

Office of Disease Prevention and Health Promotion
Healthy People 2020: Who's Leading the Leading Health Indicators?
Mental Health Webinar, April 26, 2012, 12:00 p.m. ET

OPERATOR: At this point in time, I would like to now introduce Dr. Don Wright, Deputy Assistant Secretary for Health Promotion and Disease Prevention at the Department of Health and Human Services.

DR. DON WRIGHT: Well, thank you. Welcome to the fourth installment of the monthly series “Who’s Leading the Leading Health Indicators?” Each month, this series will highlight an organization that is using evidence-based approaches to address one of the Healthy People 2020 Leading Health Indicator topics. The series includes a monthly webinar, email bulletin and active conversation via Twitter and LinkedIn. All of the webinars will be archived on <http://www.healthypeople.gov>.

During today’s webinar, you’ll hear from distinguished speakers. First of all, Assistant Secretary for Health Dr. Howard Koh will introduce this month’s LHI topic, Mental Health. Next, Health and Human Services regional health administrator of Region VII, CAPT Jose Belardo, will give a snapshot of mental health activities in HHS Region VII. From the University of Connecticut, Dr. Robert Aseltine will discuss the school-based suicide prevention program SOS, Signs of Suicide, that addresses suicide risk and depression while reducing suicide attempts. We will also hear from Sara Strawhun from the Ferguson-Florissant School District. This school district in Missouri has implemented SOS in 100 percent of its schools.

What is Healthy People? Well, for four decades, Healthy People has provided a comprehensive set of national, ten-year objectives that have served as a framework for public health activity at all levels and across the public health community. Often called a roadmap for national health promotion and disease prevention efforts, Healthy People is about understanding where we are now, taking informed actions to get where we want to be over the next ten years. Please visit <http://www.healthypeople.gov> for more information.

Well, what are the leading health indicators? The leading health indicators – the focus of this series – represent critical health issues that, if addressed appropriately, will dramatically reduce the leading causes of preventable death and illnesses. These indicators, or critical health issues, are linked to specific Healthy People objectives. They’ve been selected to communicate high-priority health issues to the public along with the actions that can be taken to address them, with the overall goal of improving the health of the entire population.

As you can see, the LHI consist of 26 leading health indicators organized under 12 topics. This month, we are focusing on Mental Health. Healthy People 2020 is committed to addressing mental health to ensure that all Americans lead longer, healthier lives. At this point, I’ll turn things over to Dr. Howard Koh.

DR. HOWARD KOH: Thank you, Dr. Wright, and many thanks to our wonderful colleagues at the Office of Disease Prevention and Health Promotion who have set up this webinar; and special thanks, of course, to the many who are on the webinar and listening across the country. I’d like to spend just a

couple of minutes giving you a brief overview on this month's leading health indicator topic, Mental Health.

Being healthy means having your emotional well-being as well as your physical well-being, and so mental health and physical health are inextricably linked. There's much data to show that mental health disorders are associated with the risk and occurrence of many serious, chronic diseases and health conditions, and also are affected by the management, progression and outcome of those conditions as well. For example, we know that children and adolescents with untreated mental health disorders are at a high risk for many unhealthy and unsafe behaviors, including self-directed violence.

Also, mental health disorders can lead to substance abuse and predisposed to violence and injury. Substance abuse will be a leading health indicator topic for the future.

We know that injury from self-directed violence is a leading cause of death and disability, and on this slide we stress that in 2009, suicide was the tenth leading cause of death in the United States, resulting in nearly 37,000 deaths. So, the link between mental health and physical health is very strong, and that's what we're focusing on today.

Let's focus on the two indicators for mental health, suicides and also adolescents who experience major depressive episodes. We know these are critical outcomes. First of all, suicide is a devastating condition that impacts not just individuals, but also their families and their communities. And also, approximately 20 percent of U.S. children and adolescents are affected by mental health disorders during their lifetime. So, these are two very important indicators, and we know that for both of them we need community interventions to address these challenges. Let's review where we are with respect to these two indicators from a national point of view.

This slide is an overview of the first indicator of suicide, showing that the suicide rate has increased by a little over 10 percent between 1999 and 2008, and is above our Healthy People 2020 target of 10.2 incidents per 100,000 population.

This slide shows very dramatically a striking disparity between suicide rates among males and females. The rate for males is nearly four times that for females, as you can see here, but we should also note that females have a much higher rate of attempted suicide; but males have higher rates of completed suicide, and that's why you see the disparity that's noted here.

This slide depicts the racial-ethnic disparities for suicide, and we see disparities for just about every leading health indicator in this series. And from this slide, you can see that Whites and American Indians have suicide rates higher than the Healthy People 2020 target, while Asians, Hispanic Americans and Blacks have rates that are lower – in fact, roughly half that of the White and American Indian groups.

This is a very graphic map that shows suicide rates by geographic region, and if you focus on the areas that are dark brown or extremely dark brown, the highest rates are seen in the Western Mountain Region; whereas, the lowest rates, that are depicted in white, are seen just east of that Western Mountain Region. So, we can have discussions about why we are seeing these trends in the Q&A and beyond.

This slide is an overview of the second leading health indicator for mental health. That is major depressive episodes among adolescents, and as you can see in the top bar, in 2010, some 8 percent of adolescents – that's kids age 12 to 17 years – have reported having a major depressive episode in the past 12 months, which is higher than the Healthy People 2020 target of 7.5 percent. And then as you go down this graph, you see disparities by gender, with the rates for females more than 2.5 times that for males. You see disparities by race, with Asian-American adolescents having the lowest proportion of major depressive episodes, and you see disparities by age, because within this age group of 12 to 17, those who are older – that is 16 or 17 – have the highest rates of major depressive episodes.

So, we have determinants of mental health that are either social factors or economic factors. And, obviously, these are complex topics; but we know, for example, that there are social factors, including interpersonal dimensions; family interactions; community dynamics; as well as race, ethnicity, sex, age, income level, educational level, sexual orientation and geographic location that all bear on these outcomes. And, again, we should stress that substance abuse is a complicating dimension for both social factors and economic factors.

We're very pleased that today we have a coalition, the CHADS coalition that you'll be hearing from in just a second that has helped implement a SOS, Signs of Suicide, prevention program in 100 percent of schools in one school district in Missouri.

And from a federal level, we want to stress that mental health and, indeed, behavioral health in its totality – including substance abuse – is a major priority for this Administration and this department. In fact, I have the honor of co-chairing the Department's Behavioral Health Coordinating Committee along with Pam Hyde, the Administrator for the Substance Abuse and Mental Health Services Administration, or SAMHSA. We have had special emphasis on suicide prevention as a major public health priority, with contributions not only from the Department of Health and Human Services, but also Veterans Affairs, the Department of Defense, Department of Justice and other federal departments.

With respect to SAMHSA's specific contributions, a prevention lifeline was launched in January 2005, with calls coming in from people in crisis around the country seeking someone to listen to them. So, we are very proud to have that service as part of SAMHSA and HHS's support services. SAMHSA is also funding some 29 states and 26 tribes to reduce suicide through grants authorized through the Garrett Lee Smith Memorial Act. The Center for Behavioral Health Statistics tracks these very important health behavioral outcomes; and then, very importantly, we have a National Registry of Evidence-based Programs and Practices that is a searchable, online registry of over 200 interventions that support mental health, substance abuse prevention, and mental health and substance abuse treatment. Together, these interventions have been implemented in over 300,000 sites across the country and are making an impact for public health. So, with that, I will turn this over to my colleague CAPT Belardo.

CAPT JOSE BELARDO: Thank you, Dr. Koh. It is my honor today to present to all of you some examples of the work that we've done here in Region VII – I am based in Kansas City, and Region VII for the Department consists of the states of Kansas, Missouri, Iowa and Nebraska – to talk about some examples of some work that we've done in the area of mental health.

And I'd first like to bring up a very important example of – right after the devastating tornado hit Joplin, Missouri, in May of 2011, it soon became very apparent – both on the television and hearing reports

from Joplin – that there would be ongoing behavioral health needs and medical needs for this community. So, to facilitate communication between government at several levels, I reached out to our state health officer and some other local organizations that we've been affiliated with. Along with myself and then regional director Judy Baker – we actually traveled to Joplin and participated in a meeting with Governor Jay Nixon to actually identify what medical, social needs there were – that were needed within the community. We actually had focus group sessions with the medical physicians whose practices and hospitals were destroyed. We also met with dental providers.

But probably the most compelling group that we met with, were the behavioral health providers, who either their practices or their facilities were destroyed; but they expressed to us the huge need to address the mental health needs in the community, were definitely compromised. Not only a lack of facilities, but even before, there were a lack of mental health providers to address the needs before the tornado. Afterwards, there was a severe need.

Hence, we developed the Joplin Behavioral Taskforce. We worked – we actually partnered with local groups in Joplin, the Ozark Community Mental Health Center, the local health department, Mercy St. John's Hospital personnel – which that was the hospital that you saw on television that was the regional medical center that was destroyed. We worked with the Area Agency on Aging and another hospital, Freeman Health. We worked with the state – Missouri Division of Health and Social Services, the Missouri Division of Mental Health, and the Missouri Aging Administration.

From the HHS response – or, level – operating divisions we worked with, we worked with SAMHSA, the Substance Abuse and Mental Health Services Administration; the Administration on Aging; the Office of the Regional Director; and the regional health administrator. We here at HHS – we hosted weekly conference calls to discuss behavioral health needs with numerous stakeholders, and the formation of the taskforce, as I mentioned – the groups that were involved developed a plan using the resources and – the federal resources and state resources that were available to develop a plan to create – to see how we could best address the mental health needs.

SAMHSA was very instrumental in helping Joplin develop – or, identify particular funds. Also, our Assistant Secretary for Preparedness and Response – they were responsible also for providing – very helpful with working with CMS with developing waivers and developing resources for Joplin to actually secure funds to bring mental health providers into the city to assist with some of the needs.

We also worked with the state, with Governor Jay Nixon, who was right there at the forefront. And, hence, one of the needs – the really large, significant needs was to work on the area of developing a center that would address children's mental health issues.

And so, basically, we then were able a few months ago – fast-forward – to open Will's Place, a children's mental health facility. We were able to bring providers into the area to assist with that, with providing mental health services to the affected children, but that was definitely one of the centers that was greatly needed to provide services and actually bring additional providers in the area.

Another very important program that I've been working on is actually working with the Military Child Education Coalition. When soldiers have – what we've seen is that when soldiers have returned from their deployments, not only are they dealing with behavioral health issues, but their families have been

severely impacted. You're talking soldiers who have been deployed for two or three times for ten months to two years at one time. And so we started to see rising cases of child abuse – instances of child abuse and spousal abuse and other behavioral health issues as it relates to the deployment. And so we're working right now with the Military Child Education Coalition. This is a coalition that is focused in on children, particularly, but also addressing needs of the soldiers. We also are working with the National Guard members, because when National Guardsmen and reservists are coming back from their deployments, access to mental health or behavioral health services in their communities may not be present. So, we are trying to address that particular disparity in working with this particular coalition.

And last, but not least, this is actually National Prescription Drug Take-Back Day week, where a community basically will identify a day; and a number of our federal agencies, including members in our Office of the Assistant Secretary for Health around the country, are having drug take-back days. And that is – it's a great opportunity for people to basically drop off unwanted prescriptions that they're no longer using into a box. That box – at the end of the day, that box is taken by the DEA, and those prescriptions – pharmaceuticals that are not being used will then be destroyed. It's a wonderful opportunity, and we have participated, now, for the last three years in this National Prescription Drug Take-Back Day.

So, if you are able to identify a location in your community where that will be taking place, I invite you to participate in that event. I was surprised at the number of unused drugs that we had in our own cabinet.

So, that is all I have to present today, and I thank you for this opportunity to present this information. And now I'd like to do a segue and introduce our next talk and just provide you with some talking points on our next presentation.

Signs of Suicide, which you will hear about shortly, has been utilized by 24 Garrett Lee Smith grantees since 2005. This is particularly important since evaluation studies have found the program reduces self-reported suicide attempts. Dr. Aseltine, who will be presenting today, conducted the initial SAMHSA-funded evaluation on Signs of Suicide and has also done important work on the relationship of alcohol use to suicide in teenagers and on screening, brief intervention and referral models to intervene with alcohol abuse for those seen in emergency departments.

Dr. Aseltine is a professor in the Division of Behavioral Sciences and Community Health at the University of Connecticut (UConn) Health Center and the Deputy Director of the Center for Public Health and Health Policy, and Director of the Institute for Public Health Research, both at the University of Connecticut. Dr. Aseltine, we welcome you and look forward to your presentation. Thank you.

DR. ROBERT ASELTINE: Thank you, CAPT Belardo, and good afternoon, all. As CAPT Belardo stated, this is a presentation about Signs of Suicide, which is a school-based, universal suicide prevention program that's developed by Screening for Mental Health, a nonprofit in Boston, Massachusetts, that may be known to you as the creators of National Alcohol Screening Day and National Depression Screening Day.

Much of the evaluation work for SOS has been conducted by the UConn Health Center independently, with funding through the Center for Mental Health Services, private funding from the Patterson trust, and also from the Department of Defense. As was noted, this has been featured as a program by many

Garrett Lee Smith Act grantees. One of them was the State of Connecticut, and we collaborated on that as well.

The goal of SOS, as a universal suicide prevention program, is to reduce suicidal behavior, primarily among adolescents in a high school setting. Typically, it is introduced to younger high school students in the ninth and tenth grades, largely because of when health is taught at the high school level in the United States. The goal is to help teens understand the connection between suicide and undiagnosed and untreated mental illness, principally depression. In doing so, it attempts to destigmatize suicide, depicting it more as the result of illness than as a lack of character, or a character defect, or just a normal-functioning individual being overwhelmed by events.

And then once that message is conveyed, the goal is then to mobilize peers to “ACT,” and “ACT” is an acronym for “acknowledge,” “care” and “tell.” And targeting peers, from my perspective as a sociologist, is very appropriate, given the developmental transitions that are occurring during this age, where peers become, really, the most prominent sphere of social activity for youth. Helping peers to recognize friends that are in trouble is, then, a critical component of this program.

The program really consists of a 1- to 2-period presentation and discussion that’s administered by either teachers or school counselors. We have worked with schools that have gone both ways on that in terms of the personnel that are used to present the program, and both have been equally effective, in our view.

The main teaching tool is a video approximately 20 minutes long, called “Friends for Life,” and it consists of roughly equal components of professionals talking about the relationship between depression and suicidal behavior and vignettes, where teens are confronted with common situations, common stressors that they face and the right and wrong ways to respond to those when a friend is presenting with distress.

Also, it includes a discussion guide that reinforces the message of the program and, finally, what I consider to be a very critical component, a screening instrument that is completed by all students and self-scored. What has been used in the program for the past several years is the Brief Screen for Adolescent Depression, or the BSAD. That has some very good psychometric data on it and is fairly easy for students to complete and score themselves.

We have done a number of different outcome evaluations with SOS. What I’ll talk most about today is one – the results that have been presented in two publications over the last five or six years that involved more than 4,000 students in schools in Connecticut, Georgia and Massachusetts. This design used in these studies, were randomized experiments where half of the classes in each school did SOS in the fall. The other half were essentially wait-list controls and did SOS in the spring, and then roughly three months following the exposure to the program among the treatment or intervention group, all students completed a questionnaire that indicated their knowledge and attitudes about suicide and depression and their recent suicidal behavior.

This was a posttest only data collection design. Now, we have since replicated these results with designs that included both a pretest and a posttest That is, we got baseline data before anyone was exposed to

the program and then, again, at the follow-up. And these were anonymous questionnaires that are completed in a group setting during class time, administered by trained, professional interviewers.

As I said, there are three sets of measures that we are primarily focusing on in terms of outcomes. The first set is indicators of knowledge about suicide and depression and attitudes regarding suicide and depression. While most of the measures that we used in the study were taken from existing instruments with known psychometric quality, these, by their very nature, had to be customized for the particular program – although we did base these measures on those that have been prominently and widely used in other suicide prevention research.

In terms of help seeking, we took three items from the National Comorbidity Survey about the extent to which youths had talked to other adults or professionals in the past three months about problems that they were having. And then, finally, we used two items – one on suicide ideation, or thoughts about suicide, and then the self-reported suicide attempts over the past three months. From the youths' risk behavior survey that many of the schools across the country had participated in through the CDC over the past ten to 15 years.

In terms of results, we saw that exposure to the SOS program created better knowledge or improved knowledge and more favorable attitudes about depression/suicide relative to untreated controls. You'll see the red bars here on this graph indicate that both effects were statistically significant. They were modest in magnitude. We would characterize this as roughly a quarter of a standard deviation, which is substantively, in this case, statistically significant.

If we go to the next slide, we also see in this – really, the critical finding that we were able to report is that, while there was only a slight decrease in suicidal ideation, it was not statistically significant. There was a substantial decrease in self-reported suicide attempts. Controls reported a rate of about 5 percent over the past three months, while those who received the SOS program reported a 3 percent rate – or, 3 percent of them reported an attempt in the past three months.

Now, this pattern of results is actually very consistent with the logic model for SOS. SOS is not a depression prevention program and, therefore, wouldn't really be expected to curtail thinking about suicide. Its focus is on preventing the actual behavior; and so seeing this pattern of results is, I think, encouraging, given the program's logic model.

And then, finally, if we go to the next slide, we also looked at the effect of SOS on health seeking. Now, it is part of the logical model to anticipate that this would be stimulated among those exposed to the program. And as you can see in this graph, that there's actually lower levels – although none of these are statistically significant – lower levels of actually help-seeking behavior on the part of those exposed to the program.

We've actually thought a lot and have been doing some subsequent work on this. This may come up in the Question-and-Answer period, but our thinking at this point is that there may be methodological issues why it is difficult for us to see some help-seeking effects in studies of this type.

So, in summary, SOS is the first program – particularly universal suicide prevention program – to be shown to curtail suicide attempts in a randomized, experimental study. It is well-received by schools. We're going to hear a presentation in a moment about those aspects of the program, but we've always

found that schools found it to be easy to use. It's very flexible. Its modular design fits into existing health curricula very well, and the kids seem to like it.

In addition – or, I should say as a result of this research, it was added to SAMHSA's National Registry of Evidence-based Programs and Practices, and currently it is used in well over 1,000 schools. I think the last time I spoke to Screening for Mental Health, their estimate was about 1,500 schools in the United States are currently using the program.

That concludes my remarks. Next, we'll hear from Sara Strawhun, who serves as the School Outreach Project Manager for CHADS Coalition for Mental Health, which is a nonprofit suicide prevention agency in St. Louis, Missouri, that utilizes the SOS program in districts across the state. She'll give us an account of how the implementation process can actually work in a given district.

SARA STRAWHUN: Hi, everyone. Again, I'm representing CHADS Coalition, and "CHADS" stands for Communities Healing Adolescent Depression and Suicide. We're based in St. Louis, Missouri, but we are a statewide organization and this school year alone we will have reached about 15,000 kids with the Signs of Suicide program.

To give you a little background on CHADS, we were founded out of personal tragedy. Our executive director and her husband lost their son Chad to suicide when he was just 18 years old. He was – you can read down his bio, but you'll see here he was very successful, both academically and athletically. And though he succeeded in a lot of ways, told his girlfriend at the time of his senior year that he was feeling incredibly depressed and suicidal. She then told his parents. They started to get him help, and eventually he was diagnosed with both depression, bipolar disorder, and OCD. Unfortunately, he died by suicide in April of 2004.

About six months later, his parents started the CHADS Coalition to basically raise awareness and to kind of start this conversation with students about mental health, about depression, about suicide. They believe that, had Chad been talked to about mental illness, growing up – whether it be in a formal or informal setting – then maybe he would've reached out for help a little bit sooner. In the end, Chad ended up admitting this was something he'd been struggling with since, actually, the third grade. So, for about ten years, he struggled without telling anybody. And the hope was that, had he had awareness or education, then he would've asked for help sooner; and his outcome would've been different.

So, well into the founding of that organization, the McCords decided that they wanted to do some kind of work with the schools in the area to prevent this from happening as much as they could, and instead of creating their own program, they found Signs of Suicide.

And, obviously, they chose to use Signs of Suicide for a lot of the reasons that Dr. Aseltine was speaking about. It is evidence-based, SAMHSA-certified, so we knew it was a quality program. But not only that, it was very accessible. So, CHADS, as an organization, could be trained in the program and then provide the program to the schools around the state and the area. Or, we could actually do the training to provide that information with the schools themselves, and that way, the counselors and teachers could provide it if we weren't able to do that.

Most of the schools that we're in, we actually do the training for them. We do the presentations in their classroom because it's the nature of our relationship with them; but we do have a few schools that, because of their school culture or the relationship that the counselors have, or want to have, with their students, they choose to be trained by CHADS in order to provide it to their students themselves.

I'm going to focus, obviously, on Missouri, but specifically Ferguson-Florissant, and this is just to give you a little bit of information about our suicidal issues here in Missouri. And you can kind of read over that chart to see it's pretty much standard, or on par with national averages. I believe we're a little bit higher, and obviously we have more females attempting, but typically more males completing, suicide.

The Ferguson-Florissant School District – we are in several – around 20 to 25 districts in the St. Louis suburban area, but Ferguson-Florissant is the only school district that we have 100 percent SOS implementation for. And that's simply because most of our school districts decide to start the SOS program in the seventh grade, though we know that it can reach all the way down to sixth grade. So, this district decided that they wanted it in every, single one of their buildings. They have K through 6 buildings, 7-8, and then 9 through 12. That way, each student was getting it one time per building: sixth grade, seventh grade and then ninth grade again.

Just to take a look at the demographics in the Ferguson-Florissant area, it is a very large area of St. Louis. The population that is highest are Black Americans, followed by Whites, and other minority groups are very small within those.

So, CHADS and Ferguson-Florissant – here're just a few things that we did to really secure this relationship with them. First of all, we were funded by a county government fund called the Children's Service Fund, which basically enabled us to provide all the services in St. Louis County cost-free to us and to them. It was actually on the taxpayers' dollars, so that helped us to get buy-in from the districts because, obviously, price is always an issue. Now, SOS is an affordable program, but sometimes – especially in these controversial topics – schools will find reasons or find ways to be nervous about implementing this program. So, we wanted to eliminate that first; and, therefore, we were able to provide the curriculum and the training cost-free, which really helped with the district buy-in.

I am the School Outreach Project Manager, so my job essentially is to network CHADS into the districts, sit down, talk to the administrators and figure out how to best work within their districts. So, that's what I did, to begin with. I started, as you can see through the flowchart, with the District Administration – talking to their Superintendent, talking to people that were in charge of the Counseling departments. And then from there, they passed me along to each of the schools.

Once you have that District Administration behind you, it becomes a lot easier to kind of filter down through each building. The Principals then get bought in, and then they filter it to the Counselors, who then connect with the Teachers.

Basically, this district decided to require the implementation. It came from the central office to each school that was coordinating, saying that they had to schedule it with me, and then they required them to then notify the district once they'd actually scheduled the presentations, to make sure they were actually occurring.

We had a really great team of people in the administration working with us to ensure that the presentations were set up, which was really helpful in making sure that each of the students were receiving the SOS program.

The last thing you see there is the end-of-the-year meeting, and that's very helpful. We basically decided to do this with all of our districts just to kind of be able to nurture that relationship with them, as well as ensure that we were providing the best services possible. So, at the end of each school year, I and maybe a few other members of my school outreach team go and meet with these administrators, talk about what worked, show them their specific learning results, show them how many kids were reached, how many kids were asking for help and all of that, so they can truly see the effectiveness of the program.

So, here're just a few outcomes. And this is from – we are done implementing the program in the entire district for this year, so we've reached a little over 2,200 students in the Ferguson-Florissant, and about 410 of those asked for help, which is about 19 percent – which is higher than average. I believe that SOS states about 8 to 15 percent of the kids that are reached with the SOS program will reach out and ask for help, but Ferguson-Florissant was a little bit higher. We're not quite sure why.

The reported outcomes in terms of the improved participant knowledge and attitudes were taken from the 2010-2011 school year. We haven't compiled our data for this year yet, but basically, we have a five-question survey to gauge how much the students are learning. We focus on how many of them understand how to use the ACT technique – “acknowledge, care and tell” – how many of them know how to recognize the warning signs of suicide/depression, and also what to do if a friend is having suicidal thoughts. Our goal is always to reach 80 percent or higher, and you can see in each of these indicators, the students said that they had at least an 80 percent mastery of that knowledge.

So, Dr. Aseltine mentioned that the kids like it, and that's a really important part of the SOS program. We can sit here and talk about great programs, and if the kids don't like them, it doesn't really matter. But the student responses to SOS are very positive. Some of them will come up to us after the presentation and simply just thank us for being in the classroom and talking about this, because they felt incredibly isolated in this experience. And just the fact that they knew somebody else was going through it and somebody cared was huge to them. Some of them learned that practical knowledge, that – how to help a friend in some of these circumstances. And also, as you see here, some of them feel like they can now empathize with others in their life that may have suffered from depression or suicidal thoughts.

So, a few challenges and barriers: first of all, something that we really are up against in many of the districts and schools is this idea that it's dangerous to discuss suicide. So, time and time again, I hear, “Well, if you talk about it, isn't it going to put it in their mind?” And, obviously, the answer to that is no. If somebody is not contemplating suicide, just saying it is not going to be enough to put it there and have it be a realistic thing for them. Oftentimes, it actually gives them the opportunity to talk about it, and they get that help. So, just talking to them about that fact and kind of dispelling that myth is helpful. BSAD was kind of a barrier for us. A lot of the administrators didn't want what we call a “paper trail” coming back. “Well, what if a kid indicates that they're suicidal, and we don't know who they are? Or, if they do attempt, then what if we get in trouble for that?”

So, the way we get around that – because we do believe in administering the BSAD for part of the SOS presentation – is doing it verbally. So, our presenters actually read the seven questions, ask the students to self-score in their head how many yeses versus how many no's and then read the scoring guide to them, telling them that they reached 4 to 7 yeses, or answered either question about suicide as a "yes," then it would be well-advised to reach out and speak with someone.

Just look down at the bottom with the screening slips. In the SOS kit, there are screening slips included that each student fills out. And the ones in SOS just simply say "yes" or "no" – "Yes, I need to talk to somebody", or, "No, I do not." Because we're in so many schools, we get a lot of feedback from our counselors, our teachers and our administration; and one administrator really suggested that we find a way to prioritize these kids a little bit better. The counselors sometimes would get 50 to 60 responses, if we were in a school all day doing multiple classrooms at a time, and they didn't know who was suicidal, who was just a little stressed out, and maybe who just wanted to talk about something regarding a different mental health concern. So, we decided to revamp these screening slips and put that they needed to talk to someone within a few days, immediately, or not at all. And this has been really well received with our counselors because they are able to prioritize those kids who want to speak immediately versus those who can wait a few days to talk about what is bothering them.

Another basic barrier or challenge is just coordinating the schedules with the teachers, making sure that this is a valued program and they see it that way. The way that we did that is we matched the learning goals for the SOS program with Missouri's grade-level expectations for both health and maintenance and guidance and curriculum for sixth through twelfth grade. So, when I pitch this program in the beginning to the District Administrator, I always bring that sheet with me and show them that this program is actually meeting exactly the requirements for their health classes, as well as their guidance and curriculum standards.

Sometimes, we have to combine those classes, just to make sure that we reach as many as possible. This is not preferred. We like to do smaller groups, from 25 to 30, so we can really facilitate the discussion; but doing 60 is better than doing zero, so we will combine when we have to – as well as training the teachers there, if they need to maybe co-present or help present. That way, we can get as many kids done as possible.

And this is just to kind of conclude. Signs of Suicide is a very good program that works well, and people like it and receive it really well. And this is a school counselor at a high school in the Ferguson-Florissant District, who talked about the fact that after her presentation that CHADS came in and did for the students – the freshmen there – we spoke to about 425 students. And she said out of those 425 students, 17 said that they needed to speak to someone, and four of those 17 were actively suicidal – all four of which she had no idea were struggling. And so this quote right here is just talking about the fact that, had Signs of Suicide not come into that program, she probably wouldn't have known that those kids were struggling and wouldn't have been able to get them to the help that she still is giving them to this day. So, thank you for – I guess we'll go to questions now.

DR. DON WRIGHT: Thank you, Dr. Koh, CAPT Belardo, Dr. Aseltine and Ms. Strawhun. I invite participants who have not already done so to send their questions through the WebEx Question-and-Answer feature. Obviously, today's discussion has generated a number of questions already, and the first one I would like to direct to you, Dr. Aseltine. The question is: Can you go into more detail on your

effect of SOS on help seeking? Were you surprised that SOS did not have an impact on help seeking when compared to the control group?”

DR. ROBERT ASELTINE: Yes. I was surprised by that – particularly when we have evidence from other sources – and Sara’s presentation, I think, highlighted what some of those sources are – that indicate that schools actually see more students presenting for emotional issues following exposure to the program. So, we know that in most schools, that is happening at the school level.

Now, there’re other resources that students are encouraged to use. If they don’t feel that they can talk to a trusted adult at school, there are adults outside of school that can be accessed. So, there’re a variety of different ways that they can get help, and that’s why self-reports, as is obtained in our studies, are a different and important component as well.

One of the issues that we’ve had to face is that, when SOS is implemented as a universal program, we as researchers lose a little bit of control over what happens to those that aren’t exposed to the program.

And so there’s the potential here for a little contamination, where once it’s out there, and once kids know what to do when confronted with a friend who is in turmoil, they’ll act, whether or not that student has been exposed to the program or not. So, I think that that has affected our results – the ones that I reported here.

We have since done some work where schools are assigned to treatment and control groups at the school level, so that everybody in the school is getting SOS versus those in other schools that are not getting it until later in the school year. And even there, we’re not seeing much in the way of help-seeking results; and, again, the problem that we have is that most of those schools had already participated in the program, and so the potential for new, ninth-grade students – even though they hadn’t been exposed to it – to be in an environment which was encouraging students to get help, regardless of whether they had had the program – we think that that could be problematic.

So, we’re still working from a methodological perspective on ways to assess this, but I think the independent data that you get from counseling offices and from school reports does indicate that there is a help-seeking effect.

DR. DON WRIGHT: Thank you, Dr. Aseltine. Now, we have a question for Dr. Koh. How are the offices working across the Department of Health and Human Services to achieve these Healthy People 2020 leading health indicators?

DR. HOWARD KOH: Well, in general, we have a federal interagency work group that coordinates these activities across government. We have leadership within Health and Human Services from our Office of Disease Prevention and Health Promotion. And then on the particular area of mental health, as I mentioned, we have a Behavioral Health Coordinating Committee that includes all the operating divisions, all the agencies, and is co-chaired by Pam Hyde and myself. So, we have extraordinary coordination on this issue, and we’re very, very proud of that.

DR. DON WRIGHT: Thank you, Dr. Koh. Now, we have a question for Ms. Strawhun. What do you think made implementation in your school district so successful?

SARA STRAWHUN: I would say our community receptiveness. I mentioned briefly the funding that we received from the county, and I truly think that having that county stamp of approval on the programs that we were doing made the schools in the area very receptive. Also, it's contagious. Once one district buys in and does it, you use that district and that results and their backing to convince or persuade other districts to buy into the program as well.

DR. DON WRIGHT: Thank you, Ms. Strawhun. Well, unfortunately, we've run out of time to answer all the questions that have been submitted, but we've recorded your questions, and we'll address them through our Healthy People 2020 group on LinkedIn.

Let me thank everyone for joining today's webinar. This webinar is part of a series, and we hope you'll continue to join us. Next month, our webinar will feature Nutrition, Physical Activity and Obesity. Healthy People continues to look for real stories from organizations that are working to make its goals a reality. If your organization is doing great work on specific leading health indicators, we want to hear from you. Go to <http://www.healthypeople.gov> to submit your story.

Again, follow us on Twitter, or join the Healthy People 2020 group on LinkedIn to continue the conversation on this LHI topic, mental health, and to learn more about other leading health indicators.

To receive notices about upcoming events, please sign up for our email announcements on the Healthy People website. That is <http://www.healthypeople.gov>.

On behalf of HHS, I'd like to say thank you to today's presenters and to everyone who's been involved with planning and implementation of Healthy People 2020. In addition, let me encourage the participants on today's call to fill out the feedback survey that will be addressed at the end of the webinar. It enables us to improve the quality of future webinars. Thank you very much.

OPERATOR: Thank you for joining the fourth of the LHI webinar series. Your session is now ending. Thank you.

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