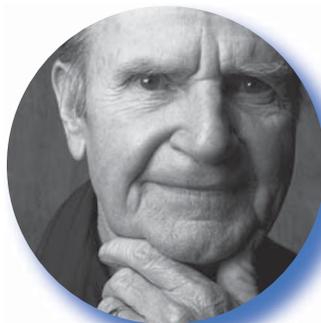


Mental Health— A Public Health Approach



Developing a Prevention-Oriented Mental Health System in Washington State



Washington State Board of Health
December 2007



ACKNOWLEDGEMENTS

The Washington State Board of Health members and staff who worked on this report would like to thank the many people—too many to name individually—whose commitment of time and expertise made this report possible. This includes the members of the Prevention Advisory Group (PAG) and the dozens of people who participated in the focus groups and the two prevention work days. In particular, we would like to thank the staff of the Mental Health Transformation Project, most notably Senior Policy Analyst David Brenna, who convened and chaired the PAG, secured additional funding when necessary, and was engaged fully every step of the way. MHTP Director Ken Stark should also be acknowledged for his unwavering support of prevention. The Department of Health provided funding for the first prevention day and several of its staff members were instrumental in the PAG and related activities. In particular, we would like to recognize the work of Child Development Specialist Tory Henderson, who coordinated the first prevention day and was engaged in planning much of the policy development process that led up to the report. Two consultants also need to be honored for their contributions. Sheri L. Hill lent her excellent facilitation skills and her professional expertise to the age-specific focus groups, and Paul G. Dziedzic provided valuable advice on the policy development process and facilitated both prevention work days.

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Washington State Board of Health

December 31, 2007

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NOTICE: This report was produced by the Washington State Board of Health in consultation with the Mental Health Transformation Project's Prevention Advisory Group (PAG), as well as individual consumers and mental health, social services, and public health providers across the state. It does not necessary represent the official views of the PAG's participating organizations.

Funding for this document was made possible in part by the Mental Health Transformation State Incentive Grant Award No. 6 U79 SM57648 from the Substance Abuse and Mental Health Services Administration (SAMHSA). The views expressed in this document do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.

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EXECUTIVE SUMMARY

Imagine our health care system treated people who had heart attacks but did not recommend aspirin, prescribe blood thinners, screen for blood pressure or cholesterol, promote exercise, or encourage healthy diets. Fortunately, when it comes to heart health, our medical care and public health systems work together to practice prevention, which can encompass health education, health promotion, prevention of risk factors, screening, early detection and treatment, and work to reduce disability and prevent recurrence. Many argue, however, that our mental health system is like a heart center that does little until a heart attack occurs. In truth, many programs across Washington State promote mental health and are engaged in mental illness prevention, but the framework for a prevention-oriented approach to mental health is incomplete and fragmented.

Mental health promotion and mental illness prevention is critical for all Americans. About 22% of the U.S. adult population has one or more diagnosable mental disorders in any given year, and the disability and economic costs of mental illness are substantial. In the United States and other market economies, mental illness ranks second only to heart disease in disease burden according to a study that measured disability-adjusted life years.

This document describes a public health approach to mental illness prevention and mental health promotion and is intended to spark a dialog about how to advance such an approach in Washington State. The dialog will culminate in a May 13, 2008, summit that will be designed to produce policy recommendations.

A significant portion of mental illness is now believed to be preventable, and recent research continues to identify new ways to implement prevention. Research has improved our knowledge about biological and environmental factors related to mental disorders, including serious mental illnesses such as schizophrenia. Evidence shows that prevention efforts can be successful with disorders that are the result of both genetic and psychosocial influence.

Our growing understanding of mental illness has stimulated interest in a public health approach to mental health, although use of a public health approach to mental health does not necessarily mean that public health agencies must lead the work. Organizations such as the National Association of State Mental Health Program Directors have recognized the need to use public health promotion and prevention practices in the public mental health system to increase resilience, decrease risk for mental illness, and facilitate recovery. Public health entities have also examined how a public health approach might address mental health.

Washington is one of nine states to receive a Mental Health Transformation Grant from the Substance Abuse and Mental Health Services Administration (SAMHSA). Washington chose from the beginning to include a prevention and promotion focus as part of its grant work. In March 2006, the Mental Health Transformation Project (MHTP), which staffs the grant, convened a Prevention Advisory Group (PAG) to engage a wide array of partners, one of which is the Washington State Board of Health (SBOH). The Board's strategic plan calls for developing a report that articulates a vision for a public health approach to mental health. The MHTP, the Board, PAG participants, and other partners have spent more than a year and a half engaged in conversations about mental health promotion and mental illness prevention. This report documents what has been learned from those conversations through fall 2007.

The PAG adopted a multistage process for policy development. First, it presented its plan to develop this report and follow it with a summit to the Transformation Work Group (TWG), the MHTP's governing body, to make sure the TWG supported the concepts of the work. Then, on July 13, 2007, it held a prevention work day that was hosted by the Department of Health with support from the Board and the MHTP. The purpose of the work day was to enlist consumers, providers, and experienced agency staff to help frame this report. Participants were assigned to groups that were asked to focus on age groups identified by the PAG as key subpopulations. Initially, these were (1) children birth to five; (2) school-aged children; (3) youth in transition to adulthood; (4) people who had experienced a first hospitalization and were at risk for readmission; and (5) older adults. Subsequent discussions led to a decision to treat the fourth population as simply adults, but to focus on promoting resiliency and recovery and preventing recurrence, impairment, and co-occurring disorders in adults with mental illness who had experienced an initial crisis. Discussions continued through October in the form of surveys and focus groups that sought input about the characteristics and needs of the subpopulations. On November 9, 2007, MHTP hosted a second prevention work day to integrate the report's discussions of age-specific populations.

These discussions have informed the content of this report, which SBOH approved in December 2007 and transmitted to MHTP for consideration by the TWG. The MHTP intends to host community forums in early 2008 to obtain reactions to this report from diverse communities around the state. On May 13, 2008, MHTP will hold a policy summit to engage policymakers in a conversation about how to create a less fragmented approach to mental illness prevention in Washington. This report does not contain policy recommendations; those are expected to come from the summit participants.

Early PAG meetings featured extensive discussions about terminology, such as what is meant by *prevention* in the context of mental health. The group eventually adopted broad definitions that will allow policy analysts and policy makers to take a whole systems view of a prevention-oriented approach to mental health. Those definitions have been used throughout the policy development process, including the drafting of this report. Part 1 of this report discusses the definitions chosen by the PAG and their significance. The PAG definition of *prevention* is work that promotes mental health, intervenes early to address emerging mental health problems, and reduces the devastating impact of mental illness. This encompasses mental health promotion and health education, as well as early screening and intervention, rehabilitation, and prevention of co-morbidities. *Mental health* is defined as the ability to cope with life's stresses, work productively, and have fulfilling relationships. The term *mental disorder* is defined as any health condition characterized by alterations in thinking, mood, or behavior that results in distress or impaired function.

Part 1 also explores what is meant by a *public health approach*. Public health does not focus on diagnosis and treatment of the individual; the field is primarily interested in the health of the population as a whole and the links between health and the physical and psychosocial environment. The World Health Organization (WHO) describes the public health model as one that works through the organized efforts of society, which means public health interventions operate at the policy level and community level, as well as on an individual level.

Public health uses epidemiologic surveillance of the whole population's health, health promotion, disease prevention, and evaluation of the availability and quality of health services to accomplish its goal of improving health for whole populations. In addition, public health identifies risk and protective factors and then works to reduce risk factors and strengthen protective factors. Risk factors are characteristics that, if present for an individual, make it more likely that individual will develop the disorder than someone selected at random from the general population. Protective factors improve individual resistance to risk factors and disorders.

Part 1 addresses whether mental disorders truly are preventable. Many mental disorders are believed to be amenable to prevention because social experience can alter brain function and gene expression in ways that affect long-term emotional health. The Adverse Childhood Experiences Study shows strong correlations between adverse childhood experiences and long-lasting emotional and physical health. Part 1 also looks at health disparities as they relate to mental health and mental health services, and it examines some barriers to implementing a prevention-oriented public health approach to mental health.

Part 2 of this report discusses mental health needs and mental illness service needs particular to the five age groups identified by the PAG. Each section was written based on review of the literature and discussions with an age-specific focus group.

- **Children Birth to Five:** Mental health for children birth to five refers to the social, emotional, and behavioral health of young children. The mental health of young children can have a substantial impact on their readiness for school and success throughout their lives. Focus group discussions revealed societal barriers to prevention work for young children; specifically, society needs to understand that young children do have mental health needs and disorders, as well as a need for developmentally appropriate diagnosis and treatment. Policy suggestions from the focus group and literature to advance prevention and promotion work include mental health consultation for preschool and child care providers; medical provider screening for mental illness and social-emotional delay for children and families; home visitation programs; a social marketing campaign to create a society-level change in understanding and perspectives on early childhood mental health; and a formal mechanism to create collaboration between different early childhood agencies and providers.
- **School-Age Children:** Mental health in school-age children means having strong cognitive, social, and emotional skills that allow them to form successful relationships with family, teachers, and peers. It is not uncommon for children to experience disabling symptoms of mental illness; the Healthy Youth Survey reveals that high numbers of youth in Washington self-report problems with their emotional and mental health. Policy suggestions from the focus group and literature to advance prevention work include more support for families and youth; more education for caregivers and educators on child mental health; more widespread program evaluation; more resources to identify risk and protective factors to target interventions to children most in need of services; more training for medical providers so they can do mental health screening and referral or integrate mental health services into their practices; and more coordination or integration of mental health screening, mental illness treatment, and social-emotional learning with schools.

- **Youth in Transition to Adulthood:** The transition to adulthood is a critical time for the majority of individuals who have mental illness or who are at risk for mental illness. Most individuals who develop a mental disorder in their lifetime will either have the disorder before this transition or will develop it during this transition. The focus group identified several barriers to prevention and treatment work for this age-group; interventions that addressed these barriers were widely presented in the literature as policy suggestions. The policy suggestions include providing developmentally appropriate services to transitioning youth within the child and adult mental health systems, bridging the gap between the child and adult public mental health systems, and decreasing the number of youth without health coverage through private health insurance and public systems. Other policy ideas discussed in the focus group include creating a system in which there is no wrong door to services, using mental health consultants within primary care practices, using the drop-in center model to provide peer support to youth, starting a leadership academy for resilient youth, and creating a social marketing campaign to reduce stigma.
- **Adults:** Adults 18-59 years of age are the majority of users of Washington's public mental health system. For this group, the PAG was interested in identifying ways to intervene early during an initial mental health crisis to prevent subsequent events, such as avoidable rehospitalization, incarceration, or homelessness. Suggestions from the adult focus group for next policy steps include continuing the effort to move the mental health system toward a recovery and resiliency model, which includes use of peer support and psychosocial rehabilitation; moving from diagnosis-based access to need-based access; and providing more transitional support services, including hospital-to-home support and support around homelessness and incarceration. Other suggestions from the literature or focus group include creating a trauma-informed system of care, developing effective and ethical interventions for individuals with precursory psychotic symptoms, and providing primary prevention/health promotion interventions for depression and anxiety.
- **Older Adults:** Too often, common mental disorders such as depression and anxiety in older adults are mistakenly seen as just a normal part of growing old and not properly addressed. Early intervention and treatment of mental disorders in older adults can prevent excess disability and premature institutionalization. Older adult focus group suggestions for next policy steps include increasing earmarked funding for older adults; drawing statewide attention to aging, including education on mental health and aging; creating a social marketing campaign to reduce stigma; and increasing outreach to bring older adults into care. Suggestions for next policy steps that emerged from the literature and focus group include providing support to individuals caring for an older adult family member and training primary care doctors to either effectively treat and identify mental illness in older adults or integrate trained specialists into primary care practices.

Part 3 of this report attempts to integrate the first two parts. One goal of this report is to articulate a public health, prevention-oriented approach to a mental health system that addresses the needs of the population across the entire lifespan. Therefore, it is important to identify overarching issues and common themes that cut across age groups. These cross-cutting themes may suggest to participants at the May 13, 2008, summit some policy approaches that would create and maintain an integrated system across the lifespan.

Following are the fourteen themes identified with the support of participants in the second prevention day:

- institutionalize communication and coordination around shared outcomes;
- market mental wellness and stigma reduction;
- increase funding flexibility;
- leverage existing funding sources;
- assess community risk and protective factors;
- screen at multiple points of entry;
- provide care based on need;
- ensure age-appropriate services are available;
- provide culturally competent services;
- meet people where they are;
- support transitions across the lifespan;
- provide mental health consultation;
- increase and improve provider training; and
- create trauma-sensitive or trauma-informed systems.

Programs and policies are already in place in this state that take a public health approach to mental health, but these individual pieces taken together do not add up to a *system* for prevention and promotion. Designing a system to institutionalize a coordinated approach to prevention likely would require addressing such related issues as leadership, governance, accountability, promotion of partnerships, common data collection and sharing of both data and analyses, and a shared research agenda. Most second prevention day participants supported the notion of creating some sort of a statewide entity to institutionalize coordination and communication. Institutionalization would create a mechanism for multiple agencies to agree on shared outcomes, create indicators to measure progress toward the outcomes, and prioritize investments to achieve the outcomes.

Washington State is committed to a wide range of prevention activities; in many respects it is a leader for the nation. It is also committed to transforming its mental health system. The reason to articulate a vision of a prevention-oriented mental health system at this time is not to diminish the existing activity. The intent is to reinforce that work and ensure that (1) prevention activities adequately consider mental health alongside physical health, substance abuse, and social welfare; and (2) mental health reform efforts leverage opportunities to intervene upstream. This document is intended to jumpstart a conversation about how to make that happen.

This report does not claim to propose all the answers for how to design a transformed system; specifically, it does not contain any recommendations. It attempts to lay a foundation that will allow the May 13, 2008, policy summit attendees to explore policy options and recommend next steps for advancing a prevention-focused, public health-style system for mental health in Washington State.

PART 1 MENTAL HEALTH AND THE PUBLIC HEALTH MODEL

I. INTRODUCTION

Imagine that our health care system treated heart disease only by operating on people who had already experienced a heart attack. Perhaps it also prescribed drugs such as nitroglycerin for people who exhibited signs of serious heart problems, but the system did not encourage people who may be at risk because of age, family history, or early warning signs to take daily aspirin or prescription blood thinners. People were not monitored for cholesterol, body-mass index, or high blood pressure. They were not encouraged to exercise and eat low-fat, low-salt, or low-calorie diets. No one prescribed cholesterol-lowering statins or beta blockers to treat high blood pressure. No one organized fun runs or walks, and for people who survived a heart attack, there was no follow-up, no rehabilitation, and no dietary counseling to prevent another attack.

Fortunately, that is not the case. We have health care and public health systems that work together and with other community partners to practice prevention, which can encompass health education, health promotion, prevention of risk factors, and early detection and treatment. It can also include screening and working with people who already have heart problems to reduce disability and prevent recurrence. Medical facilities that benefit financially from performing heart surgery also work with their patients to manage cholesterol levels and sponsor community walking and cycling events. The public health system works to prevent disease across communities. Public health agencies educate people about the importance of exercising regularly, eating nutritious meals, and not smoking. Some help restaurants develop healthy menu options, work with schools to remove soft drinks and high-calorie snack foods, distribute maps of bike and walking trails, encourage developers to add sidewalks and traffic calming devices to make neighborhoods more walkable, hold health fairs to promote screening, and urge people to quit smoking.

When it comes to heart health, we have a prevention mindset and a comprehensive, coordinated system in place to implement a variety of interventions at the individual, family, community, and societal level. Many argue, however, that the same cannot be said for mental illness; we have a system for treating mental illness that is akin to the heart center that does very little until a heart attack occurs and it is time to operate. In fact, government-funded mental health service providers have disincentives to engaging in promotion and prevention.

However, there are some programs across Washington State that actively promote mental health and prevent mental illness. Programs and program support are provided by a host of state agencies. The Department of Social and Health Services provides several programs and program support through the Children's Administration, the Juvenile Rehabilitation Administration, the Health and Recovery Services Administration, and the Division of Alcohol and Substance Abuse with its statewide prevention effort. Other programs and program support are provided through other agencies, including the Department of Early Learning, the Office of Superintendent of Public Instruction, the Department of Health, the Department of Veteran's Affairs, Children's

Trust of Washington, the Family Policy Council (FPC), and more. There are also service delivery systems that reach into communities to provide preventive mental health services tailored to each community's needs. Examples include the area agencies on aging, schools, local public health and social service agencies, and the FPC community public health and safety networks.

We have in place the outline of what could become a framework for a mental illness prevention and mental health promotion system, but it is incomplete and fragmented. Many of its components do not traditionally view themselves as part of a prevention-oriented mental health system. What we typically think of as the mental health system (clinics, hospitals, regional service networks and mental health providers) are focused on mental illness, not mental health, and are discouraged from contributing their expertise to a greater whole. There is not a mental health agency in every county, as there is with public health, that thinks broadly and systematically about mental health across the lifespan; conducts community mental health assessments and tracks mental health outcomes; assures the availability of core services; delivers coordinated prevention services; and is accountable to a local elected officials, the state, and its peers. The regional support networks (RSNs) typically do not serve the functions of a preventive system; instead, they tend to serve those with persistent mental illness or those in crisis.

Promoting mental health and preventing mental illness is critical for all Americans. About 22% of the U.S. adult population has one or more diagnosable mental disorders in any given year.¹ Between 5% and 7% of adults have a serious mental illness in any given year,² and 5% to 9% of children have a serious emotional disturbance.³ Data from a household survey in Washington State show a lower rate, although variation is likely due to a difference in the definition of mental disorder or a different methodology for data collection.⁴ Twelve percent of respondents to a Washington State household survey reported that they had a clinical mental disorder in 2000.⁵ The rate was 15% for individuals below 200% of the federal poverty level.⁵

The disability and economic costs of mental illness are substantial. In the United States and other market economies, mental illness ranks second only to heart disease in disease burden according to a study that measured disability-adjusted life years (DALYs⁶).⁷ This burden comes with great economic costs. In the United States, mental illness is estimated to be the cause of 59% of economic loss from illness or injury-related productivity loss.⁸ In addition, mental disorders are very expensive to treat. Alzheimer's and schizophrenia have the highest and second highest yearly cost per patient of twelve major conditions; the cost per patient is higher than for cancer or stroke.⁸

There have been substantial advances recently in our knowledge about interventions for preventing mental disorders.⁹ Studies have documented successful prevention efforts in areas such as dysthymia (a mood disorder characterized by mild depression that lasts at least two years), major depression, and conduct disorder.⁷ In addition, research has improved our knowledge about biological and environmental factors related to mental disorders, including serious mental illnesses such as schizophrenia. Evidence shows that prevention efforts can be successful with disorders that are the result of both genetic and psychosocial influence.

At the same time, the relevance of emotional health to physical health and physical health to emotional health has become increasingly clear. Poor mental health plays a significant role in the weakening of the immune system, the development of certain illnesses, and premature death.¹⁰ Conversely, physical health affects emotional health; heart disease and cancer, for example, can increase the risk for depression.¹⁰ Truly comprehensive efforts to reduce the prevalence of obesity and overweight may be more successful if the relationship between obesity and adverse childhood experiences is considered. Weight gain can be a self-protective response to childhood trauma such as sexual assault,³⁶ and weight gain is a typical side effect of some psychotropic medications.¹¹

Our growing understanding of mental illness has led to increasing calls from many quarters for the development and implementation of a public health approach to mental health that emphasizes promotion and prevention. Indeed, the convergence of thinking on this issue over the last few years has been striking.

In 2004, for instance, the National Association of State Mental Health Program Directors (NASMHPD) adopted a position statement that “recognized the necessity of using public health promotion and prevention practices in the development and delivery of the services provided by a public mental health system to increase positive functioning and resilience and decrease the risk of developing mental illness and facilitate recovery.”^{12(p.5)} The NASMHPD statement is noteworthy because most state mental health programs focus on providing treatment services to individuals with serious mental illness who meet strict eligibility requirements. Government responsibility for mental health has traditionally resided primarily at the state and local level, and some observers characterize the social contract between most states and the people they serve as a government agreement to offer assistance only if one is poor enough and sick enough for long enough or if one is in a bad enough crisis. Some would add that the contract applies only to those who are old enough because children’s mental health needs are treated as secondary to those of adults.

State mental health programs have focused on individuals whose existing diagnoses and incomes make them eligible for Medicaid, while public health professionals traditionally have focused largely, although certainly not exclusively, on promoting physical health and preventing physical ailments. Public health entities, however, are becoming more interested in ways that the public health model can address mental health. Both the National Association of County & City Health Officials (NACCHO) and the Centers for Disease Control and Prevention (CDC) released documents on the role of public health in mental health work during 2005.¹³ A CDC report declared that mental health “is integral to overall health and should be treated with the same urgency as physical health.”^{14(p841)} A NACCHO issue brief found that there is “growing recognition that the historical separation between mental health and public health is an artificial one that threatens the health and well being of individuals, families and communities.”^{13(p3)}

In 2006, two public health journals, the *American Journal of Public Health*¹⁵ and *Public Health Reports*,¹⁶ dedicated issues to the intersection of mental health and public health. Writing about children’s mental health, *Public Health Reports* contributors Karen Hacker and Karen Darcy said that “the public health community is only beginning to acknowledge its role in the mental health of our youngest citizens.”^{16(p292)}

The Washington State Board of Health created a strategic plan in 2005 that called for developing a report that “examines the capacity in the state to deliver preventive, community-oriented, population-based mental health services, articulates a vision for a public health approach to mental health, and makes policy recommendations.”

Concurrently, there has been increased recognition of the need to address mental health and mental illness in the context of delivering primary medical care services. The Improving Mental Health in Primary Care through Access, Collaboration, and Training (IMPACT) Program, a partnership between the American Academy of Pediatrics and the federal Maternal and Child Health Bureau (MCHB), is a case in point.

Federal efforts to transform state mental health systems in the wake of the President’s New Freedom Commission Report on Mental Health³ have also identified the need to place more emphasis on prevention. The U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) awarded five-year Mental Health Transformation Grants to nine states. The federal vision for a transformed mental health system, as described in the grant application, states that the use of evidence-based practices for early detection and prevention will be an explicit priority of all service agencies.⁵

Washington State is one of nine recipients of these grants and has included a prevention and promotion focus in its work. The Mental Health Transformation Project established a Prevention Advisory Group early in its work process. The Phase I Mental Health Transformation Plan developed in the first year of the grant includes a chapter on prevention, which is an area of emphasis during the third year of the grant.

Through the work of the State Board of Health, the Mental Health Transformation Project, and many other partner agencies and organizations, the conversation on mental health promotion and mental illness prevention that has been emerging nationally over the past few years is well underway in Washington State. This report is meant to document what has been learned from that conversation through fall 2007 and to lay the groundwork for the next stage of the discussion, which will be a series of community meetings followed by a summit for policy makers on May 13, 2008.

This report stops short of making specific policy recommendations since such recommendations will come out of the policy summit, and the summit recommendations will be informed by the community conversations that have yet to occur.

The intent is that this report will allow participants in the summit and the community conversations to enter the discussion at a fairly high level, rather than starting at the beginning, because it will have

- provided a context for this work;
- described the process that led us to where we are now;
- defined a common language;
- addressed some of the barriers to implementing a prevention approach;

- explained briefly the basis for claiming mental illness is preventable;
- articulated a vision of a public health model for improving mental health for age-specific populations and across the lifespan;
- identified key components of a mental health promotion and mental illness prevention system that are already in place, as well as those that are missing; and
- laid out a list of policy options and suggested some criteria for narrowing that list down to an action strategy

If summit participants can start with a common language, common knowledge base, and common set of assumptions, they should be able to focus their attention during the summit on identifying policies and programs that can move Washington State closer to having an integrated, coordinated, effective, efficient, and accountable *system* for promoting mental health and preventing mental illness.

The NASMHPD position paper explained that prevention is especially important when resources are scarce:

In a time of increasingly limited resources, the case for prevention becomes even more compelling. Prevention science has demonstrated that prevention practices can reduce risk factors and enhance protective factors. Further, these interventions are a cost effective use of resources relative to more expensive, treatment-based approaches. By not utilizing prevention and promotion approaches, we waste both human and financial capital.^{12(p1)}

In Washington State, for instance, when the Legislature made new investments in prevention activities such as Nurse Family Partnership, the Caseload Forecast Council lowered its projections for the number of future prisons the state would have to build.¹⁷

The next section of Part 1 of this paper provides background on the Mental Health Transformation Project and the Prevention Advisory Group. It is followed by a section that discusses mental health promotion and prevention in the context of the public health model, as well as a discussion of what is meant by those terms in this paper and in the work of the Prevention Advisory Group. The fourth section discusses health disparities related to mental illness. The fifth section addresses the question of whether mental illness is indeed preventable. The sixth section briefly explores barriers to prevention.

Part 2 of this paper explores prevention as it relates to five different populations: (1) children ages 0–5; (2) school-aged children; (3) youth in transition to adulthood; (4) adults; and (5) older adults. The age-specific sections are followed by Part 3, which discusses common elements to effective interventions across the subpopulations, the need to institutionalize communication and coordination around efforts to achieve shared outcomes, and some thoughts about ways to prioritize future policy choices.

II. BACKGROUND

The Washington State Board of Health prepared this report in close collaboration with the Mental Health Transformation Project. The project's Prevention Advisory Group (PAG) provided guidance throughout, and many other partners were involved at various stages of development. (See Appendix A for a list of PAG participants.) A portion of the Board staff time that went into researching and drafting this report was paid for with SAMHSA Mental Health Transformation Grant funds provided through a contract with the Mental Health Transformation Project.¹⁸

This report represents the fourth step in a multistage strategy proposed by the PAG and endorsed by the Transformation Work Group (TWG), the body that oversees the creation and implementation of the Comprehensive Mental Health Plan. This section describes the roles of the organizations involved in this report, the process used to develop its content, and how it fits within the strategy advanced by the PAG.

A. Mental Health Transformation Grant

The Mental Health Transformation Grant awarded to Washington is part of a federal effort to transform our mental health system. President Bush launched the New Freedom Initiative in 2001 to promote community-based alternatives for individuals with disabilities.¹⁹ The next year, he signed Executive Order 13263 to create the President's New Freedom Commission on Mental Health. Its mission was to comprehensively study the U.S. mental health service delivery system and to advise the president on methods for improving the system. Its final report, submitted July 22, 2003, recognized the enormous need for better provision of mental health services and recommended a fundamental transformation of the nation's approach to mental health care.

In 2005, SAMHSA developed a Mental Health Action Agenda to advance the New Freedom Initiative's work. It included awarding grants to states willing to transform their mental health service delivery systems. The grants are intended to build the infrastructure for an ongoing process of planning and innovation. Washington was one of nine states to receive one of these five-year grants. It received \$2.7 million annually in 2005 and 2006, the first and second years of the grant, and anticipates \$2.7 in the third year.

Governor Christine Gregoire created Partnerships for Recovery to implement the SAMHSA grant. The Transformation Work Group (TWG), which is directed by the Governor, is at the center of the partnership.²⁰ The Governor appoints the chairperson, who oversees all transformation group activities and is responsible for the creation and execution of the comprehensive mental health plan.⁵ The 33 TWG members include representatives from all of the human service state agencies and related support agencies, a representative of the Governor's office, consumers, consumer and family organizations, local government, providers, and regional support network representatives.²¹ The product of this group will be the Comprehensive Mental Health Plan. The key elements of the TWG plan will include initiating a social marketing campaign to reduce stigma, ensuring participation of consumers as providers in the mental health system, reducing ethnic and geographic disparities, increasing incentives for evidence-based

practices, and adopting a consumer-driven care model in all state agencies serving individuals with mental illness.

The TWG released Phase 1 of the Mental Health Transformation Plan in 2006. The plan states that prevention is an essential component of a comprehensive mental health system, and it describes Washington's prevention system as fragmented.²⁰ Chapter 4 of the plan discusses the formation of the Prevention Advisory Group to develop strategies for emphasizing prevention, to inform policy development, and to encourage a less fragmented prevention system. It states that the group will consider prevention and early intervention outcomes targeted to the community and family.

B. State Board of Health

The State Board of Health is a constitutional agency of Washington State. The Board's mission is to provide statewide leadership in developing and promoting policies that protect and improve the public's health. This mission is achieved by

- reviewing and monitoring the health status of all people in Washington;
- initiating and supporting policy development, analyzing policy proposals, providing guidance, and developing rules;
- promoting system partnerships; and
- fostering public participation in shaping the health system.

In summer 2005, the Board began to develop its five-year strategic plan for the 2005-07 biennium and beyond. A key aspect of strategic planning for the Board is to identify the best use of its limited policy development capacity. A leading idea that emerged was the articulation of a vision for a public health approach to mental health that would focus on promoting mental wellness and preventing mental illness. Significant mental health reform legislation had passed during the 2005 legislative session, but these efforts had focused largely on funding for individuals with serious mental illness, more mental health hospital beds, and better performance and accountability for the regional support networks across the state.

Board staff met with Mental Health Transformation Project staff to discuss how its idea of a report on a public health approach to mental health might intersect with work being funded by the grant. Out of those meetings came an understanding that a report such as the one envisioned by the Board would be consistent with the goals of the project and could complement the work already being planned. The strategic plan formally adopted by the Board in January 2006 included the report as one of its planned activities. As a first step, Board staff began to participate in the Prevention Advisory Group.

C. Prevention Advisory Group

The PAG began meeting in March 2006 and continued meeting roughly monthly thereafter. An electronic listserv that grew to include more than 85 participants allowed for discussions between meetings and kept participants, as well as interested individuals who could not attend meetings, informed. Meeting size varied depending on people's availability, but the meetings were well

attended and interest remained high. Anyone who wanted to was permitted to attend, though outreach to possible participants was limited at first to professionals involved in delivering mental health services, conducting academic research, or developing policy.

Early meetings featured several robust and far-ranging discussions about what is meant by *prevention* in the context of mental health—whether there even is such a thing and what kinds of programs and policies would constitute a functional prevention system. The challenges of defining mental health promotion and mental illness prevention are discussed in the next section, but the Prevention Advisory Group agreed that what it meant by prevention is creating a system that promotes mental health, intervenes early to address emerging mental health problems, and reduces the devastating impact of mental illness. The significance of this phrase in the context of other attempts to define prevention and promotion is discussed in section III (C) of this report.

The group also identified five age-specific populations to focus on in its work. Initially, these were (1) children birth to five; (2) school-aged children; (3) youth in transition to adulthood; (4) people who had experienced a first hospitalization and were at risk for readmission; and (5) older adults. Subsequent discussions led this report to treat the fourth population as simply adults, but its focus is on adults who have been diagnosed with mental illness and have experienced an initial crisis, such as hospitalization, incarceration, or homelessness. It also focuses on promoting resiliency and recovery and preventing recurrence, impairment, and co-occurring disorders.

As its discussions became more concrete toward the end of 2006 and the early part of 2007, the PAG settled on a four-step process to advance the policy discussion to the point that it could lead to real change. The strategy culminates with a summit that is intended to generate specific policy recommendations. That summit is now scheduled for May 13, 2008. A second key part of the strategy was to generate this report, which provides the groundwork for a productive summit.

The four steps later expanded to six. The six steps are listed below.

1. **TWG Support:** Mental Health Transformation Project and State Board of Health staff briefed the TWG on the PAG's work and proposed strategy on April 27, 2007. TWG members agreed this was valuable work consistent with the TWG goals.
2. **First Prevention Day:** On July 13, 2007, the Department of Health, in partnership with the Board and MHTP, held a prevention work day to enlist consumers, providers, and experienced agency staff to help frame this paper and to begin policy discussions. Discussions continued through October in the form of surveys and focus groups.
3. **Second Prevention Day:** On November 9, 2007, MHTP hosted a work day to integrate discussions for the age-specific populations and to avoid policy silos.
4. **White Paper:** On December 13, 2007, the Board approved this report and agreed to transmit it to the TWG for further action by the end of December.
5. **Community Forums:** The MHTP will host community forums in early 2008 to obtain feedback and input on this report from diverse communities around the state.
6. **Policy Summit:** On May 13, 2008, MHTP will hold a policy summit to engage policymakers in conversation about how to realize the report's vision for a less fragmented approach to mental illness prevention in Washington.

III. TERMINOLOGY

A key initial step in any policy analysis is to agree on common terms and definitions. The early work of the PAG and a review of the literature over the last two decades make it clear that this is not an easy task. Phrases such as *building a public health-oriented system that promotes mental health and prevents mental illness* leave considerable room for miscommunication. The NASMHPD policy paper notes that there is unfamiliarity and confusion about the public health/prevention conceptual model among mental health professionals and that unfamiliarity with public health language is a barrier to communication: “The perspectives of the fields of public health and mental health are different. Prevention requires new thinking, a new language, and a new set of skills for professionals and paraprofessionals in the field of mental health.”^{12(p3)}

This section describes definitions and uses of the terms mental health, mental disorders, public health approach, promotion, and prevention. In particular, it defines how these terms are used in this paper and in PAG policy discussions.

A. Mental Health and Mental Disorders

Health is more than the absence of illness. The preamble to the World Health Organization (WHO) Constitution calls health “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”¹⁰ Similarly, *mental health* is more than the absence of mental illness. A 1999 report from the surgeon general defined mental health as “an individual’s capacity to realize his or her abilities, to cope with the normal stresses of life, to work productively and fruitfully, and to have fulfilling relationships with other people.”^{7(p ix)}

The PAG and the State Board of Health support this notion of mental health and believe society should be concerned with promoting mental well-being as well as physical well-being. However, they also recognize that it is a long and expensive journey to go from where we are today to ensuring everyone can cope with stress, work productively, and enjoy fulfilling relationships. This paper, therefore, will focus primarily on programs and policies likely to reduce the incidence, prevalence, and severity of mental disorders.

The 1999 surgeon general report describes a *mental disorder* as any health condition characterized by alterations in thinking, mood, or behavior that results in distress or impaired function.⁷ The Board and the PAG have adopted this working definition. Mental disorder and mental illness are used interchangeably in this report.

There have been a variety of attempts to develop classification systems for mental disorders as complements to the World Health Organization’s *International Classification of Diseases* (ICD). The dominant one is the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR) of the American Psychiatric Association.²² Work on the next iteration of the manual, DSM-V, has begun. There are likely to be several changes to the classification system, including changes to the diagnosis criteria for trauma disorders. Trauma will be discussed throughout this report. There are many criticisms of the DSM-IV-TR. A criticism voiced by some consumers is that assigning a diagnosis to individuals can inaccurately categorize them because there is variation

in the constellation of symptoms between individuals with the same diagnosis, and people may be identified and treated not as individuals but as diagnoses.

A classification system specifically for young children is ZERO TO THREE's *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood, Revised* (DC:0-3R). This classification is similar to the DSM-IV-TR system, but it attempts to identify and describe mental health problems of very young children in a way that is developmentally appropriate. This classification system recognizes the role of family members, particularly primary caregivers, in identifying disorders,⁶¹ which may lead to primary caregiver involvement in treatment.

This report tries to discuss particular mental disorders in a way that is consistent with established classification systems without relying exclusively on one system. In addition, the report tries not to lose sight of the notion that a mental disorder is a health condition characterized by alterations in thinking, mood, or behavior that results in distress or impaired function.

B. The Public Health Model

Though public health has traditionally focused on physical health, the public health model is well suited to address the broad concepts of mental health and mental illness.

Public health is distinguished from medical care in that it does not focus on diagnosis and treatment of the individual; the field is primarily interested in the health of the population as a whole. The surgeon general describes the public health model as “characterized by concern for the health of a population in its entirety and by awareness of the linkage between health and the physical and psycho-social environment.”^{3 (p.3)} The model's foci include epidemiologic surveillance of the whole population's health, health promotion, disease prevention, and evaluation of the availability and quality of health services.

The World Health Organization (WHO) describes the public health model as one that works through the organized efforts of society, which means public health interventions operate at the policy level and community level, as well as on an individual level. Public health interventions tend to be population based, rather than targeted at specific individuals.

Public health policy often relies on the social-ecological model as a framework for a multi-level approach. This model recognizes complex links between individual health and the health of a population. An intervention aimed at changing behavior or health outcomes for the individual only is less likely to be successful than an intervention that changes the family, community, and society to support individual change.²³

The social-ecological model is often depicted as five levels that can be addressed to influence the health of individuals and their communities.²⁴ (See Figure 1.) The five levels are individual, interpersonal, organizational, community, and society.

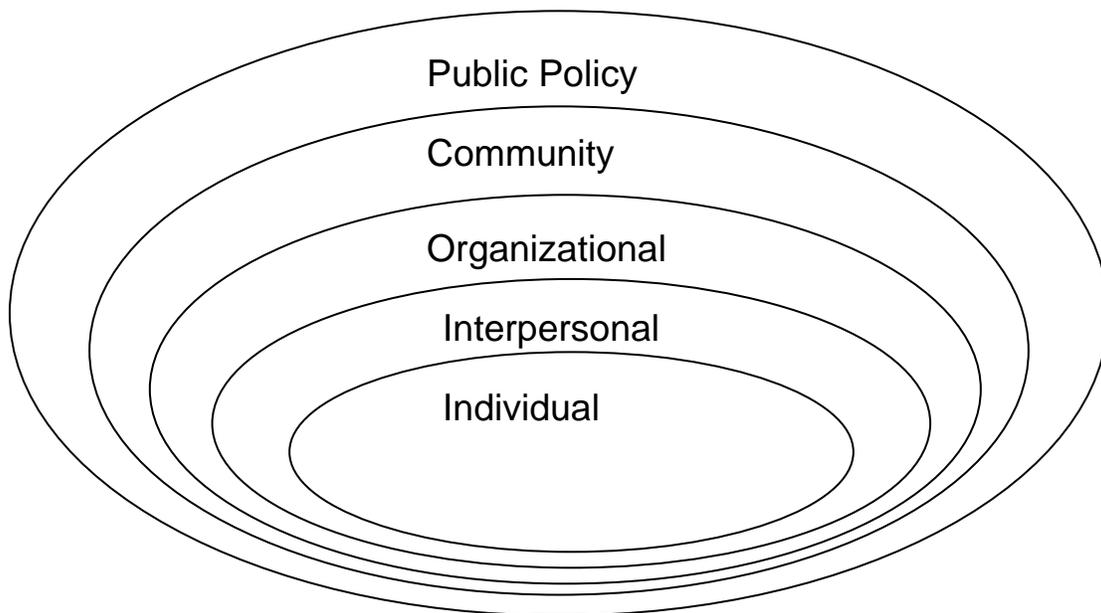
- An intervention works on an **individual** level when it works to change the beliefs, attitudes, or behaviors of individuals.

- It works on an **interpersonal** level when it works to change beliefs, attitudes, and behaviors in interpersonal groups, such as families, groups of friends, and clubs.
- It operates on an **organizational** level when it influences organizations by changing the culture or practices at schools, places of employment, places of worship, community groups, or sports teams.
- It works on a **community** level when it works to change the policy of a local government or improve the space, facilities, food supply, or other community elements relevant to the target of the intervention.
- Intervention works at the **society** level when it changes public policy on a level larger than a community level; this may include introducing new legislation or changing school policies statewide. A society-level intervention could also be a large media campaign or other large-scale program.

Simultaneously addressing all levels of the model is important because individual change is much more possible and more likely to be sustainable if many levels of society change to support individuals.

Figure 1

The Social-Ecological Model



SOURCE: The five-level social ecological model was first proposed as a model for health promotion in McLeroy KR, Bibeau D, Steckler A, Glanz K. *An Ecological Perspective on Health Promotion Programs. Health Education Quarterly. 1988;15:351-77.*

Pointing out that a public health model could be applied to mental health does not necessarily mean that public health agencies should spearhead the work. Spending for public health agencies has declined even as public health has been presented with a growing number of challenges—for example, the need to prepare for potential acts of bioterrorism, the need to respond to new and re-emerging communicable diseases such as West Nile virus, and the need to address chronic

diseases, most notably those associated with obesity. The state's local health jurisdictions recently went to the state Legislature for additional funding to shore up their capacity to control the spread of communicable disease and received only a portion of what they said was needed. Most public health agencies are reluctant to continue expanding their responsibilities without new revenue sources.

Nonetheless, many public health agencies are already involved in mental health activities. The Office of Maternal and Child Health in the Department of Health (DOH) has made promoting a public health approach to mental health a priority since 2000. Public health agencies are also involved in general public health activities, such as conducting community health assessments, that have implications for mental health (assessment tools like the Healthy Youth Survey cited below can be used to identify community risk and protective factors). One intervention for young children that will be discussed later is nurse home visiting programs for families. In many counties, local public health already provides this service, and local public health officials ranked this kind of program high on the list of services they would like to provide if public health received additional state funding.

This report is primarily concerned with articulating a vision for an integrated statewide approach to promoting mental health and preventing mental illness. By saying it is a public health approach, we are saying that it should be community-focused and population-based, and it should make every effort to address potential problems upstream. Achieving that vision will require the cooperation of many partners, one of which will need to be public health agencies. NACCHO noted that, “(t)he mental health system is rooted in the creation of the public health system; however, it has since evolved into a professional specialty independent, in many respects, from public health. The divergence has created challenges in the effort to offer a truly comprehensive and holistic public health care system.”^{13(p1)}

C. Prevention and Promotion

Mental disorder prevention focuses on the causes of mental illness.²³ It strives to reduce the occurrence of mental disorders and reduce the symptoms of mental disorders.²⁵

Mental health promotion is related and overlapping, but because mental health is more than the absence of illness, health promotion has a broader focus than mental disorder prevention. It works to improve the positive mental health of the whole community by building on competencies and resources. Promotion works by influencing determinants of good mental health; for example, promotion efforts may work to reduce unemployment, improve education, and reduce stigma and prejudice.²³ Mental health promotion is likely to have a secondary effect on mental disorder prevention.²⁵

WHO has defined *health promotion* as “the process of enabling people to increase control over, and to improve their health.”^{26(p8)} Mental health promotion has been defined many ways, including as the enhancement of the capacity of individuals, families, groups, or communities to support positive emotional and cognitive experiences.²⁶

The term *prevention* has been extensively analyzed in the public health field, and it is important to understand how the concept of preventing mental disorders does and does not fit within classic public health prevention terminology.

The traditional public health classification system for prevention includes three levels: primary, secondary, and tertiary.²⁵ Primary prevention includes all efforts to prevent a disease or condition before it occurs, including efforts to prevent new cases in the general population, reduce risk factors in the general population, and target prevention to those who have increased biological, psychological, or social risk factors. Secondary prevention seeks to reduce the rate of established cases of an illness or disorder through early detection and treatment. Tertiary prevention seeks to reduce disability from illness and prevent recurrence of illness.

A more recent classification system of prevention weighs the risk of disease to an individual or group with the burden (cost and harm) of the prevention.⁹ This system classifies preventive interventions as universal, selective, and indicated. A universal prevention is one that is appropriate for the general public, including children and the elderly, because the benefits outweigh the risks for everyone. Examples of universal prevention include adequate diet, immunizations, and the use of seat belts. A selective measure is one that is appropriate only for individuals or subgroups whose risk of becoming ill is above average. A subgroup may be based on characteristics such as age, gender, or family history. Examples of selective prevention include special immunizations for people at increased risk for exposure to a particular disease and cancer screening based on gender or family history. An indicated prevention is appropriate for individuals who have been identified as having symptoms, abnormalities, or biological markers that do not yet meet diagnostic criteria but indicate a precursor to a specific diagnosable condition.²⁵ Examples of indicated prevention measures are medical control of hypertension or monitoring an individual following the removal of precancerous cells.⁹

The National Institute of Medicine (IOM) found both of these systems to be problematic when applied to mental health, so it created an additional classification system for mental illness prevention and intervention.⁹ It is difficult to apply these systems to mental disorders because it is difficult to identify a case given the variation in diagnostic criteria over time, the variation among diagnostic frameworks, and the variation among theoretical perspectives of providers. Given these issues, IOM created a mental illness intervention spectrum that contains three categories: prevention, treatment, and maintenance. This spectrum uses the term *prevention* only for those interventions that occur before the initial onset of a disorder. Prevention includes universal, selective, and indicated prevention measures. The spectrum uses the term *treatment* to apply to the interventions of case identification and standard treatments for known disorders. *Maintenance* is used to refer to long-term treatment interventions to reduce relapse/reoccurrence and to refer to after-care. In practice, these categories may not be so distinct. For example, providing medication to a patient with bipolar disorder is a treatment, but it may also be considered an intervention if it prevents dependence on alcohol. The IOM's classifications have not been widely adopted.⁷

A WHO report gives a broader definition of mental disorder prevention in public health; in this report, prevention includes primary, secondary, and tertiary prevention.²⁵ The report states that mental disorder prevention aims to reduce incidence, prevalence, time with symptoms,

reoccurrences, and the impact on family and society. Prevention efforts include reducing risk factors and increasing protective factors.

After extensive discussion, the Prevention Advisory Group chose to define prevention as **work that promotes mental health, intervenes early to address emerging mental health problems, and reduces the devastating impact of mental illness.** This definition is similar to the one in the WHO report. It encompasses both mental health promotion and mental illness prevention. It includes work that public health would call primary, secondary, and tertiary, but the PAG chose not to use this terminology, in part because it is too difficult to determine exactly when an individual acquires a mental disorder or is recovered from a mental disorder. The PAG definition includes work that is universal, selected, and indicated, but the group chose not to use this terminology because it does not include the important concept of tertiary prevention. The PAG did not adopt the IOM definition because it restricts prevention to interventions that avert the initial onset of a disorder. Instead, the PAG chose to include all of the IOM categories, reflecting the reality that many treatment and maintenance efforts also serve prevention functions. Treating an individual with bipolar disorder may prevent dependence on drugs or alcohol, for example, or successful maintenance efforts for an individual with severe mental illness may reduce the impact of the illness and prevent hospitalizations.

Emphasis is given to the use of the term prevention as it applies to mental health and how it may be used as a stand-in—a kind of shorthand—for a range of activities designed to keep us healthy and to anticipate and head off things that are detrimental to our health. Some of these activities might be discussed elsewhere as promotion, early diagnosis, early intervention, treatment, and maintenance. Prevention activities need not be limited to individual interventions. The prevention advisory group has adopted the spectrum of prevention,²⁷ which is based on the classic social-ecological model (See Figure 2).

Figure 2



SOURCE: The Prevention Institute, accessed at http://www.preventioninstitute.org/tool_spectrum.html

The spectrum of prevention has six levels: strengthening individual knowledge and skills; promoting community education; educating providers; fostering coalitions and networks; changing organizational practices; and influencing policy and legislation. Like work across the social-ecological model, work across the spectrum is more likely to be effective than work on only one level of the spectrum because work on several levels will provide the support necessary for individual change.

D. Examples of Prevention and Promotion Models

Currently, Washington is implementing a model for drug and alcohol abuse prevention planning within a public health framework. Washington has a five-year strategic prevention framework state incentive grant from SAMHSA. As the implementer of the grant, the Division of Alcohol and Substance Abuse must follow the SAMHSA strategic prevention framework, which promotes a public health approach to drug and alcohol abuse prevention. The framework has five components.²⁸ The first is to collect data to define the community problems and the risk and protective factors. This step involves mobilizing community stakeholders to collect the data and creating epidemiology work groups to build a data infrastructure. The second is to build the financial and local leadership capacity to implement the intervention, including the identification of financial resources, the mobilization of community leaders and key stakeholders, and the creation of partnerships between the intervention and community groups. The third step is to develop a data-driven strategic plan to address the problems identified in the assessment process. The plan should identify performance targets, develop ongoing action plans, select evidence-based practices, and develop a sustainability plan. The fourth step is implementation, which requires implementation of evidence-based practices. The fifth is to monitor and evaluate the program, including its effectiveness, efficiency, and fidelity in relation to the strategic plan. Program staff should make any needed corrections to improve the program. The SAMHSA framework is designed so that sustainability and cultural competency permeate the entire process.

There are some examples of mental illness prevention and mental health promotion efforts that implement practices to address multiple levels of the social-ecological model. One example is the implementation of social and emotional learning standards in the Illinois schools. In 2003, the Illinois Legislature passed the Children's Mental Health Act, which required the development of the Children's Mental Health Plan,²⁹ the implementation of social-emotional learning (SEL) standards, and SEL curricula in all school districts.³⁰

A second example is a guide published by the British mental health promotion organization.³¹ It provides examples of interventions for specific population groups; each intervention operates on a different level of the social-ecological model, but different interventions could be chosen to work simultaneously in order to address multiple levels of the model. One population discussed is older adults. A society-level intervention suggested is to address age discrimination, particularly low expectations for the mental health of older adults held by health professionals, families, and older adults themselves.³¹ On an organization level, the guide suggests working to create volunteer opportunities for older adults. On an interpersonal/individual level, the guide suggests a program called Widow-to-Widow, which provides one-to-one support for recent widows to assist them with accessing social support and resources in the community. Other individual interventions are suggested, such as home visits and telephone support. This guide to

evidence-based practices exemplifies how mental health promotion activities for specific populations can be chosen to address multiple levels of the social-ecological model.

It is important to create prevention and promotion efforts that address all levels of the social-ecological model. This model is designed to account for the links between individual health and the health of society. An intervention is more likely to be successful if it is able to make organizational or societal changes to support risk and protective factor changes for a whole segment of the population.²³ With such an intervention, society, communities, organizations, and interpersonal groups change with individuals so individuals do not have to fight against the norms to make important health changes.

IV. HEALTH DISPARITIES IN MENTAL HEALTH

The term *health disparities* describes the disproportionate burden of disease, disability, death, and other adverse health conditions that exist among specific populations or groups. Health disparities based on race are well documented for a variety of conditions.³² Whether the disparity is in the rate of illness or in the disability burden, addressing disparities is an important priority for public health.

Nationally, the prevalence of mental disorders is thought to be similar for whites and many communities of color.³³ However, there is information about some variation in prevalence among racial/ethnic groups in Washington State. One Washington survey reported that the rate of medium-level mental health need was highest for Native Americans (5.93 per 100), followed by Caucasians (4.12 per 100), African Americans (3.87 per 100), Hispanics (2.51 per 100), and Asians (1.45 per 100).³⁴ An individual is defined as having a medium-level mental health need if he or she has a major mental disorder³⁵ and is either functionally limited, is a user or desires to be a user of mental health services, is a danger to self or others, or is dependent on public assistance. After the release of the survey data, there were concerns about its accuracy.³⁴ Concerns included possible under sampling due to language barriers, varying comfort levels with the use of the telephone for the survey, and cultural differences in terms used to describe symptoms of mental illness.

A U.S. Surgeon General report found that communities of color have about the same prevalence of mental health problems as whites, with some variation, especially in subgroups within racial/ethnic groups.³³ African Americans and Asians have about the same prevalence of mental health problems as Whites, with variations in rates among subpopulations of these two groups. Similarly, different groups of Latinos have very different rates of mental health problems. The report found that American Indians and Alaska Natives are likely to have a disproportionately high burden of mental health problems.

The most concerning and well-documented disparity in mental health is the unmet need for mental health care in communities of color; this leads to a disparity in the disability burden.³³ There are large variations in utilization rates of mental health services between communities of color and whites. With similar prevalence rates but lower utilization rates, communities of color have a higher proportion of individuals with unmet needs; therefore, communities of color suffer greater loss to overall health and productivity.

A significant factor in differences in utilization is the lack of culturally appropriate mental health care for communities of color.⁷ The mental health care setting relies heavily on language, communication, and trust between consumers and providers. It is crucial that there is a good rapport between the provider and the consumer and that the provider understands the consumer's cultural identity, social support system, self-esteem issues, and community stigma. It is difficult to achieve this rapport and understanding when there are major differences in the manifestation of mental illness in different cultures, as well as different ways of communicating symptoms and seeking help. The difficulties that arise from cultural differences related to mental health are compounded by mistrust as a result of racism, discrimination, and maltreatment of persons of color.³³

A culturally competent mental health system would be one that meets the diverse needs of all consumers. Cultural competence is based on the recognition of consumers' different cultures and the development of treatment practices that are effective within different cultures. Effective treatments are ones that are tailored to specific cultures. Tailoring involves developing a set of skills, knowledge, and policies that are responsive to a group's language, history, traditions, beliefs, and values. In addition, a culturally competent model would include considerations such as differences in the way that medications may be metabolized across ethnic populations. Cultural competence models place the burden of competence, or the burden of providing effective treatment, on the mental health system, not on the individuals seeking treatment. Models of cultural competence for use in the mental health field have been developed and put into operation.³³ Transformation of the mental health system must include reforms that integrate cultural competency. The Mental Health Transformation Project (MHTP) is developing cultural competency trainings for professionals to begin to address this issue.

Disparity between rural and urban populations in access to comprehensive mental health services is a significant concern. Specifically, there is a lack of comprehensive services in rural communities. The MHTP recently completed a study that found urban areas have significantly more service capacity and refer more patients to hospital services than rural communities. The report contains recommendations for improved delivery of distant services, such as telemedicine approaches. This study and report were completed through the University of North Carolina.

V. ARE MENTAL DISORDERS PREVENTABLE?

In any discussion of a prevention-orientated approach to mental health, it is not unusual for someone to challenge the very notion that mental disorders can be prevented. There have been several examples in the not-so-distant past when individuals with mental illness, their parent figures, and other individuals were wrongly blamed for mental disorders. In the 1960s, for example, some psychologists attributed autism to "refrigerator moms"—cold, distant mothers who allegedly caused their children to withdraw. We now know this was not true. Indeed, we have made great progress in understanding that mental illnesses are diseases just like physical illnesses. They have underlying genetic, environmental, and biochemical causes that can be treated. They are not the result of personal frailty.

Recently, however, there have been substantial advances in our understanding of mental disorders. This emerging knowledge suggests concrete ways that we can promote mental health,

intervene early to address emerging mental health problems, and reduce the devastating impacts of mental illness.

For instance, we are learning about the complicated interplay between genetics and the environment in the development of mental disorders. Studies in rats have shown, for example, that the quality of maternal care can affect gene expression related to stress responsiveness.²³ The studies compared infant rats that received a high level of licking and grooming with infant rats who received lower levels of such care. The biological offspring of one mother were exchanged with the same-age offspring of another mother so that different outcomes could clearly be attributed to levels of maternal care, rather than genetics. Infant rats that received the higher levels of licking and grooming in the first six days of life were able to express a gene that increased the receptors that sense the circulation of a stress hormone. This slowed the brain's stress circuit and allowed for greater tolerance of stress. This study reveals how social experience can alter brain function and gene expression in a way that alters long-term emotional health.

Similarly, the organization and function of the human brain depends on experiences that influence the expression of the genome.³⁶ Research has been done to show how specific types of childhood maltreatment alter the brain. For example, studies show that both sexual and physical abuse produce lasting effects on brain development.³⁷ In addition, there is evidence that verbal abuse alone is associated with moderate to large effects on measures of dissociation, limbic irritability, depression, and anger-hostility.³⁷ Previous research has shown robust correlations between dissociation and the size of certain areas of the brain and between limbic irritability and blood flow to certain areas of the brain. This study raises the possibility that exposure to verbal aggression may be a stressor that alters brain development in susceptible individuals. Research on the impacts of social experience on brain development provides evidence that prevention work designed to improve the social environment for children may prevent later mental health problems.

This section discusses some specific areas of research that support the thesis that preventive interventions for mental disorders are indeed possible. A full exploration of this issue is beyond the scope of this paper.

A. Social Experience in Childhood and Mental Health Outcomes

At least one large-scale study shows a strong correlation between adverse childhood experiences and long-lasting emotional and physical health. The Adverse Childhood Experiences Study (ACE) analyzed information about adverse childhood experiences with data on health outcomes for 17,337 members of the Kaiser Permanente Health Maintenance Organization (HMO) in San Diego.³⁸ These members were older and more educated than the general population. The mean age of participants was 56 years, about 75% of participants had at least some college education, and 75% of participants were white.

There were two study group waves between 1995 and 1997; each wave of participants was recruited at the time of a physical exam at the HMO. Kaiser patients undergoing a complete physical exam were asked to complete the Medical Outcomes Study, a 36-item short form health survey, at the time of their physical exam.³⁹ All HMO members who completed the form were sent a family health questionnaire by mail. This questionnaire contained 162 questions about

exposure to child abuse, sexual abuse, and family dysfunction. It also included questions about current health behaviors and conditions.

Study participants were given an ACE score of 0-10 based on the number of categories of ACEs experienced.⁴⁰ Five of the ten categories scored were emotional abuse, physical abuse, sexual abuse, emotional neglect, and physical neglect. A sixth category was whether the participant had divorced/separated parents, and a seventh was whether the participant witnessed domestic violence against a female caretaker. The remaining three categories scored were living with a household member who abused alcohol or drugs, experienced depression or mental illness, or went to prison. The study found that more than half of the participants experienced at least one ACE, and one quarter of participants had two or more ACEs.

The ACE study showed that increased ACE scores were associated with poorer outcomes related to physical, emotional, and behavioral health. The study found that the mental health score⁴¹ of participants decreased in a dose-response fashion as the number of abuse types increased.³⁹ There was a dose-response relationship between number of ACEs and both lifetime and current depressive disorders, which indicates that childhood experiences may significantly increase the risk of depression decades later in the child's life.⁴⁰ The risk of depressed affect for an individual with four or more ACEs increases 3.6-fold compared to an individual with no ACEs.³⁶ Only 1.1% of those who experienced no ACEs had a lifetime prevalence of at least one suicide attempt.⁴⁰ This prevalence rate rose to 35.2% for those who reported seven or more ACEs. The risk of panic reactions and anxiety also had a graded relationship with number of the ACEs of participants; the risk of panic reactions increases 2.5-fold and the risk of anxiety increases 2.4-fold with four or more ACEs compared to a participant with no ACEs. The risk of hallucinations increases 2.7-fold with four or more ACEs compared to an individual with no ACEs.

The ACE researchers found similar graded relationships related to the prevalence and risk of somatic health disturbances.³⁶ For example, the risk of severe obesity is 1.9-fold higher for an individual with four or more ACEs compared to an individual with no ACEs, and the risk of sleep disturbance is 2.1-fold higher.

The ACE researchers found relationships between ACE scores and the prevalence and relative risk of substance use and risky sexual behaviors.³⁶ The risk of smoking, alcoholism, illicit drug use, and injected drug use increased 1.8-, 7.2-, 4.5-, and 11.1-fold respectively for individuals with four or more ACEs compared to individuals with no ACEs. Similarly, the risk of early intercourse, promiscuity (30 or more partners), and sexual dissatisfaction increased 6.6-, 3.6-, and 2.0-fold for individuals with an ACE score of four or more. Last, the risk of perpetrating intimate partner violence is 5.5-fold for individuals with four or more ACEs.

The ACE study showed a significant dose-response relationship between ACE scores and ischemic heart disease, cancer, chronic bronchitis or emphysema, history of hepatitis or jaundice, skeletal fractures, and poor self-rated health.⁴² The researchers also found a dose-response relationship between ACE scores and each of the ten risk factors for the leading causes of death studied by the researchers. The ten risk factors were smoking, severe obesity, physical inactivity, depressed mood, suicide attempt, alcoholism, any drug use, injected drug use, 50 or more sexual partners, and history of a sexually transmitted disease.

The ACE study has several limitations. First, it was conducted with primarily middle-class, well-educated, white, older respondents who have access to quality health care. Its findings may not be valid for the U.S. population as a whole. Second, the information about the occurrence of ACEs is based on self-reporting; although research indicates that self-reporting often results in underreporting of abuse and neglect.

The ACE researchers argue that there is a causal relationship between ACEs and the outcomes reported in the study based on nine criteria for establishing an argument for causation.³⁶

1. There is a strong association between the causative agent and the health outcome, which is shown in the dose-response relationship between ACEs and various outcomes.
2. There is consistency of findings in numerous studies across different populations that show a relationship between various adverse childhood experiences and a variety of symptoms and behaviors.
3. While specificity is lacking in the ACEs study, the ACEs score is a combined measure so it is not meant to provide evidence of specificity. In addition, ACEs would be expected to be associated with multiple outcomes because the experiences affect a variety of brain structures and functions.
4. The temporal sequence supports causation because exposure to adverse childhood experiences predates the outcomes measured.
5. The dose-response relationship between the number of ACEs and each of the outcomes is strong and graded.
6. The causal relationship is biologically plausible given that recent studies in the neurosciences show that childhood stress can affect brain function.
7. The cause and effect interpretation is coherent because it does not conflict with what is known about the natural biology of the outcomes measured in the ACEs study.
8. Randomized experiments on animals show that stressful experiences cause neuroanatomical and neurophysiologic differences as well as aggression and drug seeking behaviors.
9. There is evidence of an analogous causal relationship; the analogous relationship is cigarette smoking as the cause of multiple outcomes, such as lung disease, cardiovascular disease, and other health conditions.

If there is a causal relationship between ACEs and various mental and physical outcomes, as the researchers argue, then the study provides evidence that intervention in the social environment of children can prevent mental illness.

The ACEs study provides information about risk and protective factors for mental disorders because the study shows relationships between specific experiences and later outcomes. The specific experiences associated with poor outcomes could be characterized as risk factors. For this reason, ACEs could be a starting point for mental illness prevention. Risk and protective factors are an important starting point in prevention work because work focused on reducing risk factors and strengthening protective factors can result in effective prevention for multiple conditions.

B. Risk and Protective Factors

Risk factors are “those characteristics, variables, or hazards that, if present for a given individual, make it more likely that this individual, rather than someone selected at random from the general population, will develop a disorder.”^{9(p127)} A risk factor indicates a higher probability that a disorder will develop; therefore, a risk factor must antedate the development of a disorder. Some risk factors are fixed, such as sex or family genetic history. Other risk factors are not fixed, such as location of residence, use of drugs, and employment status. Risk factors can be causal; for example, heavy drug use may cause increased expression of schizophrenia in some vulnerable individuals.⁹ Alternatively, risk factors can be merely associated with the condition. For example, inability to visually track moving objects with smooth eye movements is associated with schizophrenia and predates its development, but this inability is not a cause of the condition. If a risk factor is merely an association, rather than a cause, an intervention to change the particular risk factor will fail to prevent the onset of the condition.

Research on risk factors for mental disorders has revealed sets of factors that are common to many disorders. The Institute of Medicine and the Report of the Surgeon General list the following risk factors as common to many mental disorders: neurophysiological deficits, difficult temperament, chronic physical illness, below average intelligence, severe marital discord, social disadvantage, overcrowding or large family size, paternal criminality, maternal mental disorder, admission into foster care, and residence in an area with social disorganization and poor schools.⁷ The World Health Organization lists twenty-eight risk factors for mental disorders, including academic failure and scholastic demoralization; child abuse and neglect; chronic pain; elder abuse; exposure to aggression, violence, and trauma; family conflict or family disorganization; low birth weight; parental mental illness; sensory disabilities or organic handicaps; and substance use during pregnancy.²⁵

Protective factors improve individual resistance to risk factors and disorders.²⁵ These factors mediate or ameliorate environmental hazards. Protective factors, like risk factors, can be present in the individual, family, institutions, or community. Protective factors can be biological, psychological, or social.⁹ The Institute of Medicine lists several protective factors for mental health, including positive temperament, above-average intelligence, social competence, a close relationship with a responsive parent, and good schools.⁹ The World Health Organization lists twenty protective factors for mental health. These factors include adaptability, autonomy, early cognitive stimulation, exercise, feelings of mastery and control, literacy, positive attachment and early bonding, and social support of family and friends.²⁵

Risk factors for specific mental conditions may be different than risk factors for mental disorders in general. Depressive disorders are caused by both genetic influences and environmental stress, including traumatic events.⁹ Evidence of genetic influence includes studies that show the rates of mood disorders in children/adolescents of parents with mood disorders to be 30% higher than in children/adolescents of parents without mood disorders.⁹ The strength of genetic influence may vary among different types of depression; for example, there is evidence that bipolar disorder is more strongly influenced by genetics than major depression.⁹ In addition to genetics, there are other biological risk factors that cause depression, including certain medical conditions and the use of certain medications. Medical disorders associated with depression include severe

infections, tumors, endocrine conditions, hypothyroidism, and hyperthyroidism. Medications associated with depression include antihypertensive agents, oral contraceptives, and anticonvulsives.⁹

There is evidence to show that psychosocial factors also play a role in the development of depression. Risk factors include being the victim of childhood maltreatment, sexual assault, or other violent crime.⁹ Psychosocial risk factors that have been studied also include, death of a family member, loss of a job, and poverty. Protective factors have also been studied, including the presence of close, intimate, supportive relationships. For example, the presence of such a relationship may protect against depression in a child who loses a parent. In considering all of the studies done, the IOM lists five risk factors for depression: (1) having a close biological relative with a mood disorder; (2) having a severe stressor such as divorce, job loss, traumatic experience, or learning disorder (in children); (3) having low self-esteem or low self-efficacy; (4) being female; (5) living in poverty.⁹ The IOM recommends prevention programs for depression because there is sufficient information about risk and protective factors. In particular, children of parents with mood disorders are a good target for preventive programs because these children are likely to have genetic and psychosocial risk factors for depression.

Schizophrenia is thought to be largely influenced by genetic factors.⁹ Even this mental disorder, though, is somewhat influenced by environmental factors. Studies have shown a greater than five-fold increased risk in first-degree relatives. Studies of adopted-away children of mothers with schizophrenia compared to adopted-away children of unaffected mothers provide evidence that the higher rates of schizophrenia in first-degree relatives are due to genetic influence rather than the result of being raised by a caregiver with schizophrenia. In these studies, between 10% and 16% of adopted-away children of mothers with schizophrenia developed schizophrenia, which is significantly higher than the rate for controls. Studies of concordance rates in identical twins have reported a fairly wide variety of rates. One study reports a rate of 64%. This rate means that in the studied twin pairs, only one twin developed schizophrenia in 36% of the pairs. These studies indicate that genetics play a significant role in the development of schizophrenia, but non-genetic factors, such as environmental factors, have some role in the development of schizophrenia.^{7,9} In addition, absence of a family history of schizophrenia does not mean freedom from risk.⁹ This research indicates that there may be ways to modify the environment to prevent the development of schizophrenia, even when an individual has genetic risk.⁷

In addition to genetics, there may be other biological risk factors for schizophrenia, including exposure to viral agents in the second trimester of pregnancy and complications during pregnancy and birth.²⁵ There is evidence that use of illicit drugs, especially marijuana, may contribute to the development of schizophrenia.²⁵ While universal prevention is not yet possible with psychosis because not enough is known about risk factors, indicated and possibly even secondary prevention may be possible.²⁵ In addition, there is evidence that early interventions can prevent reoccurrences.

Designing interventions that reduce particular risk factors or strengthen particular protective factors can be effective in addressing several conditions in one intervention. For example, childhood maltreatment appears to be a risk factor for many mental disorders. Therefore, interventions that address this issue could work to prevent several types of disorders. Currently

available information about the risk and protective factors could be used to design mental disorder interventions and identify individuals who most need intervention. For example, it is possible to design screening surveys to identify individuals with risk factors for particular disorders. The Communities that Care Youth Survey was developed to assess a broad set of risk and protective factors in adolescents related to health and behavior outcomes, including substance use, violence, and delinquency.⁴³ The survey is designed to be administered in one 50-minute period. Such a survey can be used to identify individuals to receive more targeted interventions.

VI. BARRIERS TO PREVENTION

The National Association of State Mental Health Program Directors (NASMHPD) lists several challenges to the implementation of prevention and promotion approaches in mental health: “These challenges include unfamiliarity and confusion about the public health/prevention conceptual model, fear that existing or new resources will go somewhere else other than our traditionally served populations, lack of a workforce skilled in both mental health work and prevention work, lack of a dedicated funding stream, and limited research regarding the effectiveness of interventions, especially in adults.”^{12(p3)}

One of the primary goals of this document is to reduce unfamiliarity and confusion about the conceptual model for a mental illness prevention system. The second challenge, fear that resources will be reallocated away from the traditionally served population (namely, individuals with severe mental illness), warrants some discussion. Part of this fear stems from the history of deinstitutionalization.

There are many factors that contributed to the process of deinstitutionalization. The process of moving patients out of public mental hospitals began in earnest in 1955. The number of patients in public psychiatric hospitals nationwide decreased 91.3% between 1955 and 1994 when adjusted for population growth.⁴⁴ The decrease in Washington State was 91.2%. The introduction of psychiatric medication in the 1950s is likely to have been one contributing factor.^{44, 45} In addition, in 1955, the Mental Health Study Act created the Joint Commission on Mental Illness and Health. Its 1961 report, *Action for Mental Health*, recommended community-based services over state hospitals. The Community Mental Health Centers Act of 1963 created a community mental health program to partially replace an outmoded institutional system with a system that allowed individuals with mental illness to stay in their communities and families. The Act emphasized prevention as a promising approach and required that prevention services be provided. The inclusion of limited mental health benefits in the Medicare and Medicaid programs, which began in 1965, may have also played a role in shifting patients from mental institutions to nursing homes.^{7, 44, 45}

A lack of services and support for those with severe and persistent mental illness is one outcome of deinstitutionalization.^{7, 44} Simply stated, money did not follow the individuals into the community. While many individuals may benefit from care in a less restrictive setting,⁴⁴ some individuals have been left without adequate care. Community mental health centers (CMHCs) were not successful in adequately caring for individuals with severe mental illness.⁴⁶ In addition, housing, vocational training, and income support are not universally available to those in need.^{7,}

⁴⁴ As a result, many individuals with severe mental illness found themselves homeless or in criminal justice institutions.^{7,44}

These problems continue to this day, and from the 1970s into the early 1980s, they were aggravated when some community mental health centers began devoting more of their resources to providing services to individuals with less severe and less persistent mental illness—a population that was easier and less costly to serve.⁴⁷ This shift in focus was sometimes couched in the language of prevention. Today, CMHCs are typically restricted to providing services to people who have serious mental illness.

Individuals with serious mental illness, their families, and their advocates are therefore understandably wary of any increased focus on prevention, not only because it might redirect attention and financial resources away from an already underserved population, but because there is a perception that this already happened in the recent past. It is important to acknowledge this history, but it is also important to recognize that we now know a lot more about prevention than we did 20 years ago, and what we mean by prevention today is qualitatively different from what was meant a quarter century ago. Also, nothing in this report is meant to promote a shift of resources away from the individuals with serious and persistent mental illness. In fact, services aimed at individuals with serious mental illness could be preventive to the extent that they strengthen functioning, improve resilience, and prevent co-occurring disorders.

The lack of a skilled workforce experienced with both traditional mental health services and prevention is addressed briefly in some of the policy alternatives described later in this report. To address the lack of a dedicated funding stream, it would be important to study ways that existing funding streams might be leveraged to pay for prevention services. This report suggests some funding opportunities.

Concerns about lack of adequate research regarding evidence-based interventions are valid, but the knowledge base in this area is growing rapidly and can be expected to continue expanding. Evidence-based policy and practice means using whatever research is available to make the wisest choices; it does not mean doing nothing until there is a critical mass of outcome data and sufficient ways to assure fidelity to a tested model. Much of what society has come to expect from public health, for example, would not qualify as evidence-based, at least in the way purists would use the term to evaluate medical interventions. One of the challenges for policy makers will be to figure out ways to fund a research agenda.

PART 2

AGE-SPECIFIC POPULATIONS

I. CHILD MENTAL HEALTH

Child mental health is characterized by achievement of expected developmental cognitive, emotional, and social milestones as well as secure attachments, satisfying social relationships, and effective coping skills.⁷ For many people, the concept of childhood mental illness is difficult to comprehend; however, childhood mental illness is not uncommon. In fact, nearly half of all lifetime cases of mental disorders develop by age 14.⁴⁸ In Washington, an estimated 7-9% of children under 17 have a serious emotional disturbance or severe emotional and behavioral problems.^{5, 49} A recent study found an increase in the number of children being diagnosed with bipolar disorder, and their treatment often includes medication developed to treat schizophrenia.⁵⁰ In addition, 11% of Washington caregivers report that a doctor or health professional told them their child has a behavior disorder, depression, autism, attention deficit disorder, or any combination of these illnesses.⁵¹ In Washington, a survey of parents shows that 8% of children have received some type of mental health care or counseling at any time in a one-year period. However, there is significant unmet need for children's mental health services; about 44% of children ages 1-17 who needed mental health care for emotional, developmental, or behavioral problems do not receive care. This is in contrast to 1.3% of children in Washington who did not receive needed medical care.⁵²

Both primary prevention and early intervention for children's mental illness is possible and effective.^{7, 51} Early intervention can be extremely beneficial. The longer a person lives with untreated mental illness the more it impacts the architecture of his or her brain, which leads to more severe and treatment resistant illness.⁵³ In addition, most people with one disorder develop co-disorders; the combined disorders create a more severe and persistent course of mental illness.⁵³

Both biological and environmental risk factors negatively impact mental health or are associated with mental illness in children. Biological risk factors include genetics; prenatal exposure to drugs, tobacco, or toxins such as lead; low-birth weight; infection; and injury.⁷ Environmental risk factors for children include dysfunctional family life such as marital discord, parent criminality, or exposure to violence.

In addition, the quality of the parent-child relationship has long been viewed as crucial to child mental health.⁷ The quality of the relationship between the primary caregiver and the child, which is demonstrated by the child's attachment style, is complex because it is formed through the interaction of the child's temperament, the personality/parenting style of the primary caregiver, and limitations of the primary caregiver.⁷ A relationship that includes childhood maltreatment is especially damaging. Maltreatment is associated with many mental disorders, including post-traumatic stress disorder, depression, conduct disorder, and attention-deficit/hyperactivity disorder.⁷ A child who experiences maltreatment may not fully exhibit mental illness or related health problems until later in life.³⁹ On the other hand, a child who experiences a healthy parent-child relationship early in life is more likely to be resilient to life's

stresses. This recognition requires further thought about policies, programs, and practices that promote mental health, intervene early to address emerging mental health problems, and reduce the devastating impacts of mental illness.

Some subgroups of children have particularly high risk factors for developing mental disorders. Their increased risk is likely to stem from a combination of environmental and biological factors. Below are short descriptions of subgroups that have higher rates of mental illness than children in the general population, although rates of mental illness are surprisingly high in the general child population in Washington. Subgroups were identified through the Department of Health's Report on Children's Mental Health in Washington State.⁵¹ These groups were highlighted because data exists in Washington to show that these groups have particularly high rates of mental illness; however, several other subgroups are likely to be at high-risk based on national data. These subgroups include children of incarcerated parents/parent figures; gay, lesbian, bisexual, transgender, and questioning youth; homeless children; Native American children; and refugee/immigrant children.⁵¹

- **Children in Foster Care**

Children in foster care are at higher risk for mental disorders for several reasons, including separation from their caregivers, exposure to abuse or neglect, and lack of attachment to a new family. A study of Washington and Oregon foster care alumni found that 54.4% of young adult alumni had clinical symptoms of a mental disorder and 19.9% had three or more mental health problems.⁵⁴

- **Children and Youth with Special Health Care Needs**

Children with special health care needs may feel isolated from their peers and community because of a physical or mental disability. The Healthy Youth Survey indicates that children with disabilities other than mental illness are twice as likely to experience symptoms of depression and almost four times as likely to attempt suicide as children without disabilities.⁵¹

- **Children in the Juvenile Justice System**

The Juvenile Rehabilitation Administration in DSHS identifies 60% of youth in the juvenile justice system as in need of mental health services. Youth are identified as in need if they had a mental illness diagnosis in the last six months, have a current prescription for psychiatric medication, or had suicidal ideation in the last six months.⁵¹

- **Children of Parents with Mental Illness**

Children whose parents have symptoms of mental illness are more likely to experience symptoms of mental illness than children who have mentally healthy parents. Children ages 6 to 11 who have parents with mental health problems were five times more likely to have severe emotional and behavioral problems than children whose parents were in

better mental health. Children ages 12-17 were three times more likely to have severe emotional and behavioral problems.⁴⁹

A. Children Birth to Five

Mental health for children birth to five refers to the social, emotional, and behavioral health of young children.^{55, 56} Mental health for young children is generally defined to include their capacity to experience, regulate, and express positive and negative emotions. It also includes their ability to form close, secure, and fulfilling interpersonal relationships as well as their capacity to explore the environment and learn.^{55, 56} The mental health of young children can have a substantial impact on their readiness for school and success throughout their lives.^{55, 56} Children who begin life on a mentally healthy path are more resilient, which means they are more able to maintain good mental health later in life even through stressful times. Alternatively, children who do not begin life with good mental health are more likely to struggle with school and experience both mental and physical health problems later in life, especially if they do not receive early intervention.

The mental health of young children is affected by many of the same factors as those that impact the mental health of children of all ages; however, there are some factors that are particularly important for young children. For young children, emotional interactions with primary caregivers affect the architecture of the child's brain.⁵⁷ As discussed in a previous section of this paper, animal studies show that the quality of the infant-mother relationship can affect gene expression in areas of the brain that control social and emotional function. In addition, a young child's exposure to excessive stress can alter the body's long-term chemical and neural responses to stress.⁵⁸ Two hormonal systems related to stress have been studied extensively: the adrenaline-producing system and the cortisol-producing system. Both of these chemicals are produced under normal circumstances and both of them are necessary for human survival. However, research shows sustained or frequent activation of these hormonal systems can have substantial impact on the development of a child. For example, long-term elevations of cortisol levels can alter the function of a number of neural systems and can alter the brain's architecture in regions essential for learning and memory. This recent research on the brain and mental health indicates that primary prevention and intervention have the potential to prevent and reduce the severity of mental illness. By working to ensure that children receive adequate emotional care from caregivers and by working to intervene when children experience extreme and persistent stress, we can prevent mental illness for some children and reduce its severity for others. The potential to prevent mental and physical illness by reducing or minimizing trauma in childhood is more fully explored in the discussion on the Adverse Childhood Experiences earlier in this report.

Mental health in early childhood not only provides a foundation for good mental and physical health later in life, it is also an important foundation for school success. A 2004 survey of kindergarten teachers in Washington found more than half of children entering kindergarten were not ready for school.⁵⁹ School readiness requires adequate social and emotional development. For example, children who have the ability and desire to cooperate, comply, and self-regulate are more able to form positive relationships with teachers and classmates, and they are more able to listen and learn.^{55, 56} Positive first experiences with school are important; children who develop positive relationships with their kindergarten teachers are more positive about going to school, more excited to learn, and more self-confident. Similarly, children who experience greater

acceptance by peers feel more excited about going to school and participate more in classroom activities. These examples demonstrate that school readiness is not simply a matter of academic preparation in areas such as language and number skills; sufficient social and emotional development is at least equally as important.⁵⁵

Transformation of the mental health system for young children must consider more than promotion of mental health; it must also consider how to screen, diagnose, and treat young children who have mental disorders. Children under the age of five do experience mental disorders, such as depression.⁵⁵ Diagnosing very young children with mental disorders is unlike diagnosing older individuals, particularly because young children have limited capacity for verbalization and abstract thinking.⁶⁰ Therefore, alternative signs of maladaptation must be used. In 2004, the *Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood* (DC: 0-3) was developed to compliment the DSM and ICD classifications systems.⁶¹ The DC:0-3 was developed by professionals working with infants and young children who found that the DSM and ICD did not cover disorders typically seen in children zero to three, and the DSM did not account for developmental stages of young children.^{60, 61} In addition, the DSM does not include alternative measures of maladaptation to diagnose children who have limited verbal skills.⁶⁰ The DC:0-3 and other appropriate screening tools can be used or adapted for use within primary care practices to allow primary care physicians or other professionals within the practice to screen young children for mental disorders.^{62, 63} Screening within primary care practices can make physicians, other professionals, and caregivers aware of how mental disorders affect young children and aware of how to recognize strengths, weaknesses, and warning signs in children and families. Appropriate screening tools can be used to identify children and get them into the services they need to prevent young children from developing more severe and persistent disorders.

In addition, it is important that mental health screening or services within primary care consider the mental health and risk behaviors of children's families.⁶⁹ Children are impacted greatly by adult risk behaviors, such as drug abuse or criminal activity, and by the mental health of their caregivers. For these reasons, the best way to help children may be to address the mental health and risk behaviors of their caregivers.⁶⁹

Early Childhood Focus Groups

The Washington State Board of Health and the Mental Health Transformation Project held age-specific focus groups to inform policy staff about what programs and policies work in Washington and what needs to be added to the system. Two focus groups were held for professionals working with children birth to five. Participants were from a variety of agencies and service organizations.⁶⁴ This section provides a summary of what works in Washington, what needs to be changed, and what policies or programs would be beneficial next steps toward an improved mental health promotion and mental illness prevention system for young children in Washington.

Focus group participants named a variety of programs that already work well in Washington. Home visit programs, therapeutic and early learning child care programs, maternal support, and mental health consultation for child care providers were all named as examples of the types of

programs that already work well in Washington. Focus group participants provided examples of successful programs in each of these areas, including Nurse Family Partnership, Early Head Start, and Part C of the Individuals with Disabilities Education Act (IDEA). Nurse Family Partnership, an evidence-based intensive nurse home visiting program, was commended for including a well designed cross-country network that shares information and data about components or practices in the program that work and where more support is needed. It was also thought to be a good program because families interact with public health nurses, who evoke less stigma than mental health professionals. Early Head Start was commended for providing mental health support to providers working with children and families. Part C of the IDEA was mentioned as a successful program because it provides comprehensive services that are truly oriented toward early intervention for children who have a delay in development or a physical or mental condition known to cause delay in development.

The focus group participants provided characteristics of successful prevention and intervention programs. Successful programs must use providers with advanced skills in early childhood mental health and providers must have the flexibility to work with the whole family, not just the child. The first point of contact for the family needs to be with a trusted entity, such as a public health nurse, and the services must go to the family in an environment that is comfortable for them, rather than requiring the family to go to the services. A successful program will also provide skill-building opportunities for caregivers.

Focus group participants felt strongly that society's conceptions about early childhood mental health must change before it can build an effective mental illness prevention system. First, there needs to be an understanding that mental health needs and mental disorders do exist in early childhood and preverbal children do have memory. In addition, social and emotional skills need to be recognized as part of mental health rather than as a discrete skills set. Second, there needs to be an understanding that mental health is relationship-based for young children because their mental state is based on their relationship with their caregivers. Third, there needs to be a society-level change in the value placed on caring for young children. Last, focus group participants would like to see an increase in the number of mental health providers specifically trained in early childhood because diagnosing and treating infants and toddlers requires education and experience distinct from that necessary to work with older children.

Based on feedback provided by the focus groups, five concrete program ideas emerged. These program ideas are suggestions for next steps to improve our mental health promotion and mental illness prevention system.

- **Create and Implement a Social Marketing Campaign.**

A social marketing campaign could be used to create a society-level change in understanding and perspectives on early childhood mental health. This campaign should be used to help the public, including caregivers, educators, medical providers, and policy makers understand that infants and toddlers do have memory and that early experiences can permanently impact their mental health. Basic concepts of the biology of mental health should be included so that the public begins to understand that mental health is based on the malleable architecture of the brain. In addition, it should convey the

message that mental health for very young children is dependent on healthy relationships with reliable caregivers because the architecture of the brain develops based on feedback received from others in the environment; therefore, the mental health of all close family members must be addressed to address the mental health of the young child. Based on this background information, the campaign should provide ways to promote mental health for infants and families. It should also encourage families to seek help if family members are struggling with depression or other mental illness or if they experience difficulty relating to their young child. Born Learning is an example of a public engagement campaign that has some of the above components.⁶⁵

- **Implement Statewide Mental Health Consultation for Early Learning and Child Care Providers and Provide Adequate Training on Child Mental Health to Providers.**

Focus group participants argued that a statewide mental health consultation program available to all child care and early learning providers would help build a system that could more successfully care for the social and emotional health of all young children. Child care providers need support from mental health specialists to successfully help children who have problems with social and emotional development. Currently, there are mental health consultation programs in Washington such as the one provided with the Early Head Start program. However, the focus groups suggested that a statewide program available to all providers, including family child care providers (home providers), would be beneficial. Connecticut's statewide Early Childhood Consultation Partnership was suggested as a model for a statewide program. Washington's Department of Early Learning is currently working to implement a pilot child care consultation program.

Focus group participants suggested that a statewide early childhood mental health training program for child care and early learning providers is needed to assist providers in meeting the mental health needs of children in their care. In addition or alternatively, a mentorship program for child care providers could be used to provide both support and training. Family child care providers (home providers) should be included in any training or mentorship program.

- **Train Physicians to Provide Mental Illness/Social-Emotional Screening and Referrals to Mental Health Services.**

Focus group participants would like to see more consistent and comprehensive screening for mental health concerns in primary care practices. Participants believe that Early Periodic Screening, Diagnosis, and Treatment (EPSDT) has good potential, but it needs to be consistently, widely, and appropriately used. In addition, all children need to be screened, not just children who receive Medicaid. Some Washington physicians have used the screening tool included in Bright Futures in Practice: Mental Health.⁶⁶ Focus group participants emphasized that any primary care mental health screening program should be designed to address physicians' concerns, such as lack of expertise and lack of time during visits. In addition, the program should either be organized for physicians to easily communicate their concerns with follow-up mental health providers and to easily

connect families to follow-up providers, or mental health specialists should be co-located or integrated into the primary care practice. In addition, screening, referral, and services should consider how to address the mental health and risk behaviors of caregivers. However, physician screening would not reach families who are unable to access primary care providers due to lack of medical coverage.

- **Serve At-Risk Infants and Toddlers under Part C of the Individuals with Disabilities Education Act (IDEA).**

Many focus group attendees felt that services provided under Part C of the IDEA work well in Washington and that Part C services should be expanded. Part C of the IDEA assists states in operating a comprehensive early intervention system for children under age three who have developmental delays. IDEA gives states the option to serve infant and toddlers at risk of experiencing a substantial developmental delay if early intervention services are not provided. Washington could create prevention oriented services if it chose to opt-in and fully fund services for at-risk children. In particular, children who are at risk for developmental delay due to child abuse or neglect could benefit greatly from inclusion in Part C services. It would be necessary to provide more state funding for Part C services if Washington opts to serve at-risk categories of children.

- **Formalize Collaboration among Different Agencies and Providers.**

Focus group participants would like a formal mechanism to create collaboration between different early childhood agencies and providers; specifically, between the Mental Health Division, Part C providers, early childhood education providers, public health departments, and the Department of Early Learning. Focus group participants felt that agencies and program providers do want to collaborate, but there are several barriers. One barrier is funding; agencies and nonprofits that receive funding from different sources can provide only certain services under each funding stream. A formal collaboration mechanism might minimize the silos created by the different funding streams and might increase existing levels of collaboration. Washington has collaboration efforts that already work well, for example the State Interagency Coordinating Council for Infants and Toddlers with Disabilities and their Families and the Snohomish County Children's Commission. Any new formal mechanism should build on Washington's current experience of what works well.

Participants also expressed interest in a more comprehensive mechanism for statewide prevention coordination. Such a mechanism could be used to identify opportunities for partnership and collaboration among already implemented programs. It could also be used to market prevention and perform outcomes evaluation.

Overall, the ideas presented by the early childhood groups are supported by the literature. Participants' concerns about society's misconceptions about early childhood mental health are widely supported by the literature.^{55, 56} Many of the five policy suggestions provided by the early childhood focus groups are also supported by the literature. For example, the literature strongly

supports mental health consultation for preschool and child care providers.^{55, 67} A national study of pre-kindergarten programs found that expulsion rates decrease significantly when pre-kindergarten teachers have classroom-based access to mental health consultation.⁶⁷ The Department of Early Learning recently released a request for proposals to pilot approaches to consultation.⁶⁸

Physician screening for mental illness and social-emotional delays is widely presented in the literature as a mechanism that has untapped potential to identify and connect at-risk children with needed services.^{69, 70} There are several barriers to effective physician screening including lack of adequate physician training, lack of time during office visits, lack of resources for referral, and lack of an effective, easy-to-use screening tool. These barriers would need to be addressed in an effective physician screening program. One way to address some of these barriers would be use of a comprehensive medical home model. A medical home is an approach to primary care in which the care is accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective.⁷¹ A comprehensive medical home would include mental health promotion, mental illness screening, and mental illness treatment through either a referral coordinated by the medical home providers or through integration of mental health professionals into the medical home. There are innovative programs, such as Healthy Steps, that could be used within medical homes or other primary care practices to integrate mental health care into primary care. Healthy Steps places early childhood mental health specialists within primary care practices.^{69, 72} In addition, screening tools such as Ages and Stages Questionnaires: Social Emotional Learning (ASQ:SE)⁷³ can be used to assist providers in primary care.

There are systems in place to reimburse for such screening, such as EPSDT; however, there is concern that even with reimbursement strategies in place, physician screening could be done more consistently and effectively. One challenge to the use of EPSDT as a trigger for services for very young children is the lack of a clear infrastructure for delivery and billing of services under Medicaid. Primary care physicians are often uncertain about referral sources and providers are often unclear about billing and eligibility issues related to an EPSDT screen. In addition, the number of professionals trained to offer infant mental health services is inadequate, and professional criteria for their endorsement does not exist in this state. Finally, there is a lack of clarity about the Medicaid service codes that authorize services to the parents of an EPSDT screened child.

One strategy for intervention and prevention of mental illness that is commonly recommended in the literature but did not emerge as a policy recommendation from the focus groups is home visitation programs.^{74, 55} Although the focus groups did not suggest home visits as a next step, the groups did mention Nurse Family Partnership as an effective program that already exists in some areas of Washington. Nurse Family Partnership is an evidence-based practice⁷⁵ that was cited as a cost-effective program by the Washington State Institute for Public Policy.⁷⁶

Programs that greet new infants and their parents in the hospital were identified as a promising practice by Mental Health Transformation Project staff. One such program is the WELCOME BABY! Program in Skagit County.⁷⁷ In this program, a mental health professional from the county's public health department visits newborns and their parents at the hospital. The mental health professional talks with the new parents about normal child development and offers

support services such as a mother/infant group and parenting classes. Parents are also connected with community resources and receive newsletters in the mail about child development. The goal of the program is to support parent-child bonding and to educate parents about child development. In addition, the program is able to offer some individual support to parents and refer parents to additional services if that is needed.

B. School-Age Children

Mental health in school-age children is characterized by the ability to function well at home, at school, and in the community. To function well, children must have strong cognitive, social, and emotional skills that allow them to form successful relationships with family, teachers, and peers.⁷ However, it is not uncommon for children to experience disabling symptoms of mental illness. In our state, mental illness was the leading cause of hospitalization among school-age children and adolescents from 1998-2002.⁵¹ About 7% of Washington youth ages 6 to 17 have symptoms of severe emotional and behavioral problems.⁴⁹ Washington parents are concerned about the mental health of their children.⁷⁸ Approximately 12% of parents in Washington have a lot of concern about depression and anxiety in their 6-17 year-old children. In addition, about 21% of parents have a lot of concern about their children's self-esteem, and 22% have a lot of concern about how their children cope with stress.

The Healthy Youth Survey (HYS) collects some detailed information about the mental health of Washington's school children. The HYS, which is conducted in Washington schools through the collaboration of several state agencies, provides self-reports from students on a variety of issues, including mental health issues. This survey reveals that high numbers of youth in Washington self-report problems with their emotional and mental health.

Healthy Youth Survey 2006⁷⁹

Questions on Survey:

During the past 12 months, did you ever feel so sad or hopeless almost every day for two weeks or more in a row that you stopped doing usual activities?

Percent of students who responded yes

Grade Level	Female	Male
12 th	35%	23%
10 th	37%	23%
8 th	30%	19%

During the past 12 months, did you ever seriously consider attempting suicide?

Percent of students who responded yes

Grade Level	Female	Male
12 th	14%	10%
10 th	19%	11%
8 th	15%	7%

How likely would you be to seek help if you were feeling depressed or suicidal? (This question was asked of all students, not just students who said that have felt depressed or suicidal).

Percent of students who answered very unlikely

Grade Level	Female	Male
12 th	13%	14%
10 th	16%	14%
8 th	14%	10%

The HYS contains several risk factor scores and protective factor scores that could be used to develop screening tools to identify populations of youth at risk for poor mental health. Such screening combined with outreach may be a crucial component of a successful intervention program given students’ indication that they may not reach-out for help. Risk factors are characteristics that make it more likely an individual will develop a disorder than an individual selected at random.⁹ Protective factors improve individual resistance to risk factors and disorders.²⁵ Measures of risk factors on the HYS include questions on early initiation of drugs, favorable attitudes toward drugs, low neighborhood attachment, poorly managed family, and anti-social behavior among familiar adults. Measures of protective factors include questions on community, school, and family opportunities and incentives for pro-social involvement; individual and peer attitudes toward anti-social behaviors; and individual and peer belief in moral order.

Correlations in the Healthy Youth Survey could be used as a starting point to identify risk and protective factors for mental illness and emotional problems in populations of youth.⁵¹ For example, HYS results show that students who regularly eat dinner with their families are less likely to report suicidal ideation. Students who were harassed based on their race, perceived sexual orientation, or physical disability were significantly more likely to consider suicide. Students who were bullied were also significantly more likely to consider suicide. On the other hand, students who can talk with adults in their neighborhood about important issues are less likely to experience feelings of depression than students who do not have adult support in their neighborhood.

Risk and protective factors for mental illness are likely to be risk and protective factors for other problems facing youth and our communities. For example, involvement with anti-social peers and rejection by conventional social groups are strong risk factors for violence in adolescence.⁸⁰ If the influence of maladaptive peers is found to be a risk factor for mental illness,⁷ then prevention and intervention programs designed to address this issue may work to address both mental illness and violence in youth. Similarly, abusive parenting and neglect are risk factors for mental illness⁷ and significant but weak indicators for later violent behavior.⁸⁰ Prevention and intervention efforts that address childhood abuse and neglect may reduce both youth violence and mental illness among youth.

School-Age Focus Group

The Washington State Board of Health and the Mental Health Transformation Project held age-specific focus groups to inform policy staff in writing this report. One focus group was held to discuss the needs of school-age children. This group’s participants were from a variety of

agencies and service organizations.⁸¹ This section provides a summary of feedback provided by the focus group on what works in Washington, what needs to be changed, and what policies or programs would be beneficial next steps toward an improved mental health promotion and mental illness prevention system for school-age children.

The focus group named several characteristics of successful prevention programs for school-age children. Characteristics include addressing societal attitudes about funding and support for prevention, working to address stigma, and using the media and other avenues for social marketing messages on particular issues. A successful prevention effort is also one that is culturally responsive and asks for input from diverse communities. Adequately trained staff able to work with multiple issues, including an ability to work with a child's whole family, is key to school-age prevention work. A successful program must also identify and build on strengths already in the community as well as build a program based on identified risk and protective factors. Finally, it would have a vision of what it expects as a return on its investment.

Focus group participants identified many currently successful prevention programs that operate in some areas of our state. School-based assessment and early intervention would be successful components of a program. Response to Intervention is an approach to education that calls for regular assessment of students to determine whether individual students need additional assistance.⁸² This approach does not wait for students to screen into any program; instead, it provides assistance with the core curriculum to identified students while they remain in their regular classrooms. Response to Intervention is currently used to provide additional assistance in core subject areas, but the program could be used to provide additional assistance with social/emotional learning/mental health concerns. A second successful strategy is to provide classroom-based social emotional learning to all children in a school, such as the Kelso Program, which teaches problem solving skills to young children. Providing schoolwide access to specialized mental health services is a third successful strategy. This strategy has been implemented through school-based health centers at some schools in our state. Providing specialized services to identified students who struggle with non-academic barriers to learning is a fourth successful strategy. At-Risk Intervention Specialist (ARIS) Program is an example of such a program; it is funded by a Readiness to Learn Grant.⁸³ ARIS provides children with a variety of services, including assessments, family support, and mentoring. It also provides services in a variety of locations, including the home, school, and community settings. A fifth successful strategy is to facilitate communication between schools and caregivers by providing structure for their conversations.

Six policies or strategies emerged from the school-age focus group as next-steps to further mental health promotion and mental illness prevention for school-age children in Washington.

- **Research Risk and Protective Factors in the School-Age Population of Washington.**

The Healthy Youth Survey is an example of one current tool that is effective in gathering risk and protective factor information on Washington's school children. The focus group suggested that the survey be expanded, especially for younger children.

- **Improve and Expand Program Evaluations that Include Systematic and Wide Dispersal of Evaluation Results.**

Funding for program evaluation should be included in the initial funding for programs, and program evaluation should be built into the design of programs. It is also important that a system be created to share program evaluation results across the state.

- **Educate Caregivers and Educators about Child Mental Health.**

Focus group participants believed that educating caregivers about child mental health is an important mental illness prevention strategy because educated caregivers would be more likely to realize what negatively impacts child mental health and act to prevent some negative impacts. In addition, caregivers would be more likely to get help for children who show signs of poor mental health. Caregivers can be educated through existing parent support groups and through outreach.

Focus group participants believed that educators could gain a better understanding of child mental illness through professional development. Educators who understand child mental illness would be more likely to work successfully with children who have mental illness and would be better able to identify children with poor mental health to connect them with mental health services. Focus group participants used trauma-sensitive schools in Massachusetts as an example of a schoolwide training program that alters consciousness of mental illness on a schoolwide basis. Trauma sensitive schools have comprehensive professional development for teachers and staff on how to educate children with trauma and how trauma impacts a child's behavior, learning patterns, and social skills.⁸⁴

- **Train Medical Providers to Provide Mental Illness Screening and Referrals to Mental Health Services.**

Focus group participants recommended that medical providers be trained on how to identify children with symptoms of mental illness so that children can be referred to mental health services. There are existing materials and screening tools that have been developed to assist medical providers. For example, materials such as Bright Futures in Practice: Mental Health are designed to guide physicians. Bright Futures has been used in some areas of Washington. Screening and referral should include screening and referral for caregivers because children's mental health is dependent on a healthy relationship with their caregivers.

Integrating mental health professionals into primary care practices or co-locating mental health services with primary practices can be an effective way to provide support for children, families, and primary care doctors and to provide intervention for children and families.

- **Provide More Support for Families and Youth.**

Focus group participants would like to see more support for youth and families. Focus group participants named a variety of programs that currently provide family and student support, such as Village Project II in King County,⁸⁵ Readiness to Learn Programs,⁸⁶ and youth leadership programs. However, there was a consensus in the group that we need to expand programs to support youth and caregivers, especially caregivers with mental illness.

- **Coordinate Mental Health Services and Screening with Schools.**

There was a very strong consensus in the focus group that mental health services need to be systematically coordinated with schools. One successful strategy mentioned was school-based health centers. Currently, there are 17 school-based health centers in Washington. Focus group participants suggested that school-based health centers be located in more schools and be expanded to K-12.

Two other strategies suggested were placing mental health services from outside agencies in school space and addressing mental health within special education programs. A third strategy mentioned is to provide a mechanism through schools to connect students with a variety of resources; one such mechanism is Readiness to Learn Grants.

Universal mental illness prevention and mental health promotion is also important. The Olweus Bullying Prevention Program⁸⁷ is a SAMHSA model program that seeks to reduce bullying through universal measures that educate all children in a school about bullying. The program also seeks to make organizational changes in the school, including teacher/staff training, to address ways the school can prevent bullying. In addition, the program provides individual interventions with children who bully and children who are bullied. Second Steps: A Violence Prevention Program⁸⁸ is a promising practice that provides universal violence prevention through classroom-based skill building curricula for children in preschool through middle school. The program seeks to reduce aggressive behavior and increase social-emotional competence.

Another way to integrate universal mental health promotion into schools is to create social-emotional curricula and learning standards for all students in a school system. Illinois has implemented social-emotional learning (SEL) standards on a statewide basis.³⁰ In 2003, the Illinois Legislature passed the Children's Mental Health Act, which required the development of the Children's Mental Health Plan,²⁹ and the Act required implementation of SEL standards and SEL curricula in all school districts.³⁰

The literature supports all six suggestions for policy and program change provided by the school-age focus group. More support for families and youth, more education for caregivers and educators on child mental health, and more widespread program evaluation are all ideas that have support in the literature.⁵¹ In addition, the literature supports providing resources to identify risk and protective factors that can be used to target interventions to children most in need of

services.^{7, 43, 51, 89} Identified risk and protective factors should also be used to shape the design of programs so they work well for those most in need.⁸⁹

Physician screening for mental illness is widely presented in the literature as a mechanism that has untapped potential to identify and connect at-risk children with needed services.^{51, 70} There are several barriers to effective physician screening, including lack of adequate physician training, lack of time during office visits, lack of resources for referral, and lack of an effective, easy-to-use screening tool. The medical home model could be used to address some physician barriers to screening. The medical home model is an approach to primary care that provides accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally effective care.⁷¹ Under a comprehensive medical home model, mental illness screening and treatment could be coordinated by the medical home providers or mental health providers could be integrated into the practice. There are already systems in place to reimburse for mental illness screening, such as EPSDT and private insurance coverage for well-child visits; however, there is concern that even with reimbursement strategies in place, screening could be done more consistently and effectively. There are materials to guide physicians that include screening tools, such as Bright Futures in Practice: Mental Health, that have been used in Washington State.

Coordination of mental health services with schools is also widely supported by the literature.^{70, 90, 91} Providing mental health services in or through schools is supported for two primary reasons: services are provided in a location where children already congregate and services in schools reduces stigma because children do not have to go to a specialized setting. Washington currently has several programs in place to provide mental health services within schools. These programs include coordinated school health and school-based health centers. Washington is funded by the Centers for Disease Control and Prevention as a Coordinated School Health Infrastructure State, and mental health services are one component of coordinated school health. The Office of Superintendent of Public Instruction (OSPI) has staff and resources dedicated to implementing coordinated school health. In addition, the Mental Health Transformation Project has taken steps to coordinate mental health services with schools. It recently worked in collaboration with the OSPI to develop a resource manual for coordinating mental health services in schools; this work should be used to develop technical assistance to schools and mental health agencies.

School-based health centers are proving to be an effective way to deliver mental health services in Washington schools. There are currently 14 school-based health centers in Seattle Public Schools, two in South King County, and one in Kitsap County.⁹² The centers operate at both high schools and middle schools. They provide medical care, preventive services, health education, and mental health counseling. The centers are designed to be teen friendly, and they offer confidential services by staff trained to work with adolescents. Each site has a nurse practitioner, a school or public health nurse, and a mental health counselor. The health centers target uninsured youth, but they serve insured youth as well. An evaluation of Seattle's school-based health centers showed promising results in terms of increased functioning at school and decreased risky behavior among students using the clinics.⁹³ Students reported that the centers enabled them to get services sooner than they otherwise would have. The evaluation also showed

some improvement in the mental health functioning of students using the centers' mental health services.

The Washington State Department of Health (DOH) recently sent out a request for grant applications to fund the development of implementation plans for school-based health centers. DOH has 11 grants of \$20,000 each available for award. The Prevention Advisory Group recommended to DOH that school-based health centers be used as a model for improved mental health promotion, early intervention, and treatment.

The Spokane Public School system has taken innovative steps to integrate mental health services into its schools. The Spokane school system is the only system in the state that is a licensed mental health provider. The school system provides master's level mental health therapists in some of its mainstream schools, and it provides alternative therapeutic schools and programs to children with serious mental illness. The school system is able to bill insurance and Medicaid for mental health services because it is a licensed provider. The school system's therapeutic programs have staff trained as teachers and master's level therapists. The therapeutic programs allow students struggling with serious emotional and behavioral needs to remain in school by simultaneously providing therapy and academic instruction in classrooms. The programs help students grow socially, emotionally, and academically so they can be successful in mainstream classrooms.

Trauma-sensitive schools also provide a way to care for the mental health needs of students within the school system. School systems that are trauma-informed or trauma-sensitive have great potential for mental illness prevention and early intervention. Without an understanding of trauma and its effect on students, teachers and school staff may respond to academic, behavioral, and emotional problems caused by trauma with punitive measures such as expulsion.⁹⁴ On the other hand, a trauma-sensitive school system would be more likely to respond with therapeutic and positive behavioral support that will help students recover from trauma and keep students engaged with school. The Massachusetts Department of Education describes trauma-sensitive schools as schools that may have comprehensive professional development for teachers and other staff, a team of personnel to assess individual student cases, expanded counseling services, consultation with and referral to outside community-based organizations, parent and family workshops on the effects of trauma, and conflict resolution training for teachers and students.⁸⁴

II. YOUTH IN TRANSITION TO ADULTHOOD

The transition to adulthood is a critical time for the majority of individuals who have mental illness or who are at risk for mental illness. Most individuals who develop a mental disorder in their lifetime will either have the disorder before this transition or will develop it during this transition. Half of all lifetime cases of mental disorders develop by age 14, and three-fourths of lifetime cases develop by age 24.⁴⁸ Schizophrenia typically begins when individuals are between 20 and 30 years-old.⁸⁹ Young adulthood is also the time when individuals with emotional problems are likely to develop substance disorder comorbidities.⁹⁵ It may be possible to prevent mental illness for at-risk youth in transition by providing transition-related services and developmentally appropriate support. Such services can help mitigate the stress of the transition and provide support for making good decisions. The same support provided to youth who

already have mental illness has the potential to reduce the devastating impacts of mental illness and even help individuals recover.

Youth and young adults, especially those who do not have parental support, often need assistance to successfully transition to adulthood; this is particularly true of those with mental disorders. Youth with mental health needs have less favorable long-term outcomes than all other disability groups in terms of employment, incarceration, and post-secondary education, despite the finding that 70% of high school students with mental illness have employment goals.⁹⁶ Providing quality mental health services to transitioning young adults can prevent the development of co-occurring disorders and it can prevent deterioration of existing disorders, which may improve their outcomes.⁹⁷ The longer a person lives with untreated mental illness the more it impacts the architecture of his or her brain, which leads to more severe and treatment resistant illness.⁵³ In addition, the combination of disorders such as mental illness and substance abuse creates a more severe and persistent course of mental illness.⁵³

The period of transition to adulthood does not have clear parameters. This is true in terms of federal, state, and local regulations and in terms of social/cultural parameters. Federal, state, and local regulations set various age limits for different programs and benefits. For example, children under age 18 can qualify for Social Security Income for Children with Disabilities if they meet eligibility requirements,⁹⁸ but children under age 19 can qualify for Children's Medical or Children's Health Insurance Program through Washington's Department of Social Health Services if they meet eligibility requirements.⁹⁹ Education programs have different age limits as well, for example, students can be eligible for special education services to age 21.¹⁰⁰ In addition to the differences in regulations related to the beginning of adulthood, there are social/cultural ambiguities on the beginning of adulthood. Adulthood can be identified by the attainment of a cluster of markers, such as completing school, leaving the caregivers' home, entering the job market, marrying, and having children.¹⁰¹ However, different individuals, cultures, and generations may not agree on what markers signify adulthood.

Alternatively, adulthood can be defined by a set of skills and attitudes needed to perform adult roles.¹⁰¹ In this report, the transition to adulthood refers to a period in which young people acquire the skills and maturity needed to successfully live independently. This period will begin and end at different times for different individuals, but the transition starts roughly in the mid-to-late-teen years and continues into the early thirties.

The amount of time necessary to gain skills to secure stable employment that fully supports living independently, especially if supporting a family, has changed over time. In the period following WWII, most men had stable employment that allowed them to support a family by age 20.¹⁰¹ Today, most young people do not achieve economic security until their late 20s or early 30s.¹⁰¹ A primary reason for the increased transition time is that it takes much more education to obtain a full-time job that supports a family than it did in the past.¹⁰¹ Indeed, 45% of 18-24 year-olds are still attending school.¹⁰²

The transition to adulthood is a difficult time for youth with mental illness because of their illness and because the socioeconomic status of their families is likely to make the transition more difficult.⁹⁵ Surveys of youth with serious emotional disturbance find an overrepresentation

of individuals from families in the lower socioeconomic groups.⁹⁵ The high poverty rate of 30% for the 18-24 year-old age group¹⁰² indicates that the transition period is economically difficult for many youth, including mentally healthy youth. However, it is likely to be more difficult for youth who cannot count on substantial support from their families to succeed in their transition. On average, youth ages 18-34 both living at home and living independently receive \$38,000 from family for food, housing, education, or direct cash assistance over the course of their transition period.¹⁰³ This averages to \$2,200 a year. The amount of financial assistance given to youth varies greatly with parental income. Youth of families in the top quarter of income categories receive 70% more in financial assistance than youth of families in the bottom quarter of income categories. However, youth living away from home receive about the same amount of assistance in parental time regardless of parental income level. Youth aged 18-34 receive an average of 367 hours of family support time in a given year, which is nine forty-hour weeks of assistance.

Continuity of mental health care can be problematic for youth. In 2001, 4.3 million teens ages 12-17 (about 18%) received treatment for mental health problems.¹⁰⁴ Service use drops to lower levels as these youth turn 18 even though it is likely that their mental health problems continue into adulthood. Transitioning youth may experience disruption for many reasons, including age limits set by systems that serve youth.⁹⁵ For example, special education, child welfare services, juvenile justice, pediatric health services, and child mental health services all end within a few years of age 18. Mental health services are one of the few programs that serve both children and adults, but youth and adult programs are administered separately, which leads to problems with continuity and the end of established therapeutic relationships. In addition, about half of youth receiving mental health treatment receive it through school-based health programs; for these youth, the end of their primary education means the end or disruption of mental health services.¹⁰⁴

Youth served by the public mental health system before their 18th birthday may experience a disruption in mental health services due to the fragmentation of the child and adult mental health systems.⁹⁶ Age limits and the administration of separate child and adult systems cause serious problems with continuity.⁹⁵ For example, in many states the eligibility requirements for Medicaid's child mental health benefits are different than the requirements for adults, which means individuals who age-out of child programs may not be eligible for adult programs. There are eleven categories of disability that qualify individuals under age 18 for Medicaid but only nine categories for adults. In addition, while the federal definitions of serious emotional disturbance (SED), the characterization given to a serious mental disorder in children, and serious mental illness (SMI), the characterization given to a serious mental disorder in adults, are similar, the definitions of functional impairment are different between the two. The difference in definition means children with SED might not qualify for services because they do not meet the definition of SMI.

There are significant problems with serving transitioning youth within our current adult mental health system because youth have particular developmental needs that are rarely considered in our adult system. Lack of consideration may be partially due to the lack of professionals trained to work with this group. Many professionals are trained to work with either children or adults and are not comfortable working with individuals in a developmental state that crosses this

distinction.⁹⁷ However, it is important to provide this age-group with specially targeted services and specifically trained professionals given the unique developmental phase of this group. For example, many youth are still imbedded in their families and their families struggle with how to relate to an adult child. In addition, transitioning youth experiment with living their life in their own way, they frequently change jobs and school attendance, they are sexually active but socially immature, and they may view drug use as normal for their age.⁹⁷ In addition, there are several developmental reasons that group work with older adults may be damaging to transitioning youth. Youth have difficulty relating to adults who are much older, which is problematic because peer approval is important for this age group. Stigma is particularly painful for young adults and placing them in services with older adults with mental illness may exacerbate this issue. To adequately serve transitioning youth a service system should include adequate services designed to assist in the transition to adulthood, have adequate staff trained to work with the transition age-group, and provide age-appropriate group work.⁹⁵

Transition to Adulthood Focus Group

The Washington State Board of Health and the Mental Health Transformation Project held age-specific focus groups to inform policy staff in preparing this report. One focus group was held to discuss the needs of youth in transition to adulthood. Participants were from a variety of agencies and service organizations.¹⁰⁵ This section provides a summary of the focus group's discussion on what works in Washington, what needs to be changed, and what policies or programs would be beneficial next steps toward an improved mental health promotion system and mental illness prevention system for youth in transition to adulthood.

There was a consensus among focus group participants that youth in transition to adulthood have several age-specific barriers, both system barriers and treatment model barriers, to receiving effective interventions. The primary issue is that neither the child mental health system nor the adult mental health system works well for them because they are in a unique developmental phase that requires tailored treatment. One example of a tailored treatment need is help with building self-efficacy in making decisions. A second age-specific barrier is that no system wants to claim ownership over these youth except colleges and universities, which serve only a segment of this population. Even within colleges and universities, the ability to help youth with serious mental health needs is limited because these institutions are wary of lawsuits over inadequate services. Wariness leads universities to refer out for services rather than serving youth with serious problems. A third age-specific barrier is lack of health coverage. Many youth lose private or Medicaid health coverage around age 18, and it is difficult for them to find new coverage.

Focus group participants gave several characteristics of prevention programs most likely to be successful for youth in transition to adulthood. A successful program must start with a firm understanding of the developmental stage of youth in transition. Such an understanding would create a program that would work to strengthen the youth's relationship with attachment figures, including family and peers. The program would also help youth build self-efficacy around making responsible choices. It would give youth room to make their own decisions when appropriate and allow some room for mistakes in decision making, although it would also educate them on which decisions are not reversible. A good prevention program would view

youth community involvement as valuable, rather than viewing youth as a problem for caregivers and schools. A successful prevention program would be based on risk and protective factors.

Transition to adulthood focus group participants named a few programs that already work well for mental illness prevention. Programs that provide vocational rehabilitation or job opportunities for youth, such as programs through the Division of Vocational Rehabilitation and Pioneer Human Services, were mentioned as strategies that work well because they provide a path to a normal life in the community. Safe Futures Youth Center, which utilizes evidence-based and promising practices to provide after-school programs, case management services, and leadership development, was mentioned as a program that works well. In a university setting, the social norms model works well to promote healthy behaviors and educate students about the biology of mental illness and medications. Programs that provide youth with leadership and community involvement opportunities work well. Two such programs are the VERA Project and the Mockingbird Society. While the Mockingbird Society is an organization for foster youth, it was mentioned as a model for creating a strong community involvement and advocacy program for youth with mental illness. The Washington State Mentoring Partnership, which is an umbrella organization for Washington mentoring programs, was also mentioned as a program that works well.

The youth in transition focus group suggested several policies as next steps toward creating a mental illness prevention system.

- **Create a System with No Wrong Door to Services.**

Focus group participants would like to see a system in which youth receive needed services through the first contact they make in their effort to get help. Currently, youth are assessed to determine whether their underlying issue is mental illness, substance abuse, or problems with social skills, among other things. Youth are often turned away if they do not make the right initial contact based on such an assessment.

- **Use Mental Health Consultants within Primary Care Practices.**

Focus group participants suggested that mental health consultants within primary care offices could be an effective way to provide needed diagnosis and referral. The mental health consultant could be a master's level provider who has the ability to diagnose for mental illness and substance abuse. The consultation system could be set-up to allow primary care doctors to be a part of a network that would allow them to call a consultant at the time that they need assistance.

- **Use the Drop-In Center Model to Provide Peer Support to Youth with Mental Illness.**

Provide drop-in centers that are less structured than the adult club house model. Drop-in centers should be run by youth who themselves have successfully managed mental illness. The centers should be organized around activities that youth enjoy; for example, a drop-in center could be an Internet café. Well-designed drop-in centers would help to

reduce mental illness stigma by celebrating youth who have successfully managed mental illness while providing support to youth at different stages of mental illness. The drop-in centers could use Lambert House¹⁰⁶ as a model. Lambert House, in Seattle, is a center for lesbian, gay, bisexual, transgender, and questioning youth who are age 22 and under. It is open to youth from late afternoon to late in the evening. It offers a drop-in center, support groups, homeless services, dinner, counseling services, a computer lab, and recreation activities. The house has a full kitchen, a pool table, a television, games, a library, and a stereo. Youth are invited to just hang out or to talk with a counselor or join a group. Lambert house offers a setting and style of service that is comfortable and appealing to youth. Any drop-in center must be designed in a way that appeals to the transitioning age group.

- **Start a Leadership Academy for Resilient Youth.**

Focus group participants suggested a leadership academy for youth who have proven themselves to be resilient by overcoming mental illness, substance abuse, or another substantial adversity. Such an academy would reduce stigma by celebrating a struggle that was once a source of stigma for the honored youth. In this way, it would help the youth who attend the academy feel accomplished and it would provide hope to youth who struggle with stigmatizing adversity.

- **Create a Social Marketing Campaign to Reduce Stigma.**

Focus group participants suggested a social marketing campaign to reduce mental illness stigma and promote mental health. They suggested using a famous performer from Washington as a way to appeal to this age-group. A social marketing campaign that uses stories of youth who have recovered from mental illness, such as the poster contest held by North Sound Mental Health Administration, could also be an effective campaign.

In the literature, the most commonly discussed strategies to improve mental health support for youth in transition are ones that address the age-specific barriers mentioned by the youth in transition focus group.⁹⁵ Three strategies emerged as the most widely discussed in the literature. The first widely supported strategy is to provide developmentally appropriate services to transitioning youth within the child and adult mental health systems.^{95, 96, 97, 107} This strategy would entail using providers trained to work with adolescents and young adults, providing age-specific group services, and providing services designed to assist in the transition to adulthood. A second widely supported strategy is to bridge the gap between the child and adult public mental health systems.^{95, 96, 97, 107} This strategy entails ensuring continuity by minimizing therapeutic relationship disruption caused by age limits, coordinating and planning individual transitions from the child system to the adult system, and changing definitions and eligibility requirements to prevent the termination of services at age 18. A third strategy is to decrease the number of youth without health coverage through private health insurance and public systems.^{108, 109} There are many strategies suggested for decreasing the number of youth without health coverage, including extending the age for Medicaid and SCHIP eligibility and extending the age at which children are eligible for dependent coverage on parental policies.¹⁰⁹

Reducing the number of youth in transition who are without health coverage or experience a gap in coverage may be a good strategy to promote early intervention for youth experiencing early stages of mental illness. In 2004, 18-24 year olds had the highest uninsured rates of any age group. Youth without private insurance or Medicaid coverage have a fairly strong financial incentive to delay seeking treatment for symptoms of mental illness. In addition, those with more serious mental illness may be more likely to delay seeking help until crises if they do not have coverage. Delay in seeking help can lead to more chronic, treatment resistant disorders and it can lead to the development of co-occurring disorders.⁵³ In addition, youth without coverage are less likely to be connected with a primary care physician or any medical professional who could screen them for symptoms of mental illness and refer them to appropriate services.

Programs that provide transition-related services and age-appropriate services can provide support to prevent at-risk youth from developing disorders and they can help youth with mental illness recover. The Partnerships for Youth Transitions (PYT) Grant from SAHMSA provided funding for the development and implementation of pilot programs designed to address both the lack of age appropriate services in the child and adult mental health systems and the lack of coordination between the two systems. Clark County in Washington was one of the grant recipients. Clark County used the four-year grant to create the Options Program, which served youth ages 14 to 25.¹⁰⁸ The program was housed at a youth community center in Vancouver, Washington and was managed by Columbia River Mental Health Services. Most of the youth served had received services through the public mental health system and were involved in the juvenile justice system. The program was staffed by four transition specialists, an employment specialist, a youth coordinator, and a program manager. The program primarily provided employment, education, and housing services. A critical component of the Options Program was the Transition to Independence Process (TIP) model.¹¹⁰ TIP is an evidence-based model that stresses the importance of providing age-appropriate services, engaging young adults in planning their own futures, and utilizing services that focus on individual strengths.⁹⁶

The Options Program had several positive outcomes.¹⁰⁸ Youth who participated in Options had a reduction in involvement with juvenile justice. The program also showed positive outcomes in employment for the youth. Preliminary findings of a cross-site analysis of PYT projects across the country show that individuals involved with PYT had increased employment rates and increased rates of enrollment in high school or post-secondary education. Participating youth also had decreased interference in their lives from their mental health conditions or substance abuse.¹¹⁰

Transition services, such as those provided through the Options Program, help youth toward recovery if participating youth experience a decreased interference from mental health conditions. Recovery from mental illness involves living a satisfying, hopeful, and contributing life with the limitations caused by mental illness and gaining a sense of identity outside of mental illness.¹¹¹ PYT uses many adult-oriented strategies of psychosocial rehabilitation, such as assistance with employment and housing, but PYT orients these services to be developmentally appropriate for youth in transition. Participating youth with mental illness may not have experienced improved mental health if they had received the same services in an adult-oriented setting.

One prevention strategy discussed in the literature but not mentioned in the focus group is very early intervention in psychosis, a disorder that typically develops during the transition to adulthood. Pre-diagnosis intervention for psychosis is in its early phases. However, many believe that very early intervention with schizophrenia is important because the prognosis for recovery worsens with each relapse and with delay in treatment after the first onset.^{89, 112} A few programs, primarily in the United Kingdom and Australia, have been developed that intervene during the prodromal, or precursory, phase of psychosis.¹¹³ Individuals in the prodromal phase show symptoms that can include flat affect, social anxiety, withdrawal, and behavioral peculiarities. Individuals in the prodromal phase do not yet meet the diagnostic criteria for psychosis, but they are identified as at risk for psychosis based on their precursory symptoms.

There are a few programs in the United States that seek to identify individuals ages 12 to 25 who are at risk for psychosis. These programs include the Portland Identification and Early Referral Program (PIER) in Maine and the Early Diagnosis and Preventive Treatment of Psychotic Illness (EDAPT) Program at Davis Medical Center in California.¹¹⁴ These programs reach youth in a number of different ways. Primarily, the programs educate professionals who have regular contact with youth, especially school professionals and clinicians, to recognize the prodromal symptoms for psychosis and refer youth to their programs. One program also uses advertisements in newspapers and movie theaters. Once youth are referred, the program treats those determined to be at high risk with psychosocial and psychopharmacological interventions.

Prodromal intervention with psychosis is controversial because the likelihood of false identification is high; a majority of the individuals identified do not develop schizophrenia.¹¹⁵ Two major ethical issues arise from false identification. First, these programs treat falsely identified individuals with medications that have known and unknown serious side effects. Second, falsely identified individuals and their families endure a great deal of stigma and stress.^{113, 115} There is consensus, however, about the enormous benefits of early intervention with individuals who can be diagnosed with schizophrenia.^{89, 116}

III. ADULTS

A significant portion of mental illness is now believed to be preventable, and recent research continues to show new ways to implement prevention.⁸⁹ In addition, research and anecdotal evidence show that people with serious mental illness often recover. For example, mental health/medical professionals once thought that schizophrenia was a chronic deteriorating condition, but long-term follow-up studies show that many individuals with schizophrenia improve and recover.⁷ This section will focus on recent efforts to prevent mental illness, intervene early, and reduce the devastating impacts of mental illness in adults.

Adulthood spans the greatest number of years of all the age-specific groups. Adults 18-59 years of age are the majority of users of Washington's public mental health system.¹¹⁷ Based on feedback received through the focus groups and a review of the literature, it appears that our mental health system is adequately focused on adults for their age-specific needs. In other words, fundamental concepts about mental illness in adults and their related service needs do not need to be reframed based on the age-specific phase of this population. However, services need to be

improved based on other misconceptions about adults with mental illness. Some of the other misconceptions are discussed below.

Rather than give substantial attention to conceptions of this group based on age or life-stage, as was done in the other age-specific sections of this report, this section will focus on adult interventions at different levels of prevention. Some disorders lend themselves to primary prevention. In addition, there are developing models for early intervention prior to a formal diagnosis for many disorders. In traditional public health terminology, these interventions targeted to at-risk individuals would be considered secondary prevention. One of the specific interests of the Prevention Advisory Group was identifying ways to intervene early during an initial mental illness crisis, whether the crisis is hospitalization, homelessness, or incarceration. Early intervention could prevent avoidable rehospitalization and increase functioning. Such efforts would be considered tertiary prevention in public health terminology, along with efforts to prevent co-occurring disorders and to promote recovery of people diagnosed with serious mental illness.

In a given year, about 18.5% of adults have a clinically significant mental disorder.¹¹⁸ Anxiety disorders, with a twelve-month prevalence rate of 18%,¹¹⁹ are the most common mental disorder in adults; this disorder affects twice as many women as men.⁷ Anxiety disorders include panic disorder, phobias, obsessive-compulsive disorder, post-traumatic stress disorder, and generalized anxiety disorder. Major depressive disorder occurs in about 20% of women and 10% of men. Bipolar disorder affects about 1 to 2% of the population and occurs equally in each sex.¹²⁰ Mood disorders in adults have a significant impact on our society in terms of suffering and disability. Mood disorders include major depressive disorder, bipolar disorder, and dysthymia (a chronic, but less severe form of depression). Schizophrenia, a psychotic disorder, affects about 1% of the population, but its severity and persistence requires significant resources in our mental health system.⁷ Symptoms of psychosis include auditory and visual hallucinations, delusions or paranoid thinking, flat affect, and social withdrawal.¹¹⁸

Primary prevention of mental illness in adults is effective for some disorders. There is the most research support for primary prevention of depression and anxiety with cognitive behavioral interventions.¹²¹ Successful mental illness prevention programs have been developed to support adults in long-term relationships and in the transition to parenthood.⁹ These programs are based on findings that failure in either of these roles can lead to mental health problems. The programs are designed to help individuals build skills and coping mechanisms to successfully negotiate marital-type relationships and parenthood. Universal interventions that target all individuals in a relationship and every new parent have been shown to reduce symptoms of depression and anxiety. Successful interventions have also been designed to target individuals at risk for depression based on poverty status or based on their role as caregivers of elderly parents. Primary prevention is thought to be possible for schizophrenia, but much more research must be done before interventions could be developed.¹¹³

Early intervention for mental disorders can prevent further morbidity because it can prevent “neural kindling,” a process that can cause untreated disorders to become more severe and treatment resistant.⁵³ Further, more severe mental illness is associated with the development of comorbid disorders.⁵³ Despite the benefits of early intervention, delay in seeking treatment for

mental disorders is common. Among those who seek treatment for mood disorders the delay is about seven years, and among those with anxiety disorders the delay is from nine to 23 years.⁵³ The most commonly reported reason for not seeking treatment among those who meet the criteria for a DSM-IV-TR disorder is that the individual does not feel he or she has a problem.¹¹⁸ This was the most common answer even among those who meet the criteria for a serious mental illness. The perceived lack of efficacy or wanting to solve the problem on one's own was reported most often among individuals with a serious mental illness who had received treatment in the past.¹¹⁸ This survey result raises the concern that campaigns to encourage people to seek early treatment would not be successful in the long term if individuals who seek treatment find treatment to be unhelpful.

For many disorders, successful interventions can be implemented before an individual develops the full criteria for a disorder. Early intervention for individuals with low-level symptoms of depression can be successful; many of the successful strategies are the same as those used to treat full-blown depression. For example, studies done in a variety of settings, including high schools, colleges, primary care settings, and health maintenance organizations show that cognitive-behavioral therapy with individuals identified as at risk for depression based on low-level symptoms can reduce symptoms and prevent onset of depression.¹²⁰

Early intervention for schizophrenia also appears to be possible, although several ethical concerns must be addressed if the intervention occurs before the condition is diagnosable. Early intervention with schizophrenia is important because many believe that the prognosis for recovery worsens with each relapse and with delay in treatment after the first onset.^{89, 112} A few programs, primarily in the United Kingdom and Australia, have been developed that intervene during the prodromal, or precursory, phase of psychosis.¹¹³ Individuals in the prodromal phase show symptoms that can include flat affect, social anxiety, withdrawal, and behavioral peculiarities. Individuals in the prodromal phase do not yet meet the diagnostic criteria for psychosis, but they are identified as at risk for psychosis based on their precursory symptoms. These programs identify youth and young adults in the prodromal phase through referrals from therapists, primary care doctors, schools, and primary caregivers. Many programs are operated in health clinics, although at least one program was a home-based program. In many of the programs, individuals are treated with low-levels of anti-psychotic medication and receive cognitive therapy. Interventions may also include psychoeducation with family members. These programs have been somewhat successful in delaying the on-set of psychosis and one study showed a reduction in the incidence of schizophrenia cases in the area in which the program was implemented. One program that used psychosocial treatment without anti-psychotic medication experienced a high rate of program participants progressing to psychosis. From these program studies, it appears that anti-psychotic medication is an important part of early intervention.

Prodromal intervention in psychosis needs more research and thought before widespread programs are implemented. A primary cause for concern is the false identification of individuals as at risk for psychosis. Our current criteria for prodromal phase identification is not very accurate; a majority of the individuals identified do not develop schizophrenia.^{113, 115} Two major ethical issues arise from false identification. First, these programs treat falsely identified individuals with medications that have known and unknown serious side effects. Second, falsely identified individuals and their families endure a great deal of stigma and stress.¹²² There is

consensus, however, about the enormous benefits of early intervention with individuals who can be diagnosed with schizophrenia.^{89, 113}

Since deinstitutionalization, treatment of individuals with serious mental illness continues to shift to a focus on community-based treatment. The community-based focus requires the development of programs to prevent the need for hospital admissions and readmissions. One such program is the Program for Assertive Community Treatment (PACT or ACT). PACT is designed for individuals with severe and persistent mental illness, and a key component of the program is that it assertively attempts to engage individuals in services.¹²³ A PACT team includes a psychiatrist, a nurse, a master's level professional, and sometimes a peer specialist. Services provided by PACT include case management, crises management, medication management, supportive individual therapy, substance abuse services, consultation with family members, and coordination of hospital admissions and discharges. This program is currently used in Washington and will be implemented more widely following legislative fiscal allocation for PACT programs in the 2007 session.¹²⁴ ACT is just one of many strategies used to reduce hospital readmission rates.¹²⁵

The recovery movement seeks to raise awareness about the potential for recovery of those with mental illness and the ways that current attitudes and treatment models impede this potential. The movement formed partially in response to the inaccurate belief and message that mental disorders were chronic deteriorating conditions.¹¹⁸ Recovery is the journey toward a sense of identity outside the parameters of mental illness. A crucial component is reorienting one's self apart from an identity completely defined by mental illness, so individuals can realize mental illness is only one element of a whole person. Recovery involves living a satisfying, hopeful, and contributing life with the limitations caused by mental illness. A recovery-oriented system incorporates the values of empowerment, personal choice, and personal involvement.¹¹¹ It also focuses on building existing individual strengths and supporting individuals' connectedness to their existing relationships and communities. Stigma and self-determination are two issues that are very important in the recovery movement.

Peer support is an important strategy of the recovery movement. Peer support can be a powerful alternative or adjunct to traditional mental health care by providing a mutually engaging and supportive relationship that does not involve labeling or a need to control or be controlled by the other.^{126, 127} Peer-run support is provided through a number of forms: mutual support groups; multi-service centers; telephone crisis and warm lines; drop-in programs that offer access to telephones, laundry facilities, computers, and transportation passes; specialized support services that offer assistance with finding housing and employment; peer-run crisis hostels or respite centers that offer an alternative to hospitalization; hospital-to-home support; and education/advocacy programs.¹²⁸ Peer support programs have been shown to be effective and to have cost benefits in comparison to traditional care programs. For example, a peer support hospital-to-home program implemented in Australia had higher rates of successful engagement and completion than similar non-peer support programs.¹²⁹ This program reported a reduction in readmissions among participants and considerable cost benefits through the reduction in bed days. A peer support program in Pennsylvania called Friends Connection also showed reduction in rehospitalization in patients with a history of frequent long-term hospital stays.¹³⁰

Psychiatric/psychosocial rehabilitation¹³¹ strives to help individuals with psychiatric disabilities become successful and satisfied in their chosen environment with the least amount of professional intervention.¹³² It focuses on treating the consequences of the illness rather than the illness itself by building an individual's skills and supports to achieve maximum functioning capacity. Psychiatric rehabilitation services include independent and social living skills training, psychological support to clients and families, housing, vocational rehabilitation, access to leisure activities, and social network enhancement.⁷ Clubhouses are among the best-known models of psychiatric rehabilitation. In the clubhouse model, staff and members work together in the operation of the clubhouse and members are involved in governance. Clubhouses help members build vocational skills through participation in the operation of the clubhouse and connecting members to paid work outside the clubhouse. The model offers a supported environment as well as support services.¹³³

A trauma-informed system effectively engages and assists individuals who have suffered from trauma.¹³⁴ A system can be trauma-informed regardless of the type of services it provides; for example, it might provide mental health services, substance abuse services, housing assistance, employment assistance, or education.¹³⁵ A trauma-informed system is one that has a commitment to providing services in a manner that is welcoming and appropriate for individuals who have suffered trauma; it does not mean that the system is designed to treat trauma or related issues.¹³⁵ A parallel can be made to a system that is welcoming to individuals with physical disabilities through the provision of wheelchair access or signing services for hearing impaired individuals.¹³⁵ In contrast, a trauma-specific intervention is one specifically designed to treat individuals for the effects of trauma.¹³⁴

To become trauma-informed, a system must go through a thorough assessment to determine how any aspect of its policies, procedures, or daily operations may be hurtful or harmful to trauma survivors.¹³⁵ The assessment should include details such as how the system's physical spaces, time-limits on services, and attitudes and behaviors of support staff might render the system unwelcoming to trauma survivors. A system must also educate all of its employees to understand how trauma can impact individual behaviors and emotional experiences. Everyone from decision makers to elevator operators must be able to interact with trauma survivors in a way that is not hurtful.

Mental health systems and mental health consumers may benefit from mental health systems that are trauma-informed.^{134, 135, 136} A trauma-informed mental health system may be more effective in engaging consumers and keeping them actively involved in treatment.¹³⁵ A trauma-informed mental health system will alter its policies and practices to ensure that its services do not re-traumatize trauma survivors.¹³⁵ For example, it will evaluate provider-patient relationships to ensure that these relationships do not replicate abusive relationships in any way, which means ensuring that the consumer is respected and treated as a partner in decision making. It also means evaluating practices in hospitals that may re-traumatize individuals; for example, seclusion and restraint may need to be replaced.¹³⁶ Hospitalization itself may re-traumatize individuals; for this reason, alternatives need to be available and seriously considered.¹³⁵ A trauma-informed mental health system could prevent further trauma to individuals who already suffer its effects, thereby reducing the devastating impact of mental illness.

Homelessness is an important concern for individuals with serious mental illness. About 25% of homeless individuals have a serious and persistent mental illness.¹³⁷ Homeless individuals with mental illness are homeless for longer periods of time and have less contact with family than homeless individuals who do not have mental illness. Most homeless individuals with mental illness could live in the community if provided appropriate housing.¹³⁷ In fact, individuals with mental illness experience improved mental health and more self-determination when they are in adequate housing.⁷ Despite the benefits of housing, there is a lack of affordable and appropriate housing for individuals with mental illness. There are many factors that contribute to the lack of housing opportunities, including Supplemental Security Income (SSI) and Social Security Disability Income (SSDI) payments that are not adequate to afford rent¹¹⁸ and housing discrimination based on psychiatric disability by landlords and public housing programs.⁷ Washington State's Mental Health Division of the Department of Social Health Services has contracted with the non-profit Common Ground to develop a statewide housing plan for individuals with mental illness.¹³⁸ The preliminary plan includes a needs assessment and initial recommendations for housing models.¹³⁸

Adult Focus Group

The Washington State Board of Health and the Mental Health Transformation Project held age-specific focus groups to inform policy staff in preparing this report. One focus group was held for adults and providers serving them. This group's participants were from a variety of agencies and service organizations.¹³⁹ This section provides a summary of the focus group's discussion on what works in Washington, what needs to be changed, and what policies or programs would be beneficial next steps toward an improved mental health promotion and mental illness prevention system for adults.

Focus group participants agreed on several important components of a prevention system. A prevention system should use assessments to determine the source of the identified problem and what sustains it. The system should also include education outreach, especially to providers within the system. For example, primary care doctors and their staff need to be trained in how to work with individuals with mental illness within practices. Finally, a successful prevention system will support empowerment for individuals with mental illness, including empowerment through policy advocacy.

Focus group participants named several types of programs that already work well in Washington. Participants named the Program of Assertive Community Treatment (PACT) as an effective intensive, community-based intervention. One successful treatment model mentioned was Dialectical Behavioral Therapy (DBT), which is widely used by different service agencies. Types of services that work well include vocational services, supported employment, and supported housing, such as the housing provided by Transitional Resources in Seattle. Warm lines, which provide telephone support to individuals before they go into acute crises, and hospital-to-home programs also work well. Programs designed to strengthen families through strategies such as family psychoeducation work well if the family has the potential to support the individual. Respite beds were mentioned as an effective alternative to hospitalization; Transitional Resources in Seattle provides two respite or hospital diversion beds through King County and Highline Mental Health. The Crisis Intervention Training for police officers was

mentioned as a successful program. The program trains officers on how to interact and respond to calls to intervene when an individual with mental illness is in crisis. The program is designed to reduce injuries to officers, reduce excessive use of force by officers, and divert individuals from jail to mental health services. Finally, peer specialist training programs can be very effective to help trained individuals as well as those they support. One such program is the Howie T. Harp Peer Specialist Training Center in New York, which trains peer specialists, and it has a program for consumers with a history of incarceration to become forensic peer specialists.

Focus group participants had several suggestions for what should be added to the system. First, the state should be flexible in regulating alternative care models such as peer support certification. Certification also needs to be changed to allow professionals to more easily receive dual certification as both a mental health and substance abuse provider. Second, case management should be reconsidered in terms of which methods are effective and which are not. For example, Highline Mental Health currently uses a recovery-oriented model for case management; agencies should change case management models to be as effective as possible. Third, the system needs more coordination across prevention efforts to facilitate communication between mental health professionals and other professionals who work with mental illness prevention but don't realize it. For example, those who work to prevent child abuse, child neglect, and domestic violence are in mental illness prevention, but they may not realize it and may not be in communication with mental health professionals. Fourth, treatment programs that treat co-occurring disorders are in short supply and these treatment programs are critical for some individuals. At the very least, it is important that mental health programs do not exclude individuals because of substance use. Finally, there needs to be more appropriate placement and transition supports available for individuals with serious mental illness leaving state hospitals, especially individuals leaving long-term hospitalizations. Resources needed include appropriate housing placements, daily living support, and therapeutic support.

The adult focus group formulated three next steps that could be taken to improve mental illness prevention. The steps are listed below.

- **Provide More Transitional Services.**

Adults need support at transition times to prevent recurring crisis. For example, individuals need support when transitioning into the public mental health system, transitioning out of hospitals, and transitioning out of incarceration.

- **Move Away from Diagnosis-Based Access to Need-Based Access.**

The DSM-IV-TR criteria are used for access criteria too often. The DSM-IV-TR criteria are a cluster of symptoms rather than a measure of need for care. Access to public and private services should be based on the need of individuals, not on their DSM-IV-TR diagnoses. However, a complete transition to need-based services is not likely to happen quickly. In the interim, services based on need rather than diagnosis should be available in addition to diagnosis-based services.

- **Continue Effort to Move the Mental Health System Toward a Recovery and Resiliency Model.**

There are several models of care that can be more effective than traditional models or can increase the effectiveness of traditional models when used in conjunction with them. Mental health systems need to move toward use of these models. For example, recovery-oriented models, including peer support models, provide many choices for providing effective care.

The literature supports recovery-oriented models as well as psychiatric/psychosocial rehabilitation models as alternatives to or as complements to more traditional care models. Support for psychosocial rehabilitation includes randomized clinical studies that show psychosocial rehabilitation recipients have fewer and shorter hospital stays than recipients of traditional outpatient treatment.⁷ The recovery movement refers to a concept rather than a treatment model, although fundamental elements of recovery could be identified to create best practices for promoting hope and healing among individuals with mental illness.¹¹⁸ In addition, models advocated by the recovery movement have been measured for effectiveness. Research has shown consumer self-help programs and consumer-run case management programs to be successful,⁷ and peer support hospital-to-home services have been shown to reduce hospitalizations.^{129, 130}

The literature supports the notion that services provided in transitional times have the potential to prevent mental illness and reduce the devastating impacts of mental illness. Interventions that provide support at critical junctures for individuals who do not have mental illness may prevent mental illness. Intervention at junctures such as divorce; loss of a loved one, job, or home; or diagnosis of a serious physical condition can help individuals successfully manage crises without developing mental illness.⁸⁹

Research should be done on whether intensive support services during or after initial crises can prevent recurring crises. Support services can reduce the devastating impacts of mental illness by preventing crisis from recurring for individuals with mental illness. For example, hospital-to-home support can prevent rehospitalization and supported housing can reduce hospitalization and improve functioning and empowerment.⁷ The research on transition support and crisis stabilization programs have been primarily done with individuals who experience multiple and frequent hospitalizations because these are the individuals who are offered the studied services. Prevention and early intervention efforts could be improved if intensive intervention services were offered to individuals during their initial crisis and subsequent research was done to determine whether intensive early intervention prevents individuals from entering a cycle of reoccurring crisis. For example, the Washington State Legislature designated funding to be used on PACT programs to reduce the need for state psychiatric hospital beds.¹⁴⁰ The PACT programs in Washington will most likely be available only to those who are the most frequent hospital users¹⁴¹ because the program was designed for these users and the program is expensive to implement. More thought and research needs to go into what type of intensive interventions should be used at an initial crisis, whether that crisis is hospitalization, homelessness, or incarceration, because there appears to be very little program experience and research done with early crisis intervention. Providing intensive support services to individuals during their first

crises, such as after their first hospitalization rather than after multiple, frequent hospitalizations, may be the best way to prevent reoccurring crisis and reduce the devastating impacts of mental illness.

IV. OLDER ADULTS

Too often, common mental disorders in older adults, such as depression or anxiety, are not recognized for what they are. They are mistakenly seen as just a normal part of growing old and not properly addressed.¹¹⁸ Older adults typically go through numerous life changes that can trigger distress. Sources of stress may include the death of a spouse, deaths of friends, loss of mobility, and the move from one's home to a nursing home or other assisted living arrangement. Leaving a job, moving to a new community, becoming infirm and possibly housebound—these transitions and more can contribute to a loss of social connectedness. Experiencing a loss of mental functioning or serious physical illness can lead to depression. The onset of dementia can mask or compound other mental illnesses, which can make diagnosis and treatment difficult. Advocates for older adults report that the DSM-IV-TR criteria for several mental illnesses do not fit the symptoms commonly displayed and reported by older adults experiencing mental health problems.

Almost one in five adults age 55 and older experience a mental disorder that is not a normal part of aging.¹¹⁸ The most common mental disorder among older adults is anxiety, followed by severe cognitive impairment and mood disorders.¹⁴² Schizophrenia and personality disorders are less common in this population.¹⁴² Suicide rates are higher for older adults than any other age group.¹¹⁷

Prevention or early intervention is possible for some mental disorders in older adults, though not for all.⁸⁹ Some types of cognitive impairment are amenable to prevention and early intervention. For example, cognitive impairment caused by stroke can be prevented through physical health promotion and early intervention starting with middle-aged individuals. Other types of cognitive impairment, such as Alzheimer's, are less amenable to prevention and early intervention because we do not know enough about the cause of the disorders. Individuals suffering from any type of cognitive impairment could benefit from early intervention designed to reduce negative physical and emotional impacts of coping with the impairment.

Anxiety and mood disorders, two very common mental disorders in older adults, are quite amenable to prevention and early intervention. Prevention of disorders such as anxiety and depression can be successful if efforts are implemented at junctures that are likely to trigger distress, such as loss of a spouse, diagnosis of a serious physical condition, or loss of independence.⁸⁹ Research shows that treatment of depression in older adults increases physical functioning and decreases risk for loss of independence.¹⁴³ Early intervention and treatment of mental disorders in older adults can prevent excess disability and premature institutionalization.⁷

Older adults have the lowest utilization of mental health services of any age group.¹⁴² Less than 3% report seeing a mental health professional for treatment. There are several explanations for this low utilization rate, including stigma around seeking mental health services, which is very strong for older adults. A second reason treatment may not be sought is failure to recognize the

symptoms of mental illness if those symptoms are confused with the symptoms of another condition. In addition, family, friends, doctors, and older adults themselves often believe that symptoms of mental illness are a normal part of aging; therefore, treatment is rarely sought for this group even though many mental disorders can be successfully treated. Finally, lack of access to care for this group is an important issue. Two access barriers are lack of financial access and lack of contact with the community. Social isolation is a widespread concern for older adults. Identifying isolated individuals and connecting them to services often requires innovative outreach efforts.¹⁴²

Primary care physicians carry much of the burden for identifying mental disorders in older adults, partially because older adults prefer to see their primary care doctors for mental health concerns.^{7,144} More than half of older adults who receive mental health care receive it from their primary care physicians.¹⁴² Mental illness diagnosis and treatment in primary care, however, is not adequate for older adults.^{7, 142} Physicians tend to under diagnose mental illness in older adults and often prescribe inappropriate psychotropic medications when symptoms are recognized. Inability to recognize depression is particularly troublesome. Up to 70% of older adults who committed suicide had seen their primary care doctors within one month of the suicide. A commonly held belief in medical practice is that depression is a normal part of aging. This belief leads to a clinical approach that does not encourage the physician to identify the signs of depression and to recognize that treatment of depression can reduce overall disability.¹⁴²

Diagnosis of late-life mental disorders is challenging because older adults have several characteristics that are distinct from other age groups.⁷ For example, older adults are more likely to present emotional symptoms as somatic symptoms and they are likely to have multiple physical disorders. The combination of these factors can make it difficult to make an accurate diagnosis. A third complicating factor is that older adults often do not meet the full DSM-IV-TR criteria for anxiety and depression, although their symptoms are quite debilitating and need treatment. Primary care physicians who regularly treat older adults need to have specialized training to recognize and treat late-life mental disorders or they need to have specialists integrated into their practice to assist them.

Support for family members caring for older adults is necessary to prevent premature institutionalization of older adults and to prevent mental disorders in their caregivers. Family members are the main source of care for older adults living in the community.¹⁴² One out of every four households in the U.S. provides care for a family member or friend over the age of 50.¹⁴² The average age of these caregivers is over 60, and three-quarters of them are women.¹⁴² The stress of caring for a family member often has a significant impact on the mental health of the caregiver; 46% of caregivers are clinically depressed.¹⁴² Studies indicate that caregiver support programs can improve the emotional health of the caregiver and postpone nursing home placement.¹⁴² Support programs include respite care, support groups, specialized information and training, counseling, and care planning.¹⁴² Postponing removal of older adults from their homes is important because living in their own homes is best for the physical and mental health of older adults if that is what they wish to do.⁸⁹ Residential homes can be harmful to older adults because of the level of apathy, helplessness, withdrawal, and disorientation among residents.⁸⁹

Social isolation and physical inactivity are risk factors for mental illness in older adults.¹⁴⁵ Health promotion programs that target younger older adults have been shown to be effective with increasing activity levels and positive views on aging.⁷ One health promotion concept is to encourage adults to prepare for aging through building a social portfolio. This concept encourages adults to find satisfying individual and group high-energy activities and low-energy activities that can become routine in their lives. Wellness programs for older adults are another health promotion activity. These programs can be held in community settings that are comfortable for older adults. The programs can contain information about mental wellness, including education about what are normal and abnormal parts of aging. The programs can also connect older adults with mental health professionals if such contact is needed.

Older Adult Focus Group

The Washington State Board of Health and the Mental Health Transformation Project held age-specific focus groups to inform policy staff in preparing this report. One focus group was held for older adults. Participants came from a variety of agencies and service organizations.¹⁴⁶ This section provides a summary of the focus group's discussion on what works in Washington, what needs to be changed, and what policies or programs would be beneficial next steps toward an improved mental health promotion system and mental illness prevention system for older adults.

Focus group participants agreed on several societal attitudes about older adults that need to change before an effective prevention and early intervention system can be built for older adult mental health. One belief that must change is the misconception that older adults do not need help with mental health concerns because failing mental health is a normal part of aging. It is especially important that this attitude change among primary care providers who are in a position to identify older adults with mental illness. This misconception leads to less attention and less money for older adult mental health. For example, much more attention is given to youth suicide than suicide among older adults even though older adults have a suicide rate that is much higher than all other age-groups. In addition, mental health funding is not fairly allocated to older adults based on their proportion of the population.

The focus group identified important components of successful prevention programs for older adults. One key to successful prevention programs is the recognition of the unique needs of this population. For example, it is important to create services that go to the older adult instead of expecting the older adult to travel to the provider. A second successful component is early identification of cognitive impairment and the early provision of support for these individuals. Finally, a good prevention system would be culturally appropriate to the population it intends to serve.

Focus group participants named many programs that currently work well. Programs that provide mental health services in the homes of older adults were identified as successful models because this approach reduces stigma associated with the service, and it eliminates the physical access barrier. The Program to Encourage Active, Rewarding Lives for Seniors (PEARLS), which is listed as a DSHS evidence-based program, was mentioned as a program that provides in-home therapy and follow-up for individuals with mild depression. PEARLS has also been tailored for the needs of different cultural communities. The Geriatric Regional Assessment Team (GRAT),

a King County program, provides in-home psychiatric assessment and crisis stabilization. Snohomish County also offers in-home geriatric depression screening and in-home counseling. In Snohomish County, individuals are identified for services mostly through family member referrals or through senior centers. In-home care provided through programs such as the Medicaid COPES program work well to help individuals with functional impairments remain in their homes.

There are several other programs that work well for prevention and early intervention for older adult mental illness. Programs that integrate geriatric psychiatry into primary care practice provide one example. Studies have shown the Improving Mood—Promoting Access to Collaborative Treatment (IMPACT) Model to be successful. This model places specialists in geriatric mental health in primary care practices. Older adults receive assessment and treatment in the primary care office.

Programs that do outreach to isolated adults, such as the Gatekeepers Program,¹⁴⁷ are also successful. The Gatekeepers Program, which was developed in Spokane County and is nationally recognized, trains postal workers, utility workers, bank tellers, and other professionals who have regular contact with older adults to identify and refer older adults suffering from mental disorders.

Finally, programs that support family caregivers of older adults also work well. One successful model is the Gentle Care Model, which teaches caregivers how to work with older adults suffering from dementia.

There was consensus among focus group participants that several system changes are needed. One important systems change is to have parity in the reimbursement rates for mental health and physical health and to allow exceptions to standard reimbursement rates for individuals who need higher levels of care due to mental illness. A second system change needs to occur with diagnostic screening for services. Older adults often do not meet the full DSM-IV-TR criteria designed for younger adults. This leads to the exclusion of older adults from needed services even when the illness is causing substantial impairment. A third system-wide concern for focus group participants is that dementia is not always seen as a mental illness. This causes serious problems because individuals with dementia often need mental health services.

Focus group participants agreed on four next steps to creating an improved prevention and early identification system for mental illness in older adults.

- **Increase Earmarked Funding for Older Adult Mental Health.**

Participants agreed more funding earmarked for older adult mental health is a good next-step. Funding should be flexible and should come with the recognition that services to older adults are very time intensive. Funding should also come with a growth plan to account for the growing population of older adults.

- **Create a Social Marketing Campaign to Reduce Stigma.**

Focus group participants would like to see a social marketing campaign for older adults to reduce stigma. Campaign planners should consider using an alternative to the term mental health.

- **Draw Statewide Attention to Aging.**

Focus group participants would like a statewide campaign to bring attention to aging. The campaign should include information on healthy aging. It should also include the concept of elder-friendly communities, which are communities that consider and accommodate the needs of older adults when designing things such as the built environment and mechanisms for social engagement.

- **Increase Outreach to Older Adults to Bring Them into Care.**

Focus group participants agreed professionals need to be paid to do case finding for older adults. Outreach needs to be done in homes and services need to be provided in homes. Gatekeepers is a good example of a successful outreach effort.

The literature supports several policy suggestions that emerged from the older adult focus group. First, there is support for the notion that the public needs to be educated to change societal attitudes about mental health in older adults, particularly the misconception that deteriorating mental health is a normal part of aging.¹⁴² There is also support for the notion that stigma is a serious barrier to care for older adults. The literature also supports outreach programs to connect isolated older adults with mental health care. The Gatekeepers program mentioned above is an example of an innovative approach to outreach.¹⁴² A study of the Gatekeepers program showed that referred clients were more engaged with support services and had reduced cognitive impairment one year after the referral.¹⁴² Other outreach strategies include case identification by public health nurses and advertising through the media and mail.¹⁴²

The literature also supports strategies not identified as next steps by the focus group, although several of these emerged from the focus group as changes that need to be made. The literature supports either training primary care doctors to effectively treat and identify mental illness in older adults or to integrate trained specialists within primary care practices. It also identifies support for those caring for older adults as an important intervention. Support for caretakers can also prevent or relieve mental disorders in caretakers.

Thought should be given to how effective mental illness treatment and interventions can be used for prevention and early intervention. One strategy to use effective practices for prevention and early intervention is to implement them at junctures when mental health is most likely to be compromised for older adults.⁸⁹ These junctures include loss of a spouse, diagnosis with a serious physical condition, and relocation out of one's own home. Providing support, whether it is peer or professional, at these critical junctures can prevent the development of mental illness.

PART 3 INTEGRATION

The goal of this document is to describe a public health approach for mental illness prevention and to spark a dialog about how to advance such an approach. The dialog will lead up to a May 13, 2008, summit that is intended to produce policy recommendations. Part 1 describes the public health approach and provides some examples of how it could be applied to mental illness prevention and mental health promotion. Part 2 describes characteristics and needs of five age-specific groups that, when combined, represent the human lifespan. Looking at age-specific populations provides a way to break a complex analytical task into discrete, manageable elements. It also makes certain the analysis addresses the ways that each group is distinct and does not shortchange any groups. The goal of this effort, however, is to articulate a vision for a *system* that protects and promotes mental health across the lifespan. The Prevention Advisory Group and the authors of this report, therefore, believe it is critical to identify overarching issues and common themes that cut across age groups. These cross-cutting themes may suggest to participants at the May 13, 2008, summit some policy approaches that would create and maintain an integrated system across the lifespan.

To assist with this process, the Mental Health Transformation Group sponsored a second prevention day, a daylong work session that took place on November 9, 2007. A group of 45 to 50 professionals and consumers, many of whom participated in the first prevention day, received advanced copies of an early draft of Parts 1 and 2 of this report. At the second prevention day, participants reviewed a preliminary list of cross-cutting themes identified by a planning group that was comprised of staff from the Board, the MHTG, and the Department of Health, as well as a professional facilitator. Participants concurred with most of the items on the list, suggested wording changes for some items, and added themes. They also provided input about strategies for institutionalizing communication and coordination and ways to prioritize investments in prevention. If communication and coordination can be institutionalized, multiple state agencies will have a mechanism to agree on shared outcomes and can then work together to prioritize investments based on work to achieve the outcomes.

I. CROSS-CUTTING THEMES

A review of the literature, an analysis of input from the age-related focus groups, and feedback from the second prevention day participants produced a list of 14 cross-cutting themes. In no particular order, they are

- institutionalize communication and coordination around shared outcomes;
- market mental wellness and stigma reduction;
- increase funding flexibility;
- leverage existing funding sources;
- assess community risk and protective factors;
- screen at multiple points of entry;
- provide care based on need;
- ensure age-appropriate services are available;

- provide culturally competent services;
- meet people where they are;
- support transitions across the lifespan;
- provide mental health consultation;
- increase and improve provider training; and
- create trauma-sensitive or trauma-informed systems

Each of these themes is briefly discussed below.

- **Institutionalize communication and coordination around shared outcomes**

A theme that emerged strongly and repeatedly from the focus groups, Prevention Advisory Group discussions, and the literature is the need to coordinate services across systems and agencies. Such coordination would increase effectiveness and efficiency; eliminate redundancy; reduce turf struggles; and prevent people, programs, and policies from falling through the cracks. If agencies in various systems have a way to communicate and coordinate, they will be more likely to build consensus on outcomes. A related theme that emerged is the need to create a mechanism for collecting data across various systems and sharing data and analysis across various systems. Both of these themes will be addressed in a separate section below on communication and coordination around shared outcomes.

- **Market mental wellness and stigma reduction**

Social marketing seeks to influence the attitudes and behaviors of a target population by employing some of the same techniques used to sell commercial products.¹⁴⁸ The best known examples are advertising campaigns aimed at tobacco-use prevention and cessation. Social marketing is designed to influence the social behavior of members of the target audience for their own benefit and the benefit of society as a whole; it is not specifically designed to benefit the marketer. Social marketing can be used to change the behaviors and attitudes of society on a large or small scale. A campaign could target the entire United States, a small community, or a particular subpopulation such as teachers.

Participants in the focus groups repeatedly expressed the belief that our society does not understand the mental health problems or needs of particular age groups. For example, people often do not realize that very young children have mental health needs and can experience mental illness. A social marketing campaign could increase understanding of infant mental health through advertising and related techniques. Professionals can also be educated through social marketing efforts; for example, geriatric health care providers who mistakenly believe that mental illness is a natural part of the aging process can be educated to recognize and screen for mental health problems and to intervene earlier. Australia currently runs a mental health promotion campaign¹⁴⁹ that includes messages aimed at different age groups. This campaign includes radio, television, and posters that encourage strategies individuals can use to promote mental health.

In addition to mental health education, a successful campaign would address stigma. Again, campaign messages may need to be modified for different age groups. For example, the current generation of older adults has stigma issues around mental illness that are different than younger generations. The Washington State Mental Health Transformation Project has contracted with the Office of Health Promotion at the Washington State Department of Health to develop a social marketing initiative to address stigma and promote recovery.¹⁵⁰ The theme of the initiative is “Recovery happens: Be part of the change.” Its purpose is to eliminate stigma in the work setting, at home, within the healthcare system, and in the community. The plan for the initiative was developed in November 2006 and specific activities are currently being implemented. One key strategy of the initiative is a speakers’ bureau and workshop, which combines the personal narratives of consumers with discussion around how to promote recovery and reduce stigmatizing attitudes, behaviors, and practices within the mental health community. A second strategy is a news bureau and editorial board that will respond to stigmatizing media portrayals of mental illness and encourage positive stories of recovery. A third key strategy is a survey of mental health professionals from multiple disciplines to identify current competencies and potentially stigmatizing attitudes towards persons with mental illness. This survey includes an assessment of implicit or unconscious biases that may affect the attitudes and behaviors of mental health professionals in terms of recovery-oriented practice.

A third issue identified among the age-specific focus groups was the reluctance to ask for help when it is needed. A comprehensive social marketing campaign should encourage people at all income levels and in different stages of knowledge about their emotional distress to seek help. The MHTP social marketing campaign is producing a consumers’ guidebook to the mental health system with tips on how to find appropriate services. The guidebook addresses thoughts and worries a person may have in deciding to ask for help. It provides guidance in how to ask for help and how to be persistent to find help that is a good fit for one’s needs. A second example of a strategy to encourage help-seeking is the Speak Up When You’re Down Campaign,¹⁵¹ a public awareness effort in Washington that encourages help-seeking behavior in postpartum women and their partners. The campaign includes a call-in support line, posters, brochures, and a Web site.

- **Increase funding flexibility**

Flexible funding streams can support more efficient and effective program models than categorical funding streams, yet many existing funding streams for mental health are not flexible. Categorical funding streams are created with a narrow view of the needs of a population, which often leads to providing services in an inefficient manner. There are many instances when this inefficiency occurs. At times it may be best to provide two or more service types simultaneously to a client, such as multiple types of therapies for different but related problems, but a provider may find it difficult to bill if the funding for each service is from two different categorical funding sources. Funding that is flexible enough to allow for co-treatments would result in more effective service provision.

Flexible funding could also be used to deliver services in a manner that addresses access problems. For example, flexible funding for services to older adults could be used to provide in-home services for clients who are unable or unwilling to travel to the provider.

Categorical funding that does not allow providers to address problems in a proactive manner may lead to a greater expenditure of resources. For example, Children's Administration provides services to foster parents of children with mental illness, but it cannot provide the same services to the parents of those children before placement. Providing such services to parents has the potential to prevent placement, which is more expensive and may cause greater distress for children and families.

- **Leverage existing funding sources**

Additional work needs to be done to identify ways existing funding streams—particularly federal dollars—can be better utilized to support prevention and early intervention strategies. A prime example would be better utilization of Medicaid's Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. EPSDT covers primary care developmental and mental illness screenings for children on Medicaid. Treatments for conditions identified through such screenings are also covered. In Washington, the federal and state governments each pay about 50% of Medicaid costs, although the portion of federal funding may be higher for some categories of coverage.¹⁵²

Medicaid providers do not consistently perform developmental or mental health screenings, however, and children identified with mental illness or at risk for mental illness do not consistently receive follow-up and referral. While underuse of screenings and failure to follow-up on the findings is not unique to the Medicaid population (a national study found that children with major depression did not consistently begin treatment with psychotherapy and/or antidepressants within two weeks of diagnosis¹⁵³), the state has a variety of tools available to drive utilization of EPSDT. These include reimbursement policies, provider education, and performance contracting. Some Medicaid providers may not refer a child for treatment because the child does not meet the access to care standards for categorical children's mental health programs and may not realize that EPSDT allows for reimbursement as part of standard Medicaid coverage.

- **Assess community risk and protective factors**

Robust and regular assessment of local community risk and protective factors would better inform local interventions. Reducing risk factors and strengthening protective factors can address several disorders in one intervention because many disorders have common risk and protective factors. One strategy to assess local risk and protective factors is the Healthy Youth Survey. This survey, which is conducted through a collaboration of state agencies, collects self-reported information from middle and high school students across the state. The survey includes questions on emotional, behavioral, family, and academic factors. Similar surveys could be developed for individuals across the lifespan. Like the Healthy Youth Survey, which is administered in schools, the survey would need to be administered in settings where cross-sections of the population already

gather. For some age groups, a survey may need to be administered in a variety of settings to capture information on the whole population. Information from the survey could be used by communities to develop interventions that address the factors and individuals that are most in need of attention in their area.

- **Screen at multiple points of entry**

Conducting mental health screenings at points of entry into multiple systems could identify problems and make it possible to connect individuals with appropriate services as early as possible. A key example would be integrating mental health screening into medical care settings, particularly primary care. Existing funding sources such as EPSDT and private insurance support such screening for children, but screening is not consistently done. Screening should also be done for youth in transition; adults, especially adults who have children; and older adults. Screening through the medical home approach to primary care could be especially effective because medical home providers would ideally have a familiar, long-term relationship with families and would be prepared to coordinate any needed mental illness treatment.¹⁵⁴ Materials that include screening tools have been developed to assist medical providers with screening, such as Bright Futures in Practice: Mental Health. For children, screening should include mental health screening for parents and other primary caregivers because mental health for children is based on a healthy relationship with their caregivers. For older adults and young children, mental health screening should be done by providers with adequate training to screen individuals in these age groups. In addition, programs that integrate mental health professionals into primary care practice can provide an effective way to do screening and referral. Healthy Steps is one such program for children. Improving Mood—Promoting Access to Collaborative Treatment (IMPACT) is a model for older adults; this model integrates geriatric psychiatry into primary care.

Screening should be done at points of entry into other systems as well, especially because screening through primary care will only reach individuals who are able to access primary care. Screening could be done at entry into child care systems and schools to connect children with appropriate services as early as possible. For older adults, screening could be done through involvement in community programs such as senior centers or at entry into institutionalized care. In addition, there should be adequate screening at points of entry into systems associated with high risk for mental illness, such as the foster care system, the juvenile justice system, and the adult justice system. Screening in systems associated with a high risk for mental illness could connect individuals with services that will reduce trauma for the individual and possibly reduce long-term cost for the system.

- **Provide care based on need**

There is a need to reframe systems of care to provide help based on need, not solely on diagnoses. The current government-funded mental health system provides eligibility if someone is in crisis or meets the criteria of a qualifying diagnosis. A diagnosis-based system does not directly assess the extent to which individuals need services. Diagnostic

criteria are a grouping of symptoms, not a measure of need. Even if individuals do not meet certain diagnostic criteria, they—and society—may benefit significantly from the delivery of services. For some age groups, such as young children and older adults, the diagnostic criteria of the DSM-IV-TR are often inappropriate for describing or reflecting symptoms and disability. In addition, a purely diagnosis-based system can lead to arbitrary discontinuation of services. For example, children who receive mental health services through Medicaid may lose services when they reach adulthood because they do not meet the adult diagnostic criteria required to receive services.

- **Ensure age-appropriate services are available**

It is critical that age-appropriate services are available across the life span. Mental health treatment and diagnosis needs to be age or developmentally appropriate to be effective. For infants and young children this means appropriate tools must be used for diagnosis, which may mean use of an age-specific tool such as the *Diagnostic Classification of Mental Health and Developmental Mental Disorders of Infancy and Early Childhood* (DC:03) rather than the *Diagnostic and Statistical Manual* (DSM-IV-TR). Providers trained in early childhood mental health should diagnose and treat young children. Similarly, older adults require providers who are adequately trained to diagnose mental illness for their age group since older adults tend to report and experience symptoms differently than adults and they often have co-occurring physical conditions. For youth in transition to adulthood, age-appropriate treatment means working with providers who have been trained to work with adolescents. It also means placing youth with their peers in treatment settings designed for their needs, rather than placing young adults in treatment settings designed for adults. For youth in transition, programs designed to help them successfully transition to adulthood can be especially effective.

- **Provide culturally competent services**

Improving the availability of culturally competent services has the potential to help reduce the disparity in the unmet need for mental health services among communities of color. There are several organizations that offer culturally competent mental health services in Washington, such as SeaMar and the Asian Counseling & Referral Service. In addition, efforts have been made to provide established programs for the general population, such the Program to Encourage Active, Rewarding Lives for Seniors (PEARLS), in a manner that is culturally competent. However, additional efforts should be made to provide culturally competent services to meet the unmet need for services in communities of color.

- **Meet people where they are**

There should be adequate outreach and treatment programs that serve individuals where they form communities. Programs that reach individuals in their usual community settings or in their individual homes are beneficial because they reduce access barriers to services and reduce the stigma associated with receiving services. There are multiple examples of such services in Washington. School-based health centers provide mental

health screening and services in the usual community setting for school-age children and by doing so they reduce access issues for these children and reduce the stigma associated with receiving mental health services. Stigma is reduced because students enter a clinic that is for both physical and mental health, which means they can receive mental health services without revealing this to classmates. Greater stigma would be associated with visiting an off-site specialized mental health center.

The WELCOME BABY! Program in Skagit County provides another example of outreach in the community. This program sends a trained mental health professional to the community hospital to greet newborns and their mothers/families. While offering support such as a mother/baby group, a parenting class, and information on child development, the mental health professional is able to assess family interactions and the mental health of the new parents. The program is able to offer some individual support and referrals to families if that is needed.

- **Support transitions across the lifespan**

Transitions can be stressful times for individuals; for this reason, periods of transition offer an important opportunity to prevent mental illness and reduce its devastating impact. Age-related transitions can occur at many points, including the transition into a school system, the transition out of the school system and into independence, the transition from Medicaid's child mental health system into the adult system, the transition out of working life into retirement, and the transition into institutional care late in life. Continuity of care support is important at these times; for example, providing continuity between the child and adult Medicaid mental health systems can prevent disruptions in care. A second example of transition supports are programs designed to prepare soon-to-retire or recently retired individuals for healthy living as older adults. Such programs can be effective by providing education on older adult mental health and by emphasizing the need to find social support and enjoyable physical activity.

In addition, support services at important junctures, such as release from a hospital or moving out of homelessness or incarceration, are important to both prevent relapse and reduce the devastating impacts of mental illness.

- **Provide mental health consultation**

Mental health consultation can be an effective way to address mental health needs in multiple systems. Mental health consultants can provide support for providers in multiple systems to help providers work more effectively with individuals who have mental illness, which may keep these individuals involved in systems that provide community support and connections. For example, mental health consultation to child care providers is an effective tool to assist child care providers in finding effective ways to help children with behavioral and emotional problems, which can reduce the number of children asked to leave child care. Keeping children engaged with child care means keeping them engaged with social and emotional learning opportunities that may help them to be more successful in school and in relationships.

Mental health consultation could be used to assist any system that routinely works with individuals affected by mental illness or at risk for mental illness that does not currently have an adequate amount of mental health support integrated into it. Such systems might include some schools, medical facilities/providers, and institutions for older adults. Mental health consultation in these systems could help identify individuals with mental illness for early intervention, and it may prevent individuals affected by mental illness from being excluded from the system.

- **Increase and improve provider training**

Providers in multiple systems can work more effectively with diverse individuals if they have adequate training in mental health, especially training specific to the population they primarily serve. The few examples below are intended to briefly describe how mental health training would benefit providers and the populations they serve; it is not meant to be an exhaustive list of providers and systems that might benefit from such training. That list could be very long, as evidenced by an Australian program now being adopted in some parts of the United States that teaches mental health first aid to the same populations that might receive traditional first aid training. Mental health first aid is intended to provide help to individuals experiencing a mental illness crises or experiencing distress from the development of a mental illness. The first aid is used to assist the person until professional treatment is received or the crises resolves.¹⁵⁵

Child care providers, school teachers, after school providers, and other providers that work with children are more effective if they have adequate training in child development. Such training would help these providers understand how social and emotional learning is critical to each child's success. With providers trained in child development, systems that primarily work with children can more readily implement social and emotional programs and standards, such as anti-bullying programs or social and emotional learning standards like those adopted by Illinois. Teachers and other providers would be more able to work with children who have diverse social and emotional needs, which may prevent some children from being excluded from systems that offer them social/emotional and academic opportunities that are critical for their success.

Providers that work primarily with older adults would be more likely to recognize ways they could intervene to prevent or treat mental illness in their clients if they had adequate training in geriatric mental health. Trained providers would be more likely to understand that illnesses such as depression and anxiety are not a normal part of aging and can be effectively treated. Such treatment is likely to reduce disability for older adults. In addition, these providers could recognize opportunities to promote mental health and prevent mental illness for older adults by arranging for appropriate support at transition times, such as loss of a spouse, diagnosis of a major physical illness, or transition into institutional care.

Providers in systems that serve populations at particularly high risk for mental illness could be more effective if they have adequate training in mental health. Such systems include the foster care system, the juvenile justice system, and adult justice systems.

- **Create trauma-sensitive or trauma-informed systems**

A trauma-informed system effectively engages and assists individuals who have suffered from trauma. A system can be trauma-informed regardless of the type of services it provides; for example, it might provide mental health services, substance abuse services, housing assistance, employment assistance, or education. A trauma-informed system is one that has a commitment to providing services in a manner that is welcoming and appropriate for individuals who have suffered trauma; it does not mean that the system is designed to treat trauma or related issues.

The mental health system and mental health consumers are likely to benefit from a mental health system that is trauma-informed. A trauma-informed system may be more effective in engaging consumers and ensuring that its services do not re-traumatize consumers who have suffered from trauma. For example, it will evaluate provider-patient relationships to ensure these relationships do not replicate abusive relationships in any way, which means ensuring that consumers are respected and treated as partners in decision making. It also means evaluating practices in hospitals and the practice of hospitalization itself when alternatives are available.

Trauma-informed systems have the potential to prevent further trauma and reduce the devastating impacts of trauma. Many systems and service providers may have more effective interactions with service recipients by altering their practices to be trauma-informed; some of these systems and service providers include child care facilities, schools, housing programs, hospitals, the foster care system, and nursing homes. Trauma-sensitive school systems were discussed earlier in this report.

II. COORDINATION & COMMUNICATION AROUND SHARED OUTCOMES

Most members of the Prevention Advisory Group chose to participate because they were already involved with organizations that provide prevention-oriented or mental health promotion services. Participants in the focus groups and the prevention days had no trouble identifying programs and policies already in place in this state that take a public health approach to mental illness prevention. But there was also broad agreement that these individual pieces taken together do not add up to a *system* for prevention and that prevention and promotion could be much more efficient and effective if coordination and communication were improved. Designing a system to institutionalize a coordinated approach to prevention likely would require addressing such related issues as leadership, governance, accountability, promotion of partnerships, common data collection and sharing of both data and analyses, and a shared research agenda.

An important benefit of institutionalizing coordination and communication is that it would create a mechanism for multiple agencies and systems to agree on shared outcomes and work together

to prioritize investments based on work to achieve the outcomes. Part of the work in building consensus on shared outcomes would be creating indicators to measure progress toward attainment of the outcomes.

Some prevention day participants felt it would be important to build on current efforts and recent successes in efforts to increase coordination and communication in prevention. The Department of Early Learning, King County Care Partners, the Family Policy Council, Child Mental Health Institute, the Children's Trust, Thrive by Five, Partners for our Children, and the Community Public Health and Safety Networks were all mentioned as efforts on which to build. Public health agencies were also mentioned as sources of strong leadership in prevention.

Many prevention day participants said we need to have data systems that are shared across agencies. This is in contrast to current systems, which generally operate as independent silos. A shared data system would help identify successful programs in local communities so the programs could be disseminated statewide. In addition, we need to have shared outcome measures and shared expectations.

Most prevention day participants supported the notion of creating some sort of a statewide entity to formalize and institutionalize coordination and communication. Some suggested establishing a new interagency coordinating council at the state level comprised of one representative from each agency or system that has a piece of the mental illness prevention and mental health promotion puzzle. Some suggested that an existing agency might be altered in some way—by expanding its scope, say, or modifying its governance structure—to perform this function. This entity could disseminate research, train agencies in partnership, and advise on leadership. Participants suggested that any agency or group charged with coordinating prevention activities should include consumers, and it should be designed to preserve a level of community autonomy so communities can develop local solutions to local problems.

It is important to note that neither of the two entities that have taken a lead in developing this report and putting on the summit—the State Board of Health and the Mental Health Transformation Project—are able, under their current authorities, to provide this coordinating function on an ongoing basis. The Board develops rules, serves as a public forum, recommends policy, and explores ways to improve the health status of the citizenry, but it does not operate ongoing programs. MHTP will exist only during the life of its five-year federal grant.

There are many models for a coordinated approach to prevention; it is beyond the scope of this document to discuss them all. However, there is a brief discussion below on six examples of different but overlapping approaches already adopted in Washington State: the public health system, the Family Policy Council, the Children's Trust of Washington, the Division of Alcohol and Substance Abuse, the Office of Superintendent of Public Instruction, and the Governor's Council on Substance Abuse. None of these systems is currently trying to address mental illness prevention and mental health promotion in a coordinated, comprehensive manner across the entire lifespan, but they represent some existing approaches that could be built on or borrowed from to develop an infrastructure that could sustain communication and coordination.

1. The public health system

Public health agencies in Washington provide critical programs and services for all people in the state—from drinking water protection to disease prevention. The public health network coordinates at the local, state, and national level to keep our communities healthy and safe. Local health jurisdictions provide services and policy development at the local level. They are often county health departments, but may be a health district that is governed by a local board of health that includes people other than the county commissioners. Some districts provide services for more than one county; others are combined city-county agencies. The State Board of Health adopts most statewide rules implemented by local jurisdictions, and the Department of Health also enacts some rules, provides coordination and technical assistance, and operates some statewide programs. Both the Board and the Department engage in policy development.

Despite local control, communication and collaboration between public health agencies is institutionalized and very effective. Local health officials coordinate through their professional association, the Washington State Association of Local Public Health Officials (WSALPHO) and its various professional forums. The Board and the Department of Health participate as guests in most WSALPHO activities. Local public health officials and elected officials who serve on local boards of health are represented on the State Board of Health, and the Department of Health works collaboratively with local health jurisdictions on issues of mutual interest.

The state Legislature in 1992 established a process to create and regularly update a Public Health Improvement Plan. Members of the Public Health Improvement Partnership (PHIP) include local health jurisdictions, the Board, the Department, the University of Washington's School of Public Health and Community Medicine, and the Washington Health Foundation. Tribes and elected local officials have also participated. PHIP subcommittees have worked statewide on such issues as communications, performance measures, health indicators, access to care, information technology, financing, and workforce development. The PHIP has collaboratively established a set of standards for all public health agencies in the state, and state and local agencies are evaluated against those standards every two years.

In 2007, the Legislature approved \$10 million a year in additional state funding for local public health activities. It instructed the Department to consult with PHIP members and other partners to develop a set of statewide performance measures for evaluating the effectiveness of the new funds, as well as a list of core services and activities that should be available across the state.

Throughout the public health system, governance and administrative systems provide considerable autonomy to local agencies while also ensuring there is collaborative statewide planning, evaluation, and policy making. Despite their independence, local agencies have agreed to be accountable to the state for providing a core set of high-quality services in every jurisdiction.

2. Family Policy Council

The Legislature established the Family Policy Council in 1992. The stated purposes of the authorizing legislation are “(1) to modify public policy and programs to empower communities

to support and respond to the needs of individual families and children and (2) to improve the responsiveness of services for children and families at risk by facilitating greater coordination and flexibility in the use of funds by state and local service agencies.” The Council is charged with providing family-oriented and culturally relevant services that are responsive to the self-identified needs of families and take into account the changing nature of the family.

The Council works with and through community public health and safety networks throughout the state. The local networks develop comprehensive plans for their communities. They identify local problems—such as child abuse and youth substance abuse—and fund local efforts to provide prevention and early intervention. They may also recommend policy changes to state and local systems serving children and families. They are community-based organizations governed by volunteer boards.

The Family Policy Council itself reviews and approves local plans; provides funds to implement the plans; offers technical assistance; and facilitates communication, coordination, collaboration, and policy development. Members of the Council include representatives of the Governor’s Office; the Office of Superintendent of Public Instruction; the departments of Health, Social and Health Services; Employment Security; Community, Trade, and Economic Development; and four legislators (one each from the Democratic and Republican caucuses of the House and Senate).

3. Children’s Trust of Washington

Children’s Trust was known formerly as the Washington Council for Prevention of Child Abuse and Neglect. The Legislature renamed it in 2007 when it created the Children’s Trust Fund of Washington, a dedicated state fund set up to accept public and private donations. However, the organization could be renamed again during the 2008 legislative session. Children’s Trust manages the Children’s Trust Fund; develops and maintains a statewide network of community-based programs to support families and promote healthy child development; funds local community-based programs; provides training, peer-to-peer support opportunities, technical assistance and program evaluation services; and partners with other groups to increase public awareness around issues like shaken baby syndrome and postpartum depression. Children’s Trust is governed by a 15-member council. The council includes seven members appointed by the Governor and four legislators. The four legislators must include members from both parties and members of both the House and Senate. The council also includes representatives from the Department of Early Learning, the Department of Health, the Department of Social and Health Services, and the Office of Superintendent of Public Instruction.

4. Division of Alcohol and Substance Abuse

Washington has a strong, community-supported prevention effort within the alcohol and substance abuse services field. The state Division of Alcohol and Substance Abuse (DASA) has been a leader since the 1980s in advancing a public health approach to preventing substance abuse. With federal block grant funds, competitive grant awards, and state funding, the state finances county-level prevention coordinators, conducts data collection and local planning, and purchases a variety of service strategies. The leaders within the DASA prevention effort have

strong connections to other systems, such as education and community development, but do not have direct ties with the mental health system. Strategies used within the DASA prevention effort consider the needs of children, infants and mothers, adolescents, and older adults. The DASA and county prevention efforts are the most mature social service prevention efforts in the state, and it is the only other system besides the public health system that has both a central planning effort and a local presence. Additionally, the DASA prevention effort was modeled on the risk/protective factor work at the University of Washington's Social Development Research Group, which pioneered a public health approach to delinquency and substance abuse prevention. The state and local coordinators also conduct major prevention events and influence policy through the Governor's Council on Substance Abuse.

5. Office of Superintendent of Public Instruction

The Office of Superintendent of Public Instruction (OSPI) offers a variety of prevention programs through local school districts and conducts coordination with other agencies involved in prevention activities. The Readiness to Learn (RTL) program, administered by OSPI, is part of the Education Reform Act enacted by the 1993 Legislature. Its primary purpose is to link education with human service providers in an effort to remove nonacademic barriers to learning so that all children are able to attend school prepared to learn. The effort creates a committed, ongoing partnership among schools, families, and communities. The partnership provides opportunities for all young people to achieve at their highest potential; live in a safe, healthy environment; and grow into productive community members. The project is coordinated at the state level and provides grants to multiple school districts, but it is not implemented statewide.

In addition to RTL, OSPI operates several other prevention programs across the state. For example, it uses federal grants to operate a prevention program called Safe and Drug-Free Schools. The program works with local education agencies to support programs that work to prevent illegal use of alcohol, tobacco, other drugs, and violence in and around schools. The intent of the program is to foster a safe and drug-free learning environment. SPI conducts other prevention activities that support improved academic performance, including recent legislation for school drop-out prevention. OSPI prevention efforts often include coordination with other state and local agencies. OSPI is also responsible for the Healthy Youth Survey, which is supported by multiple state agencies. The youth survey provides reliable data on risk and protective factors related to health behaviors.

6. Governor's Council on Substance Abuse

The Department of Community, Trade and Economic Development (CTED) provides a prevention program effort of note: Community Mobilization. Born of the war on drugs in the late 1980s, Community Mobilization engages community members to do grassroots organizing, and it engages them in alternative activities in response to substance abuse. Activities are directed by the Governor's Council on Substance Abuse, which was established by executive order in 1994. The Council was created to respond to the significant human, social, and economic costs that substance abuse inflicts on individuals, families, and communities in Washington. Council membership includes private industry, local and tribal government, treatment providers, community groups, educators, and law enforcement. State government is represented on the

Council by the directors of the seven state agencies that provide substance abuse programs. In addition, one legislator from each caucus of the House and Senate are on the Council. The Council is staffed by CTED. The Council works with state and local agencies and communities to develop common substance abuse reduction goals. It advises the Governor on substance abuse issues through recommendations for policy, program, and research strategies. The Council is currently embarking on a data collection effort, which would support local prevention planning, but it does not have an infrastructure that includes capacity to direct overall prevention policy.

III. PRIORITIZING PREVENTION INVESTMENTS

This document identifies policies and programs that could be used as part of a public health approach to mental health in Washington. Some are already established, some are in place but would benefit from additional resources, and others do not yet exist in this state or exist only in pockets. Throughout the discussions and activities that provided input into this document, participants were concerned with how to choose our next policy and program investments.

This document stops short of making specific recommendations on next steps—leaving that work to the summit participants. Individuals, organizations, and communities may make their own recommendations after reviewing this document or participating in community meetings leading up to the summit. There was some attempt, however, to identify criteria that could be used to prioritize new investments or to reprioritize existing investments.

Participants in the second prevention day were asked to review a long list of possible criteria, and many participants concurred with the list, although some items on the list were in conflict. For example, incremental policies that are least disruptive and build on existing strengths made sense to some participants, but initiatives that resulted in major system change also had appeal. Many participants felt children should be the greatest focus because addressing the mental health needs of young children could result in the greatest gains across a lifetime, but services for all and equity across age groups were also important to many of the participants. The team working on this document developed some suggestions for how to prioritize investments.

- First, efforts should build on current successes. The notion of a public health, prevention-oriented approach is new to many. It may be important to make ties to existing programs and efforts and to show some early successes as a way to build buy-in and garner both understanding and support.
- Second, efforts should be transformative. Transformative efforts would consider input from consumers and include peer-support or peer-run components. Transformative efforts would also take a multidisciplinary approach and a science-based approach.
- Finally, efforts should be sustainable. There should be a clear and ongoing nexus of responsibility and accountability to ensure continuity. Pilot programs should be used sparingly to gather information about the feasibility and effectiveness of possible interventions; they should not be used to avoid making long-term commitments that require ongoing funding.

CONCLUSION

Washington State is committed to a wide range of prevention activities—in many respects it is a leader for the nation. It is also committed to transforming its mental health system. The reason to articulate a vision of a prevention-oriented mental health system at this time is not to diminish the existing activity. Instead, the intent is to reinforce it and round it out so that (1) prevention activities adequately consider mental health alongside physical health, substance abuse, and social welfare, and (2) mental health reform efforts leverage opportunities to intervene upstream.

This document is intended to jumpstart a conversation about how to make this vision happen. It does not claim to propose all the answers—specifically, it does not contain recommendations—but neither does it simply pose questions. Building on input from the PAG, the first and second prevention days, the focus groups and other sources, it has attempted to create a foundation that will allow the organizers and attendees of the May 13, 2008, summit to identify the right questions and then answer them effectively.

Part 1 of this report suggests a common language for the discussion—an essential activity for any policy initiative. Then it reviews emerging research about mental health and attempts to answer the question of whether mental illness is preventable. The report finds that it is preventable in many instances.

Part 2 discusses policies, programs, and services that would be needed to say honestly that we have taken a comprehensive, prevention-oriented, public health approach to mental health in Washington. Sections specific to certain age groups explore what is already working; what providers, advocates, and consumers say is missing; and what could be some next steps.

Part 3 identifies common concepts that could advance mental illness prevention across the lifespan. It particularly focuses on the perceived need to establish some kind of statewide infrastructure that institutionalizes coordination and communication. The long-term goal, however, should not be to create another isolated prevention system dedicated to mental health that stands alongside but apart from other prevention-oriented systems. A truly comprehensive, coordinated approach to mental health would better integrate public health and mental health, public health and medical care, mental health and medical care, mental illness care and mental illness prevention, health and education, and health and substance abuse.

It is often said about states, including Washington, that the social contract for mental health between the people and their government is an agreement by the government to provide help only if one is poor enough and sick enough for long enough or in a bad enough crisis. Some argue that the agreement is only for those who are old enough because children's mental health needs are a secondary to those of adults. If this bare-bones social contract ever truly existed in Washington State, it has certainly begun to change in recent years. The 2005 mental health reform bills, the Mental Health Transformation Grant efforts, the 2005 and 2007 mental health parity bills, and the 2007 children's mental health bill have all changed the unwritten understanding between the government and the people.

A public health approach to mental health has the potential to change the social contract even more. When it comes to public health, there is already a prevention-oriented social contract in place. People understand that they can count on their government agencies to prevent foodborne illness, respond to communicable disease outbreaks, reduce the risk of illness from environmental contaminants, and much more.

Ideally, a social contract around mental health would fully embrace the notion of mental wellness. It could be as simple as the following statement: Society will work to ensure that each individual has the capacity to realize his or her abilities, to cope with the normal stresses of life, to work productively and fruitfully, and to have fulfilling relationships with other people. Fulfilling such a bold vision, however, would require that all sectors of society work together. Government cannot be seen as the only answer. Its resources are limited, the importance of personal responsibility should not be overlooked, and the business and non-profit sectors would also need to be part of any truly comprehensive approach. It is possible, nonetheless, to imagine a future social contract between the government and the people that declares that Washington is committed to promoting and protecting the mental health and well being of all of its residents. The details of such a contract might look something like this:

Washington is committed to proactively addressing the mental health needs of all people in the state in order to promote mental wellness and reduce the devastating personal and social impacts of mental illness. We will support healthy families to encourage a strong bond between children and their primary caregivers. We will strive to protect the people of this state, especially our children and vulnerable adults, from physical, emotional and psychological trauma, and when we are not able to do that, we will provide trauma-informed care systems. Our communities will conduct mental health assessments and work to reduce risk factors and increase protective factors. We will provide safe schools, promote school connectedness, and teach children social and emotional skills that build resiliency. We will support people through difficult transitions. We will meet people where they are to provide mental health screenings and help them access care when they need it. Health care providers will have the knowledge and commitment to identify and help address the mental health needs of their patients. People who provide social, health, criminal justice, and educational services will be trained to recognize and respond appropriately to the mental health needs of the people they serve, and they will be able to call on mental health consultants for help. Our programs and policies will be culturally and age-appropriate. We will work to educate service providers and the public about mental illness to eliminate misconceptions, reduce stigma, and encourage people to seek help. When people do develop a mental illness, we will intervene early to prevent disability, avoid co-occurring disorders, and support resiliency and recovery.

On May 13, 2007, providers, consumers, advocates, policy analysts, policy makers, and others from across the state will gather. They will have an opportunity to explore policy options and to recommend next steps for advancing a prevention-focused, public health-style system for mental health. What they do on that day could have a huge impact on what Washington State's social contract on mental health will look like in the future.

APPENDIX A

Prevention Advisory Group Members (Partial List)

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Walt Bowen	Infant Toddler Early Intervention Program, Department of Social and Health Services
Kathleen Boyle	Citizen
David Brenna	Mental Health Transformation Project
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TJ Cosgrove	Public Health - Seattle & King County
Victoria Crescenzi	Naval Hospital Bremerton
David Crump	Spokane School District and State Board of Health
Sharon Doyle	Human Services Policy Center, Evans School of Public Affairs, University of Washington
Joann Freimund	Mental Health Planning and Advisory Committee
David Hawkins	Social Development Research Group, School of Social Work, University of Washington
Tory Henderson	Department of Health
Ron Hertel	Office of Superintendent of Public Instruction
Sheri L. Hill	Early Childhood Policy Specialist
Ron Jemelka	Mental Health Transformation Project
Wendy Janis	State Board of Health
Lonnie Johns-Brown	Washington Coalition of Sexual Assault Programs, Washington Society for Clinical Social Work, Washington Association for the Education of Young Children
Doug Johnson	Greater Columbia Behavioral Health, Mental Health Planning and Advisory Council
Mickey Kander	Department of Health
Rebecca Kelly	Juvenile Rehabilitation Administration
Mike Krebs	Citizen
Michael Langer	Division of Alcohol and Substance Abuse
Laurie Lippold	Children's Home Society of Washington

Sandy Loerch	Morris Infant Toddler Early Intervention Program, Department of Social and Health Services
Sabina Low	Sadberry Center for Children
Robin McIlvaine	Mental Health Division
Craig McLaughlin	State Board of Health
Martin Mueller	Office of Superintendent of Public Instruction
Steve Norsen	Mental Health Division
Daisye Orr	Department of Health, Office of Health Promotion
Jennifer Pariseau	Citizen
Erin Peterschick	Mental Health Transformation Project
Laura Porter	Family Policy Council
Barb Putnam	Children's Administration
Deborah Ruggles	Department of Health
Jill Sells, MD	Docs For Tots Washington State
Joan Sharp	Children's Trust of Washington
Steve Smothers	Division of Alcohol and Substance Abuse
Cheryl Strange	Division of Developmental Disability
Bronwyn Vincent	Mental Health Division

Endnotes

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⁶ Disease burden is measured by disability-adjusted life year, a measure that expresses years of life lost to premature death and years lived with a disability of specified severity and duration. The disease burden for mental illness includes suicide. The disability component is weighted for severity, which allows for comparison among conditions. For example, the disability burden for major depression is the same as the burden for blindness or paraplegia. The disability burden for active psychosis as experienced in schizophrenia is the same as the burden for quadriplegia.

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