

**Office of Disease Prevention and Health Promotion**  
**Healthy People 2020: Who's Leading the Leading Health Indicators?**  
**Mental Health, May 23, 2013, 12:00 p.m. ET**

**CARTER BLAKEY:** Welcome, and many thanks to you. Over the next 45 minutes we'll explore the topic of mental health. First, I would like to give you a brief overview of the indicators. This brings attention to the important issues related to the health of our nation. It's a monthly view of topics and data and trends and showcases states, communities and organizations addressing the LHIs in innovative ways. This month we are focusing on the critical issue of mental health. During today's webinar you will hear from speakers. Dr. Susan Carol will give you an overview of this month's topic, mental health, and discuss the issue of youth suicide among the Native American population. Dr. Irma Arispe will discuss mental health indicators. Novalene Goklish and Mary Cwik will address the alarming rates of youth suicide among the tribes. During our round table discussion we'll be joined by Richard McKeon, Chief of Substance Abuse and Mental Health Service Administration. Dr. McKeon will help answer questions related to youth suicide. I would like to also remind everyone on the webinar today that throughout the webinar you may submit questions to us that our speakers will answer at the close of the session. There is a feature – you should see it on your screen – that will allow you to submit these questions. With that, I would like to turn the microphone over to Dr. Carol to get us started. Dr. Carol, the show is yours.

**SUSAN CAROL:** Thank you, Carter and good afternoon everyone. Good mental health is essential to a person's well-being. It is important for their interpersonal relationships and contributes to their ability to live a full and productive life. As you know, addressing mental health is a critical step to improving the mental health of our population. The two indicators are suicides and MDEs. We'll focus on the leading health indicators of suicide and we'll go over the White Mountain Apache Tribes in Arizona. We will hear more about their strategies in just a moment. First let me give you some information on issues related to mental illness.

Mental illness is defined as health conditions characterized by alterations in thinking, moods or behaviors associated with stress and/or impaired functioning. Mental health accounts for a large number of disability in developing countries, more so than any other groups of illnesses including cancer and heart disease. CDC's Mortality and morbidity stats report in 2004 an estimated 25 percent of adults in the United States reported having mental illness. Nearly half of adults in the United States will develop at least one mental illness during the lifetime. Getting help for mental illness can help prevent suicide. Suicide has a serious impact among the population and the nation. Suicide was the 10th leading cause of death and there were a total of 38,000 in the United States in 2010, or an average of 105 per day. Suicide affects individuals at various stages of life. Among the 14-24-year-old population, suicide is the leading cause of death. And suicide affects adolescents and young adults in all groups. Some groups are at higher risk than others. For example the 2010 suicide rate for American Indians and Alaska natives between 15-34 was about 50 percent higher than the national rate for that group. Suicide impacts individuals, families and communities. They are complex and often determined by multiple factors. As a nation we can continue to work to prevent suicide by promoting evidence-based strategies that reduce the risk factors and increase protective factors – factors that promote resilience in our population. By providing information and resources for individuals that need help and implementing suicide prevention programs, we can take steps to help address this serious concern. I would like to turn the program now to Dr. Arispe to give you update on the leading health indicator, suicide. Dr. Arispe?

**IRMA ARISPE:** Thank you, Dr. Carol. Good afternoon. In the next slide I will provide data to help with the leading mental health indicators and I will be able to answer any questions. I would like to begin by

saying for the population as a whole between 2000-2010, the age adjusted suicide rate increased. That is from 10.4 to 12.1 throughout the population. Suicide rates vary by age. The age group of 45-64 has the highest rate of 18.6 per hundred thousand while the lowest group ages 12-17 have the lowest rate of 14.9 per hundred thousand. Rates of suicide already vary by race ethnicity. You see the total I talked about in the previous slide. The lowest rate, 5.4 per hundred thousand, is seen among non-Hispanic blacks and then you see the rate almost twice this high. Specifically, the rate for American Indian Alaska Natives and the rate for non-Hispanic whites. Next slide.

This next slide depicts the Healthy People 2020 objective that is closest tied to the topic of mental health. This tracks adolescents grade 9-12 that needed mental health attention in the last 12 months. However, disparities were observed for a number of population groups. Specifically, males had a lower proportion of attempts – 1.9 percent compared to females at 2.9 percent. Looking at race ethnicity, white, non-Hispanic adolescents had the lowest proportion of reported suicide attempts in the past 12 months, while American Indians or Alaska Natives had the highest at 6.6 percent. People who attempt suicide and survive may experience serious injuries such as broken bones, brain damage or organ failure. These injuries may have long-term effects on their health, and they may also have depression and other mental health problems, and we need to address suicide attempt when they occur. By doing this, we are taking steps to prevent suicide. I would like to turn it back to Dr. Carol.

**SUSAN CAROL:** Thank you, Dr. Arispe. On behalf of Health and Human Services, I would like to thank Dr. Arispe, Ms. Blakey, Ms. Goklish and Ms. Cwik. Ms. Goklish, I believe you will start off.

**NOVALENE GOKLISH:** Thank you. Good morning. Our presentation will be on suicide prevention for native youth. My name is Novalene Goklish. I work with the Apache tribe, and I work with the coordinator and my colleague, Mary Cwik, works with John's Hopkins University. Next slide.

As you can see the White Mountain Apache Tribe rates is high, especially among our youth. Something to point out is the gender differences where it's similar to national data, but attempts differ nationally. Females make more attempts than males. Next slide. The White Mountain Apache Tribe tribal leaders work in collaboration with John's Hopkins University to implement a prevention suicide program. I have worked with John's Hopkins for ten years and through the years I have worked to help awareness among all department and community members. Currently I oversee all of the suicide prevention efforts locally with the tribes and John's Hopkins.

This slide provides an overview of our celebrated Life program. The tribes mandated reporting in 2001 starting with all first responders, and in 2006, the tribal mandate was expanded to all departments, tribal, and community members within the tribe's borders. The in-person follow up is conducted with everyone we receive a referral on. In addition, 71 youth participated in a quantitative study to help us better understand risk and protective factors for our Apache youth. Finally we have a comprehensive program of universally selected and indicated interventions. These programs are informed by -- surveillance and study area with programs and training that we conduct on the reservation. If we can turn to the next slide please.

**MARY CWIK:** My section of today's presentation will focus on the two complimentary interventions for youth and suicide attempts. Tribal leaders and key stakeholders selected these from the registry. They selected New Hope, because they wanted to give youth a brief intervention that provided them with some skills and focused on getting them into care after an emergency department visit. Cultural adaptations were made using mental health workers and home settings. Next slide, please.

The second longer intervention named Re-Embracing Life was selected because it was developed for American Indians and promoted resiliency through coping skills development. This intervention is meant to follow and build upon New Hope. Both of these innovations demonstrate that communities can adopt practices enough to meet their needs but not change the core content of these interventions. For example, Re-Embracing Life was a school-based curriculum, and the Apache adapted to an individual prevention for youth attempters and their families. Next slide, please.

New Hope was evaluated in an open trial with a largely female sample whose average age was 14 years old. As you can see there were changes in target outcomes of coping skills development after a three month follow up period. Other results to note include increased knowledge of risky situations and the importance of staying in counseling, high satisfaction levels with the program and the community mental health workers, and decreased suicidal ideation over time. These preliminary findings warrant further study of intervention in the randomized control style.

This slide summarizes some of the overall outcomes of the comprehensive Apache suicide prevention program, specifically the award winning surveillance system. Program staff and the community feel these data illustrate the impact of having someone from your own community listen to your story and connect you to care. The next two slides summarize some of our keys to success. Importantly, the Apache community was ready to address suicide and had key advocates in place to do so. Tribal leaders and key stake holders were also open to data collection using evidence based practices and actively participating in all steps of the process.

Another important take-home message is that the Apaches and other tribes have the power to bring innovation to western mental health models. These models can be disseminated to other communities nationally and internationally, as well as lead the field of suicide prevention. These innovations include the use of community mental health workers in the continuum of care, collaborations across multiple disciplines and using various evaluations. This last slide summarizes the public health approach used by the Apache in John's Hopkin's collaboration, which utilizes local data to continually feed into itself to develop interventions and improve them and resulting in the empowering of the community to prevent suicide. We thank you very much for your time and attention. Our contact information is listed on the slide and you can see a picture of the community there, and I believe we'll be transitioning to the round table question and answer period.

**CARTER BLAKEY:** Great. Thank you very much Dr. Carol, Dr. Arispe, Ms. Goklish and Dr. Cwik. Before we point out, the timing of the webinar today happens to coincide with May as the National Mental Health Awareness Month. So we feel fortunate that we were able to coordinate this with this important public health observance. If you didn't know that, you now know it. So I would like to remind the folks on the webinar that if you have not already done so to please go ahead and submit your questions via the chat function on your screen. But I'm happy to say that we do already have questions that have come in and there seems to be a great deal of interest in data with today's presentation. I think we are actually anticipating this and we may have some graphics that we can share. In light of this interest, I'm going to send the first couple of questions over to Dr. Arispe. One of them has to do with suicide rates by sex. Our viewers are asking whether or not we have any data on that. Dr. Arispe can you answer that question?

**IRMA ARISPE:** Yes. I talked earlier in my presentation that between 2000-2010 the total rate increased by 16 percent. So you also see the distribution for males and females with the rates much higher for males than for females. In fact the rates for males were almost four times that of females. In the year

2010, the most recent year for which data are available, females have the lower suicide rate and the rate was 5 per hundred thousand. In comparison, males had a rate of 19.8 per thousand population age-adjusted.

**CARTER BLAKEY:** Thank you, the other data question had to do with the second leading health indicator for the mental health and that's the indicator for major depression among adolescence. I think we have some graphics for that as well. Dr. Arispe, can you answer that question, please?

**IRMA ARISPE:** Yes, we also have a graphic as you see here for major depressive episodes among adolescents. It tracks the proportion of adolescents from 12-18 years and records the latest incidents. The overall rate is 2 percent of the population disparity over the group. A lower proportion of adolescent males reported having an MDE over the last 12 months compared to females at 12.1 percent. The rate for females was more than two and a half times that for males. Looking at the same chart lower, as you see the race by race and ethnicity, blacks were 8 percent more than whites, and that's one of the ones you heard today. The rates for whites and non-Hispanics were 23 percent and 36 percent higher than that for black non-Hispanic adolescents. Although the difference between black, non-Hispanic or American Indian and Alaska Natives were not significant. The last category on this chart presents age breakdown for adolescents. Those ages 12-13 had the lowest proportion of record major depressive episodes in the last 12 months, and that is 4 percent compared to 8.6 among 15 year-olds and 11.6 percent among 15-18 year-olds. It was more than twice as high and nearly three times as high for the rate of the youngest group 12-13 respectively.

**CARTER BLAKEY:** Great. Thank you very much. Dr. Carol, we have a question for you. Can you talk a little bit about some of the challenges and barriers to addressing American Indian youth suicide?

**SUSAN CAROL:** Sure, I will be happy to. Major suicide risk factors including mental health disorders, prior suicide attempts, intergenerational or what we call historical trauma, substance abuse and some of the social determinants informants of health – such community wide issues as poverty, educational issues – they can become some of the major risk factors. When we've looked at it and some of the most significant protective factors against suicide for our American Indian and Alaska Native population stem back to cultural and spiritual beliefs, getting back to the community, getting good effective mental health care... which can be challenging in our situation, but trying to accommodate that need is important. Having individual family and community connect together, that's so important. I can't stress more importantly. People feel kind of set apart, have more difficulty. If you are talking with your family, friends and community, you are doing much better. Development of problem solving, coping skills, dealing with conflict resolution skills or non-violent ways of handling disputes can also be helpful, and contacting your caregiver and your provider is extremely helpful also.

**CARTER BLAKEY:** Thank you very much. Dr. McKeon, we have questions for you. We realize that youth suicide prevention is an important aspect with the substance abuse and mental health administration does. Can you tell us where communities find programs they can use?

**RICHARD MCKEON:** Yes, there are a number of things that I can mention. First, the funds, the suicide prevention resource center, this is a national resource center that is available to work with individuals, with communities, with states and tribes to help them think through what suicide prevention approaches might be most useful for their communities. In addition, SAMHSA has practices that include suicide prevention programs that have been found to be effective as well as a summary of the evidence base for those initiatives, as well as information about how the programs can be accessed. It's also

important for people to know that currently, SAMHSA practice that focuses on youth programs has an opportunity for funding for states or tribes to apply for the youth suicide prevention funding. That can be found also on SAMHSA's website. Can you give us the website?... SAMHSA.gov.

**CARTER BLAKEY:** Great information. Dr. Goklish and Ms. Cwik, we have a lot of questions for you. Can you tell us how to empower community and community participatory planning?

**MARY CWIK:** Do you want to go ahead and start?

**NOVALENE GOKLISH:** Sure. Within our communities when we are working with community members our grass root leaders and tribal elders and tribal leaders we hold round table discussion to work with the community on an equal level and have them identify problems and issues and how they would like for us to address them, what type of programs they feel would empower the community, what type of skills we would need to focus on for our youth that we are working with to help them develop additional skills so is that they have ways of coping and so we usually work directly with the community on the programs that we've developed throughout the years and with their input and their guidance we've been able to add to the programs if need be. If the community feels the information that we are providing isn't strong enough, then they will let us know that we need to add to it and they prefer we be more realistic when we are sharing information with the youth. Most of the programs we work on are designed for youth who have made an actual attempt and they don't want to us sugar coat anything when we are working with them. We work directly with the community, our local health board as well to give us the guidance we need that the community feels would help benefit the community members and our youth. I don't know if you want to add something?

**MARY CWIK:** Just a couple of brief points to that is the tribal leaders and key stake holders help us develop the programs and select them and in the adaptation process and they see drafts in the curriculum and material and give us feedback about wording and pictures and that process can take a year or two to adapt these curriculum. It's very intensive. Then also the last point i want to make is that i think it empowers the community is the tribe owns these programs and all of the data. So John's Hopkins provides the technical assistance and they are the ones that own and steer everything and that is really important to the collaboration.

**CARTER BLAKEY:** Okay. Another question for you two, how would you recommend spreading the evidence base approach to other tribes?

**NOVALENE GOKLISH:** I can start and you can fill in if you want. I think word of mouth and presentations for groups like ourselves and other groups doing this kind of work do better. I think whenever we sort of talk about the process and how we've done it and shown groups our interventions and the video that we have adapted, other tribes do get very excited about the prospect of looking at evidence based practice and seeing how they might be able to make it their own and so raising awareness and getting out there. Sometimes each tribe can be their own community at times and we would like to do a little bit more outreach.

**MARY CWIK:** I think you have covered that one.

**CARTER BLAKEY:** Thank you. Dr. Arispe, we have another data question for you. What are the different data sources space can use to monitor suicide attempts and is it included?

**IRMA ARISPE:** Yes. We have data sets that most people use to look at sites. First is the national vital statistics system, the mortality data and we use underlying cause of death and that information is a state and federal partnership. The data are compiled by the state and supplied to NCHS. The second... and then NCHS is part of CDC. The second data system is about suicide attempts is based on a survey of adolescents that is conducted biannually. It's called the Youth Risk Behavior Surveillance System, YRBSS. It's also a data system. That data are available at the state level. The third data source is from the National Survey on Drug Use and Health, and that is the data that is used for the objective on major depressive episodes among adolescents. It's survey data and annually and is not representative of the state. Our other expert, Dr. Bruce Jonas. Those are the three data systems. All of these data are available on the healthy people.gov website. The last one I mentioned was by the Substance Abuse and Mental Health Administration.

**CARTER BLAKEY:** Dr. Mr. McKeon. Would you like to add something?

**RICHARD MCKEON:** Sure. They are using this on an annual basis, whether they have made a suicide plan, a suicide attempt and whether they have made a suicide attempt that's required medical attention. This is for those 18 and older and the data is broken down by state.

**CARTER BLAKEY:** Great. Thank you. And Dr. Arispe, before we let you go, there is another question that has come in about your data. Someone has asked if you can define what a major depressive episode is?

**IRMA ARISPE:** We'll refer to SAMHSA on that if that's okay with you.

**CARTER BLAKEY:** What is a major depressive episode?

**RICHARD MCKEON:** Basically the distinction is a depressed mood as symptom and a major depressive episode really includes a clustering of symptoms. So it's not necessarily only having depressed mood but it can include other things as well, such as loss of interest in everyday activities, loss of pleasure, suicidal ideation, disruption in sleep or in appetite and the criteria for that are set by the diagnostic and statistical manual published by the American Psychiatric Association which is to just be redone. I think the major notion is that while many people may have a depressed mood and may have some part of the spectrum of depressive disorders or problems, it needs to occur and you need to have a number of different symptoms and you also need to have it for a defined period of time, usually for at least several weeks before it's considered a major depressive episodes.

**CARTER BLAKEY:** Okay. Thank you. And Dr. Carol, we have a couple more questions for you. Can you talk about some of the suicide risk and protective factors for the Native American population?

**SUSAN CAROL:** Well, I think I mentioned that a little bit already with the risks of including mental health disorders, some prior suicide attempts, historical trauma, substance abuse and the social determinants of health. The protective factors again will include use of cultural and traditional and spiritual beliefs for the American Indian and Alaskan population. For example, obtaining effective mental health care and connecting with individual's family and community along with some of the more social issue of developing coping skills, conflict resolution skills, nonviolent ways of handling disputes and circling back to work with your primary caregiver.

**CARTER BLAKEY:** Okay, thank you. Can you also, Dr. Carol, tell the audience what resources does the Indian Health Services provide to assist with tracking and reporting behavioral health among the native American population?

**SUSAN CAROL:** Sure. The Indian Health Services utilizes an electronic health record called the resource patient management system. We abbreviate that RPMS. It includes the behavioral health system module that documents and tracks patient care related to mental health and it also includes a suicide reporting form which is a standardized and systemic method for documenting issues incidents of suicide or attempts.

**CARTER BLAKEY:** Great. Thank you. And then back to Dr. Goklish and Ms. Cwik. Did the Apache community indicate information regarding general trauma with community members?

**MARY CWIK:** You want to address that and I can add?

**NOVALENE GOKLISH:** The programs we work on have educational material that is designed to be culturally appropriate to address trauma that that community has sustained when an individual has died or made an attempt within the community. We work with a variety of programs as resources and refer to them as much as possible to also see if they can get additional information or help if needed. We also work with our elders council and our tribal leaders to help us identify traditional information that we can share with families and youth if they are wanting to seek traditional resources to help them deal with different situations that they are experiencing to help overcome the barriers that they might be facing when they are struggling with life. I think the tribe has done a really good job in stepping up and taking the lead in an allowing us to provide a lot of these programs and supporting us and giving us guidance and letting us know what we can and what we could not do with the reservation and what we can and what we cannot share with the tribe. So they have given us a lot of information.

**MARY CWIK:** I think Novalene covered it. The tribe has given us a lot of feedback in terms of a family approach and community approach is important. They really believe in including the family and that means extended. It's not just our traditional definition of a mom and dad. It could be grandparents and whoever is significant in that child's life. They are getting at that idea and recognized that multiple people are affected and that's why intervention should have that family and community approach.

**CARTER BLAKEY:** okay. And this is somewhat related question not dealing so much with prevention but the aftermath. How did the White Mountain tribe address family and community trauma from youth who did commit suicide?

**MARY CWIK:** Novalene you can go up first for that.

**NOVALENE GOKLISH:** So, in the early 90s when the tribe was hit hard with a lot of death by suicide, it seemed to continue and we have this trend where we were losing a lot of our youth to suicide. It sort of slowed down where the deaths were not happening but we still have community members who were making attempts. In 2001 we had a large number of deaths by suicide and the community members and family members that were hit hard by this, really wanted something to be done. So they were the ones that went to the tribal council and said enough is enough. We want you to do something about this situation that is happening with our youth where they feel that they can't live anymore for whatever reason and the families are suffering and we need your help to do something. I think that the tribe really did a good job by establishing the tribe's suicide surveillance system and a allowing our department to

lead it and do a follow up intervention in there as well. With the follow-up we work very closely with the families and the individual that made the actual suicide attempt by working with them, getting resources for them and helping them deal with the difficulties of after an attempt what happens. A lot of families don't like to talk about suicide or the actual attempt that took place and the person that made the actual attempt is still suffering and is not receiving services. So follow up portion of the surveillance system helps us track the family in the community to offer services.

**MARY CWIK:** You did a great job covering. I think the surveillance system is the best way that the community reaches out to those that have survived the attempt or the death of a loved one. They also do a couple community things they have a walk that they have in some of the different communities. Walks in remembrance of those that have passed away and the other thing that is starting up in the community is they are trying to get survivors and support groups specifically to the cycle. There are more general groups for any kind of death but Novalene and her colleagues are starting groups specific for survivors of suicide.

**CARTER BLAKEY:** Thank you. We actually, can squeeze in one more question. There is a very specific question about the surveillance system. Can you tell us who is responsible for actually reporting and entering data into this system?

**MARY CWIK:** Novalene, i will let you take that one.

**NOVALENE GOKLISH:** Thank you. The tribe has the first resolution that the tribe passed. Mandating first responders was in 2001 and the tribe felt that individuals in the department were receiving information on individuals who had suicidal behaviors but were not reporting them. So in 2006, the tribe did an amendment to the resolution mandating all the members in the department to report suicidal behaviors to the system so that a follow up could be done and the purpose is that they wanted to make sure if someone was presented with suicidal behaviors that a follow up could be done so they can receive services. The tribe has the resolution and if the department is questioning the resolution or the mandate, then we share that information with them and we explain that this is coming directly from the communities and they approach the tribe and the tribe is acting on behalf of the community by establishing a resolution and mandating all the report.

**CARTER BLAKEY:** Thank you. We have so many other questions that have come in. We have enough material for a follow-up webinar. Thank you to each of our presenters for joining us today. It's been a terrific attendance. And I would like to give you a heads up. We have more coming your way in terms of leading health indicators in June. Our topic will be Reproductive and Sexual Health. In July we have a Progress Review which is another Healthy People 2020 activity where we will be looking at immunization and infectious diseases and global health with a focus on TB, and in July our webinar will look at Maternal and Child Health. Keep your calendars open and you will be receiving notices about these events. Thank you for joining us and we hope you will tune in next month.