THE TIME IS NOW

Report of the NECON Task Force on Mental Health Promotion and Mental Illness and Substance Abuse Prevention

The New England Coalition for Health Promotion and Disease Prevention (NECON), a not-for-profit, non-partisan organization, was established in 1984 with the creation of working groups and health-examining task forces whose members represented multiple disciplines from all six New England states. Today, NECON is a coalition of the New England state health departments, the region's schools of public health and federal health agencies led by region I of the U.S. Department of Health and Human Services, as well as medical societies, legislators and representatives from industry, labor and voluntary associations. Its mission is to serve as an instrument for the development and enhancement of disease prevention and health promotion public policies in New England.

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EXECUTIVE SUMMARY

Mental illness is a significant problem in the United States. It is a problem our society has failed to address, partly because it has not been viewed as a public health problem, and partly because of the myth that it cannot be prevented, treated, or controlled. But the costs to society and the cost to families, employers, and public programs is too large for us to continue sweeping mental illness under the rug. The purpose of this report is to open a dialogue on the place of mental health promotion and illness prevention in the New England health system in the twenty-first century.

Impact on Health: Four mental disorders are among the top ten causes of disability worldwide: major depression, bipolar disorder, schizophrenia, and obsessive-compulsive disorder. One of these, major depression, is associated with suicide, which is the 8th leading cause of death in the United States. (Three New England states—Maine, Vermont, New Hampshire—have suicide rates considerably above the national average, and which are increasing.)

Cost to Society: In 1996, direct costs of mental illness in the United States approached $100 billion, including:

- $69 billion for mental health services,
- $13 billion for direct treatment of substance abuse, and
- $18 billion for treatment of Alzheimer's and other dementias.

A 1990 estimate of indirect costs—including everything from absenteeism and lost wages to involvement in the criminal justice system—indicated a $79 billion loss to the U.S. economy from mental illness.

Mental disorders are health problems and, as the Surgeon General of the United States has said, should be approached in the same way that we approach prevention of other health problems; i.e., that we:

1. identify underlying risk factors,
2. develop and implement preventive interventions, and
3. actively promote good mental health.

The emphasis on prevention is appropriate because it forestalls suffering and improves the quality of life, is considerably less expensive than treatment, and can contribute potentially significant savings to the nation's economy. And there is considerable evidence that prevention works.

Three giant steps are required in order to move mental health promotion and illness prevention into the mainstream of America:

1. increased public awareness and understanding,
2. increased active engagement and participation of primary care physicians, and

3. increased public investment, especially under the Medicaid program, which provides coverage to populations with some of the highest rates of mental and emotional problems.

The recommendations in this report describe three strategies for achieving these objectives in collaboration with NECON:

- Establish working groups to assess service needs and resources in the region, and to develop reliable statistical indicators to measure performance of prevention and promotion programs.
- Provide the required financial support for mental health programs and services by assuring mental health parity with physical health in public and private insurance coverage, and by applying Medicaid and a portion of state tobacco settlement funds to mental illness prevention and mental health promotion.
- Establish and expand mental health promotion in schools and community settings, and to educate and involve primary care physicians in routine incorporation of mental health screening as part of a clinical prevention practice.

INTRODUCTION

The New England Regional Task Force on Mental Health Promotion and Disease Prevention was convened in the year 2000 to report to the New England Governors Conference. The Task Force has a charge to report back to the Governors on:

1. the health and social impact of mental illness,
2. approaches to mental health promotion and mental illness and substance abuse prevention,
3. mental health resources and programs in the New England region, and
4. recommendations for action by the New England states.

Because mental illness is such a significant public health problem; and because it is a problem our society has failed to address effectively; and because of the myth that it cannot be prevented, the purpose of this report is a call to action to change these perceptions. It is also intended to initiate a dialogue on the place of mental health promotion and mental illness and substance abuse prevention in the New England health system in the twenty-first century.

The time is ripe for instituting a proactive approach to mental health promotion. Over the last 25 years mental health has been the subject of intensive scientific research and public policy analysis, culminating in three ground-breaking reports:

In 1978, the President's Commission on Mental Health recommended the creation of a Center for Prevention at the National Institute of Mental Health, subsequently established in 1982 (President's Commission on Mental Health, 1978).

In 1994, the Institute of Medicine report entitled Reducing Risks for Mental Disorders: Frontiers of Preventive Intervention Research summarized research that clearly demonstrated that prevention of mental illness was feasible (Mrazek & Haggerty, Eds., 1994).

In 1999, the Surgeon General's Report on Mental Health stated flatly that "mental health is fundamental to health" and that "mental disorders are real health conditions", and laid out the principles for a public health approach to mental illness prevention, i.e., to

1. identify risk factors for mental health problems,
2. mount preventive interventions that block emergence of severe illness, and
3. actively promote good mental health (USDHHS, 1999).

Now, at the beginning of the twenty-first century, the time has come to systematically apply what has been learned.

DIMENSIONS OF THE PROBLEM

Health Impact

The disease burden of mental illness, measured in years lost to premature death and years lived with a disability, is second only to that of cardiovascular conditions, according to a 1990 study. Four mental disorders have been identified as among the top ten causes of disability worldwide: major depression, bipolar disorder, schizophrenia, and obsessive-compulsive disorder (USDHHS, 1999).

There is growing evidence that the health disparities among Americans are exacerbated by the lack of access to appropriate mental health services. This is especially true for racial and ethnic minorities, according to a panel of the American Psychological Association at a recent conference in Washington, D.C. (American Public Health Association, 2000). At this same conference, Jeanne Miranda, Ph.D., associate professor of psychiatry at Georgetown University, presented research showing that when minorities receive mental health services, "health outcomes improve beautifully." Mental health problems are also associated with some of the most pressing negative social consequences of concern to our society, e.g., problems of substance abuse, poor performance in school and at work, teen pregnancy, violence, and suicide. For example, the National Co-Morbidity Substance Abuse and Psychiatric Disorders Study, funded by the National Institute of Mental Health, found that 47 percent of persons with schizophrenia are substance abusers and 32 percent of persons with affective disorders (including depression) have substance disorders. Persons with schizophrenia are 4.5 times as likely to abuse alcohol or drugs than the general population. Nationally, an estimated 7.2 million people between 18 and 54 suffer from co-occurring disorders (Regier, 1999). The relationship between substance abuse and mental illness is clear.

The correlation of suicide to depression may be taken as an example of the impact of mental health on physical health. In 1998, the most recent year for which statistics are available, suicide was the

8th leading cause of death in the United States. As seen below, suicide rates in three New England states are above the national average and rose dramatically from 1997 to 1998. Major depression accounts for over two-thirds of suicides each year. In 1997, 77 percent of adults diagnosed with depression failed to receive treatment.

Table A
Suicide Rates in New England States: 1997 and 1998

State	1998 Rate	1998 Number	1998 Rank	1997 Rank	1997 Number	1997 Rate
Maine	15.8	196	10th	37th	137	11.0
Vermont	14.6	86	13th	21st	73	12.4
New Hampshire	13.0	154	20th	32nd	136	11.6
USA TOTAL	11.3	30,575			30,535	11.4
Rhode Island	8.7	86	45th	49th	72	7.3
Massachusetts	8.2	506	47th	45th	492	8.0
Connecticut	7.8	257	49th	46th	259	7.9

Suicide rates increase with age, e.g., 1.6/100,000 for 10- to 14-year-olds; 9.5/100,000 for 15- to 19-year-olds; 13.6/100,000 for 20- to 24-year-olds—up to 47.0/100,000 for men aged 80 to 84, in 1996. Suicide rates are highest for minorities, e.g., 11.4/100,000 among African-American male adolescents in 1997, and 62.0/100,000 among Native American male adolescents and young adults in Indian Health Service areas.

Social Costs

In 1996, the U.S. spent $69 billion on direct costs for mental health services; another $13 billion was for direct treatment of substance abuse; and $18 billion was spent for treatment of Alzheimer's and other dementias, or a total of $99 billion in direct spending.

In addition, a 1990 estimate of indirect costs (including everything from absenteeism and lost wages to involvement in the criminal justice system) showed a $79 billion loss to the U.S. economy from mental illness. The fact that morbidity costs comprised about 80 percent of indirect costs indicated an important characteristic of mental disorders: mortality is relatively low, onset is often at a younger age, and most of the indirect costs are derived from lost or reduced productivity in the workplace.

Given the costs of mental illness simply in dollar terms, the advantages of investing in primary and secondary prevention are obvious.

PREVENTION WORKS

Mental health conditions have multiple causes and some are more amenable to preventive interventions than others—interventions that prevent onset (primary prevention) or treatment to retard or reverse progression (secondary prevention), e.g., counseling and medications.

Prevention programs that have proven successful are:

- targeted toward specific populations,
- aim at long-term change,
- give people new skills to cope more effectively in the face of life transitions,
- strengthen natural supports such as family, community and schools, and
- collect rigorous research evidence to document their success.

The following are some examples of such programs.

In the *Children of Divorce Intervention Program* (CODIP) (Pedro-Carroll, Alpert-Gillis, 1997), five- and six-year-old children whose parents had been divorced participated in a supportive group environment where identification, acceptance, and appropriate expression of divorce-related feelings were facilitated. This process promoted understanding of divorce-related concepts and encouraged exploration and clarification of divorce-related misconceptions. Relevant competencies such as communication and problem-solving skills were taught. This enhanced children's perceptions of themselves and their families. *Program children increased significantly in such school related competencies as tolerating frustration, getting along with classmates, being appropriately assertive, and asking for help when needed. Program children were significantly less anxious, withdrawn, and tended to be less disruptive than a non-program, divorce-control group of demographically-matched peers.*

The 1994 prestigious Lela Rowland Prevention Award of the National Mental Health Association was given to the San Francisco Prevention Research Project (Munoz, 1995). This project sought to prevent the incidence of serious depression as well as to reduce the duration and intensity of depressive episodes, if one does become depressed. Low income, minority, adult participants were taught several cognitive-behavioral techniques focusing on three main areas: thoughts, increasing pleasant activities, and interpersonal skills. A social learning approach was used to teach participants about the connection between their feelings, thoughts, and behaviors. *Depressive symptoms were significantly lowered* after the intervention for participants in the Depression Prevention Course compared to participants who watched a video or who had no intervention at all.

In *The Colorado Separation and Divorce Program: A Prevention Intervention Program for Newly Separated Persons* (Bloom and Hodges, 1988), recently separated men and women received one-on-one consultation support, whenever needed, during a six month period. Results indicated *better adjustment in the experimental subjects* in the areas of career and employment, legal and financial, single parenting, housing and homemaking, and socialization.

In the *Widow-to-Widow: A Mutual Help Program for the Widowed* (Silverman, 1988), already widowed aides visited newly widowed to give support. Reports on what was learned regarding the bereavement process and the effectiveness of visits were regularly produced, leading to numerous successful replications. Although it could not be demonstrated empirically that risk among the widowed for serious emotional problems had been reduced, a measure of *the merit of this model is reflected in the success of replicated efforts.* Evaluation in this example was process oriented, qualitative and descriptive.

The Stress Management Training Program (Tableman, Marciniak, Johnson, Rodgers, 1982), provides life planning skills, stress management strategies, experiential activities, "self-discovery" exercises, and changing perceptions of oneself for adult participants. Results included *reduced depression and anxiety, improved cognitive skills, improved internal locus of control, and improved self-confidence/esteem.*

We know what to do—let's do it.

INVESTING IN PREVENTION

"Prevention is an active process of creating conditions and personal attributes that promote the well-being of people." (Lofquist, 1983) Mental health promotion initiatives do not generally receive a positive response from legislators when compared to the pressing need to adequately fund overburdened treatment systems. Yet, in a well-balanced system of care, promotion initiatives play a key role in both diminishing the negative social consequences of mental illness as well as promoting an important anti-stigma message.

Promotion and treatment are not "either/or" propositions. Good treatment for mental illnesses includes the promotion of "mental health" or positive coping mechanisms. Similarly, attention devoted to a mental health promotion agenda will bring added support to treatment systems. Mental health treatment and mental health promotion occur on a continuum where treatment is provided for those "most in need" while continuing emphasis is placed on a vision that furthers the mental health of all people.

We are increasingly aware that mental health and substance abuse disorders are intertwined. Continued segregation of funding streams to treat these disorders runs counter to convincing evidence that successful outcomes require integrated treatment.

There will likely be a need for dual infusion of resources in the short term—the support of effective, timely treatment along with the prevention efforts—before long term results are achieved in terms of health improvement and budgetary savings. Interrupting the cycle of family violence, for example, involves treatment/interventions for the adults who may be suffering an emotional disorder such as depression or substance abuse, as well as prevention of known likely problem behaviors that follow in children, such as poor focusing in school or conduct disorders. In the long run, such prevention

efforts reduce the need for expensive services as these children age into adulthood. Such services include public financial support for unemployment or underemployment, medical and behavioral health care, and law enforcement costs. The question is not whether we can afford emotional and behavioral illness prevention but whether we can afford not to support it.

In this vein, an examination of the Medicaid program is most revealing. Medicaid is a remarkably versatile program. In every New England state, Medicaid covers a broad array of behavioral health care services: individual and group family therapies, pharmaceuticals, screening, rehabilitation, and when necessary, hospitalization. Most importantly for this discussion, Medicaid can cover more specific screening, diagnostic, and treatment services than it does now. The program can be weighted more toward early detection and early treatment of mental illness. Medicaid can also make changes to the current delivery system to ensure there is an appropriate continuum of behavioral health services and that they are integrated with primary care.

The Medicaid program has two broad requirements that focus on early identification and treatment: Early Periodic Screening, Diagnosis and Treatment (EPSDT), and Pre-Admission Screening and Resident Review (PASRR). Recent studies have shown that screening for behavioral health is not well incorporated into states' EPSDT requirements. For example, only 14 states have specific tools for mental health screening. (Bazelon Center for Mental Health Law, 1997) Considering the now widely recognized importance of early detection for autism, depression, and other disorders, earlier and better behavioral health screens for children are a priority.

Until we begin to allocate an appropriate percent of available funds to prevention/promotion activities, the need for services will continue to outpace the demand, leading to greater and greater deterioration in quality of life and the public good. In his 1991 benchmark publication entitled Prevention: The Critical Need, Jack Pransky states that, "In all problem-based and health promotion fields combined, prevention receives a mere fraction of the resources it needs to make a noticeable difference. . . If prevention were given the necessary resources to affect everyone in a community who needs it, prevention would clearly be able to demonstrate community-wide, statewide, and even nation-wide reductions in problem behaviors."

STATE MENTAL HEALTH INITIATIVES

Every New England state has a number of prevention efforts under way. These efforts range in scope from local initiatives organized in collaboration with state offices to federally-funded activities that take a statewide systems approach. The common themes among all New England states include a focus on early childhood and youth oriented prevention programs, both community and school-based. These programs target the general population as well as children at risk. Special emphasis is also placed on youth suicide and violence prevention. The availability of federal support has furthered these efforts.

Annual depression screenings are conducted in some states through their Mental Health Association affiliate or other organizations. These screenings target adults and the elderly and are conducted in local hospitals, health clinics, shopping malls, and universities. Participants in the screening view an educational video and then complete a brief questionnaire with a trained health care professional. If results from the questionnaire indicate risk, the participant is referred to an appropriate source for services. A goal in several states this year is to encourage primary care physicians to conduct such screenings in their offices. Research has shown that treating depression in primary care settings can prevent unnecessary hospitalizations.

VERMONT

Vermont developed and passed the first state mental illness prevention law (Vermont's Act 79 of 1983). Beginning in 1985, the Children and Family Council for Prevention Programs has shared responsibility with the Vermont Prevention Institute to produce a biennial Vermont Primary Prevention Plan. This year's plan focuses on four key areas: 1) expanding the idea of prevention, 2) recognizing the impact of economics on prevention, 3) treating people as resources, and 4) collaboration. One example of their prevention efforts is early childhood funding via CUPS (Children's Upstream Services) to develop core competencies.

CONNECTICUT

In January, 2000 Connecticut Governor John G. Rowland created a Blue Ribbon Commission on Mental Health. One of the six elements in the Governor's charge to the Commission was that it "emphasize potential applications of new knowledge in the area of prevention and earlier identification of mental illness." Primary recommendations of the commission included: implementation of a community education campaign; integration of primary prevention into the state system of care; development of a comprehensive interagency state plan with an agenda to promote mental health across the lifecycle; and establishment of primary prevention programs based on proven models, driven by indicators and benchmarks. This agenda will be financed by a prevention budget across departmental lines.

RHODE ISLAND

In 1996, Rhode Island established the Mental Health Advancement Resource Center (MHARC). MHARC provides technical assistance to organizations wishing to implement prevention/promotion programs. The center maintains a resource library and a web page; conducts annual forums and conferences on the theme of prevention in the field of mental health; participates in numerous state partnerships and collaboratives dealing with prevention issues; and has awarded annual mini-grants to organizations competing for prevention program and research grants. The Department of Mental Health, Retardation and Hospitals, in conjunction with the Department of Human Services, the Departments of Elementary and Secondary Education, the Department of Health, and the Department of Children, Youth, and Families have embarked upon an emotional competency agenda for all Rhode Island citizens. A joint resolution has been passed in the Rhode Island General Assembly encouraging the establishment of emotional and social competency learning programs in local school districts.

MASSACHUSETTS

Massachusetts has focused its prevention agenda on children and adolescents, specifically on violence and suicide prevention. The Department of Mental Health has collaborated with the Massachusetts Association of School Superintendents on efforts to prevent violence in the schools, and is a partner with "Screening for Mental Health" in an outreach activity to enroll 500 high schools in Massachusetts to participate in National Depression Screening Day. This activity offers a new suicide prevention program for high school students. Massachusetts conducts research efforts through the two Massachusetts Centers for Excellence on the cause of, and early intervention in, serious mental illness; and continues to expand the "Changing Minds" campaign to reduce or eliminate stigma.

MAINE

Maine has created the state government Office of Women's Health that reflects the goal to incorporate behavioral health issues. The incidence of depression in women is double that of men. Maine is also focusing on trauma as a significant issue in both mental illness and substance abuse.

NEW HAMPSHIRE

New Hampshire is working in the context of Healthy People 2010 to focus on a series of mental illness prevention initiatives. These initiatives will be directed primarily toward the child/adolescent population and toward the reduction of stigma. Work is underway in collaboration with the State's Department of Education to utilize the school setting to promote both information about mental illness as well as positive interventions to encourage mental and emotional well being. A public information campaign is being developed by the State's Division of Behavioral Health to address the issue of the stigma experienced by those who have mental illness.

Current mental illness prevention efforts are fragmented and not well-funded or coordinated. Proven models with demonstrated efficacy are not being used in a systematic fashion. Much has been learned in the area of substance abuse prevention that can serve as the basis for development of effective mental-illness prevention programs, especially for those disorders that are not caused primarily by biological and genetic factors.

INFORMATION NEEDS

Planning adequately funded public health care interventions requires quantitative information. The information must address both the needs for interventions and the priority that society places on meeting these needs. Measuring the needs for interventions requires considering the following more objective variables:

- Demographics: The types and numbers of persons with specific risk factors. For example, males are four times more likely to die from suicide than are females. However, females are more likely to attempt suicide than are males.

- The types and amounts of services needed to avoid or protect against risk factors. For example, screening for depression by primary care physicians could significantly reduce suicide in elderly men.
- The costs of delivering the interventions under foreseeable delivery options. For example, should managed care pick up the costs for screening and early intervention since they stand to benefit from the reduced costs of health care?
- The positive outcomes the interventions would achieve and the negative ones they would avoid. For example, early intervention for children who witness violence provides support that can prevent future depression in them as adults.

Given this information, planners can describe the persons needing prevention services, the types and amounts of services they will need, the costs of these services, the positive impact of the services, and why public funds should be used to support these services. In this framework, public officials in the executive and legislative branches of government can decide to fund prevention services responsibly—with a well-defined understanding of why and how public funds are to be expended.

This type of information needs to be developed for specific populations. Children, adults, and older persons are vulnerable to different risks for mental disorders and their consequences require different prevention interventions. Factors such as race, ethnicity, and co-occurring physical conditions also need to be considered. For instance, depression may look different in a ten-year-old Caucasian boy than it does in his grandmother, and it may be understood differently in the Cambodian-American community than it is in mainstream American culture. Cultural differences among diverse American populations are reflected in differences in the expression of depression and the preferred styles of coping and help-seeking behavior. These differences impact the utilization and effectiveness of treatment. Culturally competent services and treatment need to incorporate respect for and understanding of these differences.

Additionally, evidence-based interventions that respond to specific risks also need to be identified. Amassing such information is a formidable, but not an impossible, task. Many public databases, such as those recording births, deaths, academic performance, arrests, and nursing home placements, aggregated and analyzed in creative ways, can be used to identify and measure risks for mental disorders and estimate needs for prevention services. New techniques for collecting research studies and synthesizing their findings make it possible to identify evidence-based practices to protect against these risks. Doing so will require resources and a willingness to solve the problems of assuring privacy associated with linking public records.

STRATEGIC APPROACHES

In order to move forward with a systematic health promotion and illness prevention program, several strategic approaches will be required. Progress will require creative effort to:

- *Create clarity and focus.* Developing an initiative that focuses on the prevention of depression and other mental disorders across the lifespan needs to be a well thought out process that involves multiple steps toward the goal of reducing the factors that contribute to the occurrence of symptoms. Such a process will involve the identification of a unique, at-risk population in communities and the development of a series of sequential interventions that can reduce the risk factors prevalent in the lives of these populations.
- *Create consensus across key stakeholders regarding a vision for a behavioral health wellness/prevention agenda.* Advocacy for mental health can include several action steps. The first and most important of these is to create partnerships with key constituencies. If we are to create "win-win" collaborative arrangements, we must learn to "walk in the shoes" of key partners to understand each other's policy, regulatory, and funding worlds; and encourage all players (state, local, private, consumers) to understand each other's underlying values. The list of possible partners is long and includes, at minimum:
    - Involving the substance abuse community in mental health promotion efforts. They are crucial to reaching the significant portion of people with mental illness who are at risk for substance abuse.
    - Creating a link between physical and mental health and enlisting the support and involvement of health care communities including the state entity responsible for health promotion and disease prevention.
    - Forging partnerships with early education and school based programs that include social and emotional learning. The literature support for some of these programs is extensive.
    - Developing linkages with the business community in the development of prevention programs and the promotion of "emotional competency in the workplace."
    - Finding partners among grassroots community groups and organizations whose mission may be interpreted to include the promotion of mental health.
- *Create win-win fiscal incentives.* Some would argue that there are ample resources in the public system to address several of the issues that the task force has been discussing. However, these funds are circumscribed in such a way that it is impossible to use them in a collaborative or "blended" manner. Mechanisms need to be developed that not only allow, but encourage, local input into funding decisions. A prevention budget should be developed across departmental lines, and states should allocate a reasonable percentage of Tobacco Settlement Funds toward prevention efforts.
- *Create a common framework.* Identify the contributing "causes" of depression for each age group in order to understand the differences and similarities in risk/protective factors for children, adolescents, adults, the elderly, the culturally diverse, and other special groups. Decide how best to utilize resources and provide prevention services based on this understanding.

RECOMMENDATIONS

"Mental health is fundamental . . . and mental disorders are real health conditions" the Surgeon General declared in his report last year. Indeed, according to a recent worldwide study for the World Bank, "the disease burden of mental illness, measured in years lost to premature death and years lived with a disability, is second only to that of cardiovascular conditions."
The New England states share this burden and in keeping with NECON's mission to foster collaboration among states, governmental agencies, and non-governmental organizations in mental health promotion and mental illness prevention, we recommend that the Governors in each state:

1. Ensure mental health parity in all insurance plans and extend state subsidized insurance to those low income, working adults without health insurance-coverage that includes screening and other demonstrated effective preventive services;

2. Assign personnel to collaborate with NECON to identify the existing programs, policies, and structures that fall within the areas of both substance abuse and mental health and determine how they might be addressed in an integrated way;

3. Identify a representative to work with NECON to form a regional working group to review public health data collection systems across the New England states. This group will be charged to identify several comparable indicators to measure improved outcomes, especially among diverse cultural groups;

4. Use proceeds of tobacco tax and settlement funds to establish or expand health promotion and illness prevention in the areas of mental health and dual disorders; to this end we can build on "common ground" with state Medicaid and other cross-agency funding, as well as public/private partnerships, to forge a broad mental health promotion and illness prevention base;

5. Establish and expand school and community based health programs that include comprehensive mental illness prevention and health education services across the lifespan. These programs require trained personnel that can identify points of intervention and can screen for early indications of depression in school and primary care settings across the lifespan; the programs also require referral linkages to services and alternative programs as follow-up screening. Improve coordination between the state departments of mental health and education;

6. Honor a significant community mental health promotion and illness prevention initiative in each of the six states with recognition from the annual New England Governors Conference.

REFERENCES

American Public Health Association. (2000, August). Speech presented by Jean Miranda. The Nation's Health.

Barton, H. A., Hopkins, K. N., McElhaney, S. J., Heigel, J., & Salassi, A. (1995). *Getting started: The NMHA directory of model programs to prevent mental disorders and promote mental health.* National Mental Health Association.

Bloom, B. L., & Hodges, W. F. (1988). *The Colorado Separation and Divorce Program: A preventive intervention program for newly separated persons.* In R. P. Price, E. L. Cowen, R. P. Lorion, & J. Ramos-McKay (Eds.), 14 ounces of prevention (pp. 153–164). Washington, DC: American Psychological Association.

Hoyert, D. L. et. al (1999). *Deaths: Final data for 1997. National Vital Statistics Report 47 (19).* Hyattsville, MD: National Center for Health Statistics. DHHS Publication No. (PHS) 2000-1120 (p. 85, Table 26). (data are by place of residence)

Loftquist, W. A. (2000). *Discovering the meaning of prevention: A practical approach to positive change* (7th printing). Tucson, AZ: Development Publications.

Mrazek, Patricia S. & Haggerty, Robert, Ed. (1954). *Reducing risks for mental disorders: frontiers for prevention intervention research.* (Institute of Medicine). Washington, DC: National Academy Press.

Munoz, R. K., et al. (1995). *Prevention of depression with primary care patients: a randomized controlled trial.* American Journal of Community Psychology, Vol. 23, pp. 199–222.
Murphy, S. L. (2000). Deaths: Final Data for 1998. National Vital Statistics Report 48 (11). Hyattsville, MD: National Center for Health Services. DHHS Publication No. (PHS) 2000-1120. (p. 86, Table 26). (data are by place of residence)

Pedro-Carroll, J. L. & Alpert-Gillis, L. J. (1997, Fall). *Children of Divorce Intervention Program (CODIP), A Developmental Model for 5 & 6 Year Old Children.* Journal of Primary Prevention. (Vol.18, #1).

Pransky, J. (1996). *Prevention: The critical need* (3rd printing). Springfield, MO: Burrell Foundation and Paradigm Press.

President's Commission on Mental Health. Vol. 4. (1978). Washington, DC: U.S. Government Printing Office.

Regier, Darrel A. (1999, Nov. 21). *Comorbidity of Mental Disorders with Alcohol and other Drug Abuse.* Journal of the American Medical Association (Vol. 264, #19).

Silverman, P. R. (1988). *Widow-to-widow: A mutual help program for the widowed.* In R. P. Price, E. L. Cowen, R. P. Lorion, & J. Ramos-McKay (Eds.), 14 ounces of prevention (pp. 175–186). Washington, DC: American Psychological Association.

Tableman, B., Marciniak, D., Johnson, D., & Rodgers, R. (1982). *Stress management training for women on public assistance.* American Journal of Community Psychology, 10(3), 357–367.

U.S. Department of Health and Human Services (1999). *Mental health: a report of the surgeon general.* Rockville, MD.

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