demonstration program focuses on oral health delivery and strengthening surveillance capacity.

Section 4201 of the ACA authorizes community transformation grants to state and local government agencies, Indian tribes, national networks of community-based organizations, and state or local non-profit organizations. The grants are to be used to develop plans for policy, programmatic, and infrastructure changes that promote healthy living. Among the activities which the ACA specifies the plans may address include developing and promoting programs, targeting a variety of age levels, to increase access to nutrition, physical activity, and smoking cessation, improve social and emotional wellness, enhance safety in a community, or address any chronic disease priority area identified by the grantee.

A modification to the Medicaid program authorized by § 4107 of the ACA provides coverage of comprehensive tobacco cessation services for pregnant women. Authorized services include diagnostic and therapy services, and prescription and nonprescription tobacco cessation agents approved by the Food and Drug Administration (FDA) for use by pregnant women, if provided under the supervision of a physician or other authorized health professional. Beneficiary cost-sharing is prohibited for these services.

Finally, §4202 of the ACA authorizes the CDC to provide 5-year grants to state or large local health departments or Indian tribes to pilot community-based public health interventions, screenings, and referrals to improve the health of individuals in the 55- to 64-year-old age group. Intervention activities may include efforts to improve nutrition,

increase physical activity, reduce tobacco use and substance abuse, improve mental health, and promote healthy lifestyles. Authorized screening activities include screening for mental health and substance abuse disorders, as well as smoking and nutrition related issues. In a mandated annual evaluation of the effectiveness of the overall program, the HHS Secretary is required to weigh the prevalence of uncontrolled chronic disease risk factors among new Medicare enrollees or individuals nearing enrollment age who reside in States or localities receiving grants, and compare that data with national and historical data for those States and localities for the same population. The Secretary is also required to review available evidence, literature, best practices, and resources that are relevant to programs that promote healthy lifestyles and reduce risk factors for the Medicare population, including evidence review on, at least: (1) physical activity, nutrition, and obesity; (2) falls; (3) chronic disease self-management; and (4) mental health.

### **XIII. Goals for SBHAs**

SBHAs have historically been committed to educating health professionals and the general public about the importance of behavioral health promotion and prevention practices, adopting proven strategies in this area, and incorporating them into the State Mental Health Plan. SBHAs have also been committed to sustaining and improving performance of promotion and prevention related activities, while meeting the demands of the behavioral health population, by: monitoring program implementation; evaluating program outcomes and effectiveness; and conducting surveillance of population-level indicators. As federal efforts produce new evidence-based approaches to the use of clinical and community based preventive services, states should seek to adopt these approaches and track opportunities for funding.

**Action:** Under the changing healthcare landscape, SBHAs should endeavor to work with several public and private sector stakeholders at the state level, including major health purchasers, to take advantage of the public policy and private sector opportunities, and the growing evidence base behind prevention and promotion, with a focus on children and youth. Opportunities for supporting primary prevention in particular should be explored.

**Action:** SBHAs could consider partnering with state Medicaid officials and other stakeholders to help design programs for individuals with behavioral health conditions that include appropriate public awareness campaigns and consumer incentives.

**Action:** SBHAs should consider partnering with state legislators and/or state Medicaid officials to: define and implement evidence-based screening for mental health and substance use conditions; develop standard-screening protocols that include patient privacy protections; and work to embed the screening function in the processes utilized by medical homes, health homes, safety net programs, school-based clinics, and other relevant provider settings. Pilot programs should evaluate chronic disease risk factors, conduct evidence-based public health interventions, and ensure that individuals identified with chronic disease or at-risk for chronic disease receive clinical treatment.

**Action:** SBHAs should communicate with pediatric and primary care professional organizations, as well as state medical boards and medical schools, to promote the universal adoption of standardized, privacy-protected screening and assessment for mental health and substance use conditions.

**Action:** SBHAs should continue to work to prevent or reduce consequences of underage drinking and adult problem drinking, as well as prescription drug misuse and abuse.

**Action:** SBHAs could work in partnership with key stakeholders to prevent and eliminate tobacco use among youth and persons with behavioral health disorders.

**Action:** SBHAs should work to prevent suicides and attempted suicides among high-risk populations, especially service members, veterans and their families, LGBTQ youth, and American Indians and Alaska Natives.

**Action:** SBHAs have been moving their behavioral health systems toward a broader definition of health by recognizing the importance of wellness and prevention services as integral to positive behavioral health outcomes. SBHAs could continue to encourage an integrated behavioral health model that incorporates mental healthcare, substance abuse treatment, and physical healthcare services into coordinated care systems.

**Action:** SBHAs could promote a data-driven strategic prevention framework that includes participation in development of that framework by representatives from multiple community sectors, including education, business, justice, housing, healthcare, and other relevant fields.

**Action:** SBHAs should work with employers and insurers to enhance workforce capacity by delivering specialized preventive services in the workplace, and should work with the broader human services workforce to support prevention and the promotion of social and mental health.

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