Mental Health is Public Health

Today, we find consensus behind the concept that mental health and physical health are interrelated. It is agreed that mental health can be influenced by our physical health, and vice versa. Yet this has not always been the case. It wasn’t until the 19th century, with the advent of the "mental hygiene" movement, that we saw a shift in both treatment of mental illnesses and an effort to promote good mental health.

Nonetheless, fueled by separate legislation and funding streams, our health care system continued a categorical response to health, artificially separating prevention and intervention programs and services that address physical health from those that address mental health disorders and illnesses.

One of the consequences is the false assumption that mental health programs and services are not in the "Public Health" domain. This struggle is particularly evident at the state level, where state agencies commonly organize around funding streams. The federal system, however, does not adhere to that separation. In fact, both the Health Resource Services Administration (source of MCH funding to the states) and the Substance Abuse and Mental Health Services Administration (source of mental health services funding to the states) are two of eight agencies that are part of the Public Health Service Operating Divisions in the federal Department of Health and Human Services.

So we have a challenge ahead of us. If we are to truly put the healthy development of our children and youth in the center and focus on what is in their best interest, we need to work across the artificial lines to bring together the strengths of the physical health and mental health systems. And we must do so in partnership with education, justice, social services, and other child and youth-focused entities, if we are to address the needs of the "whole child" and his/her family.
Mental Health is a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her own community.

Strengthening Mental Health Promotion: Mental Health is not just the Absence of Mental Disorder. WHO Fact Sheet 220 is available at www.who.int/inf-fs/en/fact220.html

This e-newsletter is one small step in that direction. Our focus is on the public health approach to mental health promotion and prevention. THE answer isn’t here. But we provide ideas, pose questions, present models, and encourage everyone to understand what his/her contribution can be toward the promotion of good mental health and the prevention of mental health problems in our youth.

A Public Health Approach to Mental Health

While addressing child and adolescent mental health per se has not always been seen as falling within the traditional public health (i.e. physical health) system’s domain, a growing national conversation is underway on the importance of taking a public health approach to mental health issues. This national conversation was significantly elevated by the U.S. Surgeon General’s 1999 report on suicide and mental health and subsequent papers detailing national strategies for prevention, intervention and treatment.*

Mental health issues are strongly associated with many adolescent physical health problems that the public health community has deemed critical—suicide, violence, obesity, teen pregnancy. A public health approach has much to offer.

Not surprisingly, mental health issues are well represented in the U.S. public health goals, Healthy People 2010 as well as the adolescent-focused 21 Critical Objectives of the National Initiative to Improve Adolescent Health by the Year 2010. Several measures are specific to mental health.

- Suicides
- Injurious suicide attempts
- Feeling sad, unhappy or depressed
- Youth with mental health problems who receive treatment

The National Initiative also includes physical health measures that, while typically addressed through other public health programs, still rely on the promotion of mental health:

- Physical fighting
- Binge drinking
- Use of marijuana
- Unintended Pregnancies
- HIV Infection
- STIs
- Abstinence or use of condoms
- Tobacco
- Obesity

While its complexities may appear to require different or special attention, mental health requires a public health approach just like any other health concern. The public health system’s critical capabilities in prevention and health promotion are vital to improving the mental health of adolescents.

Prevention

For most mental health professionals and the public mental health system, the primary focus is on the treatment and care of people with mental illness and those with mental disorders. Public health (physical health) plays a unique role in early intervention, often focusing efforts “upstream” to prevent emotional and behavioral problems.

Source

*This article is based on the Minnesota Department of Health’s publication entitled:


For copies of this publication call 651-281-9900.
early. A public health approach also focuses on creating an environment that allows for successful recovery from, or effectively living with, mental disorders.

Public health's prevention activities address a variety of behaviors in many different settings.

Examples include:

- Screening for problems and referral to mental health assessment services and other resources;
- Home visiting and other programs with parenting components for families;
- Public education on infant, child and adolescent growth and development;
- Assuring a variety of resources to meet the public’s mental health needs;
- Public education regarding the signs and treatability of depression;
- Programs for students struggling with school attendance or alcohol abuse;
- Assuring an effective and timely community response to people who are feeling suicidal; and
- Programs that address domestic violence and child abuse.

**Promotion**

Mental health promotion is an umbrella term that covers a variety of strategies, all aimed at having a positive effect on mental health. Promotion activities include the encouragement of individual resources and skills, as well as improvements in the socio-economic environment. Thus, a public health approach can “set the stage” for people to take an active role in maintaining good mental health. For example:

- Understanding the range of human behaviors across the life span allows for support of those who are healthy and assists in identifying those who may need assistance or mental health care.
- Maintaining good physical health may help one cope better with the loss of a loved one.
- Learning how to identify and reduce stress may prevent the onset of unmanageable emotions and violent behaviors.
- Creating a school environment that allows students to openly discuss mental health issues may encourage students to seek help when needed.

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**The Public Health Action Wheel***

Exploring the Intersection of Mental Health Promotion and Public Health

The Public Health Action Wheel creates a public health framework used to address adolescent physical health.

This framework can also be applied to the promotion of mental health as a specific focus area for public health professionals.

In the Wheel shown here, each of the Public Health action steps includes an example of a suitable mental health action.

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*The Public Health Action Wheel is adapted from The Public MCH Program Functions Framework: Essential Public Health Services to Promote Maternal and Child Health in America and the USDHHS Public Health Function Project’s Public Health in America Statement. http://www.health.gov/phfunctions/public.htm*
The following article is an excerpt from: 
*The Promotion of Mental Health and the Prevention of Mental and Behavioral Disorders: Surely the Time Is Right* by Nancy J. Davis, Ed.D.

Published in the *International Journal of Emergency Mental Health*, the paper provides an overview of key issues related to promotion and prevention in mental health. Full citations are available in the article.*

The excerpt included here is an examination of the increasing role mental disorders play in the burden of disease—essentially a primer on why prevention and promotion are such critical needs.

The full article discusses the controversies surrounding constructs such as mental health and prevention and the links among promotion, prevention, treatment and recovery. It enumerates principles for effective programs and examples of findings from evidence-based programs. Recommendations are presented for the prevention science field followed by a conclusion with information about the worldwide response to the need for promotion and prevention services.

For copies of the complete article, contact Nancy J. Davis at ndavis1@samhsa.gov

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**Source**

The following article is an excerpt from:

*The Promotion of Mental Health and the Prevention of Mental and Behavioral Disorders: Surely the Time Is Right* by Nancy J. Davis, Ed.D.*

**Why Prevention and Promotion?**

From *The Promotion of Mental Health and the Prevention of Mental and Behavioral Disorders: Surely the Time Is Right* by Nancy J. Davis, Ed.D.*

**They Said It Couldn't Be Done**

*Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it is the only thing that ever has.*

*Margaret Mead, 1958*

Human history is replete with accomplishments that conventional wisdom, at one time or another, declared impossible. Throughout centuries, as smallpox killed millions of people, physicians used many techniques to try to control the disease. It was not until 1766, however, that an English surgeon, Dr. Edward Jenner, experimenting with the Eastern practice of inoculation, discovered that giving a person a small dose of the relatively benign cowpox virus could provide protection again the dreaded smallpox virus (*Jenner, 2000)*.

The use and success of smallpox vaccinations grew throughout the 19th and 20th centuries, but as late as 1967, an estimated 2,000,000 people died from the disease. At that point, the political will and funding came together to eliminate smallpox from the planet. The World Health Organization launched a massive vaccination project, and in 1977, smallpox was declared eradicated from the earth (*Smallpox, 2000)*.

Mental illnesses have probably plagued humankind for at least as long as did smallpox. As was the case with smallpox, various attempts were made over the centuries to "control" mental illnesses, but all too often, the approach was to banish people with mental illnesses from society. It was not until the 19th century that the movement to promote mental health and prevent mental and behavioral disorders got under way in the United States with the advent of the mental hygiene movement. A number of organizations have been formed and reports commissioned over the years, but thus far, no national agenda to promote mental health and prevent mental and behavioral disorders has been developed in the United States.
The Need for Services to Promote Mental Health and Prevent Mental and Behavioral Disorders

Mental disorders already take an enormous toll on the U.S.’s resources in terms of both human suffering and health care dollars. Consider the following statistics:

- An estimated 20 percent of all children and adolescents in the U.S. have mental disorders with at least mild functional impairment (US Department of Health and Human Services, 1999).
- During a 1-year period, 22 to 23 percent of the U.S. adult population – or 44 million people – have diagnosable mental disorders. When addictive disorders are added, the rate increases to 28 to 30 percent (U.S. Department of Health and Human Services, 1999).
- 60% of visits to physicians for medical symptoms are due to psychosocial problems, but the frequency of a mental disorder being diagnosed in general medical practice is only 11 to 36 percent (Mrazak & Haggerty, 1994).
- Only 10 to 30 percent of people in need of mental health services receive appropriate treatment (U.S. Department of Health and Human Services, 1999).

In children and adolescents, common mental disorders include autism, attention deficit hyperactive disorder, depression and anxiety disorders, and/or alcohol and other drug abuse or dependence. In addition, according to Dr. Mark Greenberg and his colleagues at the Prevention Research Center for the Promotion of Human Development at Pennsylvania State University, “disorders of conduct are among the most prevalent and stable of child psychiatric disorders. Many of our most costly and damaging societal problems (e.g., delinquency, substance use and adult mental disorders) have their origins in early conduct problems” (Greenberg et al., 1999).

Why Prevention and Promotion? Continued from page 5

Child and Adolescent Mental Health Resource Guide

The Association of State and Territorial Health Officials (ASTHO) has developed a mental health resource guide for public health agencies. The document, titled Moving Towards a Multi-Systematic Approach for Child and Adolescent Mental Health focuses on children’s and adolescents’ unique mental health needs and the role that state agencies can play in partnership with state mental health and education agencies. The document consists of a series of fact sheets with corresponding issue briefs that provide information on the following topics:

- Overview of Child and Adolescent Mental Health
- Moving Towards a Multi-System Approach for Child and Adolescent Mental Health
- Financing Partnerships in School Mental Health Programs
- Interagency Collaborations to Prevent Mental Health Problems in Children and Adolescents

Copies of these publications are available on-line from ASTHO.

Why Prevention and Promotion? Continued on page 6

Bright Futures in Practice: Mental Health

Looking for mental health educational materials for physicians and practitioners? Bright Futures in Practice: Mental Health is a guide designed for a wide array of professionals in primary care practice.

This two-volume set considers the mental health of children in a development context, provides information on early recognition and intervention for specific mental problems and mental disorders, tools for use in screening, care management, and health education.

National Center for Education in Maternal and Child Health
Georgetown University
www.brightfutures.org

RESOURCE
Conduct disorders are extremely difficult to treat, so their prevention becomes all the more important.

Among adults, depression is one of the most common mental disorders. As well as being a concern for adolescents, major depression (which often has its origins in adolescence) affects nearly one in six adults in the United States (Munoz, 1997). In terms of the severity of disability a disorder or condition may cause, a World Health Organization, World Bank and Harvard University study ranked unipolar major depression in “Disability Class 6” out of a possible seven classes, along with blindness and paraplegia (Murray & Lopez, 1996).

In his keynote address delivered to the Seventh Annual European Conference on the Promotion of Mental Health, Dr. Ricardo Munoz stressed that depression is “a major public health problem that goes far beyond unipolar major depressive disorder and beyond suicide in terms of its effect on the health of our societies” (Munoz, 1997). He noted that seven of the nine causes of death (that account for half of deaths in the United States) may well be influenced by depression.

He cites other researchers who elaborate on the possible link between depression and these causes of death as follows:

- Many youth and adults use tobacco, alcohol, or other drugs to manage their mood, risking death through injury or illness. Further, mood states influence people's activity levels and eating patterns leading to heart disease and other poor health outcomes.
- Teenage girls with depression are more likely to engage in sexual intercourse with multiple partners increasing risk for HIV infection and STDs.
- Suicide accounts for over half of the deaths due to firearms in the United States.

While recognizing the enormous importance of treatment and recovery services, issues related to promotion require equally vigorous attention.

The time is clearly right for the mental health field to follow the lead of smallpox researchers and others in the medical community and to invest heavily in the promotion of mental health and the prevention of mental and behavioral disorders.

**Surgeon General’s Conference on Children’s Mental Health: A National Action Agenda**

On September 18 and 19, 2000 the Surgeon General’s Conference on Children’s Mental Health: Developing a National Agenda was held in Washington, D.C. to develop specific recommendations for a National Action Agenda on Children’s Mental Health.

This report introduces a blueprint for addressing children’s mental health in the United States. It includes the goals listed here – each supported by action steps.

1. Promote public awareness of children’s mental health issues and reduce stigma associated with mental illness.
2. Continue to develop, disseminate, and implement scientifically-proven prevention and treatment services in the field of children’s mental health.
3. Improve the assessment and recognition of mental health needs in children.

4. Eliminate racial/ethnic and socioeconomic disparities in access to mental healthcare.
5. Improve the infrastructure for children’s mental health services including support for scientifically-proven interventions across professions.
6. Increase access to and coordination of quality mental healthcare services.
7. Train front line providers to recognize and manage mental health issues, and educate mental health providers in scientifically-proven prevention and treatment services.
8. Monitor access to and coordination of quality mental healthcare services.


www.surgeongeneral.gov/cmh/default.htm
When Congress created the Substance Abuse and Mental Health Services Administration (SAMHSA) in 1992, it instructed the Secretary of the Department of Health and Human Services, acting through the Administrator of SAMHSA, not only “to improve the provision of treatment and related services to individuals with respect to substance abuse and mental illness,” but also “to improve prevention services (and) promote mental health....”

Thus, the Center for Mental Health Services (CMHS), is charged with leading the national system that delivers mental health services. The goal of this system is to provide the treatment and support services needed by adults with mental disorders and children with serious emotional problems.

Thus from its inception, CMHS has pursued its promotion and prevention mission in many ways. One familiar example is Healthy People 2010. In collaboration with the National Institute of Mental Health (NIMH) – which is part of the National Institutes of Health – CMHS took the lead in developing the 14 objectives for the Healthy People 2010 section on Mental Health and Mental Disorders.

Here are examples of some of their other efforts.

**Safe Schools Healthy Students Initiative**

This multi-faceted school violence prevention program is a landmark collaborative effort of the US Depts of Education, Justice and Health and Human Services. As a grant program designed to develop real-world knowledge about what works best to reduce school violence, this Initiative has awarded $145 million to 77 local school districts that have formal partnerships with local mental health and law enforcement agencies.

School districts are using the funds to help communities design and implement comprehensive educational, mental health, social service, law enforcement, and juvenile justice services for youth.

**The 15+ Make Time to Listen... Take Time to Talk**

Campaign is based on the premise that parents who talk with their children about what is happening in their lives are better able to guide their children toward more positive, skill-enhancing activities and friendships. The campaign provides practical guidance for parents and caregivers on how to strengthen their relationship with their children by spending at least 15 minutes of daily, undivided time with them and focusing on them. This turn-key parenting education program offers a wealth of targeted materials.

**Information and Resources**

The CMHS www site offers a wide range of mental health focused publications that can be ordered or downloaded. Topics include adolescent mental health disorders (anxiety, attention deficit, autism, etc.), glossaries, Spanish language pieces, community action materials, and social marketing materials. It is also an excellent starting point for finding mental health resources within the federal system as it offers many links and resource listings.

www.mentalhealth.org
After dramatic increases in the young male suicide rate between the mid-1960s and the mid-1980s, the youth suicide rate has fallen by 30% or more in most groups over the past 12 years (Teen Suicide Fact Sheet, Shaffer and Greenberg, 2002)*. Yet suicide remains the third leading cause of death for adolescents (15-24-years of age). More teenagers died from suicide than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia and influenza, and chronic lung disease combined.

Method
Firearms are the most common method of suicide by youth–this is true for both males and females, younger and older adolescents and for all races. The increase in the rate of youth suicide (and the number of deaths by suicide) over the past four decades is largely related to the use of firearms as a method. Guns in the home, particularly loaded guns, are associated with increased risk for suicide by youth, both with and without identifiable mental health problems or suicidal factors (Youth Suicide by Firearms Task Force, American Association of Suicidology, 1996).

Gender
More than four times as many male youth die by suicide, but girls attempt it more often and report higher rates of depression. The difference in suicide completion is likely due to the difference in methods: Boys and men are more likely to use firearms which lead to a fatal outcome 78-90% of the time. Girls are more likely than boys to ingest poisons or toxins.

Age
The suicide rate for teens 10-14 years old is still much lower than the rate for older teens. Research suggests that the increase in suicide rates with age may be due to the increased likelihood of exposure to critical risk factors. Studies have found that for younger children exposed to such risk factors, the suicide rate is similar to that of older teens.

Source
This article was excerpted from the section dedicated to youth suicide at the www site of:

The National Youth Violence Prevention Resource Center (NYVPRC)

The resource center is a collaboration between the Centers for Disease Control and Prevention and other federal agencies. The NYVPRC Web site, www.safeyouth.org, and call center, 1-866-SAFEYOUTH (723-3968), serve as a single access point to federal information on youth suicide.

*Unless otherwise noted, citations for the facts referenced here and more information about youth suicide can be found in the “hot topics” area of their www site.

RESOURCE
Need to Know?
The National Adolescent Health Information Center (NAHIC) offers a series of fact sheets on adolescent health issues – including one on Adolescent Suicide. These factual presentations are a concise and easily digestible snapshot suitable for any audience.

http://youth.ucsf.edu/nahic/pdf.html#
In 1998, white males accounted for 61% of all suicides among youth 10-19, and white males and females together accounted for over 84% of all youth suicides. The suicide rates among Native American male youth is extremely high compared to the overall rate for adolescent males – 19.3 vs. 8.5 per 100,000 (aged 10 to 19).

The most rapid increase in suicide rates is noted for African American males aged 10-19 – doubling from 2.9 to 6.1 per 100,000 from 1981–1998.

In 1999, Hispanic students were found to be more than twice as likely as white students to have reported a suicide attempt (12.8 vs. 6.7). Among Hispanic students, females (18.9) were almost three times more likely than males (6.6) to have reported a suicide attempt.

Research findings can not conclusively report that gay and lesbian youth are at higher risk for completing suicide than other youth. For suicide attempts, some studies have reported that high school students who have had homosexual or bisexual experiences have higher rates of suicidal thoughts and attempts compared to those with heterosexual experience.

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**Risk and Protective Factors**

To better understand the complexities of teen suicide, researchers identify **risk factors** associated with an increased risk for suicide and **protective factors** that may reduce the likelihood of suicidal behavior. These factors are frequently used for program development, assessment, and evaluation.

**Protective**  
- Perceived parent & family connectedness  
- Academic achievement  
- Perceived connectedness with school  
- Problem solving skills  
- Impulse control  
- Conflict resolution  
- Nonviolent handling of disputes  
- Family/community support  
- Access to appropriate & effective mental health care  
- Cultural & religious beliefs that discourage suicide

**Risk**  
- Previous suicide attempts  
- Mental/behavioral disorders or co-occurring mental & alcohol or substance abuse disorders  
- Family history of suicide  
- Stressful life event or loss  
- Easy access to lethal means, especially guns  
- Exposure to suicidal behavior of others  
- Incarceration  
- Violence victimization  
- Violence perpetration  
- Alcohol/marijuana abuse  
- School problems

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**Sexual Orientation**

Research findings can not conclusively report that gay and lesbian youth are at higher risk for completing suicide than other youth. For suicide attempts, some studies have reported that high school students who have had homosexual or bisexual experiences have higher rates of suicidal thoughts and attempts compared to those with heterosexual experience.

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**Culture**

In 1998, white males accounted for 61% of all suicides among youth 10-19, and white males and females together accounted for over 84% of all youth suicides.

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**Keys to Prevention**

- Promote overall mental health among school-aged children by reducing early risk factors (see Risk and Protective Factors Box, left) for depression, substance abuse and aggressive behaviors, and by building resiliency.
- Detect youth most likely to be suicidal by confidentially screening for depression, substance abuse and suicidal ideation. If a youth reports one of these problems, a professional evaluation should follow and appropriate and effective treatment provided.
- Develop and implement strategies to reduce the stigma associated with accessing mental health, substance abuse and suicide prevention treatments
- Support efforts to limit young people’s access to lethal agents – including firearms and medications.
- Educate the media. The risk for suicide contagion as a result of media reporting can be minimized by appropriate media reporting of suicides.
- Following exposure to suicide or suicidal behaviors within one’s family or peer group, family members, friends, peers and colleagues of the victim should be evaluated by a mental health professional and, if deemed at risk, referred for mental health services.
- Be aware that some types of suicide prevention efforts may be counter productive. Some school-based programs have been shown to have an unintended effect of suggesting that suicide is an option for young people who have some of the risk factors and in that sense "normalize" suicide. It is critical to be confident that programs are safe and effective before used or promoted. When possible stick with proven or evidence-based programs.

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“The pain experienced by the young may seem to them to be hopeless and unending because they have not yet had the experience of living through and conquering it.”

_Gisela Konopka, 1983_  
*Exceptional Children, Volume 49, Number 5*
Program Effectiveness

The challenge of addressing youth suicide is exacerbated by the fact that to date, there is only limited, if any, evidence for the effectiveness of any strategy for suicide prevention.

This is not to say that there is a lack of prevention programs or approaches, but these programs are largely unevaluated and those that are typically show only limited or even no evidence of efficacy. In some cases, prevention programs have resulted in negative effects.

Program Types - Pros and Cons

Gatekeeper Training targets people who have contact with youth to help them identify and refer students at risk for suicide. It also teaches them how to respond to suicide or other crises. There is no evidence that such training is effective in reducing suicide, but there is evidence that people trained as gatekeepers are better prepared to intervene.

Screening Programs employ a screening instrument to identify high risk youth for further assessment and treatment. Popular programs like SOS and Teen Screen do offer research findings indicating that they are effective at identifying teens at risk. It is important to remember, this model is only good if there are adequate evaluation and therapy services for referrals and follow-up.

Educational Approaches in which students learn about suicide, its warning signs and how to seek help seem intuitively correct, but there is only sparse evidence of their effectiveness. Criticisms of educational programs include concerns over their unselectivity, focus on environmental stresses vs. mental health, "one-time" (vs. sustained) approach and the potential for negative reactions from students who have previously attempted or considered suicide.

Crisis Center Hotlines which provide telephone counseling, drop-in centers and other services are a logical approach with anecdotal evidence of effectiveness. No sound evidence exists and there are concerns that teens

Source

This article is based primarily on the writings of Lloyd Potter, PhD, MPH formerly of the CDC now with the Children’s Safety Network. Dr. Potter is a nationally recognized expert on adolescent suicide and has contributed to a number of significant federal initiatives and publications.

Dr. Potter’s September, 2002 response to a SAHCN listserv query for some insight into proven suicide prevention programs was the genesis of this article and much of the content is derived from it. In addition, the article includes information from Dr. Potter’s work Youth Suicide Prevention Programs: A Resource Guide from 1992 and MMWR Recommendations and Reports (4/22/1994 43(RR-6); 1-7). To find the full reports visit the CDC web site: www.cdc.gov

The accompanying sidebar Principles of Suicide Prevention Effectiveness is from Suicide Prevention: Prevention and Effectiveness published by the National Center for Injury Prevention and Control and SPANUSA (Suicide Prevention Advocacy Network). To download a copy, go to www.spanusa.com.
and males, in particular, are less likely to use them.

**Means Restriction** refers to limiting the availability of firearms and medications, and while there is evidence that these strategies can reduce suicide rates, it is a politically charged topic to address. A number of studies have shown that guns in the home, particularly loaded guns, are associated with increased risk for suicide.

**Postvention Programs** focus on friends and relatives of persons who have committed suicide. Again, there is no sound evidence of their efficacy, but supporting those who have experienced a trauma is a sound idea.

**Prevention Recommendations**

Lacking evidence-based information about the efficacy of suicide prevention strategies, one strategy can not be recommended over another. In that context the following general recommendations can be made.

- Prevention programs must be linked as closely as possible with professional mental health resources. Identifying at-risk adolescents is only successful to the extent that appropriate services, including qualified mental health professionals, are available.

- Use a comprehensive, multi-faceted approach which employs several strategies simultaneously. Avoid reliance on one prevention strategy.

- Incorporate promising, but underused strategies into current programs where possible. Means Restriction is one of the most promising, but underused strategies. Peer support groups for adolescents who have exhibited suicidal behaviors or who have contemplated and/or attempted suicide also appear promising, but should be implemented carefully. Working relationships with other prevention programs, such as alcohol- and drug-abuse treatment programs, may enhance suicide prevention efforts.

- Incorporate evaluation efforts into suicide prevention programs. Outcome evaluation should include measures such as incidence of suicidal behavior or measures closely associated with such incidence (ideation, depression, alcohol abuse). Be aware that suicide prevention efforts may have unforeseen negative consequences. Evaluation efforts should be designed to detect these consequences.

- Be aware that programs designed to improve other psychosocial problem areas among adolescents (such as alcohol- and drug-abuse treatment, services to runaways, pregnant teenagers, school drop-outs and GLBT youth) often address risk and protective factors for suicide. Reclassify these as contributing to suicide prevention and evaluate them as such. When possible, apply proven principles from these related prevention programs to suicide prevention programs (see “Principles of Suicide Prevention Effectiveness” above).

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**Principles of Suicide Prevention Effectiveness**

- Prevention programs should be designed to enhance protective factors. They should also work to reverse or reduce known risk factors. Risk for negative health outcomes can be reduced or eliminated for some or all of a population.

- Prevention programs should be long-term, with repeat interventions to reinforce the original prevention goals.

- Family-focused prevention efforts may have a greater impact than strategies that focus only on individuals.

- Community programs that include media campaigns and policy changes are more effective when individual and family interventions accompany them.

- Community programs need to strengthen norms that support help-seeking behavior in all settings, including family, work, school, and community.

- Prevention programming should be adapted to address the specific nature of the problem in the local community or population group.

- The higher the level of risk of the target population, the more intensive the prevention effort must be and the earlier it must begin.

- Prevention programs should be age-specific, developmentally appropriate, and culturally sensitive.

- Prevention programs should be implemented with fidelity – that is with no or minimal differences from how they were designed and tested that might weaken or dilute the intervention.
Many governmental, educational and community-based organizations have joined forces to end suicide as a health problem. Driven by their interest, a number of significant events have inspired the development of the National Strategy for Suicide Prevention.

One of these was the Surgeon General’s Call to Action to Prevent Suicide in 1999. The Call to Action promoted the “AIM” approach and 15 recommendations that then became the basis for the National Strategy for Suicide Prevention. In addition to establishing an approach used by many states in developing their own suicide prevention plans, the Surgeon General’s Call to Action was the impetus for energy, attention and focus on the issue of suicide prevention.

Why a National Strategy?

A national strategy to prevent suicide is a comprehensive and integrated approach to reducing the loss and suffering from suicide and suicidal behaviors across the life span. It encompasses the promotion, coordination, and support of activities that will be implemented across the country as culturally appropriate, integrated programs for suicide prevention among Americans at national, regional, tribal and community levels.

The National Strategy represents a synthesis of perspectives from researchers and scientists, practitioners, leaders of non-governmental organizations and groups, Federal agencies, survivors, and community leaders.

While goals and objectives are required elements for a national strategy, they are not the entire strategy. They should help guide an informed selection of activities for suicide prevention across the nation. The national
dialogue to determine specific activities for accomplishing each objective will be an extension of the consensus reached on these higher order goals and objectives.

**Goals of the National Strategy for Suicide Prevention**

1. Promote awareness that suicide is a public health problem that is preventable.
2. Develop broad based support for suicide prevention.
3. Develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse and suicide prevention services.
4. Develop and implement suicide prevention programs.
5. Promote efforts to reduce access to lethal means and method of self harm.
7. Develop and promote effective clinical and professional practices.
8. Improve access to, and community linkages with, mental health and substance abuse treatment services.
9. Improve reporting and portrayals of suicidal behavior, mental illness, and substance abuse in the entertainment and news media.
10. Promote and support research on suicide and suicide prevention.
11. Improve and expand surveillance systems.

**$15,639,000,000**

*This figure shows the cost of completed suicides and medically treated suicide attempts among youth (ages 0 – 20) in the United States for 1996.*

*For more information about how this figure was calculated, and to see a state-by-state breakdown, visit http://www.csneirc.org/pubs/tables/youthsui.htm*

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**ADOLESCENT SUICIDE**

... *by the numbers*

<table>
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<td>Percent of high school students who seriously considered attempting suicide in 2001</td>
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<td>Percent of youth suicide victims who have a mental disorder</td>
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<td><em>(D. Shaffer, L Craft; Jml of Clinical Psychiatry, 1999)</em></td>
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<th><strong>28.3%</strong></th>
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<tr>
<td>Percent of high school students who felt sad or hopeless almost every day for two weeks in a row.</td>
</tr>
<tr>
<td><em>(YRBS, 1999)</em></td>
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<tr>
<th><strong>83.8%</strong></th>
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<tr>
<td>Percent of all suicides from 1980-1997 among 15-19 year olds committed by males.</td>
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<tr>
<td><em>(NCHS, 1999)</em></td>
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<th><strong>60%</strong></th>
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<tr>
<td>Percent increase in the overall suicide rate attributed to firearm-related suicides for adolescents 15-19 years olds between 1980-1997</td>
</tr>
<tr>
<td><em>(NCHS, Census Bureau, WISQARS)</em></td>
</tr>
</tbody>
</table>
Funding Suicide Prevention

Not surprisingly, review of the state plans for adolescent suicide prevention reveals that funding is a primary challenge. Many states have no funding for suicide prevention efforts while others successfully acquire state appropriations or allocations from state departments of health or mental health.

Others find ways to use federal funding sources for suicide prevention programs. Most common is use of the Maternal and Child Health Block Grant but the EMSC grant is also used in several states.

Funding Spotlight: Maine

The state of Maine web site provides detailed information about their Youth Suicide Prevention Program development, their approach to gatekeeper training, liability issues for postvention response, and a funding summary which is provided below.

Funding for Maine’s Youth Suicide Prevention Program

Maternal and Child Health Block Grant: program and data coordinators, clerical support, gatekeeper training and awareness education programs, print materials, school-based crisis team conference, school-linked mental health sites, data training and attempt data compilation

Preventive Health and Health Services Block Grant: evaluation consultant, Teen Yellow Pages

State General Fund: Mental Health Crisis Service System, statewide toll-free crisis hotline, Comprehensive School Health Education grants to schools, materials dissemination

Substance Abuse Prevention and Treatment Block Grant: Statewide Information Resource Center, educational books, videos, print materials

Safe and Drug Free Schools and Communities Act: Reconnecting Youth curriculum, training and ongoing consultation

Medicaid Match: Mental Health Crisis Service System

Children's Cabinet Pooled Flexible Funding: print materials, school-based suicide prevention education training, media education, development of firearm safety video, suicide prevention training for college level, medical personnel, substance abuse treatment providers

Private Sector Contributions: print materials

EMSC Grant: development and delivery of gatekeeper training to EMS audiences

School-linked School-based Mental Health Services Grant: provided infrastructure supports to develop school-linked or school-based mental health services

Coordinated School Health Infrastructure Grant: supporting coordination work among state agencies

CDC Cooperative Agreement: funds 12 communities to conduct and evaluate comprehensive youth suicide prevention programs

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Source

The articles on pages 14 and 15 are based on information from a web site developed by:

Davis C. Hayden, Professor and Director
Mental Health Program, Dept. of Psychology
Western Washington University

www.stateplans.org

This web site uses an interactive map to provide links to every State suicide plan, offers updates and snapshots of state activity.

A complementary resource is the DHHS web site.

http://www.mentalhealth.org/suicideprevention/government.asp

In addition to information about state level activity, the site offers access to federal and private resources.
**AIM Approaches to Youth Suicide Prevention Plans**

The “AIM” approach, proposed in the 1999 Surgeon General’s *Call to Action*, has been adopted by a number of state suicide prevention plans. This landmark document includes 15 key recommendations that represent a framework for suicide programs. “AIM” is used to categorize and organize these recommended actions.

- **Awareness** – Appropriately broaden the public’s awareness of suicide and its risk factors.
- **Intervention** – Enhance services and programs, both population-based and clinical care.
- **Methodology** – Advance the science of suicide prevention.

The Surgeon General’s *Call to Action* approach is pervasive – almost every state plan makes some reference to AIM or the Call to Action itself.

Many state plans directly apply the Surgeon General’s approach to their own plan. In these cases, AIM creates an organizational structure, the 15 recommendations are directly sited and the state’s response, activities, or objectives are delineated for each recommendation.

For example, the State of Georgia’s plan (6/2001) offers a concise description of how the Surgeon General’s elements were used:

*There are three large pieces that make up the Plan. These pieces represent its foundation, its building blocks and its keystone.*

**Suicide Resources on the Internet**

There is no lack of suicide-related resources on the internet – in fact the topic is so well covered, the real challenge is knowing where to go for what. While a number of resources have been mentioned in this newsletter’s articles, following are some additional internet based resources:

**Federal Resources**

SAMSHA, CDC, NIH, HRSA and IHS collaborate on the National Strategy for Suicide Prevention – http://www.mentalhealth.org/suicideprevention/

**Evaluation**

Youth Suicide Prevention Programs: A Resource Guide 

wonder.cdc.gov/wonder/prevguid/p0000024/p0000024.asp

CDC Evaluation Working Group – www.cdc.gov/eval

**Training/Distance Learning**


**National Organizations**

American Association of Suicidology – www.suicidology.org

American Foundation for Suicide Prevention – www.afsp.org

National Center for Injury Prevention and Control – www.cdc.gov/ncipc

Children’s Safety Network – www.childrenssafetynetwork.org

National Mental Health Association – www.nmha.org

National Institute of Mental Health – www.nimh.nih.gov

**The foundation** of the Plan uses the public health approach for suicide prevention. The public health model for suicide prevention is a systematic approach to developing and implementing interventions that are effective in reducing suicide.

**The building blocks** of the Plan are arranged as opportunities for Awareness, Intervention, and Methodology (AIM) to improve suicide prevention. These major action steps are presented as goals and objectives.

**The keystone** of the plan is implementation; that is, putting the Plan to work.

Other states customize the approach for their own uses. The State of Ohio’s plan (5/2002), for example, establishes overarching goals for each of the AIM categories, then establishes their own sub-objectives within each area, as follows:

- **Awareness Goal:** Increase awareness that suicide is a public health and mental health problem in order to reduce stigma and increase people’s ability to seek help.
- **Intervention Goal:** Reduce factors that increase the risk of suicide
- **Methodology Goal:** Gather more data about suicide attempts and evaluate the effectiveness of programs designed to prevent suicide.

For states who have yet to develop a youth suicide prevention plan the message is clear: the AIM approach is ready to be implemented.
The Konopka Institute
for Best Practices in Adolescent Health

The Konopka Institute is an interdisciplinary group of experts focused exclusively on the needs of young people.

The Institute has a singular mission:

To work with community organizations, service providers, policy makers, public agencies and other citizens to adopt and/or adapt public interventions, policies and systems that show the greatest promise of supporting health youth development.

Dr. Gisela Konopka serves as the Institute’s namesake and inspiration. Renowned for her work “Requirements for the Healthy Development of Youth,” Dr. Konopka continues to guide the Institute’s mission.

State Adolescent Health Resource Center

To support and promote the health needs of adolescents, the federal office of Maternal and Child Health created the State Adolescent Health Resource Center for State MCH Personnel.

Built on a cooperative agreement with the Konopka Institute for Best Practices in Adolescent Health, the Center’s mission is to strengthen the knowledge, skills and capacities of state MCH professionals so they can more effectively address and improve the health of adolescents.

In this capacity, the Resource Center acts as an Information Clearinghouse and provides technical assistance as well as training and education.

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Information Toolkits

Coming soon to a mailbox near you – The Mental Health Information Toolkit!

Brought to you by the National Initiative to Improve Adolescent Health by the Year 2010 and created by the State Adolescent Health Resource Center, the Mental Health Information Toolkit is the first in a series of Toolkits focused on the 21 Critical Objectives for adolescent health.

The Toolkits puts the information you need at your fingertips. Each Toolkit provides topic specific information, including:

- Definitions and descriptions
- Risk and protective factors
- Experts and resources
- Best practices and promising programs
- Partner Briefings
- Topical Public Health Wheels

Look for the first Toolkit in June of 2000!

The May 2003 issue of Growing Absolutely Fantastic Youth e-newsletter is available as a PDF file on the Konopka Institute www site. Permission is granted to photocopy this publication.

www.konopka.umn.edu