
THE TIME IS NOW: CREATING
A PUBLIC POLICY ACTION AGENDA
ON PREVENTING MENTAL ILLNESSES



THE CARTER CENTER
MENTAL HEALTH PROGRAM

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

NOVEMBER 7 AND 8, 2007

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OPENING REMARKS

Rosalynn Carter

Chair, Carter Center Mental Health Task Force

This is an exciting time in the mental health field with people living in recovery, which we never dreamed of 35 years ago when I first got involved. During this symposium, we are going to be talking and thinking about prevention of mental illnesses. That really would have been inconceivable even just a few years ago. Part of the mission of the Carter Center's Mental Health Program is to promote mental health and advance prevention to reduce the incidence and prevalence of mental illnesses. So I am looking forward with great anticipation to the program.

A number of things have brought us to this point. In 1999 the Surgeon General's Report on Mental Health stated that:

The field of prevention has developed to the point that reduction of risk, prevention of onset, and early intervention are realistic possibilities. Scientific methodologies and prevention are increasingly sophisticated, and the results from high-quality research trials are as credible as those in other fields of biomedical and psychosocial science.

There is a growing recognition that prevention does work. I think a lot of us were thinking about prevention, not out loud probably, many years ago, but then in 2000 we had here at The Carter Center the first biennial international conference on the Promotion of Mental Health and the Prevention of Mental and Behavioral Disorders. We were part of a much larger group including the surgeon general, the director general of the World Health Organization (WHO), the Centers for Disease Control and Prevention (CDC), the National Institute for Mental Health (NIMH), the Substance Abuse and Mental Health Services Administration (SAMHSA), and others sharing research on promotion and prevention programs from around the world. That was one of the most exciting programs I think I have ever attended. It was very emotional just thinking about the advances in research and learning about these programs from experts who came from all over the globe. Out of about 200 people attending, we had 80 people come from overseas at their own expense — that's how excited people were about research on prevention and promotion.

I have had the privilege of serving as honorary patron of the biennial conference since its inception. Through the tireless efforts of my dear friend and colleague Mrs. Beverly Long and others, mental health prevention and promotion have started to gain the recognition and focus they deserve.

I would like to briefly acknowledge those efforts by my friend Beverly Long, who recruited me to her cause in 1971 when Jimmy became governor. I had been working in the campaign and had so many people asking me what my husband would do, if elected, for a mentally ill loved one at Central State Hospital. There had been a big exposé of the hospital, and patients were being moved out before there were services available in the community. One day while campaigning, I said that I might work on mental health issues; someone heard me, and it was printed in the newspaper. Immediately, Beverly and all of the advocates in Atlanta — all five of them — descended on me. If you can imagine, in 1971 no one talked about mental health issues; no one wanted to talk about

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

Beverly has been there all these years supporting me in everything that I have done. She is one of the most wonderful people I have had the pleasure to meet. She has worked tirelessly to focus attention on prevention for as long as I have known her, and Beverly will tell you she has harassed people to talk about prevention, to recognize that prevention is important. She has worked harder on this issue than anyone I have ever known. Now her hard work is starting to pay off.

And it is not just the mental health community that is making a positive difference. Policy-makers and service providers in health, education, and social services have begun to intervene earlier in children's lives. Maybe not as much as we would like for them to, but the fact that we know that early intervention works is important. The World Health Organization summary report on the Prevention of Mental Disorders states that health care providers often do not see prevention as their primary responsibility. So if efforts are going to focus on prevention, it means that public health authorities and health professionals are going to have to play a leadership role. We all know that a cornerstone of public health is promotion and prevention, so we in the mental health community need to take these two issues just as seriously as public health takes tobacco control, cardiovascular disease prevention, and other health conditions. That puts a lot of responsibility on us to make that happen. We are way past the time for becoming involved and focusing our attention on prevention.

There are evidence-based programs and policies that can be implemented. They have been found to reduce risk factors, strengthen protective factors, and decrease psychiatric symptoms and disability as well as the onset of mental disorders. They also contribute to better general health, including both physical and mental. We also need to address the interrelatedness of mental illnesses and general medical conditions such as diabetes and cardiovascular disease. We all need to think about how we can change policies in our various organizations so that prevention is included in our efforts as we work on issues around treatment and services.

We have been fighting to reduce the stigma surrounding mental illnesses for a long time. Some of the stigma comes from the idea that there are not any effective ways to prevent mental illnesses. I believe that by highlighting successful programs, we can help reduce stigma. This is one of the most important things we can possibly do to help people with mental illnesses. We are going to discuss some of those programs, but please remember that these are just a few examples. There are many more possibilities that you can explore.

KEYNOTE PANEL: ADVERSE CHILDHOOD EXPERIENCES STUDY

Vincent Felitti, M.D.

Co-principal Investigator

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

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

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

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

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



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

Dr. Robert Anda at the U.S. Centers for Disease Control and Prevention took our clinical observations and designed a major study, the purpose of which has been to make what was known to the few, credible to the many. The study's structure, analysis, and findings have attracted significant attention in the Western world. Unfortunately, none of this has yet led to action.

Study Design and Population

We chose 10 categories of adverse childhood experiences because of their high prevalence in the weight program. Their prevalence in a general, middle-class population was also unexpectedly high. For each individual, we created an ACE score, a count of the number of categories of adverse childhood experiences that had occurred during the first 18 years of life. ACE score does not tally incidents within a category; if anything, this tends to understate our findings and, therefore, can range from 0 to 10.

Findings

In the first 12 years of this ongoing study, we have learned that adverse childhood experiences have a powerful, proportionate, long-lasting, and

Adverse childhood experiences have a powerful, proportionate, long-lasting, and generally concealed effect

generally concealed effect on mental health, risk behaviors, social function, biomedical disease, and health care costs.

A person's well-being can be exemplified

by chronic depression, suicide attempts, and psychosis. Risk behaviors can be exemplified by the addictions, generally defined as the unconscious, compulsive use of psychoactive materials or agents.

Perhaps this sheds some light on why our treatment programs have fared so poorly overall. It's hard to give up something that almost works: the next cigarette, the next drink, the next fix,

the next woman or man. Are we treating the wrong thing? Are we treating the smoke instead of the fire?

This was the case in the weight program when we were treating the marker for the problem and often unwittingly removing a solution, rather than understanding and dealing with the core issues. For example, 12 years after regaining over 400 pounds, one woman decided to have bariatric surgery. After losing 96 pounds, she became intractably suicidal, was hospitalized five times in one year, and received three courses of electroshock. We are back again to the public health paradox. It is comfortable to miss the point, to assume people do not know better, to call these bad habits or self-destructive behavior.

Social Function

Using teen pregnancy, promiscuity, and impaired job performance as indexes of social malfunction, there was a strong, proportionate relationship to adverse childhood experiences.

Biomedical Disease

We found that many major biomedical diseases in adults have a significant and proportionate relationship to adverse childhood experiences. Liver disease, chronic obstructive lung disease, and coronary artery disease are three examples.

The very idea that life experiences can ultimately transmute into structural biomedical disease is a deep concept. Two paths are becoming evident. One path is the development of later disease as the result of an initially beneficial but ultimately damaging self-help attempt. Smoking, drinking, drugging, and overeating are fairly easy to understand. The other path is more obscure. It is the result of chronic stress and the effect of persistently high levels of cortisol on the development of the brain and on the function of the body's organ systems, including the immune system.

Costs

Decades later, a brief sampling was taken of our ACE study findings in the realms of mental health, risk behaviors, social function, and biomedical disease and pharmacy costs. You can

readily infer that the costs of adverse childhood experiences are monumental, whether measured in dollars or in the currency of humanity.

Intervention

We have some preliminary experience in using the ACE study findings for intervention in medical practice. In a unique setting that provides comprehensive medical evaluation to 58,000 adults a year, we have radically changed our medical history questionnaire by incorporating a number of questions that are highly nontraditional in medical circles. In medicine, there are only three sources of diagnostic information: history, physical examination, and laboratory studies. Although patients routinely anticipate that laboratory studies will be diagnostically the most important, experienced physicians understand that the great majority of diagnoses are established by medical history.

Over an eight-year period, we have routinely posed these questions, and others like them, to 440,000 adults. Obviously, this has been acceptable to patients and organizationally affordable, even though it took some training to get our staff comfortable and facile with using this new information. It was only after several years — and by accident — that we came to understand the economic impact.

An outside firm, specializing in the computer technique of neural net analysis, carried out an outcomes analysis of two years' work: 120,000 medical evaluations. What they found was of major significance and totally unexpected.

There was a 35 percent reduction in doctor office visits in the year subsequent to evaluation, compared with the year prior. There was an 11 percent reduction in emergency room visits and a 3 percent drop in hospitalizations. We even had a control group from a number of years earlier when we operated in a conventional biomedical mode. At that time, we had an 11 percent drop in doctor office visits but were not smart enough to measure emergency room visits or hospitalization.

Conclusions

The influence of childhood experience, including often-unrecognized traumatic events, is biomedically, socially, and psychologically as powerful as psychoanalysts originally described it to be. This influence is long-lasting, and neurobiologists are now describing its intermediary mechanisms. Many of our most intractable public health problems are the result of attempted personal solutions to problems caused by traumatic childhood experiences.

The ACE study has attracted intense intellectual interest in this country and abroad but no actual involvement. The reasons for this are important to ponder, but, before that, Dr. Anda and I ask you to consider the possibilities of actually using this information. The opportunities are extraordinary, and no one is ahead of you in line.

Questions & Answers

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

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

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

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

A The general topic is resiliency. We measured what children experienced growing up in their households, which is part of the ecology of childhood. We saw that things that would be protected, or what people talk about as resiliency factors, are inversely related to the ACE score. The more dysfunctional the ecology of the household was, the lower the percentage of the protective factors in those households.

One other aspect of resilience that I think needs to be considered is: resilient to what? If you start looking at multiple domains — mental health function and sexuality, performance on the job, relationships, violence — and you start adding up the things that you can measure in a medical setting, you see that the average number of multiple problems goes up. In thinking about resilience, I'd say resilient to what — or resistant to what?

Q Pierluigi Mancini: Does the study include any recently arrived immigrants, especially from areas of the world where there is unrest?

A There were some but not many. The 10 adverse childhood experiences that we picked were issues that we stumbled into commonly in a very middle-class population. Had we a broader range of that population, I think issues of torture would have been prominent; issues of murder within the family would have been even more common than they are. So, if things are this bad in a middle-class population in the sixth largest city in the country, things do not tend to get better in the prisons or among the homeless or recent immigrants.

Q Jerome Lawrence: Now that it is out in the open that we treat each other badly, can you give me any idea as to why?

A One of the things that we see in the human plausible reasoning theory is that people who are affected by ACEs, people who are involved in the perpetuation of domestic violence or are victims, are susceptible to being victims or perpetrators. Difficulty managing anger is something that has a very strong relationship to adverse childhood experiences; alcohol, drug abuse, a number of sexual partners, and difficulty maintaining relationships are all highly associated with adverse childhood experiences. I think people get put at risk for being victims and perpetrators by their structural development.

Q Gwendolyn Keita: Several of us have been talking about the importance of the biopsychosocial model. In recent years, there seems to be an increasing focus on the biomedical model to the point where it is very difficult to even get funding for research in any other area. Can you give some ideas of how to work through this?

Questions & Answers

A How could one, on a very large scale, provide illustrations in an affordable and acceptable way of what positive parenting looks like? I'd like to propose the idea of soap operas. In San Diego, at home visitation programs for 700 newborns, following them from birth to age 3, the striking similarity in all of the homes was that, when we walked in, the television was always on, and nobody was watching Discovery Channel or CNN. People were watching soap operas. It is tough talking to a neighbor about your husband having an affair, the kid is gay or is on drugs, somebody in the family has AIDS. But if that is in the story line of the soap opera, then you are not talking about yourself, you are talking about what is up there on the screen. I see soap operas as an enormous opportunity to improve parenting in storytelling by illustration. They have enormous audiences, the bill is paid, and the thematic content has aspects of luridness that would be appealing. Nobody has really picked up on it in a meaningful way.

Q Lisa Brenowitz: How do you account for sibling differences or twin studies where both have experienced the same trauma but one is more resilient than the other? Do you acknowledge some genetic differences?

A I am less enthralled by the idea of genetics in terms of genetic mutations explaining much of this. But there is a new, rapidly growing field called epigenetics that asserts that experiences can alter the expression of your genes and that alteration can be transmitted from generation to generation. That might help to explain why some of these problems are so resistant to change.

Q Terry Mason: How do you account for the 35 percent difference in the group receiving the biomedical screening versus the one receiving the biopsychosocial screening? And once you ask those questions and open those doors, what do you do with the information?

A All of us who have been involved in this believe that probably the most important thing that has happened is that, for the first time, large numbers of people were enabled to tell the worst secret of their lives to someone else deemed socially important — doctor, nurse practitioner — and came out of that feeling still accepted as a human being. I cannot overstate the importance of that.

Why did it revert back to its prior baseline two years out? We used a unified medical record; everything that happens is in one folder. We saw that, although our findings were literally printed with laserlike clarity, they might as well have been printed with invisible ink. Nobody touched them with a pole — nobody. What would happen if one carried out this affordable experiment: Make a DVD of a group of pediatricians of different age groups, sexes, and races talking comfortably to parents about things that are never discussed, and send one to every pediatrician in the state? Might there not be some people who might say, well, you know, somebody looking like me knows how to do that, and maybe I could learn?

PANEL I: PREVENTION PROGRAMS FOR CHILDREN

Jane Knitzer, Ed.D.

Moderator, Director, National Center for Children in Poverty, Mailman School of Public Health, Columbia University

There is no better way to begin the conversation about creating a public policy agenda to prevent mental illness, trauma, and other bad health-related and life-related outcomes than with a discussion about how to get young children and families facing special risks back on a healthy developmental trajectory. This panel is going to turn the spotlight on three different emerging approaches to helping young children thrive in ways that use the best clinical and scientific evidence about getting early relationships right, including evidence from neuroscience and developmental psychology. Then we are going to engage the central questions that we face:

- How do we give this knowledge away?
- How do we embed it in the systems that serve children and families?
- How do we implement and pay for them?
- How do we train the work force?

Resistance in the children's mental health world gets played out in a paradigm that says mental health dollars only are used to serve the most seriously at-risk children. The very paradigm that we have that drives all of the funding is antithetical to a preventive framework, antithetical to helping children by improving their parenting. Parents are seen as collateral. This panel is trying to challenge that with evidence-based interventions.

William Beardslee, M.D.

Chair, Department of Psychiatry, Boston Children's Hospital; Principal Investigator, Parental Mental Illness Study; Member, Carter Center Mental Health Task Force

My focus is not on a single intervention strategy or on a single population but on a set of strategies that focus on a widespread public health problem that shows up in almost every sector: depression in parents. Depression is the fourth leading cause of morbidity in the world today and will be the second leading cause in the year 2020, yet we have very effective evidence-based treatments for it. Only about one-third of the people with serious depression get treatment. It causes enormous suffering for the individual (as one mother said, "It is circles within circles; a sadness out of control") and great suffering for the family. People with depression do not come to either a general practitioner or a mental health practitioner and ask for treatment.

Parental depression shows up as the explanatory cause for a variety of other difficulties. Mothers who are unable to put together an asthma regime at home tend to be depressed. The same is true in studies of seat belt use. In studies of welfare populations, it is

mothers with depression who don't avail themselves of the many programs that were designed to help. Clearly, those who have experienced childhood trauma are at much greater risk for depression. Just as clearly, in any of the major medical illnesses, the combination of the illness and depression leads to a far worse outcome than the illness alone.

Dr. Julius Richmond has advanced the idea that effective public health programs have three main elements: a knowledge base, an implementation strategy, and the political will to make them happen. I believe we have a strong knowledge base. We have some examples, primarily from Europe, of implementation strategies showing that this is a treatable illness. Treating it and focusing the parents' resources on parenting can have immensely positive effects.

Against the backdrop of the value of psychoeducational approaches in general, our group and others have demonstrated sustained, long-term gains for parents and children from family psychoeducational approaches for parental

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

We have delivered these interventions primarily in our long-term trials in group discussions or in a family talk intervention. A clinician works with parents to get a history and do some teaching. The clinician also sees the children, sits with the parents until they are ready to run a family meeting with the children, conducts the family meeting, and then does long-term follow-up. We have shown sustained effects four-and-a-half years after enrollment of families,

with very little sample loss. Parents who change the most have children who change the most. In following families over the long term, we recognized that healers emerge within families. The strategies become self-sustaining because the parents employ them. But the conversations are dynamic, not static.

I have worked extensively with Head Start to develop a program that could be used nationally, based primarily in a teacher development model teaching teachers how to engage difficult families, how to build resilience in kids, and how to recognize and refer for depression care where needed. We chose this approach because Head Start estimates that 50 percent of its parents are depressed. You could never use individual clinician approaches for a problem of that magnitude.

What kinds of models might we use for large-scale implementation? The most important work from a systems point of view has been done by Dr. Tytti Solantaus in Finland. Seven years ago, she began a deliberate strategy to place someone in every health care and every mental health care setting who knew how to talk to parents with depression or related difficulties about their children and help them with it. With support from the National Finnish Academy of Sciences and the health care sector, she invested heavily in training master trainers who have subsequently trained other master trainers.

She used our approach, the Family Talk Intervention, and advanced the thesis correctly that what is needed is a family of flexibly employable interventions: a brief intervention that can be taught to clinicians in one or two sessions with parents and a much more elaborate group intervention. She and her colleagues adapted the intervention for use with breast cancer patients, substance-abusing parents, foster care parents and in other settings. From this I learned that it is important to have a flexible array of strategies to adapt interventions to the settings as needed and to have a long-term strategic plan.



In this country, we have also emphasized actively assisting patients to break down barriers and get access and the need for systems reform. Perhaps most importantly, our work was a long-term commitment to families. This involved

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

asking what they wanted, helping them get it, staying with them, and changing as their needs changed. There are many systems in which effective treatment for parents with depression, and a focus on parenting, could yield large results. Illnesses change over time, risks become different, and systems that make a long-term commitment to follow people not only are much more likely to succeed but, in fact, are taking on the problem in a preventive way.

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

clinicians of all disciplines. Most of the cases of depression, if they present in the health sector at all, will present to internists or pediatricians.

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

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

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

Mary Dozier, Ph.D.

Professor, Department of Psychology, University of Delaware

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

Infants and toddlers are biologically prepared to depend upon a caregiver. When they enter foster care, they usually have experienced neglect, almost always experiencing a disruption in care with their caregivers. The caregiving system has fundamentally failed here. Over the

last 10 to 15 years, we looked at the ways in which children cope with these challenges and how we can help them and their caregivers cope more effectively.

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

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

The second obstacle to nurturing care is that some caregivers are not naturally nurturing. For the most part, our kids do okay in homes where there aren't a lot of risks. But, children who have experienced early adversity need this nurturing care, and they need a caregiver who can provide it. We could not go through several years of psychotherapy with the parents. So in several sessions, we tried to get people aware of what we call their "voices from the past," the things that are telling them, "Don't pick up that baby; you will raise a spoiled kid" or "He will be a big baby." Children who experience early adversity are often dysregulated behaviorally, biologically, and physiologically. In terms of behavior, dysregulation is pretty easy to see, for example, a child who is bouncing off the wall or is not able to sit and attend in school.

In physiological dysregulation, the main marker is the production of a steroid hormone called cortisol. We all have a pattern across the day. A normal pattern is highest in the morning and goes down across the day. It is not that we are less stressed as the day goes by; this is just part of our biological system that is designed to get us up in the morning and help us go to bed at night. It is part of a circadian rhythm. What we have found with babies in foster care is that this is thrown off. For dysregulation, behaviorally and biologically, we figured out a way to help a caregiver provide an environment that will help this child develop his or her regulatory capabilities.

We do this in several ways, but one of the main ways that has a good evidence base is by helping the caregiver follow the child's lead. Learn to follow the child's lead. We do this intervention

through a series of 10 sessions in the home in which we use video feedback and a primary method. We help the parent see her strengths and the child's strengths.

We assess this empirically by randomly assigning two interventions: our attachment in biobehavioral catch-up and what we called developmental education for families, which was just an educational intervention. What we found is that the children in our attachment in biobehavioral catch-up intervention were more likely to show secure attachments or to develop trusting relationships with their caregivers. Their caregivers were more likely to report fewer behavioral problems, and the production of cortisol looked much more like children who had never been in foster care and very different from children who were in the educational intervention.

This intervention looks like it is effective, at least in the short run. It is effective in terms of the first couple of years following the intervention; we have yet to follow children five years, 10 years, but we are excited to be able to affect biology and behavior.

We have to have policy changes also, such that children are not moved any more frequently than is absolutely essential, so that when children are placed into foster care, they are in potentially adoptive families, they are with stable, consistent caregivers. We've got strong evidence that intervention with babies and toddlers can be such that they can develop better behavioral regulation, better physiological regulation, and are more likely to develop secure attachments. But there is a limit to what any system can stand. We do not want to rack up risk factors here; rather, we have got to change our policies such that the children are more likely to stay in a stable home, whether that is a foster home, an adoptive home, or their birth home.

The second obstacle to nurturing care is that some caregivers are not naturally nurturing.

Carolyn Webster-Stratton, Ph.D.

Professor of Family and Child Nursing, Research Affiliate, Center of Human Development and Disability, University of Washington; Principal Investigator, Incredible Years

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

Why Treat Aggressive Behavior Problems in Young Children?

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

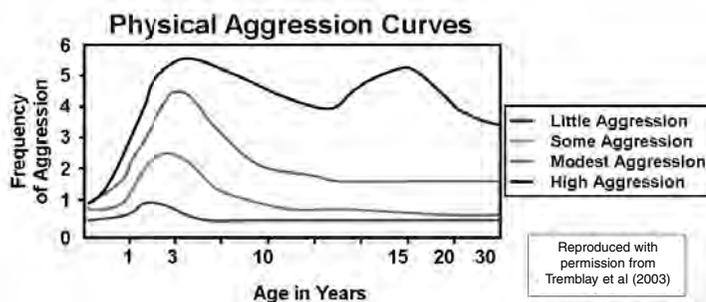


Figure 2. Normal Trajectories of Physical Aggression

Normal Trajectories of Physical Aggression

Each line in Figure 2 represents frequency of aggression in a subset of the population. Clearly, there are individual differences in the amount of aggression exhibited by children. The top line is of most concern because it does not decline.

These trajectories have been shown in studies worldwide. (Graph reprinted with permission from Tremblay.)

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

Why Intervene Early?

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

The Problem

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

The Solution

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

Research Outcomes

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

IY Prevention Studies — Head Start

Of the Head Start children in the intervention condition (IY teacher training), 91 percent showed at least a 30 percent drop in behavior problems in the classroom at the end of the school year, compared with 57 percent of children in the regular Head Start classrooms. Sixty-nine percent of Head Start children in the abnormal social competence range at baseline (beginning of school year) moved into the normal range at the end of the school year, compared with 36 percent of children in regular Head Start classrooms. At one-year follow-up, 80 percent of intervention children were in the normal range for social competence, compared with 48 percent of children from regular Head Start classrooms. In Head Start intervention classrooms (where teachers and parents were

trained), the average level of aggression was reduced by 35 percent at the end of the year, whereas in the regular Head Start classrooms, children became 25 percent more aggressive.

Prevention Studies — Head Start and Public Schools With High Rates of Economically Disadvantaged Families

Children in intervention classrooms who received the dinosaur curriculum showed more social competence, emotional regulation, school readiness, and fewer conduct problems than children in control classrooms. The program also had a large impact on children from classrooms where there were low levels of school readiness and high conduct problems. Children in the combined intervention condition (parent training plus classroom dinosaur curriculum) were reported to have fewer behavior problems than children in control condition and children in the classroom-only condition. This finding suggests the added value of combining parent programs with classroom interventions, particularly for the highest risk children.





IY Treatment Studies for Children Diagnosed with ODD, CD

Posttreatment, 83 percent of children who had had IY child treatment plus IY teacher classroom

Parent training remains the single most effective strategy for preventing behavior problems and promoting social and emotional competence in young children.

management training showed a minimum of 30 percent reduction of aggressive behavior in the classroom, compared with 60 percent of children who had had parent and teacher training (no direct child training), 54 percent who had had parent training only, and 20 percent control (no treatment). This suggests the added value of

child and teacher training for improving aggression in classrooms. At one-year follow-up, 95 percent of children treated with IY parent and child programs showed at least a 30 percent reduction of aggressive behavior compared with 73 percent of child-only treatment and 60 percent of parent-only treatment, suggesting the added value of training both parents and children for home improvements in children's behavior.

Solutions

Solution 1: Parent training remains the single most effective strategy for preventing behavior problems

and promoting social and emotional competence in young children.

Solution 2: Child training (Dinosaur School Program) produces improvement in social behavior with peers at school. For highly aggressive children, the combination of parent and child training produces better long-term results than either alone.

Solution 3: Teacher training in classroom management and delivery of social and emotional curriculum reduces classroom aggression and increases children's social and emotional competence as well as school success in all children, but especially for the most aggressive children with the poorest school readiness skills.

Questions & Answers

Q Carl Bell: One of the major conclusions of Dr. Satcher's Youth Violence Report was that you could not predict the child who was going to be violent. You could predict children who were at risk and add protective factors, which would prevent them from being subsequently violent. But it sounded like you were saying that you could diagnose adolescents as antisocial personalities.

A If you talk to preschool teachers, they can tell you the one or two children in the classroom who are at risk because they have a high frequency and intensity of aggressive behavior. They stand out quite clearly. We do know from our research and other people's research that about 50 percent of those children will continue on that trajectory and 50 percent will normalize.

After 25 years of research, we have not been able to figure out exactly which ones continue on the trajectory and which ones do not. We have looked at risk scores to see whether that might be the predictor. We identified places where we have a high degree of risks, such as Head Start or schools that serve high numbers of immigrant families or where 60 percent or greater of the students qualify for free lunch. When we are in those schools, we offer the parenting program to all of the children, because we do not want to create a feeling of stigmatization.

Q Sybil Goldman: Have you seen strategies that really begin to look at the family as the unit of care and break down some of these funding challenges?

A We need to think about reimbursement systems that reward people for taking care of children and adults, rather than reimbursement for one or the other. We need reimbursement systems that will reward practitioners for supporting parenting and doing prevention as well as for treating diagnosable disease.

We do not even have systems that allow people to be reimbursed for talking to other providers, even though any of us who work with kids can do that all the time. I do think that all of the work we are talking about is not individual centered but centered in the interactions — parents, teachers, child care center. Thinking about those in more organic terms is probably useful.

Q What have you found in your programs in terms of intervention for children with ADHD?

A For quite a while, our primary diagnosis had to be oppositional defiant disorder or conduct disorder to get into the study. About 50 percent of those children also had ADHD and other learning problems. Because ADHD was not the primary diagnosis, we did not write them off as treatments of ADHD, but they were there. Now, children have to have diagnosed ADHD to get in our study. They are between the ages of 4 and 6, and we are finding that 90 percent of them also have conduct problems.

Q Christina Metzler: Have you addressed academic achievement as an outcome of your programs, either specifically for the children you are intervening with or for the whole classroom because the teacher is less disrupted by a child?

A We looked at academic outcomes as well as social and emotional outcomes. They were higher in groups that had teacher training and the social and emotional curriculum. Cognitive development and social and emotional development are inextricably linked and need to be bound together. A lot of the programs that have focused only on academic attainment have missed that. There is very good evidence that high-quality, well-run day care can lead to very substantial differences, not only in academic attainment but in staying in school, avoiding adolescent pregnancy, and so on.

Questions & Answers

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

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

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

A We have to think about strengthening the foster care system and the system that transmits social and developmental knowledge to parents and to kids. The thing we have also lacked in the health care sector, and to some extent also in the early education sector, is a real focus on prevention. Preventive approaches tend to be population based rather than individually centered; they tend to think about strengthening resources.

How do you get these programs into the hands of clinicians? How do you help to get the clinicians to deliver those programs with fidelity, with quality? What happens is they get gunned down with each iteration. Somebody looks at a 20-session program and thinks, “We can only afford to offer eight sessions, so we are just going to take this little chunk out of it.” They are still calling it an evidenced-based program but it is not. It is like taking half your ampicillin. We need to do interventions on the agencies so that the supervisors understand what it takes for their

clinicians and therapists to do these programs. And that includes schools too — what it takes for a teacher to deliver a program like this; it just cannot be done in a three-day workshop.

Q Wilma Townsend: How do we get to the point where we have used the social networks, where we are not just saying it has to come from the top down but it has got to come from the bottom up as well?

A Across the country we have efforts to bring together conversations about health care, early childhood, and mental health. We have strategies to work with pediatricians, not only to do developmental screening of young children but to do maternal depression screening. We are just going to have to work very hard and get some new paradigms in place that really do respond to the knowledge base because we are way out of synch right now.

Comment: Douglas Ronsheim

PNC Bank in Pittsburgh has invested over \$100 million over the next 10 years; that is \$10 million a year to address these issues. If one bank invests that kind of money, what other banks would not be challenged to do that? Think about the public sector as partners in reinvesting in a different way in our communities.

DINNER ADDRESS

Terry Cline, Ph.D.

Administrator, Substance Abuse and Mental Health Services Administration

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

I love looking at trends, at data. It is important not to see just where we are but where we have been and where we hope to go. Looking at the mental health services delivery system, we have made indisputable progress. As a nation, I believe we have come a long way in widening the circle of opportunities that were promised in the Declaration of Independence. Throughout our

nation's history, this promise has been broken for certain people. Certain groups have been left out and these individuals include people with mental illness.

Over 40 years ago, the Kennedy administration signed into law the Mental Retardation Facilities and Community Mental Health Center Construction Act.

The focus was on buildings at that time, less so on services.

Although the act accomplished many things, I believe its most important accomplishment was uprooting the notion that those with mental illnesses were irreparably damaged.

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

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

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

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



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

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

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

Consumer and family movements have flourished.

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

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

Current Status

We have more than 32,000 suicides in the United States every single year. We have as many as 700,000 Americans who are homeless on any

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

given night, and an estimated 20 to 25 percent of these individuals have a serious mental illness. One-half of this subgroup also has an alcohol and or drug problem. Studies indicate that between 16 and 50 percent of all incarcerated individuals have mental illnesses.

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

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

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

Integration of Services

There is plenty of debate around the value of integration.

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

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

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

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

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

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

related disorders. The majority of these individuals are not receiving the specialized care they need to address their problems.

Screening

One example of health care integration is screening through primary care, which moves us ahead in several different ways. First, primary care practitioners have access to a large segment of the population, and numerous screening instruments are available. These screening tools are valid and reliable and can be applied to the general population or to a targeted population successfully, either as stand-alone assessments or as part of general health questionnaires. Ultimately, this leads us to greater success when screening is combined with intervention, appropriate treatment, and recovery supports.

Early Intervention and a Public Health Approach

I want to just mention a few elements that I think are important to a public health approach.

It is population-based and focused on improving behavioral health indicators for an entire population, as opposed to individual improvements or outcomes for individuals.

It is comprehensive and holistic in terms of the needs of an individual and the community and recognizes the interplay between behavioral health, physical health, and other aspects of well-being.

This approach is able to work across systems, professions, and disciplines.

The underlying premise of a public health approach is to promote health and to prevent illness before an illness begins. It is that basic.

A public health approach involves working “upstream” as well as “downstream.” While we need to continue to rescue drowning individuals, we also need to move upstream to try to keep people from falling in the river in the first place. Moving upstream drives the focus toward children and families. Half of all lifetime cases of diagnosable mental illnesses begin by age 14, three-fourths by age 24. Moving upstream to catch people before they end up in a river just makes good sense.

The challenge before us is great. We are working in an environment where stigma is strong, and, too often, our society provides incentives and rewards for addressing symptoms, not preventing the problem or promoting mental health. We need to be smarter about what we do.

I look forward to the day when we do what we know, when mental illness and substance abuse are treated with the same urgency as other illnesses, when we have policies and systems that build resilience and facilitate recovery. Only then will we have a truly healthy and rich nation.

Questions & Answers

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

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

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

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

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

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



Questions & Answers

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

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

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

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

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

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

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

PANEL I I: PREVENTION PROGRAMS FOR ADOLESCENTS

Larke Huang, Ph.D.

Moderator, Senior Adviser on Children to the Administrator of SAMHSA

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

Poverty puts youth at risk for poor outcomes as youth in poverty are at greater risk for experiencing behavioral or emotional problems.

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

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



Carl Bell, M.D.

President/CEO Community Mental Health Council, Inc.; Professor of Psychiatry and Public Health, University of Illinois at Chicago; Member, The Carter Center Mental Health Task Force

Back in 1982, I was practicing clinical psychiatry and seeing a lot of children. What struck me was that the children I was seeing were exposed to violence — domestic violence, family violence. So we started this whole thing on children exposed to violence.

The problem was when we did the Institute of Medicine Suicide Report, we looked at Felitti's study because it showed that if you had four or more adverse childhood experiences, your suicide attempts would be 12 times greater than that of a person who had had no adverse childhood experiences. But, here is the thing you have to understand: 20,000 people out of 100,000 get depressed; 8,000 out of 100,000 attempt suicide. But only 20 out of 100,000 complete suicide.

My question always is this: What is going on with the other 7,980 people? It has to be protective factors. Felitti told half the story yesterday when he cited me during his talk: If you are overwhelmed by trauma, you will be broken. As we learned from the Youth Violence Report and the Institute of Medicine and Suicide Report, risk factors are not predictive factors because of protective factors.

The Illinois Department of Children and Family Services is doing a child and adolescent needs and strength assessment, and we finally have convinced them to look at which child was at risk. They needed to change what they were doing in foster care because they were measuring depression, attachment, and problem behaviors; they were not measuring trauma behaviors in a population that we know is traumatized.

They measured trauma symptoms, and, as the number of trauma experiences went up, the number of trauma symptoms went up. When trauma was finally added, you see the traumas at 25 percent. Attachment, anger, and depression are a little lower, so they are measuring trauma. And the key to this is, as the traumas increase, the trauma centers increase. On 8,000 real children, not a randomized control trial, there was real-life external validity, not internal validity but real validity.

What it showed was this: As the number of strengths and protective factors — connect- edness, social fabric, social skills, communication frequency and comfort with the parent, self- advocacy — increases, the trauma symptoms flattened out. So risk factors are not predictive factors because of protective factors.

When Dr. Satcher was at the U.S. Centers for Disease Control and Prevention, he brought us into a strategy think tank to figure out how do you do this, how do you move science into

service? You have to have somebody, that first player, and, then, get all the key silos in the room and create a shared vision. You have got to figure out where you all

want to be in five years. Once you figure that out, you have to get consensus on the strategy, on how you are going to get there. These are soft skills; these are leadership skills; these are emotional intelligence skills. Once you do that, you get synergy and execution, and that gives you social value. Shared vision plus consensus on strategy plus synergy and execution get you social value.

Now, let me tell you what we are doing in Chicago. We are constructing this shared vision. We are propagating psychological first aid in the public schools, in the Chicago Department of Public Health, everywhere that we can get it, we are doing it. We have convinced the Illinois Department of Children and Family Services to put protective factors in place for the children in child protective services.

You need somebody who can execute and manage, and that is why we need business people. The challenge is going to be execution. I strongly recommend that you use Chicago as a model. You can use the state of Maine's early identification of traumatized children as a model, with psychological first aid as an attachment to that because once you identify it, you have got to fit it. There are all these models, but we have got to put them into practice.

Risk factors are not predictive factors because of protective factors.

David Osher, Ph.D.

Managing Research Scientist, American Institutes for Research

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

Let me back up a bit. As someone who had the opportunity to be around for the release of the first Surgeon General's Report on Mental Health, I find much of what is happening now quite interesting as well as challenging. In that first report, we defined mental health as "the successful performance of mental functions, such that one could be productive in his or her day-to-day activities and could develop and maintain positive relationships with other people." We also said that mental health was "the ability to adapt to change in one's environment and to deal with adversity." I was in office, of course, during the time of the Oklahoma City Federal Building bombing and worked closely with the fire

And, even if you build it and schools and staff come, the interventions will be implemented poorly or marginalized if they do not address contingencies that educators face.

department and police officers for a year after that. In Oklahoma City, the firefighters had gone through a training program before the bombing of the federal building and were much better prepared than the police. We saw dramatic differences in the following year in terms of how firefighters were able to cope with their experiences, compared with police officers. So the idea of training to prepare for disasters is very important.

I also was involved when our embassies were bombed in Kenya. President Clinton asked me to lead a group of physicians to Nairobi and Tanzania to see if we could be helpful following the bombing. Risk and protective factors are very important but not sufficient — the name of the

game is creating the conditions where all kids thrive. Schools are key to creating those conditions. Let me start with some propositions.

Schools are never neutral. Schools either help kids thrive or contribute to mediocre or rotten outcomes. Schools can build and strengthen protective factors and assets, or they can create or exacerbate risk factors.

Schools have been promoted as a key site for public health intervention. We can use them for promotion by providing social-emotional learning programs and for prevention by implementing evidence-based prevention interventions. We could also use schools as a treatment site, such as school health centers. Successful intervention, however, requires addressing the dynamics of schools. Even if you "build it," schools or their staff may not use them because they have other priorities. And, even if you build it and schools and staff come, the interventions will be implemented poorly or marginalized if they do not address contingencies that educators face.

The challenge is to create conditions where schools and districts have the desire, capacity, and support to address students' mental wellness and mental health needs. In terms of institutionalizing school-based mental wellness and health, the name of the game is creating conditions where no children are left behind academically and where all children thrive.

The inextricable link between cognitive and social-emotional factors is important here, as it creates leverage points for institutionalizing mental health interventions. Let me tell you about our work on the four conditions for learning:

Safety

Students should feel physically, emotionally, and socially safe and feel they are being treated fairly. The school must be safe and orderly, and students must have the capacity to avoid risky behaviors.

Support

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

Social-Emotional Learning

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

Authentic Challenge

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

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

manage their emotions) and where the motivations for learning are enhanced (e.g., where students feel connected to teachers). The conditions for learning enhance students' ability to attend and the teachers' ability to be in the zone of proximal development for all students all the time.

The conditions for learning are important for everyone but are particularly important for students who struggle with multiple risk factors



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

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

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

A distinguished expert panel came to a quick consensus around the first two questions and identified the four conditions of learning. Then, we conducted 22 different focus groups with students, teachers, and parents and held cognitive labs to make sure that the questions were interpreted in the way that we intended them. We developed and piloted a 59-item survey that normally could be completed in less

than 15 minutes and then administered it citywide to essentially all high school students. Then, we produced a high-quality, eight-page score report that gave people not only the overall data but also disaggregated data and helped them understand what they can do with it. During the second year, we extended the surveys to elementary schools and developed a Web-based tool, linked to school reports, that helps schools identify appropriate evidence-based strategies and programs.

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

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

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

Paulette Running Wolf, Ph.D.

Running Wolf & Associates; Acting Executive Director, First Nations Behavioral Health Association

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

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

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

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

Unlike the Zuni version, the metaphors and behavioral incidents described in the intervention represent the diverse beliefs of diverse

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

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

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



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

We paired that GONA with a community mobilization piece and restructured it to allow opportunities for community members at the height of their excitement and understanding to volunteer to participate in community mobilization and planning. Really crucial was the fact that it was not just community members

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

involved in this process, it was school personnel, local tribal colleges, law enforcement — all of those silo structures that were not working together. If you go to a native community and ask about their resource and referral system, you are going to get a blank look. We have our systems, but they do not make sense in a traditional setting.

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

We also do not take much notice of the tribal communities’ fear of research and evaluation, which has a real choke hold. We need to address the myth that if a program is being evaluated,

then there is no need to keep evaluating it. We can provide training certification via tribal community colleges, which builds local resources, and we need to design ways of involving families, such as a companion training for parents.

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

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

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

Questions & Answers

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

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

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

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

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

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

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

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

Comment: Ellen Whitman

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

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



PANEL III: PREVENTION FOR ADULTS AND OLDER ADULTS

Gail Hutchings, M.P.A.

Moderator; President and Chief Executive Officer, Behavioral Health Policy Collaborative

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

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

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

Professor of Sociology in Psychiatry at Weill Medical College

My job is to talk to you about an intervention that we call PROSPECT, which stands for the Prevention of Suicide in Primary Care Elderly: Clinical Trial. PROSPECT was based on a suicide prevention model in that we targeted a large population with a high density of people at the highest risk for suicide in late life, and that is going to be in primary care.

The vast majority of older adults who have taken their lives by suicide have actually been to see their primary care physician within a month of their death. We focused on depression because depression in late life is, by a huge magnitude, the largest risk factor for suicide. It is in itself highly prevalent and modifiable; therefore, it is suitable for a prevention intervention.

Depression is a condition that robs people of their abilities, making it hard for people to contribute, whatever their physical status. It has an impact on people and their suffering, an impact on family, an impact on people's own

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

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

functioning medical status. And it is costly. Conducted in primary care settings, PROSPECT had three major components.

PROSPECT Intervention: Component 1

Help make sure that people get the benefits of what we know from clinical science about treatment — medication treatment, psychotherapy, or, perhaps, some combination. We know an awful lot about how to treat depression. The problem is people do not get treated. Or, they get started on treatment and they are not treated well. And, they are not treated well because they are not managed over time.

PROSPECT Intervention: Component 2

Have someone manage the depression over time. Someone needs to monitor symptoms, make sure people are getting better and are adhering to the treatments. If there are any problems, make sure that information gets back to the treating

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

PROSPECT Intervention: Component 3

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

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

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

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

someone to pay for the “whole box.” But, we can also think about the major components of the interventions.

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

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

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

Eric Goplerud, Ph.D.

Director, Ensuring Solutions to Alcohol Problems, George Washington University Medical Center

Five fairly typical case presentations:

- 55-year-old male admitted to the hospital for acute pancreatitis
- 23-year-old male traumatically injured in a car crash and admitted to the ER into a trauma center
- 45-year-old woman comes into a community health center for gastritis, acid reflux, and mild wheezing of asthma

- 19-year-old woman comes to the community health clinic to check about possible sexually transmitted diseases
- 37-year-old male seriously depressed with suicidal ideation comes to a community mental health center for service

What do these people have in common?

First, they are coming into contact with our health care system. They are likely to have alcohol or drug use that contributes to or complicates their treatment, and, likely, they are never asked about and never intervened for that condition. Had they received counseling as short as five minutes or as long as two to three sessions of 30 minutes, you could expect reductions in health care use, in injury, and in repeat DUIs, improvements in the kinds of health outcomes that the health care system is trying to achieve.

Screening and Intervention

What is screening and brief intervention?

One acronym: AIMS (Assess, Inform, Motivate, Support).

Assess. Use a standardized instrument. The World Health Organization has developed a terrific one called the AUDIT, a 10-item questionnaire that asks about frequency and quantity of use. The first three questions, which ask about average number of drinking days per week, average number of drinks on a drinking day, and days consuming five or more drinks (for a male, four or more for a female), have high sensitivity and specificity.

Inform. Provide feedback and expression of medical concerns about their substance use and educate, often just providing a brochure about use and unhealthy use.

Motivate. Use enhancement techniques to motivate the individual to explore options around changing their behavior because, after all, they are the ones who are going to be doing the work. Create a patient-generated plan and a commitment to following through.

Support. Support that individual in taking action through the plan with information, through telephone follow-up or scheduling a follow-up contact.

What is the evidence that this very brief, simple process can be useful? In 2005, the U.S. Preventive Services Task Force identified 54 randomized controlled trials that assessed the effectiveness of screening and intervention in emergency departments, trauma care, in-patient, ambulatory primary health care, employee

assistance programs, managed care, and even over the Internet. The vast majority of them found substantial positive effects.

Outcomes

After a brief intervention, the likelihood of reinjury and rehospitalization is reduced by nearly 50 percent in the following three years. For every nine screenings and brief interventions performed in an emergency department, there is a corresponding reduction of one DUI in the subsequent year. Following screening and brief intervention (SBI), there are meaningful reductions in hazardous drinking and drug use.

Is SBI being done routinely? Absolutely not! RAND found that only 5 percent of patients who were hospitalized

for trauma received any notation that their alcohol or drug use was screened.

PacifiCare Behavioral Health, a large West Coast managed behavioral health care company, found that there was a 70 percent discrepancy between patients who self-disclosed that they had serious drinking or drug use problems and any notation in the clinical file that the patient had ever been asked about alcohol or drug use. Surveys of family practice physicians, pediatricians, and ob-gyns find that SBI is something they know would be good to do, but they do not do it.

After a brief intervention, the likelihood of reinjury and rehospitalization is reduced by nearly 50 percent in the following three years.

Getting It Done

All kinds of training have been evaluated. It is free; it is online; it has been developed by the National Institute on Alcohol Abuse and Alcoholism, by the Center for Substance Abuse Treatment, by Boston University. Continuing education credits are available and free, and evaluation has been done on the effectiveness of training. The American College of Surgeons Committee on Trauma now requires that all Level I and Level II trauma centers demonstrate that they know how to do, and are doing, screening and brief interventions in order to retain accreditation.



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

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

I am going to describe the successful activity of a wildly diverse, interorganizational, intergovernmental, interdisciplinary group that got together and said the only way we are going to move SBI into the mainstream of American medicine is to get mainstream medicine paid to provide the services. Initially, the loose group of SBI advocates developed a proposal to CMS (Center for Medicare and Medicaid Services) to get new Medicaid reimbursement codes, called HCPCS codes, that will cover screening and brief intervention in general medical settings. That was accomplished, and in Jan. 1, 2007, two new HCPCS codes were made available by CMS for SBI. But is there a single Medicaid agency that pays on these codes? Not yet. Simply having codes available is not sufficient to get them turned on. To get individual state Medicaid agencies to start paying on these codes requires a state-by-state process.

Next, the SBI work group turned to the real mainstream of health care payment: the CPT, or Common Procedure Terminology. CPT is the primary way physicians and other health care providers account for their time and get paid by insurance companies. CPT is what Medicare, Medicaid, and health insurers use for reimbursement.

Incredibly, the American Medical Association approved the SBI work group's application for new screening and brief intervention procedure codes. As of Jan. 1, 2008, there will be two new CPT codes specifically for alcohol and drug screening and brief intervention. They are in the section of the CPT manual that says these are regular, general medical services. These SBI procedures are not specialist, psychiatric services. The AMA also specified that the new SBI CPT codes can be used by physicians and other qualified health professionals. It is not necessary to be a mental health or substance use treatment professional to use them. It is not necessary to be on a behavioral health provider panel of a managed behavioral health insurer to be paid for them. In addition to direct reimbursement for

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

We not only have the science, the training, and the tools, we have got the payment mechanism. Is this going to work? We hope so. This ought to be something that community

Richard Price, Ph.D.

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

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

Work fills most of our waking time and adult life, but it also spills over into family life. It is important for us to remember that jobs are packages of vital resources. Some of those resources are material, some of them are psychosocial, but they are crucial for psychological well-being, particularly an adequate income.

Jobs are also pathways of well-being for people with more severe mental health problems as they attempt, and often do, re-enter productive and valued roles in society. Job loss, and the resulting economic hardship and cascade of negative life events associated with it, produces individual and family stress, including increased risk for marital conflict, child abuse and neglect, increased rates of alcohol and drug abuse, increased criminal activity, and the onset of significant episodes of depression.

A single life event can cascade out into the life of individuals, their families, their colleagues, and their fellow workers in ways that can be extremely powerful. We developed the JOBS program, which is designed to help people re-enter the work force and gain higher quality jobs. In the last 20 or 25 years, that work has

gone from initial pilot work with Detroit autoworkers to randomized trials, first in the United States and later in other countries.

mental health organizations and behavioral health care providers jump all over, because this is going to help our clients with mental illnesses who have substance use problems to get SBI services at the point that they come into contact with the health care system.

We have worked in Michigan intensively, in Maryland, and in California in both East Los Angeles and Silicon Valley. We worked in Finland, where the JOBS program is now the national program; in the Netherlands; and in the People's Republic of China, where a JOBS program is still continuing in seven different cities.

We have some experience, and we have learned a great deal, not only about implementing a research-based prevention program in a wide variety of sociocultural settings but also about how good science and cultural differences can and do almost always go together.

Outcomes

In our randomized trials, we found that the JOBS program produces significant reductions of the level of depressive symptoms and depressive episodes in participants. It gets people re-employed more quickly and in higher paying and higher quality jobs. It helps populations at highest risk for depression; in fact, that is the subpopulation helped most by this program. It can be, and has been, implemented successfully in a wide variety of community settings: churches,

A single life event can cascade out into the life of individuals, their families, their colleagues, and their fellow workers in ways that can be extremely powerful.

community health centers, labor union halls. And it reduces the need and the cost for mental health services for those people. Data from a number of cost and benefit analyses suggest that

It is the right of children and families to get high-quality help in this country.

even just the increased tax revenue associated with re-employment means that the JOBS program pays for itself in approximately seven months of re-employment. That does not include the cost savings associated with increased utilization of health and mental health services.

There are now dozens, perhaps nearly 100, of programs over the last 25 or 30 years that have shown they can have a positive impact, and there are a number of other promising programs on the way. If we have such a good prevention science base across the whole life span, why are they not operating in all of our communities? I want to return to Dr. Julius Richmond's formula that what we need are three things: a knowledge base, an implementation system that really works, and political will. We now actually have a respectable base of knowledge, scientific knowledge, and more promising interventions on the way for children and families across the whole life course. Just 30 years ago, there were almost no programs that we could be assured that they really had an impact. That is an incredible accomplishment in 30 or 40 years, a huge leap forward, and we cannot take it for granted.

Implementation

Our implementation system is fractured and is only occasionally managed for quality. Political will means being able to mobilize patients, families, elected officials. It is the right of children and families to get high-quality help in this country. So what do we need to get that in place? We have the scientists; we have a surprisingly good range of high-quality science. We need to train more people who really care about

leading and managing, and we need advocates. We need leaders in this movement; it is not going to happen by itself.

Now when I talk about leaders, I mean champions. Champions do not do the science, but they make it their business to know the science. They also insist on quality delivery, and they know the difference between first-rate quality and not, which often depends on insisting on training and avoiding half measures.

The last piece is, of course, the advocacy piece. Champions get to elected officials and to other community stakeholders and bring the family to the table. They insist that we pay for prevention. It is a responsible investment in our future, and we could do no less.



Questions & Answers

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

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

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

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

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

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

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

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

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

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

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

Questions & Answers

There is activity around performance measures. The American Medical Association, National Committee for Quality Assurance, and the Joint Commission are actively considering the development of performance standards, as well as accreditation standards, for a screening and brief intervention for inpatient, emergency department, ambulatory health, and community mental health that they accredit. It is just beginning, but there is activity.

Q How can we develop best practices and integrate the great technology that we have today?

A Each of us needs to develop in the areas that we are most passionate about. We cannot be experts about everything. One way is to drill deeper than where we are because those same sets of issues are recurrent. If we become experts in moving some of those leverages in arenas where we are most expert, we will make some real progress.

Comment: Terry Mason

In my mind, one of the major risk factors is simply loneliness. There is no stimulation, we have isolated our seniors, we have gotten so busy in the way that we live that we start compart-

mentalizing our lives and compartmentalizing our families and taking our seniors out of the interactive circle. Some of the stuff that we need to do is just going back to the good old-fashioned things we used to do a long time ago, and it does not require a lot of research.

Comment: Wilma Townsend

Prevention cannot be about just assessment. Prevention is about the values that people carry. People who have a strong value system where they are, who know what they are going to do, who know what the community is about do prevention at home. We have lost a lot because we have gotten caught up in looking for the money and not looking at the person. Our values used to be that we took care of our old folks. Now, we leave them in nursing homes and forget to visit them. It wasn't putting them there; it is that we left them and forgot to do anything with them. Then they get depressed. If we talk about this in the realms of codes, money, and program and not about people, we are still going to lose. The value has got to be there.

POSTSCRIPT

Thomas E. Bornemann, Ed.D.

Director, Carter Center Mental Health Program

Gregory L. Fricchione, M.D.

Associate Chief of Psychiatry, Director, Division of Psychiatry and Medicine, Massachusetts General Hospital; Member, Carter Center Mental Health Task Force

One of the Carter Center Mental Health Program's strategic goals focuses on advancing prevention efforts to reduce the incidence and prevalence of mental illnesses. Harnessing the power of prevention and applying it to inhibit the onset or exacerbation of mental illnesses are long overdue. Neglecting prevention as a viable tool takes not only a human toll but also represents economic and societal costs in terms of lost productivity and disability.

Currently, the United States lags behind other developed countries in prevention services. Indirect costs of mental illnesses outweigh direct treatment costs by two to six times in developed countries, making the true cost to society staggering.

Historically, prevention services have been neglected and underfunded compared to treatment and rehabilitation services. Recent national events — positive and negative — have focused attention on preventing mental illnesses now more than ever before. Incredible stories of resiliency in the wake of hurricanes Katrina and Rita and troubling questions emerging from the Virginia Tech shootings drew the public-at-large into a national dialogue about the consequences of mental illnesses and the necessity for prevention. Prevention must take its place alongside other mental health practices and services.

Goals and Objectives

The goal of the 2007 Rosalynn Carter Symposium on Mental Health Policy was to nurture the development of a national leadership focus and public policy action agenda on the prevention of mental illnesses and their exacerbation.

Unlike past years' symposia that focused on specific populations, the 2007 meeting employed a life-span approach that more accurately reflects the public health challenge that prevention represents. This change in approach was designed to ensure that participants were provided with prevention-related research and service delivery models and programs that are germane to children, adolescents, and adults. In addition, faculty were requested to use a public health model to frame presentations and to emphasize the integration of science and practice.

In response to the President's New Freedom Commission report, federal government, state governments, and local communities are striving to transform their respective mental health systems. As a result, there is a collective acknowledgment of the imperative now to focus on prevention and early intervention for populations across the life span.

Due to many historical developments, the nation's attention is now focused more on preventing mental illnesses than ever before. The public has been an active participant recently in a national dialogue about the consequences of mental illnesses and our need to focus on prevention. The time is right for a national leadership focus on prevention, which can be supported by each stakeholder committing to initiate or expand at least one prevention activity within his or her organization.

The Charge

Participants met in working groups both days of the symposium. The first day they were asked to discuss what it would take for their organizations to promote or implement prevention interventions in their domain. On the second day they

were asked to identify the tools or information they would need to promote and implement preventive interventions in their domain or expand existing prevention initiatives, and what barriers or obstacles would need to be overcome.

Charge 1: *Identify barriers to wide-scale adoption and strategies for overcoming them. The most salient barriers identified by the presenters and participants included the following:*

Reactive Model of Health

One of the biggest challenges for implementation is to shift attention to the onset of illness by encouraging a public health approach to mental health.

A new model that considers comprehensive factors such as a history of abuse when conducting patient medical history questionnaires is sorely needed.

Policies in Health System

Physicians and health care providers must be paid to carry out screening and brief intervention practices because many current policies serve as disincentives to the full implementation of evidence-based interventions. For example, currently, laws in 32 states allow insurance companies to deny payment for people who were under the influence of alcohol when they were injured. This leads many health care providers to avoid testing for blood alcohol level, since they fear they will not be reimbursed for services administered to patients under the influence.

The current system rewards providers for treating symptoms, not for preventing the problem and promoting mental health.

Policies in School Systems

School administrators and staff are not encouraged, trained, or paid to focus on social-emotional factors of development in children and adolescents but are instead busy trying to meet academic achievement requirements on standardized examinations.

It becomes critical to demonstrate the importance of social-emotional factors in education, since carrying out research related to social-emotional factors in education is expensive and not considered a priority within the system.

Policies in Foster Care System

One of the biggest barriers to proper mental health that foster children face is the lack of a stable, consistent caregiver. The system must be reformed to provide a more stable environment for the developing child.

Lack of Political Will and Activism

Despite a growing knowledge base, political will and activism for mental health initiatives are lacking. Patients, families, and elected officials must be mobilized to create changes in the current system.

Inadequate Training of Primary Care Staff

Health care providers in primary care settings must be adequately trained to identify depression and other behavioral issues in children and adults since the majority of cases present in the primary care setting and are overlooked.

In addition, colleagues in medicine and surgery must be engaged and committed to prioritize the prevention and proper treatment of mental illnesses.

Lack of Implementation of Research Models and Data

Data and research findings are not being used constructively and actively in society. The current body of knowledge must be incorporated into everyday practice within hospitals, schools, and communities at large.

Data needs to be collated, repackaged, and translated so that it is more generally available.

Need for Business Model in Mental Health

The adoption of a business model may help overcome the challenge of putting the extensive number of models proposed by research into action.

The training of leaders and managers within the mental health system also should occur.

Cultural Differences

Cultural differences should be taken into consideration when conducting research with populations such as Native American tribes. Since many of these groups fear and mistrust the research and evaluation of interventions in their communities, it is necessary to involve important figures and the community at large.

Cultural interventions that do not rely on evidence-based research are often ignored. Many of these interventions have proven successful within the specific cultural groups they grew out of and should be given more consideration.

Ageism

One of the biggest barriers older adults face when seeking care for late-life depression is the public perception that it is normal for older individuals to be depressed and that treatment is therefore futile.

Stigma

Patients still feel shame in reporting a history of abuse during medical evaluations.

Parents are still reluctant to seek help for their own and their children's behavioral problems.

Poverty

There is still a great need for a comprehensive package of interventions to reduce child poverty and increase family investments in youth. Youth in poverty are at greater risk for experiencing behavioral or emotional problems.

Individualism

The biggest obstacle to screening, early intervention, and many of the other topics discussed during the symposium is a fundamental and societal belief in individualism. Although there is much talk of community and collaborative measures, people still think and act on an individual level, which may lead them to avoid seeking help or intervening on behalf of others.

Charge 2: *Identify gaps in the scientific evidence and encourage controlled outcome studies to address them.*

Symposium participants identified the need for further research with the following populations:

- Immigrants/Refugees
- Prisoners
- Homeless people

Participants also identified the following as areas that have been ignored:

- Interventions that are not evidence-based arising in specific cultures, such as Native American tribes
- Interventions in rural settings

Conclusion

The symposium used a public-health-oriented approach and examined prevention across the life span. It drew attention to the importance of policy-level changes in public health and mental health systems and services. It provided participants with an opportunity to disseminate research supporting changes in policy that will increase the use of prevention programs for people at risk for or currently experiencing mental illnesses.

Holding the symposium does not mean an end to the Carter Center's activities in developing a national leadership focus and public policy action agenda on the prevention of mental illnesses and their exacerbation. An immediate follow-up activity to the symposium is our online survey of participants. The information provided will lead to a better understanding of what they and their organizations have been able to accomplish in implementing or expanding prevention activities and what barriers they overcame and what barriers remain. This information will be shared with the field to help determine what steps need yet to be taken.

Biographies



William R. Beardslee, M.D.

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



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



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

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



Terry Cline, Ph.D.

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



Mary Dozier, Ph.D.

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



Vincent J. Felitti, M.D.

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



Gregory L. Fricchione, M.D.

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



Eric Goplerud, Ph.D.

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

**Larke Nahme Huang, Ph.D.**

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

**Gail P. Hutchings, M.P.A.**

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

**Jane Knitzer, Ed.D.**

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

**David Osher, Ph.D.**

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



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



Paulette Running Wolf, Ph.D.

An enrolled Blackfeet tribal member, Paulette Running Wolf is a counseling psychologist with more than 20 years of experience in American Indian program development, research, and evaluation in education, community mental health, and social services. Running Wolf has provided community mobilization and planning services in more than 30 tribal communities nationally and is committed to the improvement of behavioral health services in tribal communities. She is currently a board member and acting executive director of the First Nations Behavioral Health Association. Running Wolf has successfully implemented national quantitative and qualitative outcome-based evaluations in numerous tribal communities, both urban and on reservations. She is a private national consultant.



Carolyn Webster-Stratton, M.S.N., M.P.H., Ph.D.

Carolyn Webster-Stratton is professor and director of the Parenting Clinic at the University of Washington. A nurse and licensed clinical psychologist, she has published numerous scientific articles evaluating training programs for helping families and teachers with children who are highly aggressive, disobedient, hyperactive, and inattentive. She has had extensive clinical experiences helping more than a thousand families whose children were diagnosed with conduct problems and attention-deficit disorder. In addition, she has offered her training program to teachers and parents as school- and community-based interventions designed to prevent young children's behavior problems from continuing into adolescence.

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