**Prevention Programs in Behavioral and Mental Health**

Prevention has gained increasing attention over the past couple of decades amid efforts to decrease health care costs. When it comes to physical health care, the benefits of preventive care seem to be acknowledged. Typically, health insurance companies now fully cover costs for preventive care such as annual well-woman exams and contraceptives, which encourages healthier lifestyles and increases the likelihood of early detection of health problems leading to more effective and less expensive treatment.

Despite this shift in physical health care, debate about the value of preventive mental and behavioral health interventions continues. The Substance Abuse and Mental Health Services Administration (SAMHSA, 2007) quotes the Institute of Medicine (IOM) definition of prevention as referring to “processes that occur before there is a diagnosable mental illness” (p. 10). On one hand, the cost of prevention is questioned due to the difficulty of quantifying outcomes and the extent of treatment needs for people diagnosed with existing mental illness and substance abuse issues. “Because funding is limited and the needs of people with existing mental illnesses are great, very little money historically has been allocated for primary prevention…The cost of the practice—which is immediate and easily quantified—may seem to outweigh the benefits—which may be long-term and difficult to assign a dollar value” (SAMHSA, 2007). The efficacy of preventive interventions is easily questioned when outcomes are positive: “Granted, the problems didn’t develop; but how can we be sure they *would* *have* manifested without those interventions? What if some other factor is responsible for the positive outcomes?”

On the other hand, Shea and Shern (2011) remind us that it is a fundamental tenet of public health that preventing a problem from occurring is always preferable to addressing the effects of a condition once it has developed. In their groundbreaking research, Felitti and colleagues (1998) have demonstrated the short- and long-term outcomes of exposure to adverse childhood experiences (ACEs), which they describe as childhood abuse, neglect and exposure to other traumatic stressors such as family dysfunction. Their research indicates that as the number of ACEs increase, the risk for a multitude of social and health problems including alcoholism, smoking, illicit drug use, depression, suicide attempts, risk for intimate partner violence, early initiation of smoking and sexual activity, adolescent pregnancy, sexually transmitted diseases, chronic obstructive pulmonary disease (COPD), ischemic heart disease (IHD), and liver disease also increases. Almost 66% of the study’s participants reported having experienced at least one ACE and 20% reported three or more (Felitti, 1998). Preventing occurrence of these adverse childhood experiences is critical, in conjunction with treatment of existing issues, in order to reduce future rates of the serious social and health problems that result.

Economic analysis has demonstrated the cost benefits and cost effectiveness of a wide range of evidence-based prevention practices (Lee, Aos, Drake, Pennucci, Miller, & Anderson, 2012), and SAMHSA has identified prevention of substance abuse and mental illness as its top strategic initiative for fiscal year 2013 (SAMHSA, 2013). The National Research Council and Institute of Medicine (2000) makes the argument that “the overarching question of whether we can intervene successfully in young children’s lives has been answered in the affirmative, and should be put to rest. However, interventions that work are rarely simple, inexpensive, or easy to implement” (pp. 396 – 397).

Benedetto Saraceno, Director of the WHO Department of Mental Health and Substance Abuse, summarizes the challenge succinctly in the forward to the summary report on prevention of mental health disorders (2004): “The big unsolved question is: Who should pay for prevention? As the cost of health care is increasing worldwide, there is increasing competition for resources. This scenario puts prevention, which is usually a long-term outcome, at a disadvantage against services with near-term benefits. Economic, including commercial, interests are also more prominent in the treatment domains than in prevention, resulting in poor investments for prevention activities. Health care providers often do not see prevention as their primary responsibility, especially for interventions that are normally implemented by sectors other than health. Public health authorities and health professionals will need to take a leadership role here, even if they cannot find the necessary resources within the health sector to implement programmes. Collaboration between mental health, public health and other sectors is complex but necessary for making prevention programmes a reality.”

I am convinced that “an ounce of prevention is worth a pound of cure,” as the saying goes. However, I believe this argument about prevention versus treatment has been polarized in a way that limits its usefulness. This should not be an “either or” issue but rather an acknowledgement of the necessity of a spectrum of services. I doubt we would be having the same conversations if the full range of services had the necessary funding to implement them. This leads me to believe that the focus should be funding options. Given the limitations of traditional funding sources for human services such as grants and fundraisers, perhaps alternate sources that would facilitate greater independence and collaboration in the non-profit sector should be identified. I hope to learn more about this aspect of nonprofit administration in order to assist in making evidence-based prevention interventions more widely available in our community.

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