

Healthy People 2020: Who's Leading the Leading Health Indicators?



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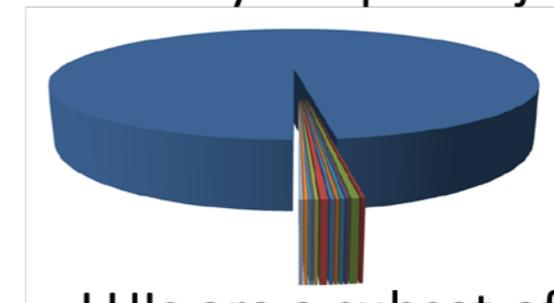
Who's Leading the Leading Health Indicators?

Healthy People
2020

- **Leading Health Indicators are:**

- Critical health issues that, if addressed appropriately, will dramatically reduce the leading causes of preventable deaths and illnesses
- Linked to specific Healthy People objectives
- Intended to motivate action to improve the health of the entire population

1200 Healthy People objectives



LHIs are a subset of
Healthy People
objectives



ODPHP

Office of Disease Prevention
and Health Promotion

Who's Leading the Leading Health Indicators?



Featured Speakers:

- **Jewel Mullen, MD, MPH, MPA** - Principal Deputy Assistant Secretary for Health, U.S. Department of Health and Human Services
- **Sean Lynch, PhD, LCSW** - Behavioral Health Scientist, Center for Behavioral Health Statistics & Quality, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services
- **Richard McKeon, PhD, MPH** - Chief, Suicide Prevention Branch, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services
- **Scott LoMurray** - Deputy Director, Sources of Strength



Office of Disease Prevention
and Health Promotion

Jewel Mullen, MD, MPH, MPA
Principal Deputy Assistant Secretary for Health,
U.S. Department of Health and Human Services



- **What is mental health?**

- 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 community.

- **What are mental disorders?**

- Mental disorders are health conditions that are characterized by alterations in thinking, mood, and/or behavior that are associated with distress and/or impaired functioning.

- **What is mental illness?**

- Refers collectively to all diagnosable mental disorders.

- **Indicators of mental health**
 - Emotional well-being
 - Psychological well-being
 - Social well-being

- **Factors linked to mental health**
 - Race/ethnicity
 - Gender
 - Age
 - Income
 - Education
 - Sexual orientation
 - Geographic location

Mental Health – Across the Lifespan

- **Children and Adolescents**

- 13%-20% (up to 1 out of 5) of children in the United States experience a mental disorder each year
- In 2015, among high school students nationwide:
 - 18% seriously considered attempting suicide
 - 15% made a plan about how they would attempt suicide
 - 9% attempted to take their own life

- **Adults**

- In 2015,
 - 18% reported having any mental illness in the past year
 - 4% reported having a serious mental illness in the past year
 - 4% reported having serious thoughts of suicide in the past year

Mental Health – Leading Health Indicators

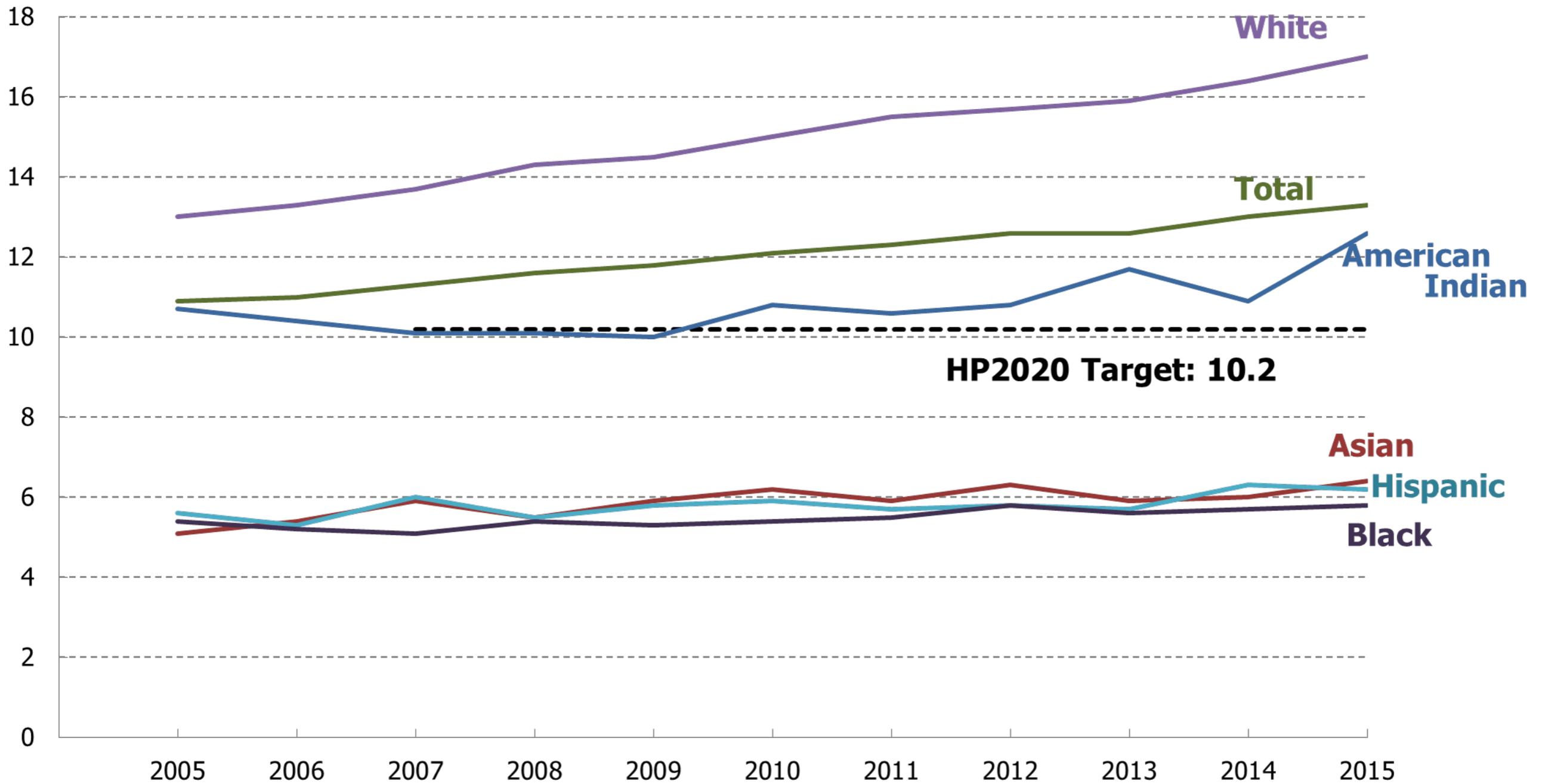
Healthy People
2020

- **Reduce the suicide rate**
- **Reduce the proportion of adolescents with a major depressive disorder in the past 12 months**



Suicide Rate by Race/Ethnicity

Rate per 100,000
(age-adjusted)

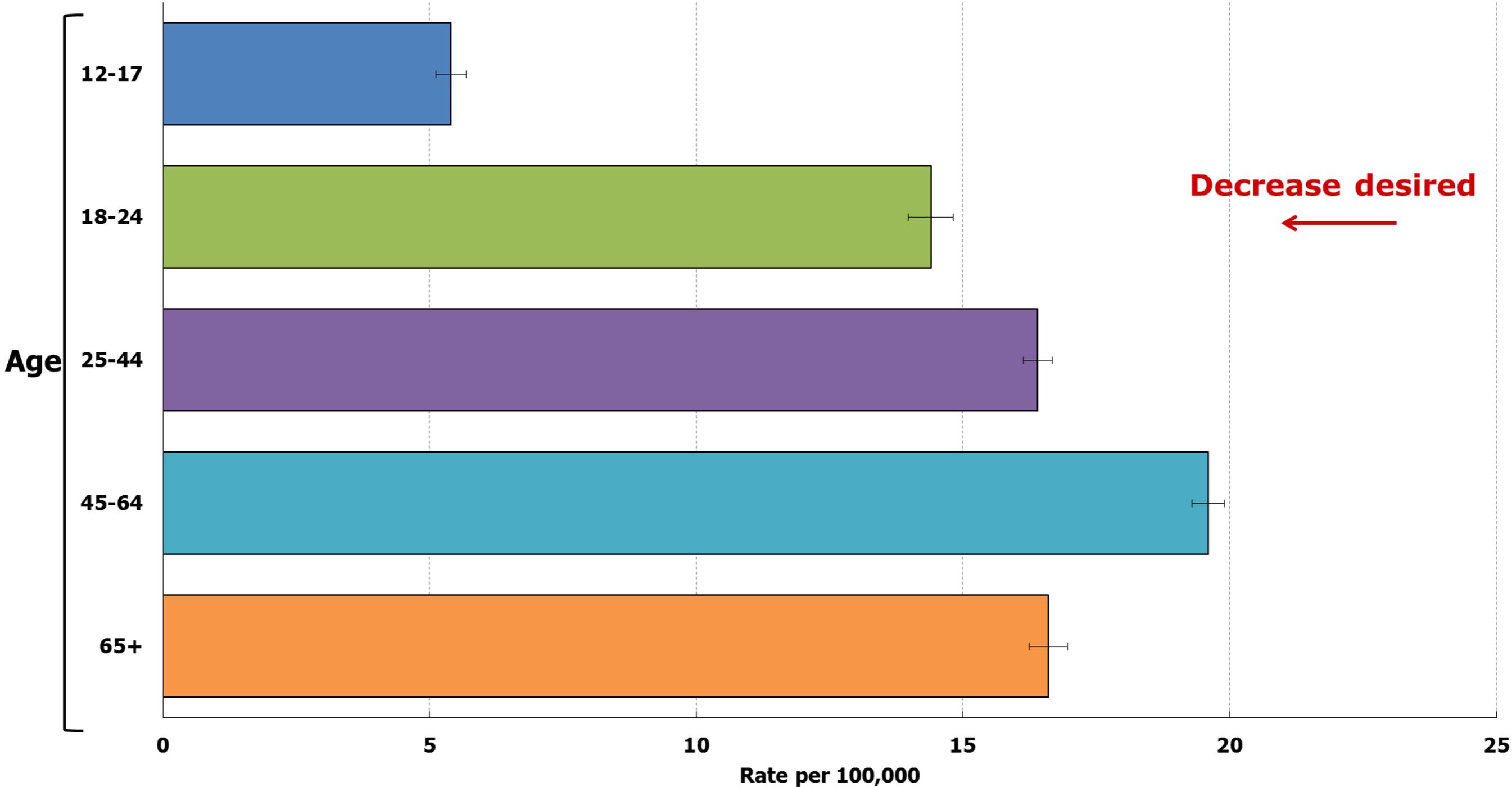


NOTE: Data are for ICD-10 codes *U03, X60-X84, Y87.0 reported as underlying cause of death. American Indian includes Alaska Native. Asian includes Pacific Islander. The categories black and white exclude persons of Hispanic origin. Persons of Hispanic origin may be any race. Data are age-adjusted to the 2000 standard population.

SOURCE: National Vital Statistics System–Mortality (NVSS–M), CDC/NCHS; Bridged–race Population Estimates, CDC/NCHS and Census.

Obj. MHMD-1
Decrease desired

Suicide Rate by Age, 2015



Decrease desired
←

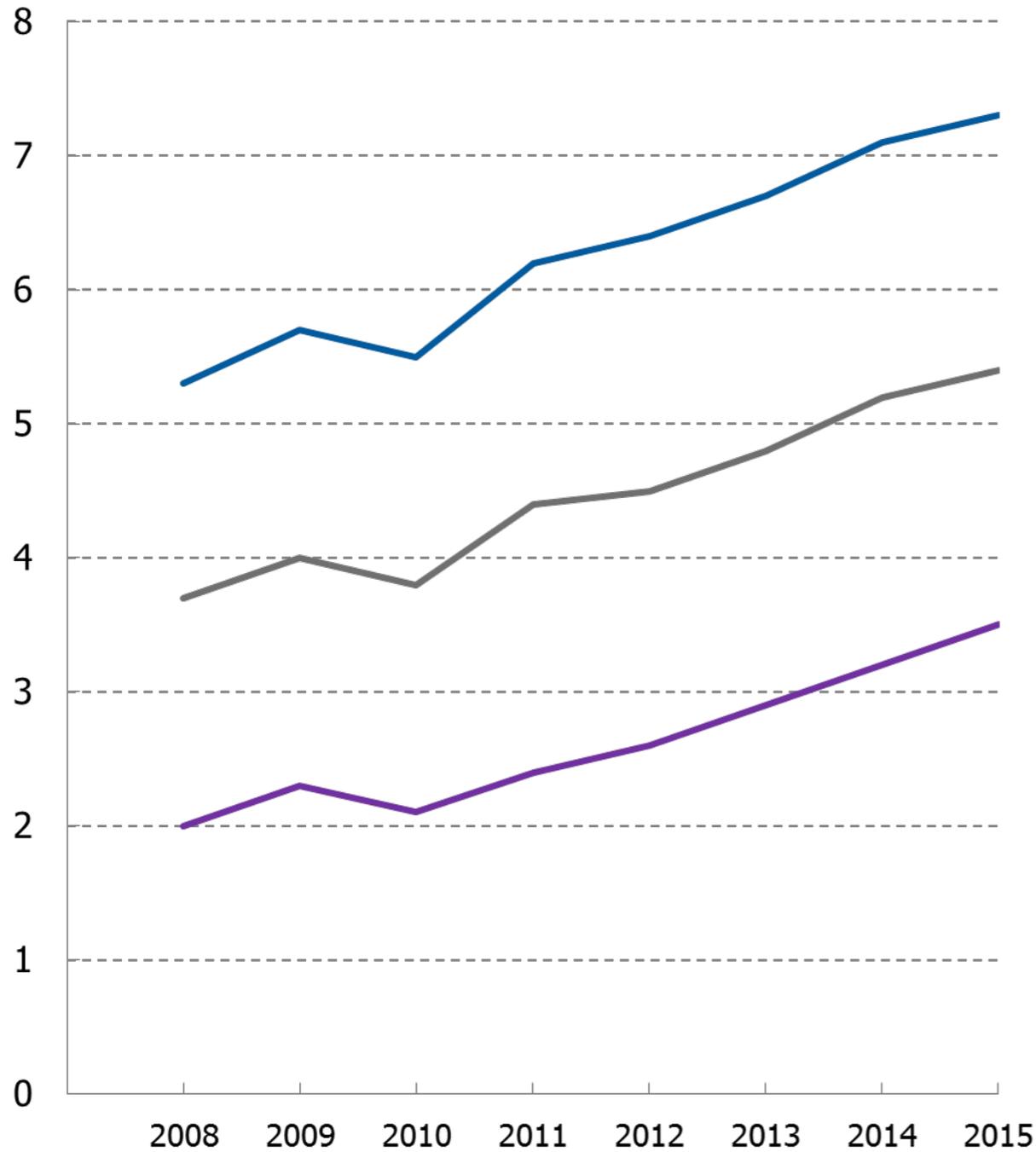
NOTE: — = 95% confidence interval. Data are for ICD-10 codes *U03, X60-X84, Y87.0 reported as underlying cause of death.

SOURCE: National Vital Statistics System–Mortality (NVSS–M), CDC/NCHS; and Bridged–race Population Estimates, CDC/NCHS and Census.

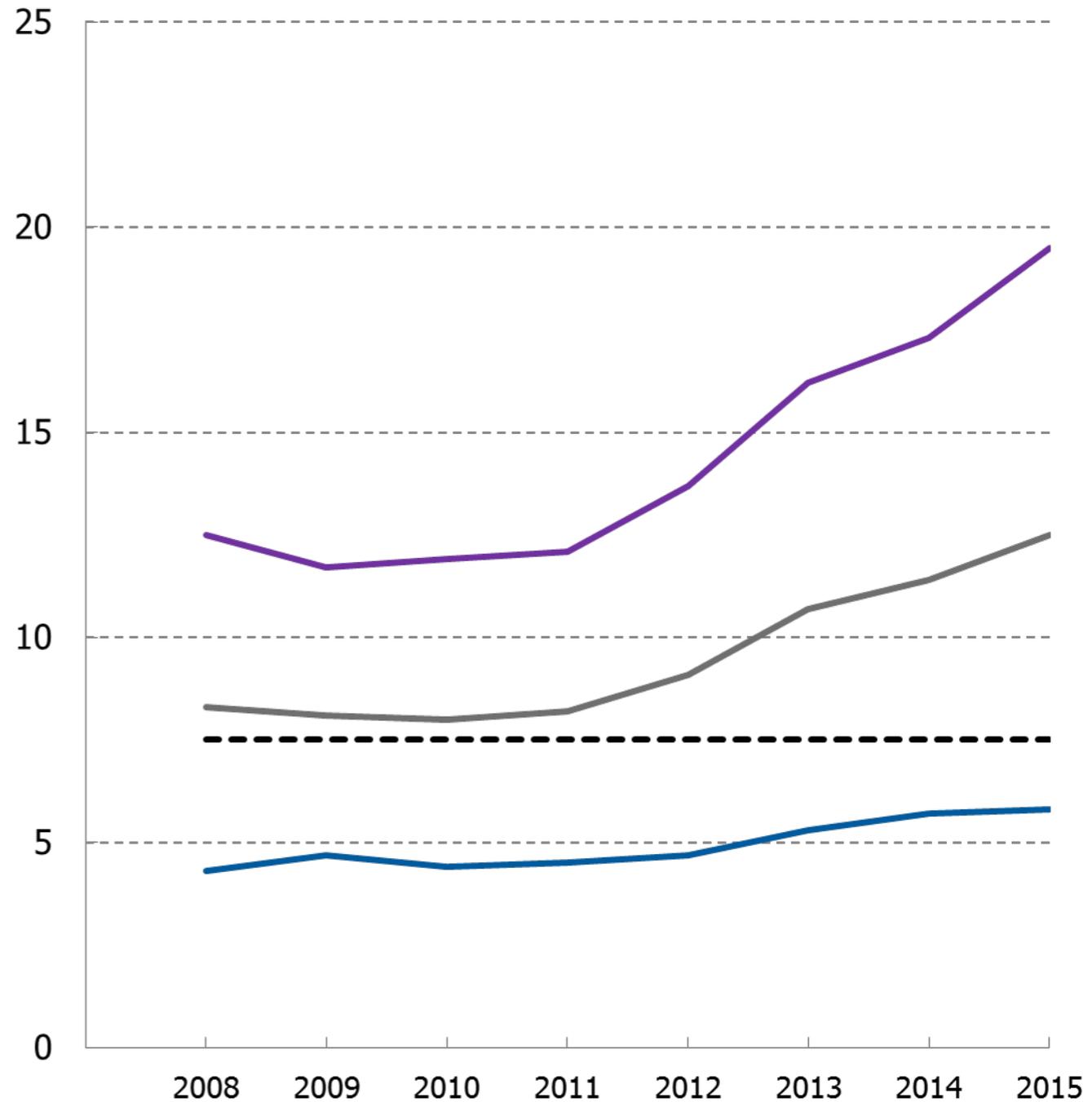
Obj. MHMD-1

Suicide and Major Depressive Episode (MDE) among Adolescents by Sex

Suicide rate per 100,000



Percent experienced MDE

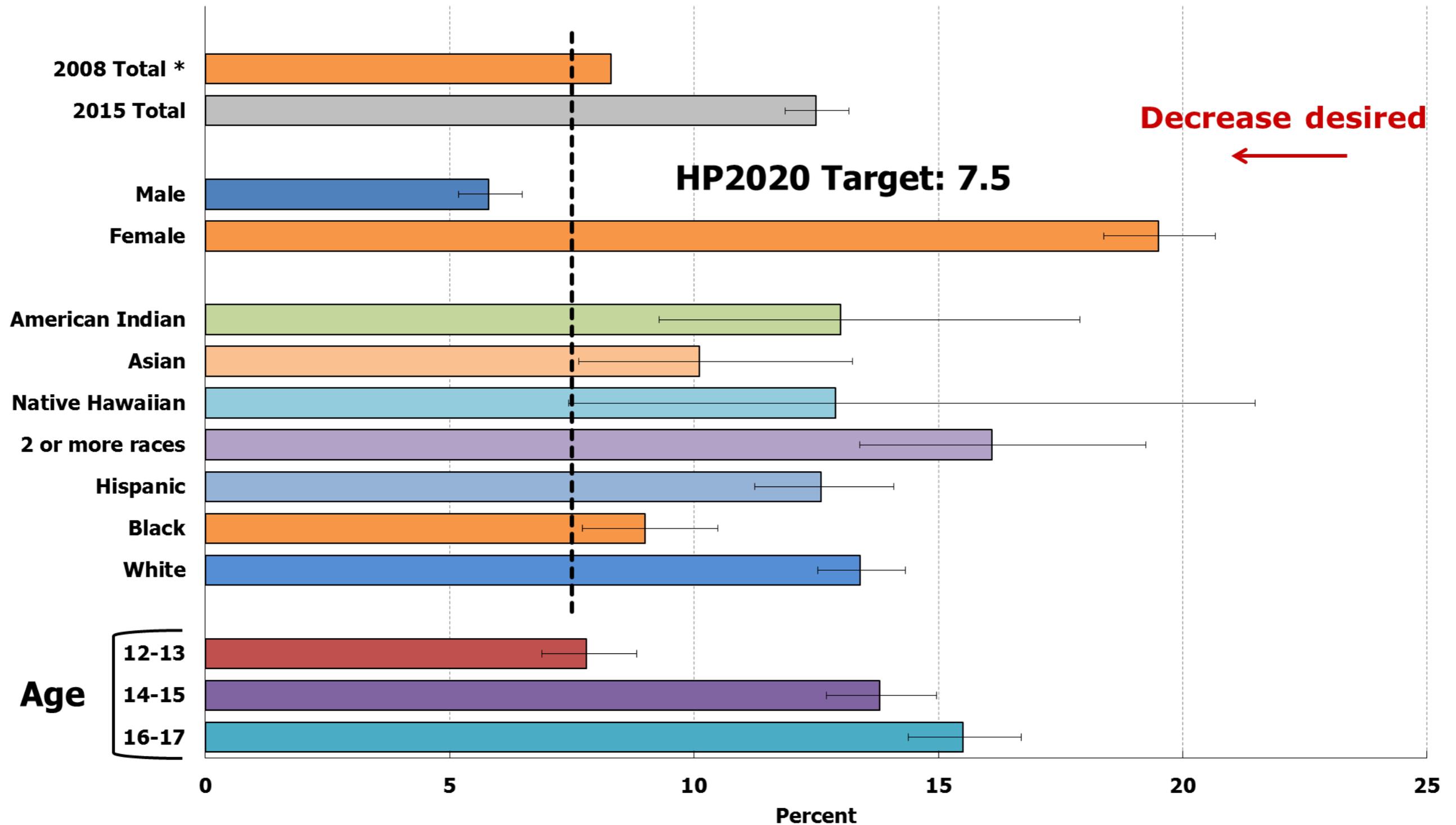


NOTE: Data are for adolescents aged 12-17 who died by suicide or reported having a Major Depressive Episode (MDE) in the past 12 months. Suicide data are for ICD-10 codes *U03, X60-X84, Y87.0 reported as underlying cause of death.

SOURCE: National Vital Statistics System–Mortality (NVSS–M), CDC/NCHS; Bridged–race Population Estimates, CDC/NCHS and Census. National Survey on Drug Use and Health (NSDUH), SAMHSA.

Related Obj.
MHMD-1;
Obj. MHMD-4.1,
 Decrease desired

Major Depressive Episode (MDE) among Adolescents, 2015



NOTE: — = 95% confidence interval. *2008 Total = HP2020 baseline. Data are for adolescents aged 12-17 years who reported having a Major Depressive Episode (MDE) in the past 12 months. American Indian includes Alaska Native. Native Hawaiian includes other Pacific Islander. The categories black and white exclude persons of Hispanic origin. Persons of Hispanic origin may be any race.

SOURCE: National Survey on Drug Use and Health (NSDUH), SAMHSA.

Obj. MHMD-4.1



Activities Supporting Behavioral Health Indicators Related to Mental Health and Mental Disorders

**Sean Lynch, PhD, LCSW, Co-Lead MHMD Workgroup
Center for Behavioral Health Statistics and Quality**

**Richard McKeon, PhD, Suicide Prevention Branch Chief,
Center for Mental Health Services**





SAMHSA Background

Substance Abuse and Mental Health Services Administration (SAMHSA's) Mission

Reduce the impact of substance abuse and mental illness on America's communities

The screenshot shows the SAMHSA website homepage. At the top, there is a navigation bar with links for Home, Newsroom, Site Map, and Contact Us. Below this is a search bar and social media icons for Facebook, Twitter, YouTube, and a Blog. A secondary navigation bar includes links for Find Help & Treatment, Topics, Programs & Campaigns, Grants, Data, About Us, and Publications. The main content area features a large banner for SAMHDA (Substance Abuse and Mental Health Data Archive) with a 'Learn More' link. To the right, there are several key service tiles: 'Find Help' with a 'Behavioral Health Treatment Locator', 'National Suicide Prevention Lifeline', 'National Helpline', and 'Disaster Distress Helpline'. Below these are sections for 'SAMHSA in the News' with three recent articles and a 'Featured Resource' for NCTSI (National Child Traumatic Stress Initiative) titled 'Helping kids recover and thrive.' A 'SAMHSA Blog' section is also visible at the bottom right.

<http://www.samhsa.gov/>

Centers

- **SAMHSA Headquarters: Centers**
 - Center for Mental Health Services (CMHS)
 - Center for Behavioral Health Statistics and Quality (CBHSQ)
 - Center for Substance Abuse Prevention
 - Center for Substance Abuse Treatment

CMHS Supports SAMHSA's Mission

- **Strengthens the Nation's mental health system by helping states improve the quality of their treatment and support**
- **Makes it easier for people to access mental health programs**
- **Encourages a range of programs such as systems of care to respond to the increasing number of mental disorders among America's children**
- **Ensures that scientifically-established findings and practice-based knowledge are applied in treating mental disorders**

CBHSQ Supports SAMHSA's Mission

- **Federal Statistical Reporting Unit**
 - *Provides national leadership in behavioral health statistics and epidemiology*
 - *Promotes basic and applied research in behavioral health data systems and statistical methodology*
 - *Designs and carries out special data collection and analytic projects to examine issues for SAMHSA and other federal agencies*
 - *Participates with other federal agencies in developing national health statistics policy*
 - *Consults and advises SAMHSA's Administrator and the Department of Health and Human Services' Secretary on statistical matters*



SAMHSA's Suicide Prevention Efforts in the United States

Richard McKeon, Ph.D.

Chief, Suicide Prevention Branch



Behavioral Health is Essential To Health



Prevention Works

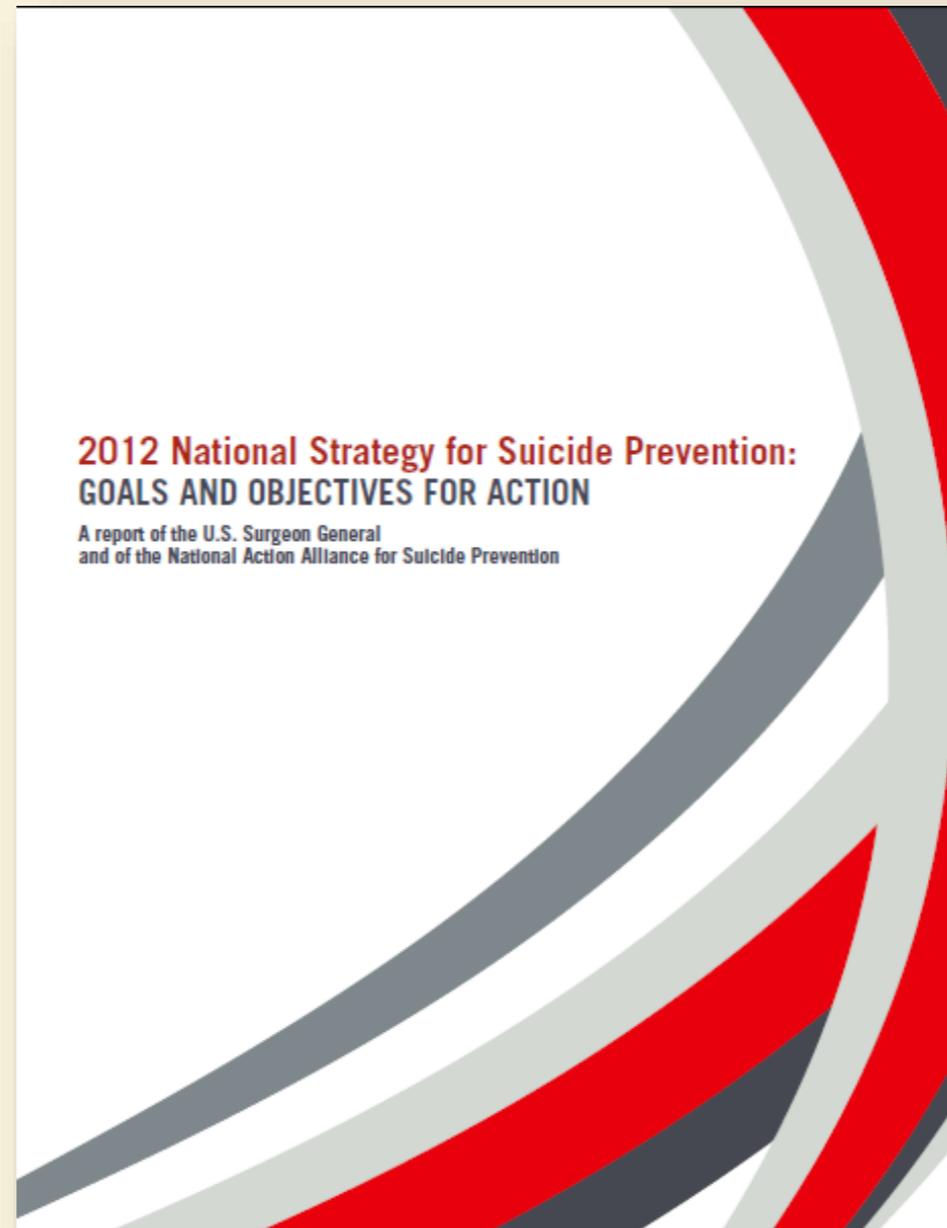


Treatment is Effective



People Recover

National Strategy for Suicide Prevention



SAMHSA Suicide Prevention Efforts

- **Garrett Lee Smith State/Tribal Youth grants**
- **Campus Suicide Prevention grants**
- **Suicide Prevention Resource Center**
- **National Suicide Prevention Lifeline**
- **National Strategy grants**
- **Native Connections**



THE IMPACT OF GLS SUICIDE PREVENTION PROGRAM ON YOUTH SUICIDAL BEHAVIOR

Lucas Godoy Garraza (ICF International); Christine Walrath (ICF International); David Goldston (Duke CSSPI); Hailey Reid (ICF International), Richard McKeon (SAMHSA)





SAMHSA & The JED Foundation Present

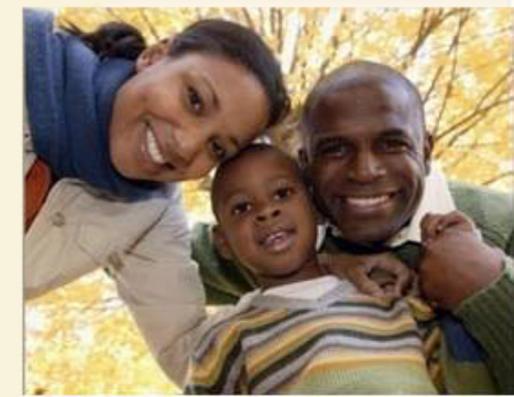
Responding to Suicide Clusters on College Campuses

August 20, 2015
1:30 – 5:00pm, ET

Welcome by Richard McKeon, Ph.D.
Facilitated by Victor Schwartz, M.D.

Part I: Madelyn S. Gould, Ph.D., M.P.H.
Kerri Smith, LCSW, MPH

Part II: Dolores Cimini, Ph.D.
Gregory T. Eells, Ph.D.
Philip W. Meilman, Ph.D.





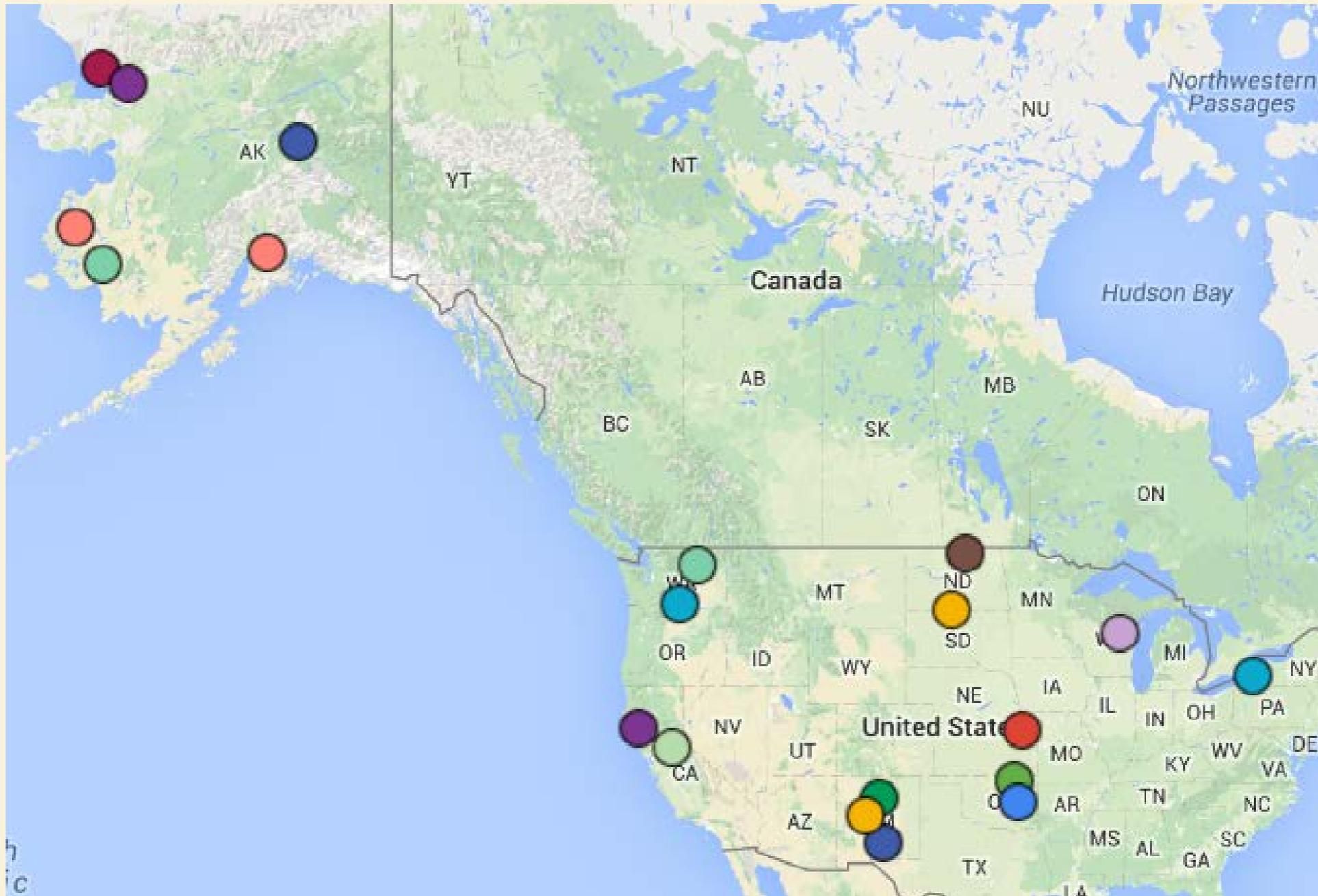
Suicide Prevention Resource Center

Promoting a public health approach to suicide prevention

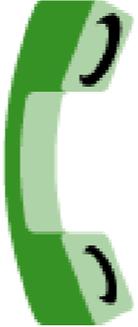


The nation's only federally supported resource center devoted to advancing the *National Strategy for Suicide Prevention.*

Native Connections Cohort 1



NATIONAL

SUICIDE
**IDE**
PREVENTION

LIFELINE™

1-800-273-TALK

www.suicidepreventionlifeline.org

Lifeline's Imminent Risk Policy (2011)

29



NATIONAL SUICIDE PREVENTION LIFELINE Policy for Helping Callers at Imminent Risk of Suicide

December 2010

Developed by the staff from the National Suicide Prevention Lifeline (Lifeline) at Link2Health Solutions, Inc. in collaboration with the Lifeline Steering Committee, Standards, Training and Practices Subcommittee, and the Consumer Survivor Subcommittee (see <http://www.suicidepreventionlifeline.org/About/ExpertLeadership.aspx> for more information) under grant No. 5 U79 SM056176-06 from the Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. Any opinion, findings, conclusions, and recommendations expressed herein are those of the authors and do not necessarily reflect the views of the Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.





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Richard.mckeon@samhsa.hhs.gov





Data Sources and Publications

SAMHSA/CBHSQ Data Sources

- **National Survey on Drug Use and Health (NSDUH)**
- **National Mental Health Services Survey (N-MHSS)**

Public Use Files

Substance Abuse and Mental Health Data Archive

SAMHDA

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SAMHDA Home

Welcome to SAMHDA—the Substance Abuse and Mental Health Data Archive!

The [Substance Abuse and Mental Health Services Administration \(SAMHSA\)](#) and RTI International are proud to launch the redesigned SAMHDA website with new designs, streamlined menus, and simplified navigation. We want to offer our users an easy way to get to the data they need for their analyses.

We encourage legacy and new users to return to the site often to explore the spectrum of available data offerings. We will update and expand our resources, tools, and documentation frequently to deliver the most relevant data for your needs.

The [SAMHDA help desk](#) is available to answer questions via the [Online Technical Assistance form](#) or by calling 888.741.7242. Need Treatment Help? Visit the [SAMHSA](#) site for more information.

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SAMHDA Help Desk
[Online Technical Assistance](#)
Phone 888.741.7242

Behavioral Health Treatment Services Locator



Find Facility

Q Washington, DC 20008, USA

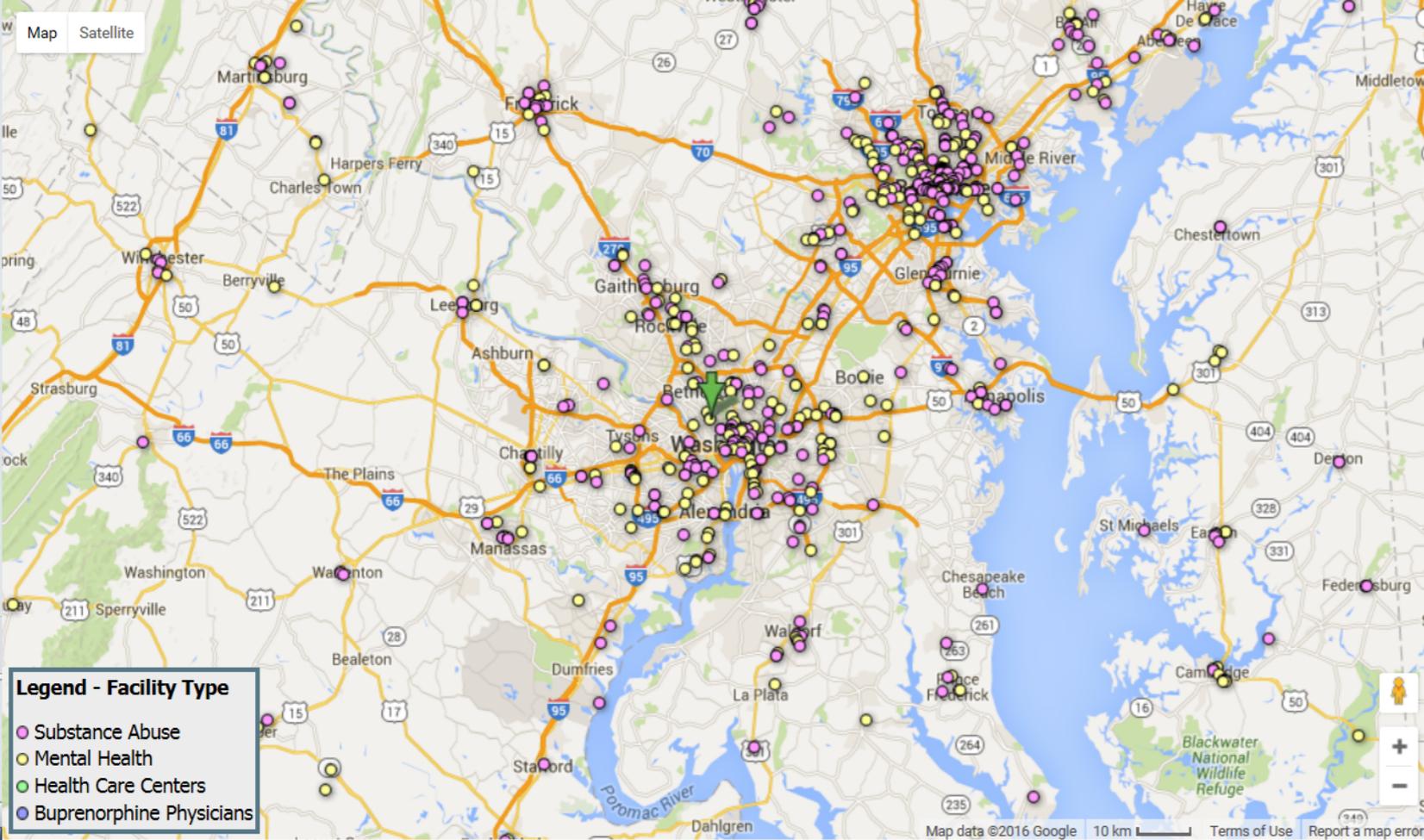
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Service: Substance Abuse (SA) ▾ Mental Health (MH) ▾ SA & MH ▾

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Facility Listing Information

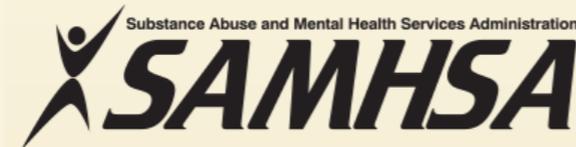
1	Psychiatric Institute of Washington 4228 Wisconsin Avenue NW Washington, DC 20016 Main Tel: 202-885-5600 Intake Tel 1: 202-885-5610 Website Directions	0.86 miles More Information
2	Executive Addictive Disease Progs Inc 4335 Wisconsin Avenue NW Washington, DC 20016 Main Tel: 202-362-2588 Website Directions	0.87 miles More Information
3	Circles of Hope Psychotherapy and Addictions Services 3000 Connecticut Avenue NW Suite 321 Washington, DC 20008 Main Tel: 202-265-2343 Intake Tel 2: 202-841-1673 Website Directions	1.11 miles More Information
4	Intensive In/Home Circles of Hope Psychotherapy and Addictions Services 3000 Connecticut Avenue NW Suite 321 Washington, DC 20008 Main Tel: 202-265-2343 Intake Tel 2: 202-841-1673 Website	1.11 miles More Information

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<https://findtreatment.samhsa.gov/>



National Registry of Evidence-Based Programs & Practices (NREPP)



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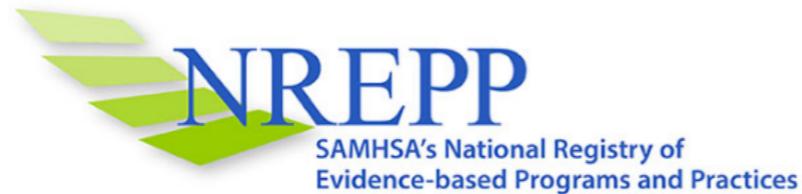
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National Registry of Evidence-based Programs and Practices (NREPP)

SAMHSA's National Registry of Evidence-based Programs and Practices (NREPP) promotes the adoption of scientifically established behavioral health interventions.

About NREPP

NREPP was developed to help the public learn more about evidence-based interventions that are available for implementation.

[Learn more about NREPP.](#)

Learning Center

[NREPP's Learning Center](#) offers resources to support the selection and adoption, implementation, and evaluation of evidence-based programs and practices.

Find an Intervention

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Reviews and Submissions

A review generally takes several months to complete, from the initial scheduling of the kick-off call to the completion of an NREPP intervention summary.

[Learn more about the NREPP review and submission process.](#)

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NREPP News

Keep up with the latest NREPP-related news, including announcements regarding recently added intervention summaries.

[Results for public comments received — January 4-31, 2016 \(PDF | 131 KB\)](#)

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Contact NREPP

866-436-7377
nrepp@samhsa.hhs.gov
[Online contact form](#)

Short Reports

Substance Abuse and Mental Health Services Administration
SAMHSA
 Center for Behavioral Health Statistics and Quality
The CBHSQ Report
 May 6, 2014

Serious Mental Health Challenges among Older Adolescents and Young Adults

In Brief

- Combined 2010 to 2012 NSDUH data indicate that 1 in 10 older adolescents aged 16 to 17 had a major depressive episode (MDE) in the past year. One in five young adults aged 18 to 25 (18.7 percent) had any mental illness in the past year and 3.9 percent had a serious mental illness (SMI).
- In the past year, 3.1 percent of older adolescents had co-occurring MDE and substance use disorder (SUD); 6.4 percent of young adults had co-occurring AMI and SUD, and 1.6 percent of young adults had co-occurring MDE and SUD.
- Among older adolescents with MDE, 60.1 percent did not receive treatment for depression in the past year. Among young adults with AMI, 66.6 percent did not receive mental health services in the past year. Among young adults with SMI, 47.0 percent did not receive treatment.
- Older adolescents with MDE and young adults with mental illness generally had poorer quality of life than those without mental illness.

In the United States, the transition into adulthood begins in the late teens and continues through the mid-20s. This can be a stressful process as young people become more self-sufficient and make decisions that shape their futures. For example, they are finding their own places to live, making educational plans, starting careers, and entering serious relationships. The challenges that older adolescents and young adults face are more difficult if they have a mental disorder (e.g., schizophrenia or bipolar disorder) or substance use disorder (SUD).^{1,2}

Mental disorders can emerge in young people during their transition into adulthood.³ Furthermore, the prevalence of major depressive episode (MDE) and SUD generally increases with age through the adolescent years.³ Studies have shown that there is nearly a twofold increase in mood disorders from the 13-to-14-year-old age group to the 17-to-18-year-old age group.⁴ Older adolescents have higher rates of mental illness than younger adolescents.^{3,4} Young adults have higher rates of co-occurring mental illness and SUD than older adults.⁵ When compared with adolescents aged 26 or older, the rate of SUD among young adults aged 18 to 25 is more than twice as high (19.1 vs. 6.8 percent), and young adults have higher rates of co-occurring mental illness and SUD than adults aged 26 or older.^{5,6}

Although older adolescents and young adults have mental health vulnerability, many do not receive mental health services.^{5,6} Clinical interventions can minimize impairments associated with mental health problems while supporting the transition to independence and adulthood.⁷ Thus, adolescence and young adulthood are important periods for both promoting positive mental health and reducing the negative consequences of mental illness.

Substance Abuse and Mental Health Services Administration
SAMHSA
 National Survey on Drug Use and Health
The CBHSQ Report
 Short Report July 07, 2016

STATE ESTIMATES OF MAJOR DEPRESSIVE EPISODE AMONG ADOLESCENTS: 2013 AND 2014

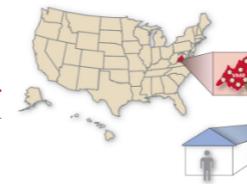
AUTHORS

Rachel N. Lipari, Ph.D., Arthur Hughes, M.S., and Matthew Williams, Ph.D.

INTRODUCTION

Depression affects adolescents in every part of the United States. Depression has been shown to affect adolescents' physical, emotional, and social development. Adolescents who suffer from depression are at increased risk for substance use, high-risk sexual behaviors, problems at school, problems with peer and family relationships, and suicide attempts.^{1,2} Like many mental disorders, depression can emerge during adolescence,³ and the prevalence of major depressive episode (MDE) generally increases with age through the adolescent years.⁴ Studies have shown that there is nearly a twofold increase in mood disorders from the 13- and 14-year-old age group to the 17- and 18-year-old age group.⁵ Because adolescent depression is a problem in every American community, this report provides state-level information on the prevalence of depression among adolescents. This information can inform policymakers' and prevention specialists' efforts to develop effective education, treatment, and prevention programs in their communities.

The National Survey on Drug Use and Health (NSDUH) provides up-to-date estimates of MDE and treatment for depression among adolescents. NSDUH asks adolescents aged 12 to 17 about past year symptoms to determine whether they had MDE in the past year. MDE is defined using the diagnostic criteria from the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders*.⁶ Adolescents were assessed as having MDE if they had a period of 2 weeks or longer during which they had either depressed mood or loss of interest or pleasure in usual activities, as well as at least four other symptoms that reflect a change in functioning, such as problems with sleep, eating, energy, concentration, and self-worth.



In Brief

- Based on combined 2013–2014 National Survey on Drug Use and Health, about 1 in 9 (11.0 percent) adolescents aged 12 to 17 in the United States had a major depressive episode (MDE) in the past year—or roughly 2.7 million of the 24.9 million adolescents in the nation.
- Rates of adolescent past year MDE in 2013 varied across the states, ranging from 8.1 percent in the District of Columbia to 14.6 percent in Oregon.
- Compared with the estimate from combined 2012–2013 data, the estimate of adolescent year MDE in 2013–2014 was higher in the United States as a whole (9.9 percent in 2012–2013 vs. 11.0 percent in 2013–2014).
- Thirteen states experienced a statistically significant increase from 2012–2013 to 2013–2014.

Substance Abuse and Mental Health Services Administration
SAMHSA
 National Survey on Drug Use and Health
The CBHSQ Report
 Short Report June 16, 2016

STATE ESTIMATES OF PAST YEAR SERIOUS THOUGHTS OF SUICIDE AMONG YOUNG ADULTS: 2013 AND 2014

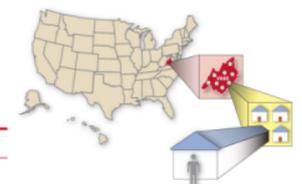
AUTHORS

Rachel N. Lipari, Ph.D., Arthur Hughes, M.S., and Matthew Williams, Ph.D.

INTRODUCTION

Suicide is an avoidable cause of mortality that is a tragedy for all involved—families, friends, neighbors, colleagues, and communities. In 2013, suicide was the 10th leading cause of death in the United States overall, with more than 41,000 deaths by suicide.¹ Among people aged 15 to 24, suicide ranked even higher as the second leading cause of death.²

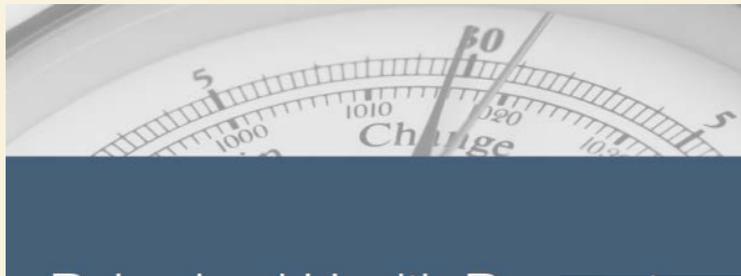
However, individuals who die from suicide represent a fraction of those who consider or attempt suicide. Research suggests that there are more attempted suicides than there are deaths from suicide.^{3,4} Out of every 31 adults who attempted suicide in the past 12 months in the United States, there was 1 death by suicide.³ In addition, people are likely to have thought about suicide before actually attempting suicide. Suicide is of particular concern for young adults because the percentage of adults having serious thoughts of suicide in 2014 was higher among young adults aged 18 to 25 than among adults aged 26 to 49 and adults aged 50 or older (7.5 percent vs. 4.0 and 2.7 percent, respectively).⁵ Assessing recent state-level trends in past year serious thoughts of suicide among young adults helps state public health officials identify areas where interventions are needed.



In Brief

- Based on combined 2013–2014 National Surveys on Drug Use and Health, 2.6 million young adults aged 18 to 25 in the United States had serious thoughts of suicide in the past year.
- Based on combined 2013–2014 National Surveys on Drug Use and Health, about 1 in 13 young adults had suicidal thoughts in the past year.
- Past year serious thoughts of suicide among young adults ranged from 6.2 percent in Texas to 10.3 percent in New Hampshire.
- The prevalence of past year serious thoughts of suicide increased in New Hampshire (when comparing 2013–2014 estimates with 2012–2013 estimates).

Barometers



Behavioral Health Barometer
United States



Behavioral Health Barometer
EXECUTIVE SUMMARY
Region VII, 2014



Behavioral Health Barometer
Nebraska, 2015



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Blogs and Publications

Health Affairs Blog

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ASSOCIATED TOPICS: DRUGS AND MEDICAL TECHNOLOGY, HEALTH IT, PUBLIC HEALTH

Suicide Prevention: Access To Behavioral Health Services Lacking

Ryan Mutter, Sean Lynch, Mir M. Ali, Brent Gibbons, Richard McKeon, and Christopher Carroll

August 10, 2016



Suicide is a leading cause of death in the United States. From 2000 to 2014, it was the third most common cause of death among 10 to 24 year olds, the second most common cause of death among 25 to 34 year olds, and the tenth most common cause of death for all ages. The medical and work-loss costs of completed suicide are estimated to be over \$51 billion. Suicide can have a devastating effect on

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Next article >

Crisis. DOI: 10.1027/0227-5910/a000439. © 2016 Hogrefe Publishing.

Parent–Child Connectedness and Long-Term Risk for Suicidal Ideation in a Nationally Representative Sample of US Adolescents

Received May 15, 2015
Accepted September 13, 2016
Published online November 21, 2016

DOI: <http://dx.doi.org/10.1027/0227-5910/a000439>

Abstract Full Text References PDF

Abstract

Abstract. *Background:* Few studies have addressed on the role of parent–child connectedness (PCC) on adolescents' risk for suicidal ideation from a longitudinal, developmental perspective. *Aim:* This study examined PCC during adolescence and risk of suicidal ideation into adulthood among a nationally representative sample of American adolescents. *Method:* The study includes 13,234 adolescents aged 11–18 from the National Longitudinal Study of Adolescent to Adult Health (Add Health) who were surveyed during adolescence (1994–1995) and then again in early adulthood (2008–2009). Multinomial logistic regression estimated the association between PCC during adolescence and having ideation during the adolescence period only, in adulthood only, and in both adolescence and adulthood as compared with those without suicidal ideation. *Results:* After adjusting for depressive symptoms and other parent and adolescent characteristics, adolescents in two-parent households who reported higher PCC during adolescence had lower relative risk of having ideation during adolescence alone and in both adolescence and adulthood. In mother-only households, higher mother connectedness was also associated with decreased risk of having adolescent ideation. *Conclusion:* PCC is an important modifiable target for the prevention of suicidal ideation from adolescence into adulthood.

Keywords: [adolescent](#), [parent–child connectedness](#), [family](#), [suicidal ideation](#), [suicide](#)

Correspondence concerning this article should be addressed to:

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Crisis

The Journal of Crisis Intervention and Suicide Prevention



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Last thoughts

- **Federal responsibility to be good stewards of the public trust**
- **Large, reliable, national surveys**
- **Data dissemination for decision making**
- **Cutting edge responses to the needs of public health providers and their constituents**

Thank You!

Substance Abuse and Mental Health Services Administration

5600 Fishers Lane

Rockville, MD 20857

Toll-Free Numbers

877-SAMHSA-7 (877-726-4727)

800-487-4889 (TDD)

SOURCES OF STRENGTH



Upstream Prevention

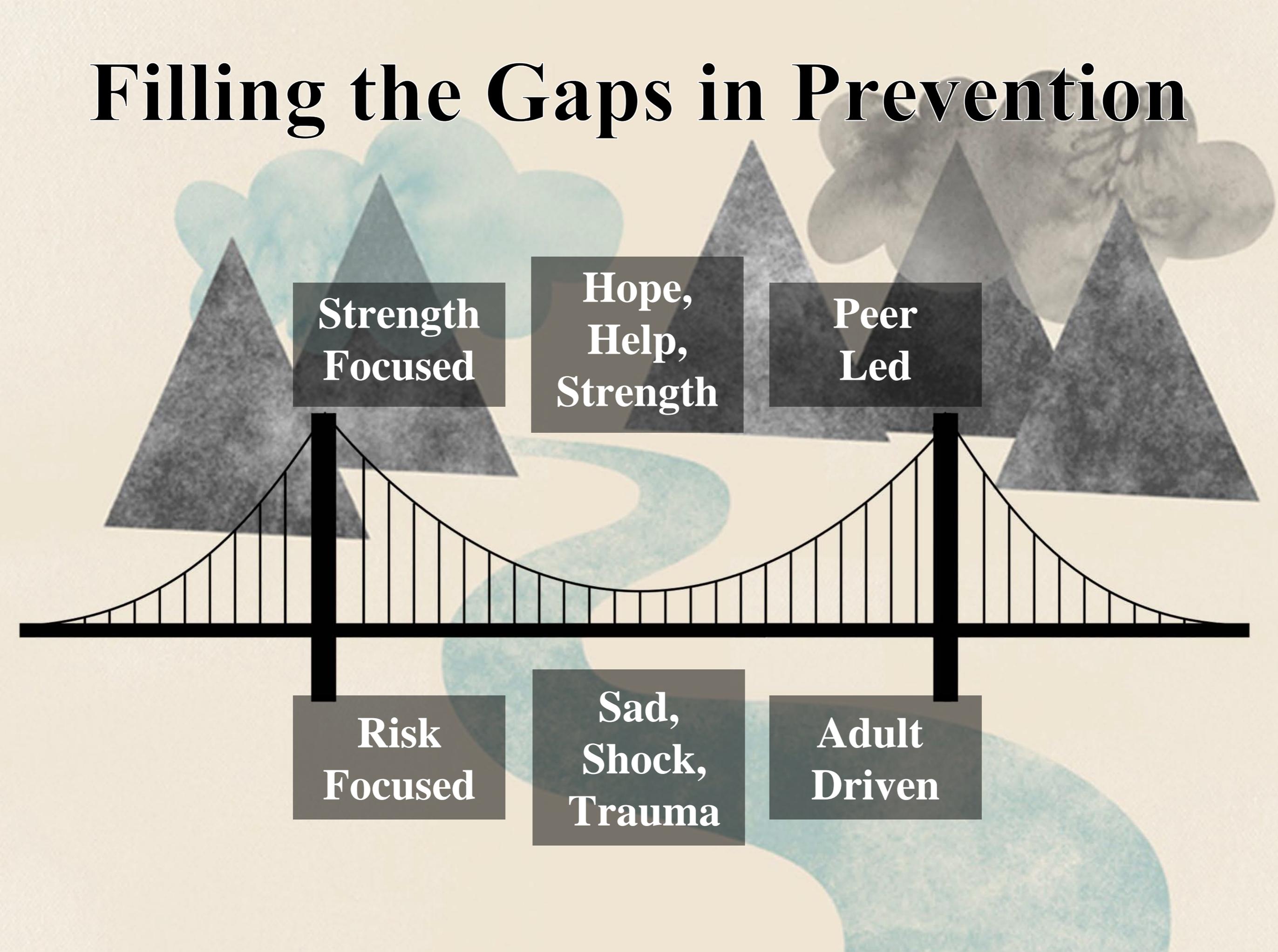


Upstream Prevention
Sources of Strength Primary Mission

Intervention
Sources of Strength Secondary Benefit

Postvention
Sources of Strength Team's can be activated

Filling the Gaps in Prevention



**Strength
Focused**

**Hope,
Help,
Strength**

**Peer
Led**

**Risk
Focused**

**Sad,
Shock,
Trauma**

**Adult
Driven**

Impact of Sources of Strength

(Phase -1)

Cluster Randomized Controlled Trial (NIMH, SAMHSA funding)
18 Schools; 465 Peer Leaders; 2,700 students

Peer Leaders

- Increased healthy coping attitudes/norms (ES .22-.75)
- More connections to adults (M +1 connection)
- 4X more likely to refer peer to adults
- Largest gains for least connected or healthy peer leaders

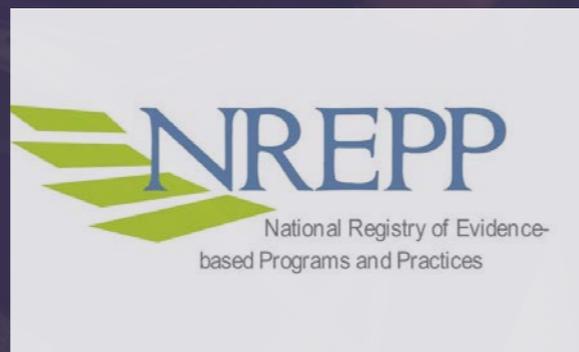
Wyman et al. (2010). *American Journal of Public Health*

Impact of Sources of Strength

(Phase -1)

School Population

- Increased help-seeking acceptability (ES .58)
- Increased perception that adults help suicidal peers (ES .63)
- Largest gains for suicidal students

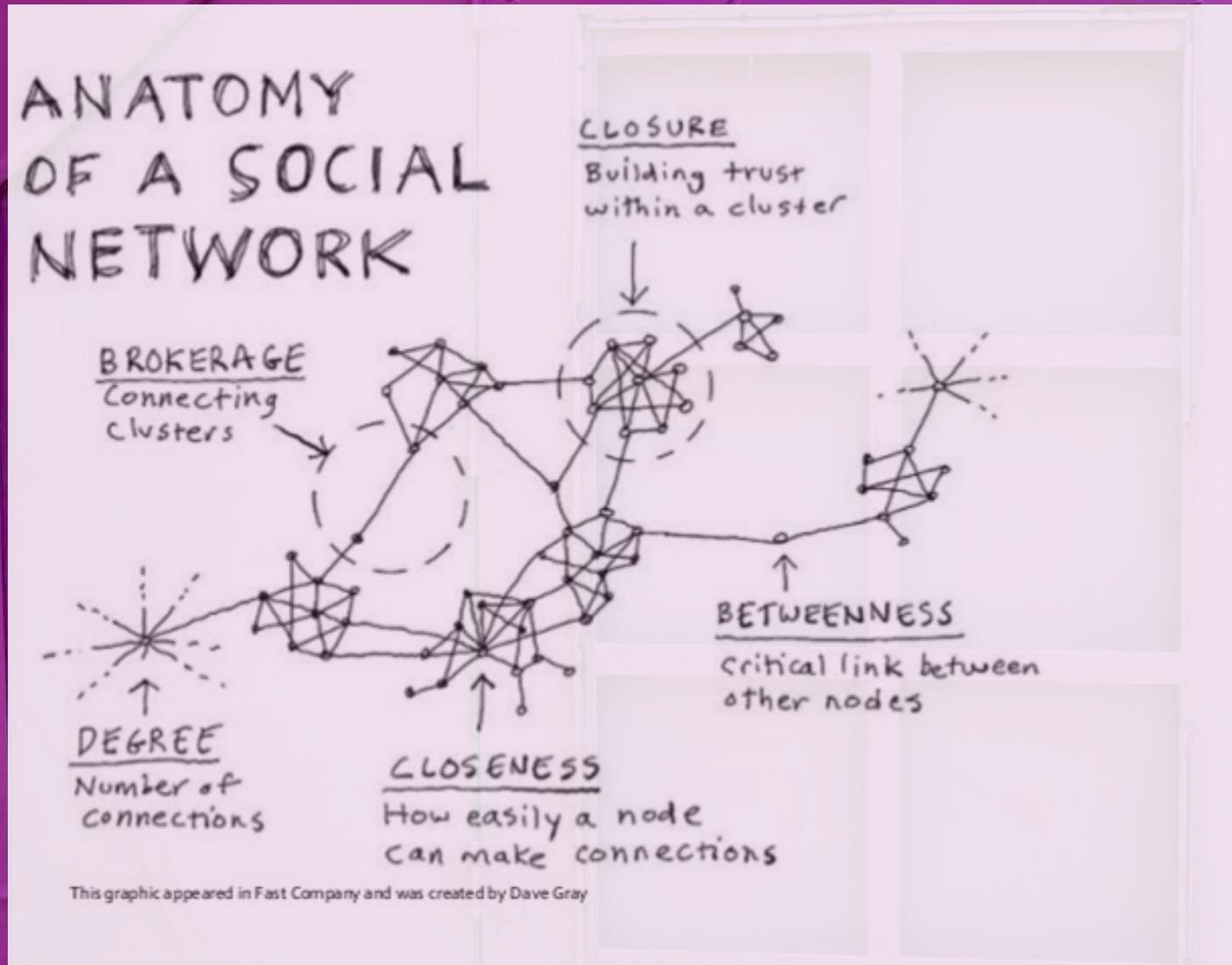


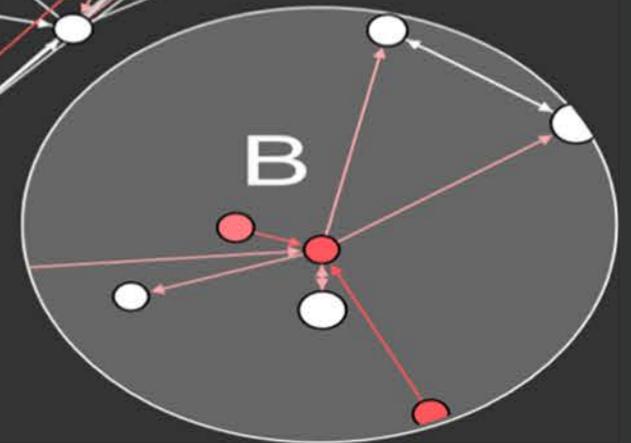
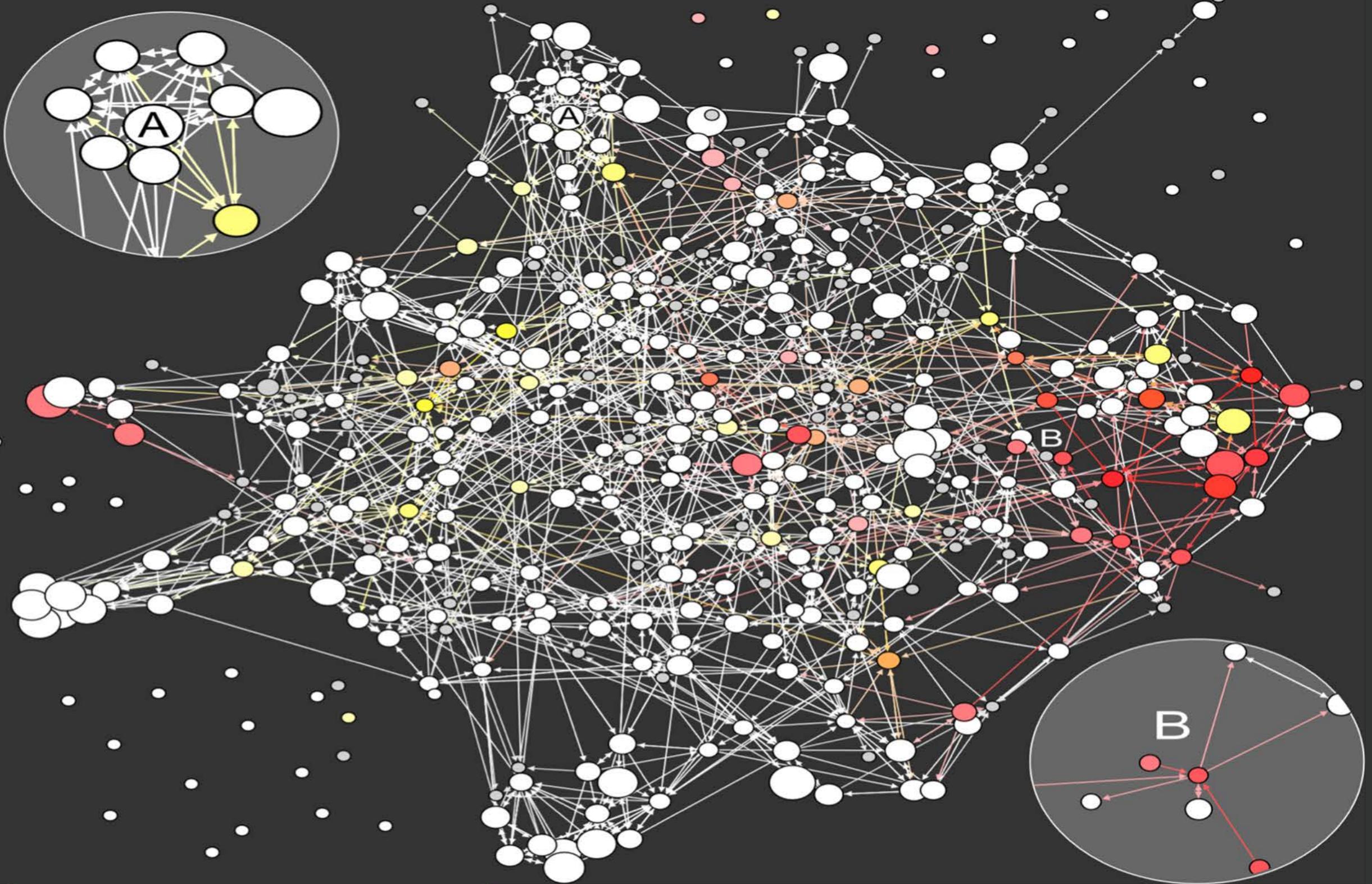
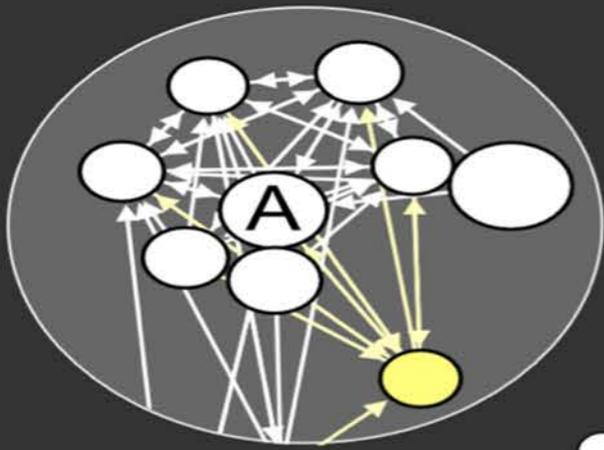
Wyman et al. (2010). *American Journal of Public Health*

Research Highlights

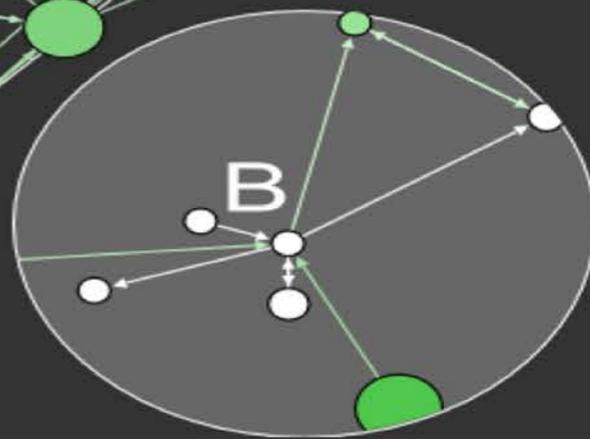
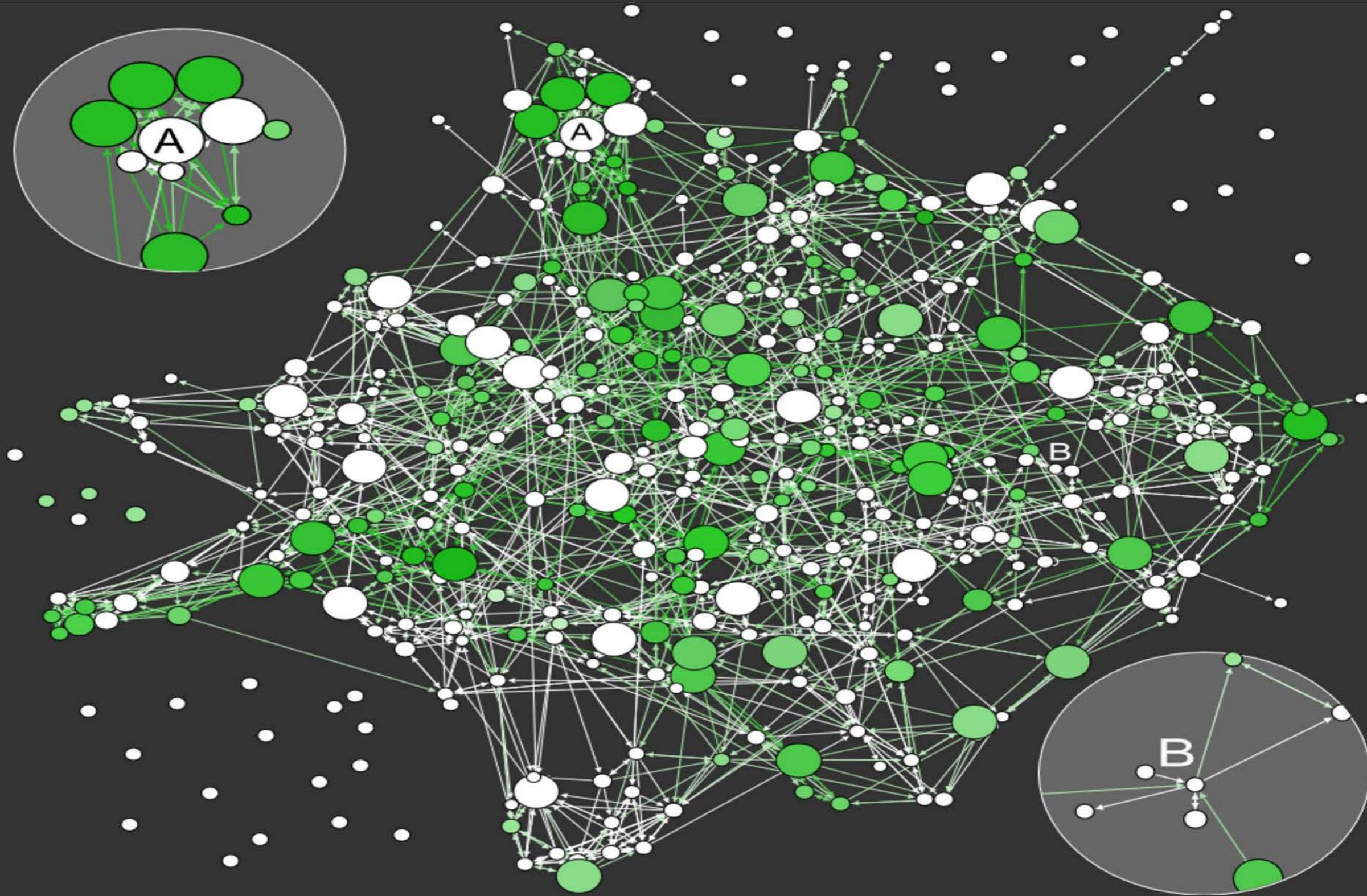
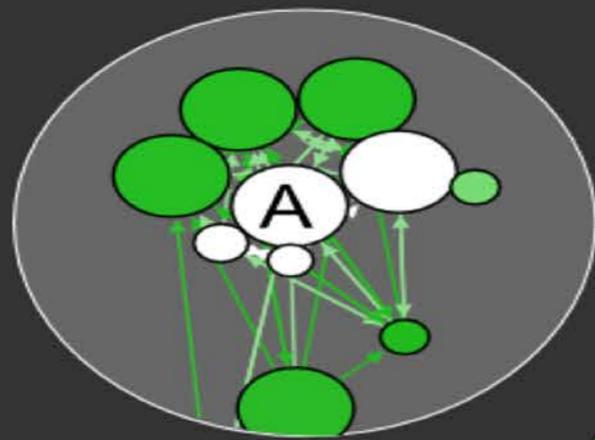
- Received American Public Health Association National Public Health Practice Award with ND Adolescent Suicide Prevention project in 2005
- Listed on NREPP in May, 2012
- National Peer Leadership Study - University of Rochester and National Institute of Mental Health
- Additional Research projects with Stanford University, University of Manitoba, Australian National University, Johns Hopkins and others
- CDC study on sexual violence outcomes (5 year randomized control trial)

Social Network Theory





● Attempt ● Ideation
Node size: local network density
Shading: suicide homophily



● Sought adult help
Node size: ties to adults
Shading: adult help homophily

Interconnected Risks

Shared Risk & Shared Protective Factors



Difficult to separate one from the others



Sources of Strength Model

Supportive
Adult
Advisors

+

Diverse
Peer
Leaders

X

Strategic
Messaging
Campaigns

=

Positive
Cultural
Change



Caring
Connected
Positive

Influence
within
Social Group

Engage
Interact
Apply

Positive
Social
Norming

Follow-up Support

- 1 month out
- End of Semester
- Beginning of Semester

Forums

- AA Forums
- PL Forums
- Trainer Forums

Call Support

- Problem Solving
- Program Wisdom
- Networking Connections

Webinars

- PL Recruitment
- New Tools & Resources
- Sustainability

Buy-in & Training

- Stakeholder Buy-in
- Recruitment
- Training

PL Support

- Weekly Texts
- Videos
- Social Media

AA Support

- Weekly Emails
- Videos
- Support Tools
- New Resources

Website Resources

- Forms & Handouts
- AA & Trainer materials
- Messaging & Activity Templates





THANK YOU!

Scott LoMurray

Deputy Director, Sources of Strength

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701-471-7183

Roundtable Discussion

*Please take a moment to
fill out our brief survey.*



NATIONAL MINORITY HEALTH MONTH 2017

#NMHM17

- HHS OMH #Bridge2Health Twitter Town Hall: April 12
- HHS OMH Health Equity Call to Action Thunderclap: April 28
- Visit www.minorityhealth.hhs.gov for social media materials and other resources, including an events calendar



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