

PREVENTION AND EARLY INTERVENTION

Commission Member: Jerry Doyle

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Issue 1 Addendum: Definitions

I. Definitions

The most commonly used definition of “prevention” is that of the Institute of Medicine (*See Issue 1: Overview and Definition*): Universal, Selective, and Indicated

A. Prevention

1 Substance Abuse Mental Health Service Administration (SAMHSA) and National Institute of Mental Health (NIMH):

- a. Prevention is different from intervention and treatment in that it is aimed at general population groups with various levels of risk for any problem.
- b. The goal is to reduce risk factors and enhance protective factors
- c. The framework can be used to match interventions to the needs of a targeted population. The three types of interventions are:
 - i. **Universal programs** (e.g., clinic-based health seminars, posters in senior centers) Target general population groups without reference to those at particular risk. All members of a community benefit from a universal prevention effort, not just specific individuals or groups.
 - ii. **Selective programs** (e.g., server interventions at bars, screening and brief interventions) Target those at higher-than-average risk any problem. Targeted individuals are identified on the basis of the nature and number of risk factors. The goal is to prevent the development of serious problems.
 - iii. **Indicated programs** (e.g., elder-specific treatment programs) Target those already using or engaged in other high-risk behaviors to prevent severe problems.

2. Public health model - An alternative paradigm more congenial to prevention research and practice (Kaplan, 2000).

- a. Attentive to whole populations and the identification of pathways to disease and disorder.
- b. Recognizes the utility of multiple intervention strategies to reduce risk, including educational and policy interventions.
- c. Has been notably successful as a framework for reducing the incidence of new cases of infectious disease, and there is reason to believe that it can be successful with more complex, multiple vector disorders such as depression

3. Puget Sound Educational Service District

- a. **Primary prevention**- To protect individuals in order to avoid problems prior to signs or symptoms of problems. Includes those activities, programs, and practices that operate on a fundamentally non-personal basis and alter the set of opportunities, risks, and expectations surrounding individuals.
- b. **Secondary prevention**- Identifies persons in the early stages of problem behaviors and attempts to avert the ensuing negative consequences by inducing them to cease their problem behavior through counseling or treatment. It is often referred to as *early intervention*.

- c. **Tertiary prevention**- Strives to end problem behavior and/or to ameliorate their negative effects through treatment and rehabilitation. This is most often referred to as treatment but also includes rehabilitation and relapse prevention.
- d. **Prevention Approaches**: Universal, Targeted and Indicated.
 - i. **Universal**- Addresses the entire population with messages and programs aimed at preventing or delaying problem behaviors.
 - ii. **Targeted**- Selecting subsets of the total population that are assessed as at risk for problem behaviors by virtue of their membership to a particular population segment.
 - iii. **Indicated**- Identify individuals who are exhibiting early signs of problem behavior(s) and target them with special programs to prevent further onset of difficulties.

B. Early Intervention

1. Puget Sound Educational Service District

- a. A process for recognizing warning signs that individuals are at risk for any problem problems and taking early action against factors that put them at risk.
- b. Can help individuals get better more quickly and prevent problems from becoming worse.

II. Conceptualization

A. Substance Abuse Mental Health Service Administration (SAMHSA)

1. Concept #1: Mental Health Continuum (See Attachment A)

- a. Broaden view of mental health to include promotion & prevention.
- b. During a lifetime one can move back and forth along the continuum
- c. Family members could be at different points along the continuum
- d. Redefine Mental Health as “Social Emotional Competencies”- a facet
- e. Primary Care Physicians and Child Care Providers should be part of the resource and interventionists along the continuum

2. Concept #2: Ecological Perspective (Greenberg, M, 2002) (see Attachment B)

- a. Early Childhood Community: Perceive role and influence the development of social emotional competencies.
- b. Yale Study (2005) reported that Pre-K students are expelled at a rate 3x that of children K-12.
- c. Philosophy: Every child is important and kids with challenges are failing. Strategies need to be adjusted.

3. Concept #3: NIMH Mental Health Intervention Spectrum

- a. Find a way to make all system efforts fit into the mental health spectrum
- b. Prevention Science: Based on analysis of risk and protective factors (See Attachment C)
- c. Different types of PREVENTION:
 - i. Prevent: Stop or Delay Onset of Problem (**Universal Prevention**)
 - ii. Prevent: Stop/Delay Onset of Co-occurring (**Targeted Prevention**)
 - iii. Prevent: Worsening Disability (**Intensive Prevention**)

4. Concept #4: SAMHSA’s Five Principles

- a. Individuals, especially children need to be viewed and understood within developmental framework.
- b. Individuals, especially, children are a part of families, so families need to be viewed and understood holistically.

- c. Prevention, early intervention, and treatment must be provided within a public health context, along a continuum and must address risk and protective factors.
- d. Services and supports for individuals and their families should be family-driven and individual-guided; culturally and linguistically competent; individualized and strengths-based; and community-based (person centered).
- e. Behavioral health care needs to be comprehensive, coordinated, and integrated across multiple individual-and-family-serving systems

B. American Psychological Association- *Linking Prevention and Treatment Within an Integrated Model* (Weisz, et. al, 2005) (See Attachment D)

1. **Universal prevention** strategies are approaches designed to address risk factors in entire populations without attempting to discern which individuals are at elevated risk.
2. **Selective prevention** is a strategy that targets groups who are identified because they share a significant risk factor and mounts interventions designed to counter that risk.
3. **Indicated prevention** a strategy that entails intervention with those who have significant symptoms of a disorder but do not currently meet diagnostic criteria for the disorder.
4. **Treatment** interventions generally target those who have high symptom levels or diagnosable disorders.
5. **Time-limited therapy**- Treatments provided in a single episode of care (e.g., 5-30 sessions, or until some criterion of success attained). In the evidence-based treatment literature, these generally consist of treatment protocols guided by a single manual, which is by far the most common form of evidence-based care.
6. **Enhanced therapy**- Supplemental strategies designed to amplify or extend treatment benefit beyond what can be obtained in a single episode of care. One example, often labeled relapse prevention or prophylactic treatment, frequently takes the form of booster sessions designed to prevent recurrence of disorder in individuals who have completed a standard treatment protocol.
7. Each strategy can be seen as a necessary but not sufficient element of a comprehensive system for promoting and protecting youth mental health.
8. Although prevention and treatment are often construed as occurring in separate settings, this does not have to be the case.
 - a. Schools are often the settings for prevention programs.
 - b. Home-based prevention programs are now complemented by treatment programs that put the therapist in the home and in other community settings.

References

California Institute of Mental Health. www.cimh.org

Kaplan, R. M. (2000). Two pathways to prevention. *American Psychologist*, 55, 382–396.

Puget Sound Educational Service District. <http://www.psesd.org/prevention/glossary.html>

Substance Abuse and Mental Health Service Administration (SAMHSA)

<http://www.samhsa.gov/Matrix/timeisright.pdf>

http://pathwayscourses.samhsa.gov/aaap/aaap_6_pg4.htm

Weisz, J., R., Sndler, I. N., Durlak, J. A., & Anton, B. S. (2005). Linking prevention and treatment within an integrated model. *American Psychologist*, 60 (6), 628-648.

Acknowledgement

Eleanor Castillo, Ph.D., Director of Outcomes and Quality Assurance, EMQ Children & Family Services, Campbell, CA

Penny Knapp, MD, Program Director, Infant Preschool Family Mental Health Initiative; Medical Director, California Department of Mental Health

Gail Ritchie, Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services, Division of Prevention, Traumatic Stress, and Special Programs, Prevention Initiatives and Priority Programs Development Branch, Washington, D.C.

Attachment A
Mental Health Status and Mental Health Care Continuum
<http://www.samhsa.gov/Matrix/timeisright.pdf>

Positive Mental Health:
High level capacity of the individual, group, or environment to interact to promote well-being, and optimal development and use of mental abilities.

Mental Health Problem:
Disruption in interactions between individuals, group, and environment producing a diminished state of positive mental health abilities.

Mental Disorder:
Medically diagnosable illness that results in significant impairment of cognitive, affective, or relational abilities.

Mental Health Status Continuum



Mental Health Care Continuum

Enhancing Health:
Promoting optimum mental health (e.g., job satisfaction, promoting resilience, self-esteem, and social skills) and improving access to income, and work place certainty.

Primary Prevention:
Addressing risk factors in vulnerable groups (e.g., coping skills for people who are unemployed, home visits for families at risk, coping skills for families experiencing separation and divorce.

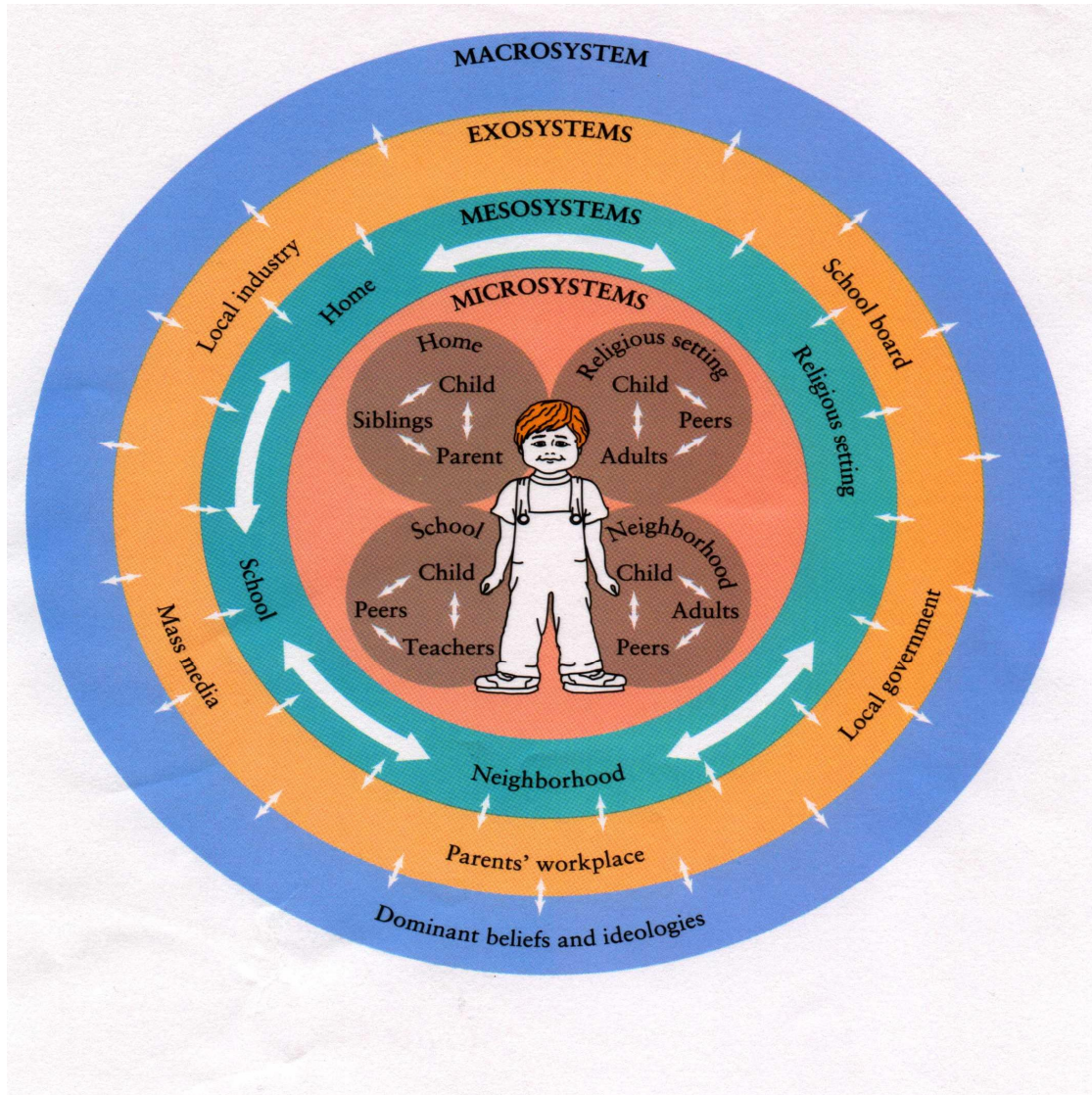
Early Recognition and Intervention:
Detecting problems or illness at an earlier stage and increasing access to effective treatment (e.g., earlier detection and treatment of depression or psychosis).

Treatment and Rehabilitation:
Intervening to reduce the symptoms of an illness, diminished ability, and improved quality of life (e.g., effective compassionate treatment, involvement of consumers and careers, information about consumers' rights, and full participation in rehabilitation programs.

Reference: Scanlon, K., Williams, M., & Raphael, B. (1997). Mental health promotion in NSW: Conceptual framework for developing initiatives. NSW Health Department, Sydney, Australia, p. 9.

Attachment B Ecological Perspective

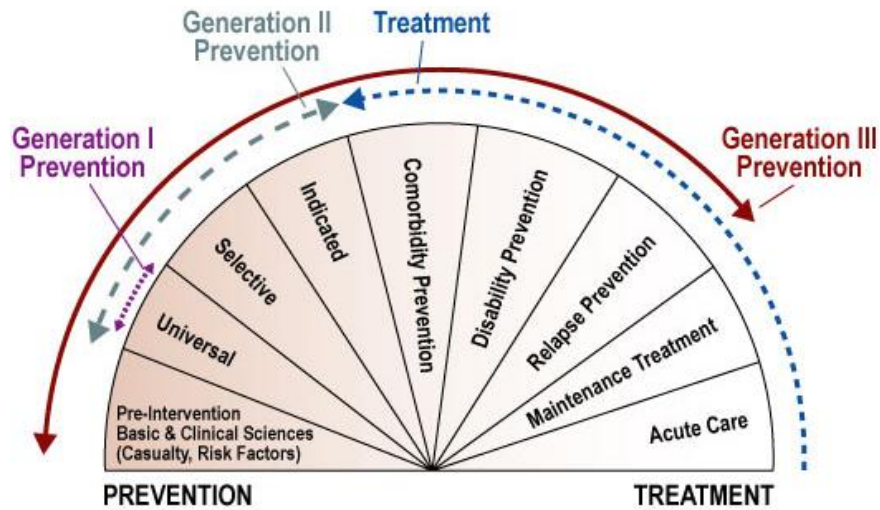
Greenberg, M. (2002) Prevention of Mental Disorders in School Aged Children: Making the Connection. Presentation at SAMHSA/CMHS and National Association of State Mental Health Program Directors Prevention Roundtable, March 14, 2002.



Attachment C
National Institute of Mental Health Conceptualization

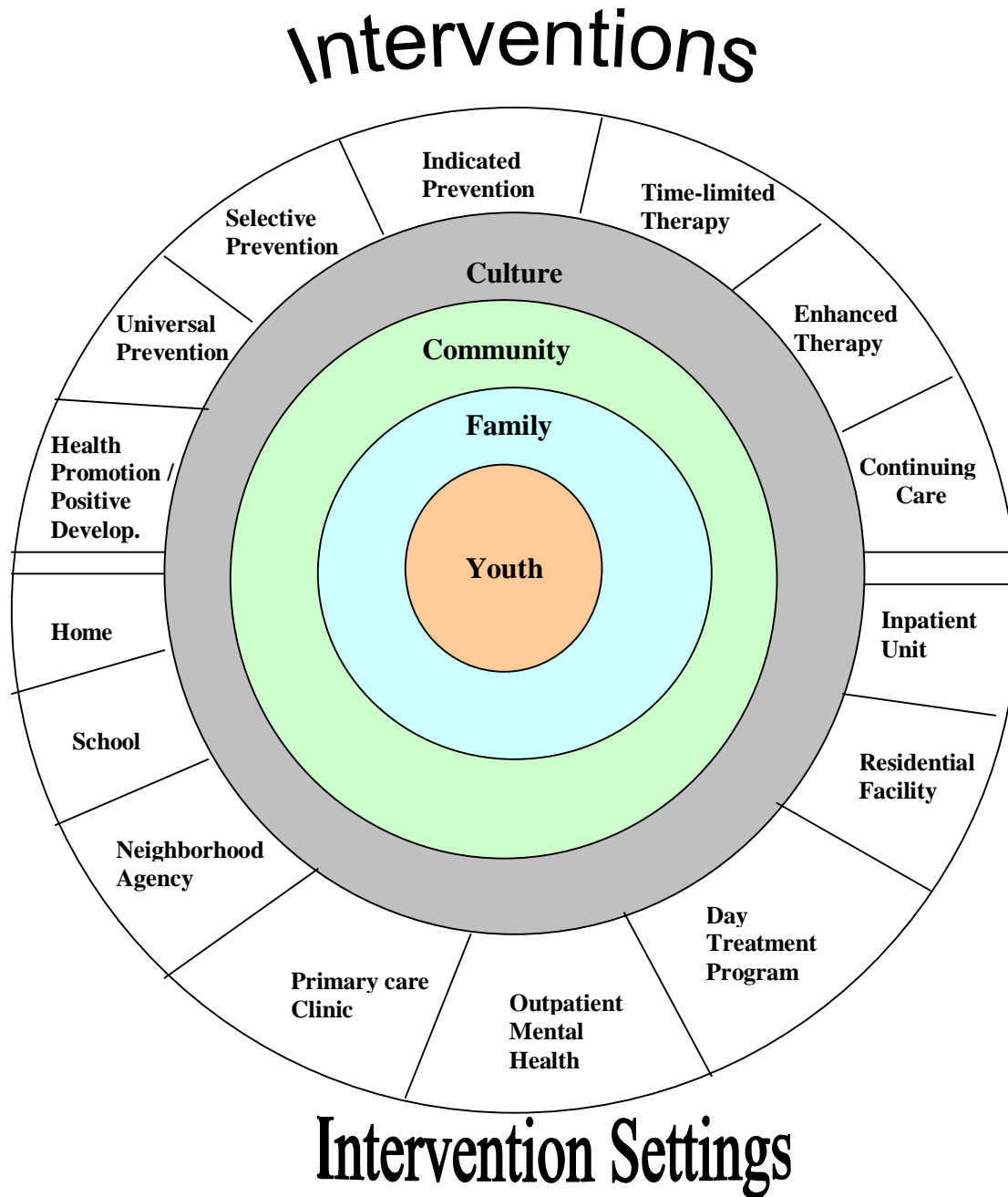
NIMH. (1998). Priorities for Prevention Research at NIMH: A Report by the National Advisory Mental Health Council Workgroup on Mental Health Disorders Prevention Research. NIH Publication No. 98-4321.

Prevention, early intervention, and treatment must be provided within a public health context, along a continuum, and must address risk and protective factors.



Attachment D

American Psychological Association: An Integrative Model for Linking Prevention and Treatment Research (Weisz, et. al, 2005, p. 633)



Note: Primary strengths reside in youths, families, communities, and cultures (center), supported and protected by effective interventions (examples in upper semicircle) delivered within an array of life settings (examples in lower semicircle). Intervention strategies are arrayed from most universally applicable (i.e., for general population groups not identified as having specific risk factors, problems, or disorders) at left to narrowly focused (i.e., for youths with rarer persistent long-term conditions) at the right. Intervention settings are arrayed from least restrictive on the left to most restrictive on the right. The upper portion of the figure is adapted from “Reducing Risks for Mental Disorders: Frontiers for Preventive Intervention Research” (p. 23), by P. J. Mrazek and R. J. Haggerty, 1994, Washington, DC; National Academies Press. Copyright 1994 by National Academies Press. Adapted with permission.

Attachment E
Author: Knapp, P.

HISTORIC CLASSIFICATION	PUBLIC POLICY CLASSIFICATION
Primary Prevention Aimed at reducing the incidence or number of new cases of mental disorder.	Universal preventive measures Must be cost beneficial for everybody in the eligible population.
Secondary Prevention Aims to lower prevalence, or the rate of established cases of mental disorder by reducing their duration.	Selective preventive measures These are cost beneficial to only a subgroup of the population whose risk of becoming ill is above average.
Tertiary Prevention Aimed at decreasing the amount of disability resulting from mental disorders.	Indicated preventive measures Measures are applied to groups who have early symptoms or who are asymptomatic regarding the disease but on examination are found to manifest a risk factor that may justify more costly and extensive interventions.

Attachment F
Characteristics of universal, selective and indicated interventions
 Author: Knapp, P.

	Universal	Selective	Indicated
1 Threshold	Low – public mental health planning	Medium -	High
2 Risk Pop.	General psychosocial risk factors	Specific risk factors, such as having a teen or depressed mother	Actual clinical symptomatology
3 Target case	The child in a context that might pose risk: example: poverty, immigration.	The child actually at risk, example, such as having suffered a trauma or loss.	The child with a diagnosis: example ADHD, Conduct Disorder, Depression.
4 Caseness	The child and his family or psychosocial context.	The vulnerable child who has not yet lost adaptive functioning.	Medical necessity or inclusion criteria per a study protocol.
5 Modality	Alteration of general environmental factors or support to general relationship patterns.	Intervention may be indirect, such as working with the parent or the parent-child relationship.	Medication or non-pharmacological therapies.
6 Timing	Early – before problems arise	After risk has been identified and before symptoms appear.	Late – after the child is clinically symptomatic.
7 Provider	May be a system rather than an individual, may not require special training. Example: Early Head Start.	May be a team, some members with and some without special training. Example: (Olds) PHNs, when replicated with paraprofessionals, less successful.	Mental Health specialist. Example: Mental health clinic with child psychiatrist.
8 Dose	Extended over time.	May vary, but should extend over time.	May be focused on acute episode.
9 Attrition	A feature of the intervention system	May imply successful early intervention <u>or</u> failure to make a connection with client.	May imply treatment non-compliance as well as therapist “failure.”
10 Outcomes	Increase in adaptive functioning etc. Example: school progress	Maintenance of normal developmental trajectory. Example: IQ, behavioral etc.	Symptom reduction or elimination: example: lower score on CBCL or other symptom measure.

Attachment G
Risk Factors Throughout Life
 Author: Knapp, P.

Stage of life	Risk factors	Examples of conditions or diagnoses resulting from untreated risk	Development	Cognitive	Regulatory	Emotional	Relationship
EARLY (prenatal – infant- toddler)	Attachment risks	Maternal depression Teen mothers Trauma, abuse, neglect					
(preschool)	Parental DV, substance abuse, trauma, abuse, neglect	Regulatory Disorders					
	Early relationship disorders, foster placement	Separation anxiety, attachment disorders					
MIDDLE CHILDHOOD	Mild, emerging or established childhood psychiatric syndromes	ADHD, PTSD, ODD, OCD, Anxiety symptoms, depression etc					
	Learning disorders	LD					
	Special Needs including DD, ASD, CSHCN						
ADOLESCENCE	Learning disorders	Academic failure, school dropout					
	Disruptive behavior	Juvenile justice involvement					
	Substance abuse						
TAY	Above, plus housing, sexuality						
YOUNG ADULT	Transition periods						
ADULT							
OLDER ADULT							

Attachment H
What Could Prevention Encompass?
 Author: Knapp, P.

	CHILD			ADULT		
PREVENTION LEVEL -->	PRIMARY	SECONDARY	TERTIARY	PRIMARY	SECONDARY	TERTIARY
<i>Target population</i>	<i>Well child</i>	<i>Child at risk of mental disorder or with special needs</i>	<i>Child with symptoms of mental disorder</i>	<i>All adults</i>	<i>Adults at risk or with emerging symptoms</i>	<i>Adults with DX not medical necessity</i>
HEALTH	1 Medical care and health maintenance, (CHDP) prophylactic care (e.g. asthma)	2 Screening and referrals for development, behavioral social-emotional problems	3 CSHCN: Medical home and available specialty care; MH: EB care	4 Health education & maintenance Reduction obesity, avoid infections	5 Early detection & RX of MH disorders, Substance abuse treatment	6 Minimize health risks assoc. with psych. DX or RX.
ENVIRONMENT	7 Safe living environment (Public Health and Public Safety)	8 Outreach, WRAP, & TBS to reduce out-of-home placements & incarceration	9 For mild, emerging conditions, MH treatment that is CSOC & EBP	10 Livable, affordable housing	11 Housing with strong environmental supports	12 Recovery-based care at least restrictive level. Reduction of hospital time.

RELATIONSHIPS	13 Support secure attachment (e.g., HV programs, Infant Mental Health *)	14 Infant and early childhood relationship based treatments. MH consultation to schools and PCPs for detection & early intervention	15 Parent-child treatments for pre-school children. MH RX well-integrated with PCP & school with strong family engagement per CSOC	16 Reduction of stigma. Strengthen available social supports e.g., faith-based, community programs.	17 MH consultation to PCPs and in occupational settings. Reduction of and RX for substance abuse.	18 MH RX that includes family and significant others (caregivers).
SCHOOL or WORK	19 Children learn tolerance for different behaviors/emotions, Early education for stigma reduction. OR School readiness and emotional-social readiness	20 Integration into reg. Schools but w. specific MH needs met.	21 School is integrated with MH treatment	22 Employment is available	23 Vocational training or supported employment. MH consultation (Occupational Psychiatry)	24 MH to co-sponsor Supported employment or meaningful activity (sheltered workshop model)
SAFETY	25 Parent education for development expectations, child-rearing teaches child to avoid danger & control impulses	26 Non-stigmatized support for parent education to protect vulnerable child, teach behavior management	27 EBPs (e.g., PCIT, IY) to teach parents to manage Disruptive Behavior Disorders; Parent education for behavioral risks associated with developmental disorders	28 Adequate public services to protect population from danger (Public health & safety)	29 Environment supports the individual's safe functioning	30 Protection from victimization, self-harm or danger to others

Attachment I
Prevention Possibilities and Examples
 Author: Knapp, P.

PREVENTION POSSIBILITIES	EXAMPLES
A Early prevention and intervention programs	IPFMHI, EI, EMHI CWS reform
B Move services “upstream” to intervene before client becomes “high end”	<ul style="list-style-type: none"> - Enlarge population served by MHPs to include children and adults with mild or emerging MH disorders - Offer TBI to children in crisis, receiving 5150 holds, but not hospitalized. - Programs for aggressive treatment of schizophrenia prodromes.
C Links & Liaisons with other programs and departments serving risk populations	Fund consultation (service not requiring “caseness”) To: Pediatrics (BEST PCP Social Services (4-E wrap) Schools Regional Centers Alcohol and Drug Juvenile Justice
D Community education	Stigma reduction <i>Partners in Outreach</i>
E Evidence Based Practices	<i>See California Institute of Mental Health document</i>

**Attachment J
What Would Outcomes Be?**

Author: Knapp, P.

Outcome Measures are identified at the four levels proposed in the MHSA performance outcome model: A (Individual level), B (System level), C (program level) and D (community level).

	CHILD			ADULT		
PREVENTION LEVEL ---→	PRIMARY	SECONDARY	TERTIARY	PRIMARY	SECONDARY	TERTIARY
<i>Target population</i>	<i>Well child</i>	<i>Child at risk of mental disorder or with special needs</i>	<i>Child with symptoms of mental disorder</i>	<i>All adults</i>	<i>Adults at risk or with emerging symptoms</i>	<i>Adults with DX not medical necessity</i>
HEALTH	1 Indices of well-child care etc (D)	2 Increased detection of early MH and developmental problems. (e.g. EMHI) (B,C)	3 Early intervention (e.g. IPFMHI) (A,B)	4 Reduction obesity, smoking, substance abuse (D)	5 RX of mild MH disorders, Substance abuse treatment (A,B)	6 Timely access to MH services. Aggressive Rx of emerging disorders. Monitor health indicators, Reduce polypharmacy (A,B)
ENVIRONMENT	7 Public Health and Public Safety indices of adequate, affordable housing, etc. (D)	8 Reduction in out-of-home placements & incarceration (B,C)	9 Evidence-based and best practice mental health treatment for children in out of home placement. (A,B)	10 Increased quantity of livable, affordable housing Reduced homelessness. (D)	11 Community-based programs to provide support to MH clients and those at risk of MH disorder. (C,D)	12 Recovery-based care at least restrictive level. Reduction of hospital LOS. Prompt follow-up (A,B)

RELATION- SHIPS	13 Treatment for maternal depression*. Increased parent-education programs. (A,B)	14 Infant and early childhood relationship based treatments. Increased MH consultation to schools Increased school-based EI programs (A,B)	15 Child has friends and social activities at age level, MH RX well-integrated with PCP & school with strong family engagement per CSOC. (A,B)	16 Increased consultation and referrals from PCPs for early MH conditions. Strengthen available social supports e.g. faith-based, community programs. (B,C)	17 Increased family awareness of & participation in treatment of at-risk or mild MH conditions. Reduction of and RX for substance abuse. (A,B)	18 Increased MH RX that includes family and significant others (carers). (A,B)
SCHOOL or WORK	19 Increased % of children come to school ready to learn, and progress academically. (D)	20 At-risk children are integrated into school programs with support and monitoring thru MH consultation Reduced NPS placements (B,C)	21 Graduation rates. Children with mild or established MH diagnoses progress academically. (A)	22 Decreased unemployment (D)	23 Vocational training. Higher employment or supported employment. (C,D)	24 Increased employment among adults with MH conditions. (B,C,D)
SAFETY	25 Decreased accidents, illness and injury. (D)	26 Increased availability of and use of programs for parents to reduce danger. (D)	27 Increased use of EBPs (e.g. PCIT, IY). Outcome measures incorporate child functional improvement. (A,B)	28 Adequate public services to protect population from danger (Public health & safety measures) (D)	29 Reduced illness, accident, injury to vulnerable or at-risk adults. (C,D)	30 Reduced incidence of 5150 holds etc. Reduced involuntary RX & Reduced suicide. (A,B,C)