Legislative Seminar Report

Sturbridge, Massachusetts
November 27, 2001

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 health policies with an emphasis on disease prevention and health promotion in New England.

The New England Coalition for Health Promotion and Disease Prevention
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INTRODUCTION

The NECON Task Force on Mental Health Promotion, Mental Illness and Substance Abuse Prevention completed its first major report, The Time Is Now, in August 2001. It was presented to the New England Governors Conference at their 2001 summer meeting in Providence, RI. The Legislative Seminar, held in Sturbridge MA in November 2001, was a follow-up to that meeting with primary focus on the state legislators and policymakers. Legis-lators and Mental Health Commissioners from each of the New England states were represented. The purpose of the meeting was to begin a dialogue with New England legislators concerning mental health promotion and mental illness and substance abuse prevention, and to provide a forum for discussion on both understanding the basics of prevention and its significance as a state health policy issue.

Representatives Patricia Dillon from Connecticut and Elaine Fuller from Maine and Senator Elaine Alfano from Vermont described prevention activities in their states and identified concerns about the relationship of mental health to prevention and the public's perception of this relationship. The relationship between the executive and legislative branches and its changing dynamic was another theme that included the allocation of resources and the establishment of priorities. Discussions among the participants followed the presentations by the legislators. A summary of the presentations and discussion is described in the body of this report.

Tom Gullotta, former editor of the Journal of Primary Prevention and currently the Director of Child and Family Agency of Southeast Connecticut, addressed the seminar on the essentials of primary prevention. His remarks are summarized in this report.

The significance of the legislative seminar rests on the unique policy responsibility state legislators have. Each state has its own culture and indigenous approaches to governance. The priority for NECON is to emphasize these strengths and important values and create a regional perspective from which collective action can occur. The regional structure allows sharing of prevention programs, research, and information and technology. It facilitates strategic opportunities that serve the larger whole as it enhances each state's individual performance in serving its citizens. This report on the Sturbridge Legislative Seminar is a first step in that direction.

Joseph J. Bevilacqua, Ph.D.
Chair, Mental Health Task Force

LEGISLATORS IN ATTENDANCE

CONNECTICUT

Representative Patricia Dillon
Representative Jack Thompson

MAINE

Representative Elaine Fuller

MASSACHUSETTS

Representative Carol C. Cleven
Representative Kay Khan
Representative Doug Petersen

NEW HAMPSHIRE

Representative Patricia Dowling
Representative Rogers J. Johnson
Senator Katie Wheeler

RHODE ISLAND

Senator Catherine E. Graziano
Senator J. Clement Cicilline
Representative Elizabeth Dennigan

VERMONT

Senator Elaine Alfano
Representative Patricia Doyle

PUBLIC AND PRIVATE AGENCY REPRESENTATIVES

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Dianne Harnad, Prevention Director, DMHAS
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DeAnna Paugas, Prevention Program Mgmt. Coordinator, CT Dept. of Children & Families
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Jennifer Perloff, Region 1, US DHHS
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Lisa Thuran-Gray

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Linda Saunders, Deputy Director, DBHS
Paul Gorman, West Institute, Dartmouth Psychiatric Research Center

RHODE ISLAND

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Arn Lisnoff, Administrator, Mental Health, Div. of Integrated MH Services
Jane Hudson, Director, Mental Health Advancement Resource Center
Elizabeth Wheeler, Chief, Child & Adolescent Services, Bradley Hospital
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Ellen Blaine, NECON
Joyce Babcock, Health Planner, Department of Health

VERMONT

Susan Besio, Commissioner, Dept. of Developmental and Mental Health Services
Ken Libertoff, Executive Director, VT MHA (Mental Health Association)

SECTION 1

LEGISLATIVE EXPERIENCES

This NECON legislative seminar marks a seminal event. It brought together for the first time a group of New England state legislators, state and federal policymakers, mental health practitioners and mental health advocates concerned with mental health promotion and illness prevention. This action launched NECON's goal of translating health promotion and disease prevention strategies into achievable political action. Indicative of their concern, all six New England states were represented. In no other region in the country has there been a similar forum addressing issues of mental illness and substance abuse prevention and mental health promotion.

At the November 27th meeting three legislators were asked to address the gathering: Senator Elaine Alfano of Vermont, Representative Patricia Dillon of Connecticut, and Representative Elaine Fuller of Maine. Their comments are summarized below.

Vermont—Senator Elaine Alfano

Vermont lawmakers recognize prevention activities as fiscally prudent investments, but operate within the framework of two decades of emphasis on tax cutting and smaller government. Each year the legislature asks the executive branch and state agencies to do more, but proposals to increase revenue meet with difficulty. In the last legislative session, a proposal was put forth to increase the cigarette tax and beer tax to help address the rising substance abuse problem. This met with cross-border arguments, especially the purported inability of premium beer makers to remain competitive with other states.

Vermont did have success last year in having people trained for middle and high school substance abuse prevention programs. These programs provide youth with an opportunity for developing ongoing relationships with adults outside the home, and offer peer support and life skills training over a broad range of topics.

A pilot program in Vermont locates mental health professionals in pediatricians' offices to do behavioral health screening. This brings behavioral health services to the primary care setting without raising the policy question of how to compensate a physician for time spent providing behavioral health services.

Connecticut—Representative Patricia Dillon

Governor John Rowland's Blue Ribbon Commission on Mental Health (July 2000) acknowledges the importance of developing a plan that includes all the issues, rather than looking solely at what is feasible and plausible since a single issue could exhaust capacity in a year without an overarching agenda.

No matter how much is known on a policy level, lawmakers respond to the stories that people tell. The judiciary—by default—ends up taking on many substance abuse and mental health issues, and this component is important to developing a strategy that identifies evidence and is research based. The commissioners can use this evidence to channel resources, providing incentive even when the expense of one department accrues benefits to another. People who are clinically indistinguishable may come into the system through different doors, such as criminal justice or child welfare. Improving access interdepartmentally for individuals with co-occurring disorders will hopefully help erase barriers that result in disparities in evaluation and treatment.

The Mental Health Strategic Trust Fund is an attempt by a senate leader to keep faith with the mental health community and providers, delivering on a promise made by a former governor to continue system building after outdated "warehousing" buildings were taken down. This year, money is set aside to oversee these promised expenditures.

Legislators are less likely to allocate to pre-

vention resources that are in competition with the more obvious demands of populations with special needs. Prevention needs to be well articulated to create the political will in the legislature to get action.

Maine—Representative Elaine Fuller

The legislative branch is taking more control over the executive branch, sanctioning and overseeing executive branch activities. The legislature is instrumental in developing a system of care, including the combining of departments and the movement toward integrated case management. There is concern of agencies being able to work together, maintain quality control, and assure that money is being used effectively.

Important initiative work has been done with the Department of Education. School-based health centers focus on prevention of depression, substance abuse, and teenage suicide. Funding for children's services has more than doubled in eight years. Crisis care and home care funding have also increased dramatically.

Maine has a nationally recognized dual diagnosis suicide prevention program. In addition, it is building a new state of the art mental health hospital.

Maine has protected its tobacco settlement funds, but there is concern that this money is in danger of being diverted.

Discussion ensued on several issues. These included:

1. The power of the executive vs. legislative branch

The relative power of the executive vs. legislative branch depends on the strength of personalities, though the office of governor is always a bully pulpit. The Massa-chusetts governor has the power to decrease individual budget items but no oversight as to how the decrease is apportioned, so that one item may be cut 25 percent while another is left untouched. Massachusetts has developed a mental health caucus among the state legislators. Forty of the 200 members have joined this voluntary bipartisan group, which has successfully gone into the community to gather and share information, conduct needs assessments, and stimulate community interest.

In New Hampshire, the strength of the commissioner at the time is a determining factor. There are currently four bills related to mental health pending before the New Hampshire legislature. Parity issues, especially when they include substance abuse/alcoholism, are a hard sell for the legislature and are opposed by the insurance industry.

In the Connecticut model, the relationship between the commissioners and the legislature is ambiguous. The Connecticut Appropriations subcommittee, however, has gained in power compared with the Public Health subcommittee.

2. Can we prove that prevention works?

Can we prove that prevention activities are effective in the mental health arena? The short answer is yes. In the area of substance abuse and conduct disorders, the research demonstrating the effectiveness of prevention is very strong, while research in depression and family strengthening is moderately strong, and then it begins to weaken. Incidentally, this reduction in effectiveness is the result of inadequate research funding rather than program failures. Simply put, study has not been undertaken in many areas, but this is not unique to prevention. The same lack of research exists for many behavioral health treatments.

A continuing problem for primary prevention is the mistaken assumption that once a prevention program is experienced the result should be lifelong. While for some people a one time exposure may confer lifelong benefits, for the vast majority repeated exposures to health promotion and illness prevention activities are necessary to attain and maintain health. Again, this is not unusual. No one expects a flu shot to confer more than a few months of partial immunity. A tetanus shot is not life long. Even the determination for "cured" cancer is measured in years (five to be exact), not lifetimes. Thus, expectation that exposure to a behavioral preventive intervention will last a lifetime is unreasonable.

Several Task Force members offered examples to show that constituencies may be built more effectively by viewing outcomes in a public health rather than mental health framework. They raised the question as to why our Task Force report is rooted in the field of mental health rather than education or public health. Discussion ensued as to the way funding streams operate, and the perceived need to protect vulnerable mental health funding by keeping it distinct.

A Northeast regional working group convened by the DHHS regional health administrator, state public health commissioners, and people who report on leading health indictors has identified existing mental health data as being deficient. A working group jointly including members of the mental health and public health communities will address the need for improved population based data in mental health and substance abuse. Each state's Department of Public Health is actively looking for data sources to plug into the Surgeon General's Healthy People 2010 indicators. The final data will encompass both incidence and indicators of disease and can be used for population based health screening and outcome measurement.

SUGGESTED IMPLEMENTATION STRATEGIES

What can NECON do to further the recommendations of the Mental Health Task Force? First, it is a vehicle for sharing information on what is happening in each state, such as legislation that may be politically useful to another state. Second, it is a forum where those with mutual interests such as parity legislation can respond with a common voice around political initiatives. Most important, NECON can continue to carry the recommendations to the appropriate forums in the New England states.

A goal of NECON is to develop a prevention caucus within each state to cut across all of the working group interests, from cancer to obesity to mental health. It is both remarkable and vitally important to be able to meet with legislators, policymakers, providers, and advocates. This was not possible a decade ago because a forum for such interaction was missing. NECON has involved 3,500 people in this multidisciplinary health promotion and disease prevention process. Together, it is possible to move the mountains of ignorance that stand in the way of health promotion. Indeed, we are on track, having been successful in bringing health status to the attention of the New England Governors.

To illustrate, at last month's New England legislators' meeting in Nashua, the discussion centered on prevention, with our legislators demonstrating interest in taking leadership roles. While we usually attribute a bully pulpit to the executive branch, each legislator has one as well. We can use our numbers, as NECON members and as New Englanders, to effect political change. The data are there; we need to use it politically. New England has a long tradition in conducting research across a wide spectrum of health and mental health issues; the question is, how do we use the outcomes of the research as part of the political process?

How do we use our effective public health and mental health infrastructures to move into communities? We need legislators to do that. We offer the resources of NECON to the legislators in order to create political change. The experience of this seminar is an excellent beginning.

SECTION 2

UNDERSTANDING PRIMARY PREVENTION

Why is Prevention Important?

Consider this observation by the National Commission on Children (1991, p. 126–127)

> Malnourishment, obesity, and the incidence of many illnesses are related to nutritional intake. Sexually transmitted diseases, accidents and injuries, and physical and mental impairments are directly attributable to early, unprotected sexual activity, drug and alcohol use, and delinquent behavior...In fact, control of a limited number of risk factors...could prevent at least 40 percent of all premature deaths, one-third of all short-term disability cases, and two-thirds of all chronic disability cases. Changes in health behaviors can also reduce medical costs and limit losses in productivity. Illnesses attributable to smoking cost individuals and society more than $65 billion a year. The total cost of alcohol and drug abuse exceeds $110 billion each year.

The Committee on Preventive Psychiatry (1980) has pointed out that epidemiological studies suggest that in any given year 20 percent of the population of the United States is seriously emotionally ill. With an estimated United States population of 288,000,000 individuals, this means that roughly 57,650,000 individuals are in need of help each year. Yet, the treatment and rehabilitation capacity of the United States is but a tiny fraction of this number. If prevention were only to reduce this population of afflicted individuals by 20 percent or 11,530,000 cases a year, it would have exceeded the total treatment capacity for the United States for any given year. Given that not all clinical interventions are either successful or are directed at those defined as most seriously ill, the cost-benefit ratio of prevention becomes readily apparent. But even more important than the cost-benefit ratio favoring prevention would be the reality that millions of children and adults would have avoided unnecessary suffering.

What is Primary Prevention?

Briefly put, primary prevention means promoting health and preventing illness universally, selectively, and for indicated groups. What does promoting health mean? It means taking actions that encourage resiliency, coping, adaptation, and developing of human social capital. What does preventing illness mean? This refers to reducing, modifying, and avoiding the risks known to foster ill health.

The terms universal, selective, and indicated are borrowed from Gordon's (1983) paper ["An operational classification of disease prevention." Public Health Reports; 98: 107–109] and adopted by the Institute of Medicine in 1994 to describe the domain for preventive interventions. Universal is synonymous with the word all. For example, to reduce the incidence of tooth decay many communities add fluoride to their public water supplies. Thus, everyone who drinks from that water supply is a recipient of this intervention known to reduce tooth decay. A selective intervention focuses more narrowly on populations at risk. In this instance, epidemiological evidence exists to suggest that a group of people is at higher than average risk for developing a disorder.

To prevent that disorder and to promote the health of that group, interventions are offered. To illustrate, schoolteachers who as a population have high contact with young people with runny noses might be encouraged to receive flu shots to avoid influenza, an illness that peaks during the school year. An indicated intervention draws on epidemiological evidence but in this instance the risk for this group is considered very high. To once again use the flu shot example, to be a teacher and elderly, have an immune disorder or heart disease would move that teacher from the selected group into an indicated group. Notice that in each instance the intervention for health promotion and illness prevention is occurring before the onset of disease. The purpose of the intervention is to prevent the development of the

disease by either strengthening the individual or preventing its onset.

Prevention has Technologies

To achieve illness prevention and health promotion, prevention uses four technologies. They are overlapping and in and of themselves rarely effective. However, when they are combined, they prevent illness and promote health.

The first technology is education. The most often used of all prevention's technologies, alone it rarely, if ever, is effective. The reason for this is that while education increases knowledge, only occasionally does it affect attitudes, and it almost never changes behavior. Thus, the tobacco user will acknowledge the hazards of tobacco use, might wish to give up the habit, but rarely acts on that motivation. This said, education nevertheless plays an important role in health promotion and illness prevention in concert with other technologies.

Education can take one of three forms. The first is public information. This can be found on the side of a cigarette package, an alcohol beverage bottle, or on the visor of an automobile. Information can be provided by means of print, radio, Internet, television, or film. It can be read, spoken, sung, or acted. In all instances the intention is to increase knowledge about a given subject and offer ways to handle that subject that promotes health or prevents illness.

A more specific form of education is anticipatory guidance. In this case, information is used to educate a group prior to some expected event. Drawing on the folk wisdom that to be forewarned is to be forearmed, the group will be better prepared to cope with the circumstances and adapt to the demands the event may place on them. Common examples of anticipatory guidance are childbirth preparation classes, children's visits to hospitals prior to elective surgery, and pre-retirement planning.

Education's third form is found in the personal self-management of behavior. In this instance, the individual or group learns how to control emotional, neurological, and physical aspects of their behavior. The methods to achieve this outcome range from yoga, transcendental meditation, and biofeedback, to cognitive behavioral approaches.

Prevention's second tool is the promotion of social competency. To be socially competent requires that one belong to a group, that the group value the membership of the individual, and that the individual make a meaningful contribution to the group's existence. Socially competent people tend to possess the following individual characteristics: a positive sense of self-esteem, an internal locus of control, a sense of mastery or self-concept of ability, and an interest beyond themselves that extends to a larger group. Thus a feedback loop is established between belonging, valuing, contributing, and individual characteristics that is self-perpetuating.

Every effective prevention program contains exercises directed at nurturing these individual characteristics, which are demonstrated in the ways in which groups embrace and value its members, and afford them opportunities to contribute to the welfare and well being of the group. This meaningful contribution can be as large as being president or as small as standing in a long line of many volunteering to donate blood after the September 11, 2001 tragedy. This value to the group can be that of the philanthropist or of the soup kitchen volunteer. This belonging is reflected in hundreds of ways from flags hung from homes and worn on clothing, emblems that display school and club and sport memberships, to songs and stories that celebrate the group's existence. To achieve the solidarity that is the essence of social competency requires not only education but also prevention's next technology.

Prevention's third technology is natural care giving—a term Gullotta (1980) first used to draw a distinction between the services offered by mental health professionals and those afforded by others. Natural care giving takes three different forms. The first is the mutual self-help group in which individuals are drawn together by some common experience. In the self-help group, members are both caregivers and care-receivers. Reliance is not on a professional but on each other. Pathology is not the governing dynamic but rather navigating through life with a companion who knows the stresses another is experiencing. By acknowledging the falls, celebrating the small

successes, and relying on each other for support and advice, the mutual self-help group members discover competency—the competency that goes with belonging, with being valued, and with being a contributing group member.

The phrase "indigenous trained caregiver" describes the second form of natural care giving that individuals turn to in time of need. While not trained as mental health professionals, people such as ministers, teachers, and police officers provide advice, comfort, and support that enables many in society to lead healthy and productive lives.

In times of need, individuals turn first to friends and loved ones, then to trained indigenous caregivers. Why? Because the power of a single caring relationship over time is both nurturing and healing. As with other forms of care giving, indigenous care giving involves behaviors such as the sharing of knowledge, the sharing of experiences, compassionate understanding, companionship, and, when necessary, confrontation (Bloom, 1995; Cowen, 1982). The indigenous caregiver accepts responsibility for her or his life and ideally invests in the life (health) of at least one other individual.

Prevention's fourth technology is its most powerful. Community organization and systems intervention (COSI) are concerned with the promotion of a community's social capital. That is, how does a community interest its members to actively participate in the process of governance and how are inequities addressed. COSI addresses these issues in three ways. The first is community development and takes a variety of forms. The neighborhood civic association formed to be a local voice on zoning issues; the local recreation league created to afford afterschool opportunities; and the neighborhood watch started to deter crime are but three examples. In each example a group of people with concerns about property, youth activities, or crime prevention draw together and act together to express their concerns and develop solutions in response to those concerns.

The second form COSI takes is systems intervention. The assumption is that every institution has dysfunctional elements within it that contribute to the needless suffering of individuals in society. Identifying those dysfunctional elements and correcting them is the purpose of this form of COSI. To illustrate, Tadmor (2002) describes her efforts to reform the medical practices used for children with cancer in one hospital. Policies and procedures that harmed children like restraining them to force compliance with the treatment regimen and separating them from parents during the treatment process were identified as dysfunctional and subsequently changed. For the outsider, while the identification of these dysfunctional practices might appear obvious, they are not. Institutions—whether schools, hospitals, social service agencies, child care centers, or larger entities like child protective services and other state agencies—develop unique internal cultures quite removed from those of the larger society. The interventions of COSI can be invaluable in effecting change in these settings.

The final form that community organization and systems intervention takes is legislative change and judicial action. Drawing upon the earlier illustration of the difficulty that accompanies institutional change, it should be remembered that no legislative or judicial action benefits all. In these legislative and judicial contests, there are winners and losers. For example, while a universal family leave policy may be good for employees needing to care for loved ones, for the employer preserving a job for someone who may not return to work, the policy can be detrimental to business. While advocating civil rights legislation in the 1960s, it was Lyndon Johnson who observed that this action would break the hold of the Democratic Party on the south, and it did. While restricting tobacco access can reduce billions of dollars in medical expenses a few decades from now, it means a loss in income to tobacco growers and the tobacco industry today.

This last form of COSI is a battleground where special interests strive to dominate the field. Over time and with growing public impatience, seat belt laws do become enacted. Lead abatement standards are established. Tobacco laws restricting youth's access to cigarettes and other products are passed. Interestingly, it is often through the efforts of organizations like MADD and the NAACP, whose origins reflect many of the characteristics of self-help groups, that these laws capable of correcting injustice and improving public

health are passed.

Thus, we come to see that when prevention's technology is fully utilized, a circle is completed. Education informs. Natural care giving unites. Social competency enables, and COSI serves as a means to achieving community change.

Conditions for Successful Prevention Activities

New behaviors develop over time and require practice to be learned. Even when individuals are immersed in knowledge, and some information is retained, retention is measured in days—perhaps weeks—rarely in months or years; and any unfamiliar skill must have repeated practice in a variety of settings and circumstances in order to improve overall performance.

New behaviors are best learned in small groups. Small groups afford the opportunity for natural care giving to occur, for competencies to be nurtured, and change agendas to be developed.

New behaviors are best learned by experiences that are lived through. Experiential learning offers opportunities to manipulate the learning experience, to vary its content, to alter its intensity and its duration. It allows the learner to interpret the information across a variety of intelligences (Gardner, 1993) [The Multiple Intelligences: The Theory in Practice. New York: Basic Books] best suited to the learner.

Finally, new behaviors need nurturance. Unless supported by the environment, new skills will rapidly disappear.

TASK FORCE RECOMMENDATIONS

The NECON Mental Health Task Force presented its report, The Time is Now, to the New England Governors Conference at their 2001 summer meeting in Providence, RI. Along with this legislators' seminar report, we will move forward toward implementation of the recommendations made in The Time is Now. We want to make mental health promotion and mental illness and substance abuse prevention strategies viable in a political context with the following six recommendations:

— 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 prevention 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 comparable indicators to measure improved outcomes, especially among diverse cultural groups.

— 4 —

Use proceeds of tobacco tax and settlement funds to establish or expand heath 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 who 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;

— 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.

NECON AGENDA

The NECON agenda for the next decade will be guided by objectives consistent with the Surgeon General's Healthy People 2010 report. The short list of recommendations, arrived at by consensus of all the NECON working groups, involves:

- Use of the proceeds of the tobacco tax and settlement funds for health promotion and disease prevention activities;
- Combat the prevalence of obesity as the root preventable cause of major illnesses such as heart disease, stroke, diabetes, etc.;
- Extend state subsidized insurance (including mental health parity) to low-income, working adults without health insurance—coverage that includes screening and other demonstrated effective prevention services;
- Increase funding for violence prevention to children and adolescents in comprehensive school- and community-based programs;
- Develop an agenda to eliminate by the year 2010 the wide racial and ethnic health disparities that currently exist;
- Establish and expand school- and community-based health programs that provide comprehensive preventive health services and health education to children and adolescents.

NEXT STEPS

Two enduring concerns persist in the recommendations of the Mental Health Task Force and the NECON agenda—the question of parity between mental health and health practices, including the kind of insurance that is available; and the prevalence of depression across the life span in the New England population. In each of these areas the New England states have very different patterns. Vermont, for example, has the nation's most progressive parity law in state statute and the remaining five are quite diverse in their parity policy. The presence of depression and the different approaches being taken by the states are also quite different and, collectively, little is known about the kinds of programs that are in place and available to the population.

Indeed, in both parity and depression, no systematic and comparative analysis has been done across the six New England states. From a regional perspective, the omission of clear standards in these two areas merits serious consideration for future study. We envisage such studies to be the next steps for the NECON Task Force on Mental Health Promotion, Mental Illness and Substance Abuse Prevention.

APPENDIX A AGENDA

New England Coalition for Health Promotion and Disease Prevention
Task Force on Mental Health Promotion, Mental Illness and
Substance Abuse Prevention

First Legislative Seminar Agenda

November 27, 2001
10 A.M. – 2:30 P.M.
Publick House
Sturbridge, MA

What is NECON: Bert Yaffe, NECON Chairman

Introduction of Participants

Opening Remarks: Tom Gullotta, Chairman, National Mental Health Association Task Force on Substance Abuse; Co-Chair, Advisory Committee on Federally Funded Safe Schools Technical Assistance Center

Personal Legislative Experiences from Three Legislators: Connecticut, Maine, and Vermont and Follow Up Discussion

Lunch

September 11 Tragedy: Prevention as Part of Disaster Planning; SAMHSA Funding of CT, MA and RI: Kathryn Power, Director, Dept. of Mental Health, Retardation and Hospitals; Wayne Dailey, Ph.D. Senior Policy Advisor, DMHAS; and Marilyn Berner, Chief of Staff, MA Dept. of Mental Health

Lessons Learned: Making Prevention a Political Priority

Strategies for Implementing the Recommendations of *The Time of Now* Task Force Report

APPENDIX B TASK FORCE MEMBERS

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