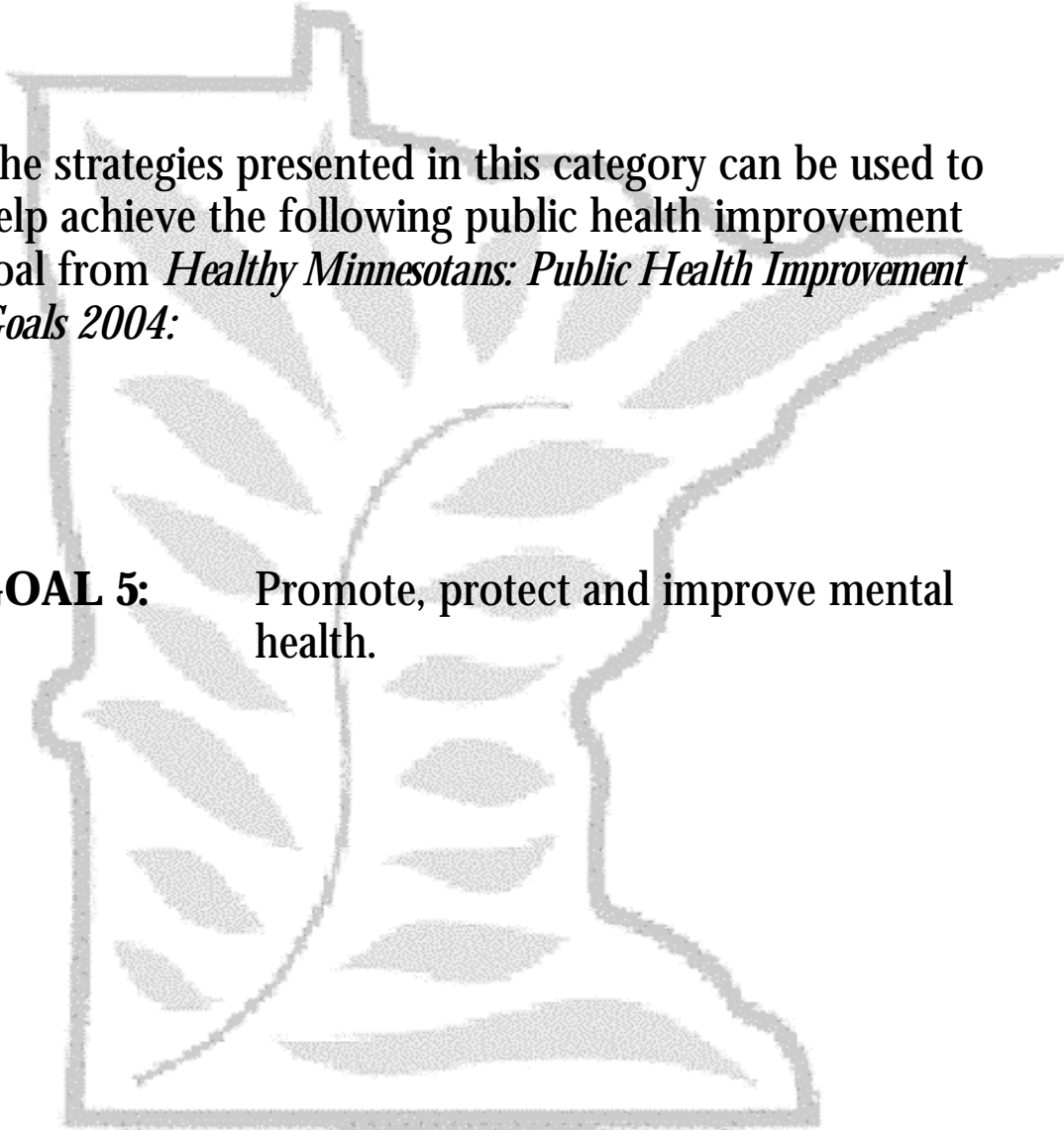


Category:

MENTAL HEALTH

The strategies presented in this category can be used to help achieve the following public health improvement goal from *Healthy Minnesotans: Public Health Improvement Goals 2004*:

GOAL 5: Promote, protect and improve mental health.



CATEGORY: MENTAL HEALTH

Introduction	1
Infant Mental Health	3
Maternal Depression	9
Mental Health	15

Mental health is a core condition for overall health. It is necessary to lead a happy and productive life, to form healthy relationships, and to successfully adjust to change and overcome difficulties. In recent years, the U.S. Surgeon General has issued no less than five reports addressing mental health and suicide prevention, heightening the importance of mental health as a major public health issue. Mental health and well-being are connected to physical health, genetics, behaviors, environments, and other social conditions. For instance, lack of social support, material and financial poverty, and stress can exacerbate many mental health illnesses and disorders. Therefore policies that work to address these root causes and contributing factors can play a powerful role in alleviating the larger financial and social costs of mental illness.

Mental health can be compromised in varying degrees, from “having a bad day” to living with a mental disorder or feeling suicidal. About one in five Americans experiences a mental disorder in the course of a year (USHHS, *Mental Health: A Report of the Surgeon General*, 1999). Mental health can also vary across the lifespan and among populations. One in ten American children have mental illnesses serious enough to cause some degree of impairment and yet only an estimated one in five receive mental health services (USPHS, *Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda*, 2000). In Minnesota, suicide is the second leading cause of death for 15- to 34-year olds; the third leading cause of death for 10- to 14-year-olds; and the fourth leading cause of death for 35-to 54-year-olds. The suicide rate for American Indians males is approximately two times higher than that of any other racial or ethnic group.

In 2000, persons aged 35-44 years in Minnesota had the highest suicide rate of all age groups, at 13.1 per 100,000 people, with the exception of people aged 85 years and older (rate of 14.0 per 100,000).

Mental disorders include depression, schizophrenia, autism, attention deficit hyperactivity disorder, conduct disorder, bipolar disorder, substance addictions, and Alzheimer's disease, to name a few. These illnesses place an extraordinary burden on the financial and social resources of the state. It was estimated that for 1990 the total national costs related to mental illnesses (not including alcohol and drug abuse) were \$147 billion (Rice, Kelman, Miller and Dunmeyer, *Economic Costs of Alcohol and Drug Abuse and Mental Illness Report*, 1990).

There is perhaps no illness or disability that is as shrouded in myth and marked by stigma as mental illness. According to the U.S. Surgeon General's Report on Mental Health, “... nearly two-thirds of all people with diagnosable mental disorders do not seek treatment” (USHHS, *Mental Health: A Report of the Surgeon General*, 1999). Much can be done to improve Minnesotans' access to effective mental health interventions, which include mental health promotion efforts as well as treatment for mental disorders and timely crisis response.

A range of strategies is needed to promote, protect, and improve mental health in Minnesota. These include promoting infant mental health through nurturing parent-child interactions; early identification of mental health problems in all ages; intervention and referral to appropriate services and treatment; and preventing violence, substance abuse, and addictions. In addition, Minnesotans can implement strategies to

address eating disorders, maternal depression, suicide, the importance of healthy growth and development among children and adolescents, and the mental health needs of children with disabilities, populations of color, American Indians, and people with chronic illnesses. Through public education and broad-based interventions with individuals, families, communities, and systems, Minnesotans can promote the mental health and well-being of its citizens.

For related strategies, see the following categories: *Alcohol, Tobacco and Other Drug Use; Children and Adolescents Growth and Development; Chronic/Noninfectious Disease; Disability/Decreased Independence; Infectious Disease; Pregnancy and Birth; Service Delivery Systems; Unintended Pregnancy; and Violence.*

CATEGORY: Mental Health

TOPIC: INFANT MENTAL HEALTH

The strategies below can be used to work on this topic.
Organizations that may play a role in implementing each strategy are indicated.

	Governmental Public Health Agencies	Health Plans	Hospitals & Clinics	Educational Systems	Community- based Organizations	Businesses/ Work Sites	Other
Develop a provider awareness campaign that provides information on the importance of responsive, nurturing interactions between parents and their infants, available assessment and teaching tools, and available community resources.	✓	✓	✓	✓	Mental health providers		
Provide public health nurse home visits to promote caregiver-infant interactions and relationships using recognized, research based tools.	✓	✓	✓	✓	✓		

The infant comes into the world totally dependent on her or his caregivers. It is through the relationship with the primary caregiver that a baby experiences the world. This relationship plays a vital role in the infant’s emotional well-being. When this relationship is nurturing and responsive, a baby develops the skills to learn, to regulate emotions and to interact socially. According to the Advisory Committee on Services for Families with Infant and Toddlers, “The child-caregiver relationships with the mother, father, grandparent and other caregivers are critical for providing infants and toddlers support, engagement, continuity and emotional nourishment necessary for healthy development, and the development of healthy attachments. Within the context of care giving relationships, the infant builds a sense of what is expected, what feels right in the world, as well as skills and incentives for social turn-taking, reciprocity and cooperation” (Advisory Committee, 1994, p.7).

In the early months of an infant’s life the primary focus of care giving is to establish routines, patterns of interaction, and patterns of communication. Through these routines and patterns of communication, caregivers and children mutually influence and provide feedback to one another. It is within these thousands of repeated interactions between caregiver and young child that children’s emotional, intellectual, and physical needs are met – or not.

Infant caregiver relationships are the primary focus of infant mental health promotion, prevention and intervention activities. Strategies to promote infant mental health build the capacities of health, early education, mental health and human services providers to recognize healthy parent-infant relationships; increase provider

skills to promote positive parent-infant relationships; and use public health nurse home visiting to promote positive, caregiver-infant interactions.

For related strategies, see the sections on Maternal Depression and Mental Health in this (*Mental Health*) category.

Strategy: Develop a provider awareness campaign that provides information on the importance of responsive, nurturing interactions between parents and their infants, available assessment and teaching tools, and available community resources.

	Systems	Community	Individual
Primary		✓	
Secondary		✓	
Tertiary			

Background:

The purpose of this strategy is to increase the knowledge of infant mental health issues among the professionals who work in health care, mental health, early childhood programs and human services agencies. Public health and community partners provide information on the importance of responsive, nurturing interactions between parents and babies at agency/clinic/program staff meetings, hospital medical staff meetings, and conferences. Public health and community partners establish and implement a process for disseminating infant mental health information to new and existing staff. Public health can meet with local professional organizations and determine ways to share information on infant mental health, available assessment and teaching tools, and community resources with their members.

Additional Resources:

- ▶ Heffron, M. 2000. Clarifying concepts of infant mental health-promotion, relationship-based preventive intervention, and treatment. *Infants and Young Children*, 12(4), 14-21.
- ▶ The Florida State University Center for Prevention and Early Intervention Policy for the Florida Developmental Disabilities Council. (2000). *Florida's Strategic Plan for Infant Mental Health*. Tallahassee, Florida. pp. 40-42.

completing a recognized, research-based training curriculum such as NCAST.

For more information contact:

MDH Maternal and Child Health Section, Family Home Visiting Team, at (651) 215-8960.

Evidence for strategy:

Studies of the impact of professional education show a relationship between improvements in provider performance and patient health outcomes where a variety of educational strategies were involved. A direct relationship with positive health outcomes is most apparent when reinforcing educational elements (such as case discussion and interactive learning opportunities) are used.

Strategy: Provide public health nurse home visits to promote caregiver-infant interactions and relationships using recognized, research based tools.

	Systems	Community	Individual
Primary		✓	✓
Secondary			✓
Tertiary			

Has this strategy been implemented in Minnesota?

No, it is currently being implemented in the State of Florida.

Background:

The purpose of this strategy is to promote positive caregiver-infant interactions and relationships. Public health nursing home visiting services provide parents of infants with information, support, and connections to community resources. Using research based methods and tools, public health nurses promote positive caregiver-infant interactions and relationships. Public health nurses also identify families who are experiencing stress, lack family support and friendships, or have health conditions that affect the parent's ability to meet baby's needs. Research based tools and methods that promote caregiver-infant interactions and assess needs include:

Indicators for this strategy:

- ▶ Number of agency/clinic/staff meetings where infant mental health is a focus.
- ▶ Number of agencies that include information on infant mental health in staff in-service training.
- ▶ Number and type of professional organizations that disseminate infant mental health information to membership.
- ▶ Number of brochures, materials, and videotapes disseminated to agency providers and members of professional organizations.
- ▶ Number and type of providers

- ▶ NCAST Parent/Child Interaction Feeding and Teaching Assessment Scales – These are the most widely used scales for measuring parent-child interaction today. Each scale contains a well-developed set of observable behaviors that describe the caregiver-

child communication and interaction during either a feeding situation, birth to 12 months of life, or a teaching situation, birth to 36 months of age.

- ▶ NCAST Keys to Care Giving – The Keys to Care Giving program is designed to teach those who work with families about the competencies and capabilities of the newborn infant, their effect on caregiver-infant interaction, and ways to effectively translate this knowledge to parents.
- ▶ NCAST Promoting Maternal Mental Health During Pregnancy – This program addresses a woman's psychological and emotional health during pregnancy. It covers issues critical to the development of the early mother-child relationship including bonding of parent to child, attachment of child to parent, the importance of early brain development, and the role that emotionally available and attentive care giving play in the child's emotional and cognitive development.

Additional Resources:

Bibliographic resources:

- ▶ Advisory Committee on Services for Families with Infants and Toddlers. September, 1994. *The Statement of the Advisory Committee on Services for Families with Infants and Toddlers*. Washington, DC: Department of Health and Human Services.
- ▶ Solchany, JE., and Barnard, K. 2001. Is mom's mind on her baby? Infant mental health in early Head Start. *Zero to Three*, (22)1, pp.39-47.

Organizational resource:

- ▶ NCAST Program, University Of Washington, www.ncast.org (206) 543-8528.

Evidence for strategy:

The NCAST scales have been shown to have predictive validity of caregiver total scores with later child cognitive tests supporting the use of the tools to promote early infant brain development. The Juvenile Justice/Court System often requests NCAST scales as a reliable and valid means of observing and rating the caregiver and child for the purpose of assessing interaction or communication problems.

Has this strategy been tested in Minnesota?

Yes, this strategy has been used in Minnesota. A 1998 survey of Maternal and Child Health County Coordinators was conducted on the practice of using the NCAST tools. Of the 48 counties reporting, 127 of 241 Maternal and Child Health/Family Health Public Health Nurses (53 percent) have been trained in the use of NCAST tools.

Indicators for this strategy:

- ▶ Number of Public Health Nurses completing NCAST training.
- ▶ Number of family records with NCAST scales.

For more information contact:

MDH Maternal and Child Health Section, Family Home Visiting Team, at (651) 215-8960.

CATEGORY: Mental Health

TOPIC: MATERNAL DEPRESSION

The strategies below can be used to work on this topic.
Organizations that may play a role in implementing each strategy are indicated.

	Governmental Public Health Agencies	Health Plans	Hospitals & Clinics	Educational Systems	Community- based Organizations	Businesses/ Work Sites	Other
Increase provider awareness about the signs, symptoms and treatment of depression during pregnancy and following birth.	✓	✓	✓		Mental Health Providers		
Conduct public health nurse home visits to provide routine education and screening for depression during pregnancy and following birth.	✓	✓	✓		✓		

Maternal depression is a term used to describe a whole spectrum of conditions that have varying consequences for a mother’s health, her functioning as a mother, her children’s development, and her family’s overall functioning. Depression in mothers of babies and young children is not uncommon. It is a major public health problem. Programs serving expectant parents and families with infants and young children need to identify and help mothers who are experiencing depression.

Year 2000 data from Minnesota Healthy Beginnings programs show that 19 percent of women with newborns needed follow-up for emotions and depression. Many of these women would not have been identified by health providers as needing follow-up services because of their older age (49 percent were ages 25 to 35 years); their marital status (57 percent were married); high educational level (47.5 percent had more than 12 years of education); and race (80 percent were white).

Maternal depression is important in the context of child rearing. The fact that a mother is depressed does not tell you how she is caring for the baby. Some mothers with depression are able to provide sensitive, responsive care to their babies and others are not. Depressed moms may respond to babies with irritable voice tones or sad or flat facial expressions. Many babies respond to this reaction by turning away. When a child is exposed to the mother’s depression for a prolonged period of time, the child is more likely to experience problems with development.

The strategies presented here are intended to support the care of women in Minnesota. To have the greatest impact, they should be

implemented in conjunction with the other strategies in this category. For related strategies, see the sections on Mental Health and Infant Mental Health in this category.

Strategy: Increase provider awareness about the signs, symptoms and treatment of depression during pregnancy and following birth.

	Systems	Community	Individual
Primary	✓	✓	✓
Secondary			
Tertiary			

Background:

The purpose of this strategy is to increase provider awareness about the signs, symptoms and treatment of depression during pregnancy and following birth. The audience for this strategy includes family physicians, public health nurses, mental health professionals, and nurse midwives. Regional workshops for physicians, public health nurses, mental health professionals, and other health providers are held to increase provider knowledge about the signs, symptoms, use of screening tools, and treatment options for depression during pregnancy and following birth. Providers would receive copies of two depression-screening tools to use in their clinic settings and would receive a list of resources for mental health evaluation and treatment.

Additional resources:

- ▶ *Postpartum Depression Screening Scale (PDSS)*, by Cheryl Beck, D.N.Sc. and Robert K. Gable, Ed. D., University of Connecticut. This tool can be ordered through Western Psychological Services

800-648-8857, custsvc@wpspublish.com.

- ▶ *Edinburgh Postnatal Depression Scale* (EPDS). This tool has been field tested by numerous researchers and can be accessed by contacting the American Psychiatric Press.

Evidence for strategy:

Studies of the impact of professional education show a relationship between improvements in provider performance and patient health outcomes where a variety of educational strategies were involved. A direct relationship with positive health outcomes is most apparent when reinforcing educational elements (such as case discussion and interactive learning opportunities) are used. The combination of patient and provider diabetes education efforts has been shown to result in the greatest improvement in health outcomes.

Has this strategy been implemented in Minnesota?

Yes, an educational program on screening for maternal depression was provided for the first time by the Minnesota Department of Health, Family Health Division, Maternal and Child Health Section in March, 2002. Training was provided to over 130 public health nurses in the use of the NCAST Curriculum: *Promoting Maternal Mental Health During Pregnancy*.

The Minnesota Department of Health, Family Health Division, has funded two home visiting programs that both utilize a screening tool to assess for potential maternal depression. In the Targeted Home Visiting Program to Prevent Child Abuse and Neglect, a *Depression Screening Tool*, developed by the Wilder Research Center, was used by public health nurses to screen for potential depression. In the Universal Minnesota Healthy Beginnings Program,

screening questions regarding depression, mental illness, and emotional health are part of the public health nursing assessment.

Indicators for this strategy:

- ▶ Establishment of clinical guidelines regarding identification and appropriate treatment of women with depression during pregnancy and following birth.
- ▶ Numbers and kind of educational opportunities e.g., forums, articles, rounds, case discussions for health professionals focusing on maternal depression.
- ▶ Provider survey or chart audit documenting health teaching about the signs and symptoms of depression; routine use of depression screening tools; and referral to mental health professionals for assessment of women with symptoms of depression lasting two weeks or longer.
- ▶ Client survey detailing information provided by health providers about signs, symptoms and available treatments for depression during pregnancy and following birth.

For more information contact:

MDH Maternal and Child Health Section, Family Home Visiting Team, at (651) 215-8960.

Strategy: Conduct public health nurse home visits to provide routine education and screening for depression during pregnancy and following birth.

	Systems	Community	Individual
Primary		✓	✓
Secondary			✓
Tertiary			

Background:

This strategy serves two purposes. The first purpose is to minimize the stigma associated with mental health by increasing consumer awareness of the signs/symptoms and treatment resources for depression during pregnancy and following birth. The second purpose is early identification of women who need further assessment and treatment. Public health nurses provide pregnant and newly delivered women with written information and education regarding the signs and symptoms of depression and the importance of treatment. Public health nurses routinely screen pregnant and newly delivered women for depression during home visits, and link women needing further mental health evaluation to available resources.

Additional resource:

- ▶ Solchany, J. 2001. *Promoting Maternal Mental Health During Pregnancy*. NCAST Publications, University of Washington, Seattle.

Evidence for strategy:

Public health nurses providing home visiting services to pregnant and parenting women use screening tools to assess for signs and symptoms of maternal depression. This strategy is an effective way to identify

women who need referral for further assessment and treatment.

Has this strategy been implemented in Minnesota?

Yes, public health nurses conducting home visits in over 20 Minnesota counties (with Prevention of Child Abuse and Neglect Programs) used screening tool for maternal depression. Additionally, in six counties (with Minnesota Healthy Beginnings Programs) public health nurses screen for potential signs and symptoms of depression and mental health problems as part of the initial public health nursing assessment.

Indicators for this strategy:

- ▶ Number of pregnant and postpartum women receiving information and education on the signs/symptoms and treatment options for depression.
- ▶ Number of pregnant and postpartum women that need public health nursing follow-up for emotions and depression.
- ▶ Number of pregnant and postpartum women that are referred to mental health resources for evaluation.

For more information, contact:

MDH Maternal and Child Health Section, Family Home Visiting Team, at (651) 215-8960.

CATEGORY: Mental Health

TOPIC: MENTAL HEALTH

The strategies below can be used to work on this topic.
Organizations that may play a role in implementing each strategy are indicated.

	Governmental Public Health Agencies	Health Plans	Hospitals & Clinics	Educational Systems	Community- based Organizations	Businesses/ Work Sites	Other
Address the stigma associated with child and adult mental disorders and seeking mental health, substance abuse and suicide prevention services by educating the general public.	✓	✓	✓	✓	✓	✓	
Screen adults for depression in primary care settings.	✓	✓	✓		✓	✓	
Ensure supply and access to effective and appropriate child and adult mental health and suicide prevention services and providers.	✓	✓	✓	✓	✓	✓	
Reduce financial barriers to child and adult mental health treatment.	✓	✓	✓	✓	✓	✓	
Train frontline providers to identify and respond to mental health issues among both children and adults with proven prevention and treatment services.	✓	✓	✓	✓	✓	✓	
Promote physical activity to improve and maintain mental health.	✓	✓	✓	✓	✓	✓	

CATEGORY: MENTAL HEALTH
TOPIC: MENTAL HEALTH

	Governmental Public Health Agencies	Health Plans	Hospitals & Clinics	Educational Systems	Community- based Organizations	Businesses/ Work Sites	Other
Educate professionals and the community to recognize suicide warning signs, to respond appropriately, and make referrals to treatment and necessary supports.	✓	✓	✓	✓	✓	✓	
Improve reporting and portrayals of suicidal behavior, mental illness and substance abuse in the entertainment and news media.	✓						Media
Promote and enforce suicide means and methods restrictions, including limiting access to firearms, promoting safe storage of firearms, and encouraging use of trigger locks.	✓	✓	✓	✓	✓		
Increase awareness of the mental health disparities between children with special health needs and their typical peers.	✓	✓	✓	✓	✓	✓	

Mental health can be compromised in varying degrees, from “having a bad day” to living with a mental disorder or feeling suicidal. About one in five Americans experiences a mental disorder in the course of a year (USHHS, *Mental Health: A Report of the Surgeon General*, 1999). Mental health can also vary across the lifespan and among populations. One in ten American children have mental illnesses serious enough to cause some degree of impairment and yet only an estimated one in five receive mental health services (USPHS, *Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda*, 2000). In Minnesota, suicide is the second leading cause of death for 15- to 34-year olds; the third leading cause of death for 10- to 14-year-olds; and the fourth leading cause of death for 35-to 54-year-olds. The suicide rate for American Indians males is approximately two times higher than that of any other racial or ethnic group. In 2000, persons aged 35-44 years in Minnesota had the highest suicide rate of all age groups, at 13.1 per 100,000 people, with the exception of people aged 85 years and older (rate of 14.0 per 100,000).

There is perhaps no illness or disability that is as shrouded in myth and marked by stigma as mental illness. According to the U.S. Surgeon General's Report on Mental Health, “... nearly two-thirds of all people with diagnosable mental disorders do not seek treatment” (USHHS, *Mental Health: A Report of the Surgeon General*, 1999). Much can be done to improve Minnesotans' access to effective mental health interventions, which include mental health promotion efforts as well as treatment for mental disorders and timely crisis response. The strategies offered here provide some

guidance in addressing these issues. For related strategies see “Infant Mental Health” and “Maternal Depression” in this category, and also strategies on “Alcohol and Other Drug Use” in the *Alcohol, Tobacco and Other Drug Use* category; “Child Maltreatment, Including Children with Special Health Needs” and “Youth Violence” in the *Violence* category; “Parenting and Youth” in the *Child and Adolescent Growth and Development* category; and “Physical Activity” in the *Chronic Disease* category.

Strategy: Address the stigma associated with child and adult mental disorders and seeking mental health, substance abuse and suicide prevention services by educating the general public.

	Systems	Community	Individual
Primary	U	U	U
Secondary			
Tertiary			

Background:

The stigma of child and adult mental disorders and seeking mental health, substance abuse and suicide prevention services continues to hinder access to effective treatment. The adequate recognition and treatment of child and adult mental disorders are inhibited by negative public attitudes and ignorance. Providing accurate information and portrayals of people with mental disorders can help to reduce this stigma. Many people with mental health problems fail to recognize symptoms of mental disorders and suicide warning signs, are reluctant to acknowledge them, or do not seek help. Ideas for public

information and education campaigns (also called health communication campaigns) can be drawn from successful campaigns addressing AIDS, substance abuse, and seat belt awareness. Public information and education activities might include production and distribution of printed leaflets, fact sheets, audio and videocassettes, books, newspaper and magazine articles, and television and radio advertisements, as well as holding interviews, press conferences, and “action weeks.”

The purpose of a public education campaign is to stimulate awareness of, and attitudinal and behavioral change about, mental disorders and the risks for suicide, thereby de-stigmatizing the issues through familiarity. The focus of these educational activities is to ensure people understand that mental disorders are common health concerns in men, women, and children of all ages, that they are a highly treatable medical conditions (like other medical conditions such as diabetes or hypertension), that they are not related to personality weakness, and that suicide is preventable.

Health communication activities typically have interpersonal (training or counseling) and community (neighborhood group or advocacy) components. In some educational campaigns, these elements are carefully interwoven through an overall strategic design. There may be reports of personal accounts by a number of ordinary, public and media figures; an increase in media coverage of mental health issues; “action weeks” consisting of media briefings and activities, conferences, and action days with specific themes; leaflets or fact sheets distributed (e.g., on topics such as children’s mental health, depression in the elderly,

mental disorders in the workplace, postpartum depression, or eating disorders) in appropriate formats for a community; books published for the general public; and video and audio cassettes.

Additional Resources:

Bibliographic resources:

- < Backer, TE., Rogers, EM. Sopory, P. 1992. *Designing Health Communication Campaigns: What Works?* Newbury Park: SAGE Publications, Inc.
- < U.S. Department of Health and Human Services. 1999. *Mental Health: A Report of the Surgeon General*. Rockville, MD: Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, at <http://www.surgeongeneral.gov/library/mentalhealth/>.
- < U.S. Department of Health and Human Services. 2001. *National Strategy for Suicide Prevention: Goals and Objectives for Action*. Rockville, MD. Available at: <http://www.mentalhealth.org/suicideprevention/strategy.asp>.
- < U.S. Public Health Service. 2000. *Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda*. Washington, DC: Department of Health and Human Services, at <http://www.surgeongeneral.gov/topics/cmh/childreport.htm>.

Organizational resources:

- < American Association of Suicidology, at <http://www.suicidology.org>.
- < Light for Life Foundation/Yellow Ribbon, Mankato, MN, at (507) 387-5020.

- < Mental Health Association of Minnesota, at (612) 331-6840, 2021 Hennepin Avenue E., Minneapolis, MN.
- < Mental Health Consumer/Survivor Network, at (651) 637-2800.
- < National Institute of Mental Health, at <http://www.nimh.nih.gov>.
- < National Mental Health Association, at (703) 684-7722 or (800) 969-6942, <http://www.nmha.org/>, 1021 Prince Street, Alexandria, VA, 22314-2971.
- < Suicide Awareness Voices of Education, at <http://www.save.org>.

Evidence for the Strategy:

Much has been written about health communication campaigns in both the social sciences and mass communication fields. Increasingly, the study of their effects has involved not only university-based scholars, but also professionals based in independent research settings, health care institutions, federal health agencies, and community nonprofit organizations. Empirical evidence has shown mass communication campaigns to be effective in initiating or changing important behaviors related to health. Progress is being made in efforts to compare campaigns addressing different topics or diseases and to look for common principles and the most effective intervention strategies. The generalizations listed above are among those identified in a comparative synthesis (Backer, Rogers, & Sopory, 1992) through an extensive review of the literature and interviews with prominent campaign designers.

Has this strategy been implemented in Minnesota?

Yes, national media campaigns such as Just Say No, Mothers Against Drunk Drivers (MADD), and the Entertainment Industry Council's AIDS and IV Drug Abuse

Campaign for the National Institute on Drug Abuse have been active in Minnesota. During the 1980's, the Minnesota Heart Health Project implemented community wide heart health communications campaigns in Mankato, Bloomington, and Fargo-Moorhead. Many individual organizations have conducted one or more pieces of a total campaign. For example, during the winter of 1997, HealthPartners produced a newsletter, *Depression Can Affect Anyone*. Among other information, the newsletter described the warning signs of depression, offered classes to help people learn more about depression and provided information on other resource materials, such as a pamphlets and books. The MDH has conducted media campaigns on tobacco use, AIDS prevention, teen pregnancy, immunization, and breast cancer.

Indicators for this strategy:

- < Number of people in the target audience exposed to the message(s). This can be measured by TV or radio ratings.
- < Number of people in the target audience aware of the message(s). This can be measured by an audience survey.
- < Number of people in the target audience reporting knowledge change. This can be measured by an audience survey.
- < Number of people in the target audience reporting an intention to change behavior. This can be measured by an audience survey.
- < Actual change in the audience's behavior. This can be measured by point-of-referral monitoring for health sources.
- < Number of people in the target audience seeking a mental health provider, minister, or other source of help, as measured by a provider survey.
- < Maintenance of the audience's

behavioral change. This can be measured by point-of-referral monitoring for health sources.

- < Rates of hospital admissions for treatment of depression.
- < Prescribing patterns (monitored before, during, and after the educational campaign).
- < Suicide rates (monitored before, during, and after the educational campaign).

For more information contact:

Candy Kragthorpe, at (651) 281-9833, candy.kragthorpe@health.state.mn.us, MDH Mental Health Program Coordinator.

Strategy: Screen adults for depression in primary care settings.

	Systems	Community	Individual
Primary	U	U	U
Secondary			
Tertiary			

Background:

Depression is common and costly, causing more disability than ischemic heart disease or cerebrovascular disease. In primary care settings, up to 50 percent of depressed patients are not recognized.

In primary care settings that have systems in place for accurate diagnosis, effective treatment, and follow-up, the U.S. Preventive Services Task Force (USPSTF) recommends screening adults for depression:

- < Many formal screening tools are available (e.g., the Zung Self-Assessment Depression Scale, Beck Depression Inventory, General Health

Questionnaire [GHQ], Center for Epidemiologic Study Depression Scale [CES-D]). Asking two simple questions about mood and anhedonia ("Over the past two weeks, have you felt down, depressed, or hopeless?" and "Over the past two weeks, have you felt little interest or pleasure in doing things?") may be as effective as using longer instruments. There is little evidence to recommend one screening method over another, so clinicians can choose the method that best fits their personal preference, the patient population served, and the practice setting.

- < All positive screening tests should trigger full diagnostic interviews that use standard diagnostic criteria (i.e., those from the fourth edition of *Diagnostic and Statistical Manual of Mental Disorders* [DSM-IV]) to determine the presence or absence of specific depressive disorders, such as major depression and/or dysthymia. The severity of depression and co morbid psychological problems (e.g., anxiety, panic attacks, or substance abuse) should be addressed. (USPSTF, 2002; see web site under "Organizational resources:" below for U.S. Preventive Services Task Force).

Additional resources:

Bibliographic resources:

- < American Psychiatric Association. 2000. *DSM-IV-TR 2000: Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision. American Psychiatric Publishing, Incorporated.
- < *Screening for Depression: Recommendations and Rationale*. 2002. Agency for Healthcare Research and Quality, Rockville, MD, at

<http://www.ahrq.gov/clinic/3rduspstf/depression/depressrr.htm>.

Organizational resources:

- < Screening for Mental Health, Inc., at <http://www.mentalhealthscreening.org/>.
- < U.S. Preventive Services Task Force, at <http://www.ahrq.gov/clinic/uspstfix.htm>.

Evidence for strategy:

This strategy is recommended by the U.S. Preventive Services Task Force (USPSTF), whose review identified 14 randomized, controlled trials that have examined the effectiveness of screening for depression in primary care settings.

Has this strategy been implemented in Minnesota?

The extent to which this strategy is implemented in Minnesota is unknown.

Indicators for this strategy:

- < Number of primary care settings that screen for depression among adults.
- < Number of adults identified and referred for depression treatment.

For more information contact:

Candy Kragthorpe, at (651) 281-9833, candy.kragthorpe@health.state.mn.us, MDH Mental Health Program Coordinator.

Strategy: Ensure supply and access to effective and appropriate child and adult mental health and suicide prevention services and providers.

	Systems	Community	Individual
Primary			
Secondary	U	U	U
Tertiary	U	U	U

Background:

Mental health services and providers who employ scientifically-proven interventions are in short supply for all ages, genders, races, cultures and disabilities. Interventions include community-based prevention and early identification programs, outreach to isolated populations, wraparound services for children and adolescents, combined services for co-occurring mental health and substance abuse disorders and addictions, and transition, management and community-based treatment programs.

Shortages are particularly critical in rural areas and among professionals serving children, adolescents, older adults, populations of color and American Indians. In Minnesota, every rural region has received the federal designation of Mental Health Professional Shortage Area. Furthermore, lack of coordination, organization, and integration of current service delivery systems further hinder access to those services that are available.

Communities, systems, and policymakers must work together to identify and address the multiple and complex obstacles to improving the infrastructure and ensuring the supply of effective, appropriate and evidence-based services in Minnesota. Community members must be engaged in community and systems assessments, identifying funding streams, and clarifying stakeholder roles.

Additional Resources:

Bibliographic resources:

- < U.S. Department of Health and Human Services. 1999. *Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental

Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, at <http://www.surgeongeneral.gov/library/mentalhealth/>.

- < U.S. Department of Health and Human Services. 2001. *National Strategy for Suicide Prevention: Goals and Objectives for Action*. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, at <http://www.mentalhealth.org/suicideprevention/strategy.asp>.
- < U.S. Public Health Service. 2000. *Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda*. Washington, DC: Department of Health and Human Services, at <http://www.surgeongeneral.gov/topics/cmh/childreport.htm>.

appropriate mental health services and providers.

- < Number of child and adult mental health services and providers per capita.
- < Number of mental health Professional Shortage Areas.

For more information contact:

- < Candy Kragthorpe, at (651) 281-9833, candy.kragthorpe@health.state.mn.us, MDH Mental Health Program Coordinator.
- < Minnesota Association of Community Mental Health Programs, Inc., at (651) 642-1903, 1821 University Ave. W., Suite 350-S, St. Paul, MN 55104-2875.
- < Minnesota Department of Human Services, Mental Health Division, at (651) 297-3933; Children's Mental Health, (651) 297-5242. 444 Lafayette Road North, Saint Paul, MN 55155.

Evidence for the Strategy:

The strategy described above is recommended in the U.S. Surgeon General's reports on mental health and children's mental health.

Has this strategy been implemented in Minnesota?

This strategy is being implemented by a number of state and community-based initiatives, health plans and providers but the extent to which it has been advanced is unknown.

Indicators for this strategy:

- < Number of state and community-based initiatives and workgroups addressing the supply of child and adult mental health services.
- < Number of consumers who are required to wait long periods to access

Strategy: Reduce financial barriers to child and adult mental health treatment.

	Systems	Community	Individual
Primary			
Secondary	U	U	U
Tertiary	U	U	U

Background:

Costs of care are often cited as obstacles to accessing child and adult mental health services and treatment and disparity remains in insurance coverage. Support for mental health parity is growing, however, it falls short in addressing the needs of the uninsured or many of those covered by self-insured plans. Data indicate that use of

mental health services increases as mental health benefits increase.

Consumers, communities, systems, and policymakers must work together to identify and address the financial barriers that discourage people from seeking and continuing treatment. Community members must be engaged in community and systems assessments and identifying funding streams and distribution of resources.

Additional resources:

Bibliographic resources:

- < U.S. Department of Health and Human Services. 1999. *Mental Health: A Report of the Surgeon General*. Rockville, MD. Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, at <http://www.surgeongeneral.gov/library/mentalhealth/>
- < U.S. Public Health Service. 2000. *Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda*. Washington, DC: Department of Health and Human Services, at <http://www.surgeongeneral.gov/topics/cmh/childreport.htm>.

Evidence for strategy:

The strategy described above is recommended in the U.S. Surgeon General's reports on mental health and children's mental health.

Has this strategy been implemented in Minnesota?

It is unknown to what extent this strategy has been implemented in Minnesota. However, a number of state and local initiatives, programs, clinics and providers

provide low or no cost access to child and adult mental health treatment.

Indicators for this strategy:

- < Number of state and community-based initiatives and workgroups addressing financial barriers to child and adult mental health treatment.
- < Number of children and adults who can afford adequate, effective and appropriate mental health treatment.
- < Number of insurance plans that include parity for mental health treatment.

For more information contact:

- < Candy Kragthorpe, at (651) 281-9833, candy.kragthorpe@health.state.mn.us, MDH Mental Health Program Coordinator.
- < Minnesota Department of Human Services, Mental Health Division, at (651) 297-3933; Children's Mental Health, (651) 297-5242, 444 Lafayette Road North, Saint Paul, MN 55155.

Strategy: Train frontline providers to identify and respond to mental health issues among both children and adults with proven prevention and treatment services.

	Systems	Community	Individual
Primary			
Secondary	U	U	U
Tertiary	U	U	U

Background:

Various child and adult serving systems and settings provide for opportunities to identify and respond to mental health issues with

effective interventions. Frontline providers can improve their skills through multi-disciplinary training and education. Training content includes culture- and gender-specific infant, child and adolescent development to accurately recognize early symptoms of emotional or behavioral problems and mental disorders. Additionally, content should focus on populations with unique risks, including children with special health needs; gay, lesbian, bisexual and transgendered youth; populations of color and American Indians; and older adults.

Additional resources:

Bibliographic resources:

- < U.S. Department of Health and Human Services. 1999. *Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, at <http://www.surgeongeneral.gov/library/mentalhealth/>.
- < U.S. Department of Health and Human Services. 2001. *National Strategy for Suicide Prevention: Goals and Objectives for Action*. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, at <http://www.mentalhealth.org/suicideprevention/strategy.asp>.
- < U.S. Public Health Service. 2000. *Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda*. Washington, DC: Department of Health and Human Services, at <http://www.surgeongeneral.gov/topics/cmh/childreport.htm>.

Organizational resources:

- < Light for Life Foundation/Yellow Ribbon, Mankato, MN, at (507) 387-5020.
- < Minnesota Department of Health, at (651) 215-5800, 400 Golden Rule Building, 85 East 7th Place, St. Paul, MN 55101.
- < Minnesota Department of Human Services, Mental Health Division, at (651) 297-3933; Children's Mental Health, (651) 297-5242, 444 Lafayette Road North, Saint Paul, MN 55155.
- < Suicide Awareness Voices of Education, at <http://www.save.org>.

Evidence for strategy:

The strategy is recommended in *Mental Health: A Report of the Surgeon General*, *Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda*, and *National Strategy for Suicide Prevention: Goals and Objectives for Action*. See "Additional resources:" above for citations.

Has this strategy been implemented in Minnesota?

Yes, multi-disciplinary training of providers occurs throughout the state but the extent to which it is occurring is unknown.

Indicators for this strategy:

- < Number of training and education events.
- < Number of providers receiving training.
- < Number of people identified and referred for services.

For more information contact:

Candy Kragthorpe, at (651) 281-9833, candy.kragthorpe@health.state.mn.us, MDH Mental Health Program Coordinator.

Strategy: Promote physical activity to improve and maintain mental health.

	Systems	Community	Individual
Primary	U	U	U
Secondary	U	U	U
Tertiary	U	U	U

Background:

There is a growing amount of evidence supporting the idea that exercise can improve not only physical, but mental health. Exercise can help depressed people feel better. While it is *not* a cure for depression, it can help to reduce its symptoms. Many people report that they feel good for several hours after an exercise session. They feel less anxious, tense, and depressed.

Mental health benefits may be obtained from frequent, low-to-moderate amounts of physical activity. Most studies have primarily evaluated the effects of aerobic physical activities, such as brisk walking and running, on mental health. The available evidence indicates that increases in cardiorespiratory fitness are not necessary for psychological benefits to occur (USDHHS, 1996). In general, inactive persons are twice as likely to have symptoms of depression, as are more active persons.

A wide range of physical activity interventions can be considered. They include community wide programs; worksite programs; interventions in populations comprising individuals who have low incomes, are ethnic minorities, or have disabilities; interventions using mass media, print media, and information technology; interventions for youth; interventions for

older adults; interventions in health care settings; and environmental and policy interventions.

Physicians are increasingly recommending regular exercise as part of the treatment of depression. Medication and counseling are the usual elements of an overall treatment for depression, but physical activity is a helpful addition to this prescription. Several studies have shown that aerobic activity plus counseling are more effective in treating mildly to moderately depressed people than counseling alone.

An important conclusion of the 1997 President's Council on Physical Fitness and Sports Report, *Physical Activity and Sport in the Lives of Girls*, stated, "Regular participation in exercise and physical activity can allay many of the symptoms of hopelessness and worthlessness, feelings typically associated with anxiety and depression. Involvement in physical activity not only counteracts these negative affective responses, but can instead create expectations of success. It is particularly important to facilitate regular participation in physical activity given that anxiety and depression are prevalent among adolescent females."

Physical activity or exercise should be considered as one possible strategy in community programs to prevent depression. Community wide programs and community recreational resources, including both built facilities and natural spaces, can be of interest in efforts to reduce the impact of depression.

Additional Resources:

Bibliographic resources:

< Blair, SN., and Morrow, JR., Jr. (Eds.).

1998. Theme issue: Physical activity interventions. *American Journal of Preventive Medicine* 15(4).
- < Centers for Disease Control and Prevention, and the Associations of State and Territorial Directors of Chronic Disease Programs, Health Promotion and Public Health Education, and Public Health Nutrition. 1997. *How to Promote Physical Activity in Your Community*. Atlanta, GA: Centers for Disease Control and Prevention. [Contact: Chris Kimber, at (651) 281-9875, chris.kimber@health.state.mn.us MDH Health Education Unit.]
 - < Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. *Ready. Set. It's Everywhere You Go*. Atlanta, GA. [This physical activity promotion kit includes video and audio public service announcements (PSAs), camera-ready art, and a guidebook with information about marketing strategies, working with the media, and developing programs and events. Contact: Chris Kimber, at (651) 281-9875, chris.kimber@health.state.mn.us. MDH Health Education Unit.]
 - < Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. 1997. *Unrealized Prevention Opportunities: Reducing the Health and Economic Burden of Chronic*. Atlanta, GA: Centers for Disease Control and Prevention, at www.cdc.gov.
 - < National Cancer Institute, Office of Cancer Communications. 1989. *Making Health Communication Programs Work, A Planner's Guide* (NIH Publication No. 89-1493). Bethesda, MD: National Institutes of Health.
 - < President's Council on Physical Fitness and Sports. 1997. *Physical Activity and Sport in the Lives of Girls*.
 - < U.S. Department of Health and Human Services. 1996. *Physical Activity and Health: A Report of the Surgeon General*. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion.
 - < U.S. Department of Health and Human Services. 1993. *Promoting Healthy Diets and Active Lifestyles to Lower-SES Adults, Market Research for Public Education*.
- Organizational resources:
- < American Association of Retired Persons (AARP), at (202) 434-2277, <http://www.aarp.org>, 601 E Street, NW, Washington, DC 20049.
 - < Fitness Fever Website, at <http://www.fitnessfever.com>.
- Evidence for strategy:**
- Physical activity appears to have therapeutic benefits and may be able to reduce the risk of depression (USDHHS, 1996). The literature reviewed in the latest report of the Surgeon General on physical activity and health (1996) supports the concept that physical activity has a beneficial effect in relieving symptoms of depression and anxiety and improving moods. There is some evidence that physical activity may protect against the development of depression, although further research is needed to confirm these findings. Worldwide research and demonstration projects designed to test community wide health promotion and disease prevention strategies to promote regular physical activity have shown that public information is a critical component of changing a

community's behavior and improving community health status. These projects include such research programs as the Minnesota Heart Health Program. Measurement of physical activity has varied across studies, making comparisons difficult. The presence of public information campaigns used in conjunction with active community coalitions, widespread community involvement, and well-organized community efforts appear to be important in increasing physical activity levels.

Has this strategy been implemented in Minnesota?

The extent to which this strategy has been implemented in Minnesota is unknown. However, a number of local public health agencies and other community organizations conduct physical activity promotion events or informational opportunities for a variety of target audiences. They work with local media to provide information for, and to gain coverage of, local health promotion events related to physical activity programs, including Fitness Fever.

Indicators for this strategy:

- < Availability of public recreational facilities in the community.
- < Annual number of visits to public or private recreational facilities.
- < Number of people who report engaging in regular low-to-moderate physical activity.
- < Number of people who report feeling sad, blue, or depressed 14 or more days in a month and who engage in regular low-to-moderate physical activity.
- < Number of physical activity programs, events, or informational opportunities conducted.
- < Number of people reached with programs, events, or informational

activities.

- < Number of people participating in event activities.
- < Number and content of articles published, as well as the circulation of those publications.
- < Number of times PSAs are played, as well as their estimated reach.
- < Recognition, understanding, or implementation of messages, as measured in surveys or interviews.

For more information contact:

- < Chris Kimber, at (651) 281-9875, chris.kimber@health.state.mn.us. MDH Health Education Unit.
- < MDH Nutrition and Physical Activity Unit, (651) 281-9875.

Strategy: Educate professionals and the community to recognize suicide-warning signs, to respond appropriately, and make referrals to treatment and necessary supports.

	Systems	Community	Individual
Primary	U	U	U
Secondary	U	U	U
Tertiary	U	U	U

Background:

Through school, community, worksite and professional education, many individuals can be supported and receive assistance in remaining safe and preventing risk for suicidal behaviors. Health and social services professionals and community members can learn about the indicators for suicidal behaviors and play a critical role in encouraging individuals to seek assistance, support and treatment.

This includes becoming knowledgeable about community resources and learning what one can do to respond appropriately to someone exhibiting suicidal behaviors. Professionals in a variety of settings can be alert to key behavioral indicators and learn to respond quickly, be supportive and available, and monitor individuals' well-being over time. These include educators, public and private health care providers (especially emergency departments), social service providers, youth workers, and ministers in faith communities.

Additional resources:

Bibliographic resources:

- < O'Carroll, PW., et al. 1992. *Youth Suicide Prevention Programs: A Resource Guide*. Atlanta, GA: U.S. Department of Health & Human Services, Public Health Service, Centers for Disease Control.
- < Richman, J. 1993. *Preventing Elderly Suicide*. New York: Springer.
- < U.S. Department of Health and Human Services. 2001. *National Strategy for Suicide Prevention: Goals and Objectives for Action*. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, at <http://www.mentalhealth.org/suicideprevention/strategy.asp>.

Organizational resources:

- < American Association of Suicidology, at <http://www.suicidology.org>.
- < Light for Life Foundation/Yellow Ribbon, Mankato, MN, at (507) 387-5020.
- < Mental Health Association of Minnesota, Phone: (612) 331-6840, 2021 Hennepin Ave. E., Minneapolis, MN.
- < Suicide Awareness Voices of Education, at <http://www.save.org>.

Evidence for strategy:

Multiple studies have shown that public and professional education can achieve several objectives, all of which are necessary for taking action. These objectives include: increasing knowledge of a topic or issue, which is accomplished by providing objective and pertinent information to the public; increasing the awareness and importance of taking action; skill-building to take action appropriately; and influencing community attitudes about the issue or problem.

Has this strategy been implemented in Minnesota?

Yes, many professional and community groups, social services and public health agencies, schools, businesses, and faith communities in Minnesota conduct ongoing education and training for professionals and community members.

Indicators for this strategy:

- < Number and type of community educational programs and events.
- < Number and type of professional educational programs and events.
- < Number of community residents participating in these programs and events.
- < Number of professionals participating in these programs and events.
- < Change in knowledge and attitudes among participants.
- < Change in practices of professionals as a result of educational programs and events.

For more information contact:

Candy Kragthorpe, at (651) 281-9833, candy.kragthorpe@health.state.mn.us, MDH Mental Health Program Coordinator.

Strategy: Improve reporting and portrayals of suicidal behavior, mental illness and substance abuse in the entertainment and news media.

	Systems	Community	Individual
Primary	U	U	
Secondary			
Tertiary			

Background:

The entertainment and news media heavily influence public perceptions and behaviors. Research indicates that media portrayals of suicide, both news accounts and fictional, may increase rates of suicide, particularly among adolescents. Modifying the representation of suicide and issues related to mental health and substance abuse may not only decrease the suicide rate but also combat stigma and reluctance to seek mental health treatment.

Additionally, communities and organizations can monitor local media coverage, develop and disseminate “press information kits” and curriculum resources for schools of journalism. A number of organizations have published media and entertainment recommendations and guidelines (see below for references).

Additional resources:

Bibliographic resources:

- < American Foundation for Suicide Prevention, American Association of Suicidology, Annenberg Public Policy Center. *Reporting on Suicide: Recommendations for the Media*, at <http://www.asc.upenn.edu/test/suicide/web/3.html>.
- < CDC-AAS (Centers for Disease Control- American Association of Suicidology)

Media Guidelines, at

<http://www.suicidology.org/displaycom mon.cfm?an=1&subarticlenbr=22>.

- < *Media Coverage of Suicide: Examples of Appropriate and Problematic Reportage*, at <http://www.mentalhealth.org/suicideprevention/newsroom.asp>.
- < U.S. Department of Health and Human Services. 2001. *National Strategy for Suicide Prevention: Goals and Objectives for Action*. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, at <http://www.mentalhealth.org/suicideprevention/strategy.asp>.

Evidence for strategy:

The strategy is recommended in the *National Strategy for Suicide Prevention: Goals and Objectives for Action*. While there is no clear evidence that the above strategy will change the portrayal of suicides and suicidal behavior, there is evidence indicating a link between portrayals and suicide rates.

Has this strategy been implemented in Minnesota?

Yes, MDH and some community-based agencies have conducted studies and are monitoring media portrayals and responding to media vendors with media recommendations.

Indicators for this strategy:

- < Numbers of media portrayals of suicide, suicidal behavior, mental disorders, and substance abuse that reflect national media recommendations.
- < Numbers of partnerships with media vendors to increase positive and accurate messages regarding suicide, suicidal behavior, mental disorders, and substance abuse.

- < Numbers of media associations and newspapers with reporting policies and practices addressing suicide, suicidal behavior, mental disorders, and substance abuse that reflect national recommendations

For more information contact:

Candy Kragthorpe, at (651) 281-9833, candy.kragthorpe@health.state.mn.us, MDH Mental Health Program Coordinator.

Strategy: Promote and enforce suicide means and methods restrictions, including limiting access to firearms, promoting safe storage of firearms, and encouraging use of trigger locks.

	Systems	Community	Individual
Primary	U	U	U
Secondary	U	U	U
Tertiary	U	U	U

Background:

Suicide means and methods restrictions refer to all common ways of committing suicide, including firearms and medications. Access to firearms is strongly associated with suicide. By decreasing access to more lethal means, a suicide attempt may be more likely to be delayed or benefit from medical intervention.

A strategy all families may employ is the *Home Safety Checklist*, developed and made available through the MDH (see below). Also, extensive educational and promotional efforts on the safe storage of medications (e.g., locked medicine cabinets), firearms, and ammunition (stored separately), and the distribution and use of trigger locks can be

implemented through the media, schools, and health and social services.

Additional resources:

Bibliographic resources:

- < O’Carroll, PW., et al. 1992. *Youth Suicide Prevention Programs: A Resource Guide*. Atlanta, GA: U.S. Department of Health & Human Services, Public Health Service, Centers for Disease Control.
- < Sloan, JH., et al. 1990. Firearms regulations and rates of suicide. *New England Journal of Medicine* 322, 369-373.

Organizational resources:

- < Minnesota Department of Health, Injury and Violence Prevention Unit. Copies of the *Home Safety Checklist for Young Children*, the *Home Safety Checklist for Older Adults*, the *Home Safety Checklist Inspector’s Guide*, and the *Home Safety Checklist Program Summary: 1989-1994* are available for a nominal fee. Contact: (651) 281-9858.

Evidence for strategy:

The *Home Safety Checklist for Young Children* includes questions on the safe storage of firearms and has been carefully evaluated. Originally pilot-tested in four counties in 1990, it was re-evaluated in 18 counties in 1994. The *Home Safety Checklist for Older Adults* includes questions on the safe storage of firearms and of medications. It was field-tested in 1998 in three counties as part of a pilot project. The checklists were found to be effective in identifying the inappropriate and risky storage of firearms and medications.

Has this strategy been implemented in Minnesota?

Yes, in 1997, there were over 100 agencies in Minnesota that used the *Home Safety Checklist for Young Children* including public health, Early Childhood Family Education (ECFE), Head Start, and other home visiting programs. It was used by 75 public health nursing agencies in the state, 35 of which used their MCHSP funding for the program. The *Home Safety Checklist for Older Adults* is used in the Living At Home Block Nurse Program in 13 neighborhoods in the Twin Cities. Additionally, firearms safety education programs are conducted throughout the state.

Indicators for this strategy:

- < Number of schools and health and social service agencies that offer education on the safe storage of firearms and ammunition.
- < Number and type of messages in the community about the use of trigger locks.
- < Ways that the safe storage of medications is promoted in the community.
- < Age of the person firing the weapon in firearm-related injuries (or incidents).
- < Estimates of firearms carried by children or youth on school or other public property.

For more information contact:

Candy Kragthorpe, at (651) 281-9833, candy.kragthorpe@health.state.mn.us, MDH Mental Health Program Coordinator.

Strategy: Increase awareness of the mental health disparities between children with special health needs and their typical peers.

	Systems	Community	Individual
Primary			
Secondary	U	U	U
Tertiary			

Background:

The Minnesota Student Survey is offered to students in the sixth, ninth and twelfth grades in Minnesota’s public schools every three years. Participation is voluntary as well as anonymous. In 1998 there were 133,794 surveys returned.

In 1998, the Survey, for the first time, included the question “Do you have a mental or physical condition or other health problem that has lasted at least 12 months?” Students responding “Yes” represented 12% of the adolescent population. The disparities in responses between this group and their same-aged peers on items indicating social, emotional and behavioral health are striking.

Summarized below are the results of the 1998 Survey pertaining to children with special health needs:

- < 23 percent of the students with special health needs report feeling almost more stress or pressure than they could take. This compares to 11 percent of the students who do not identify themselves as having special health needs.
- < 22 percent to 32 percent, depending upon grade or gender, of the students with special health needs felt “quite a bit” to “extremely” discouraged or hopeless at some point in the 30 days preceding the survey. This compares to

findings of 9 percent to 16 percent for their same aged peers.

- < 13 percent of the students with special health needs report having tried to kill themselves in the last year. 4 percent of the students without special health needs report having tried to kill themselves in the last year.
- < 62 percent of 6th grade boys with special health needs have been physically assaulted on school property compared to 49 percent of their peers without special needs.
- < Students with special health needs are at three times the risk of non-familial sexual abuse than their healthy peers.

This special population needs to be identified by teachers, social workers, school nurses, school counselors, physicians, and parents as being at high risk for having serious social and/or emotional concerns.

Service providers need to include health and disability status as a factor in existing efforts directed toward eliminating unfair or biased treatment based on ethnicity, gender, race and sexual orientation.

Positive developmental assets need to be fostered in children with special health needs. Frequently, school programming, as well as other interventions, are “deficit directed” and the child’s positive attributes are overlooked or not capitalized upon. The result may well be that the child may not feel he or she has attributes that are “good.” The child’s family may be discouraged from emphasizing the positives in their family member’s life by the constant focus on negatives.

Families of children with special health needs require information as well as encouragement to help their child and themselves plan for the future. Knowing what is possible, and receiving the tools to carry out thoughtful planning will direct activities towards a positive future for both the family and the child.

For related strategies, see “Early Identification” in the *Child and Adolescent Growth and Development* category.

Additional Resources:

- < *The ASQ/SE User’s Guide: A Parent Completed Child Monitoring System*, Brookews Publishing Company, First Edition, 2001.
- < Minnesota Student Survey, 1998. Contact your local public health agency, or your local school district for more information.
- < *Search Institute: 40 Developmental Assets*. 1997. Available at: <http://www.search-institute.org/>.
- < Ohio State University Press Release *Study Finds Characteristics that Identify Bullies and Victims*, 5/19/97.

Evidence for the Strategy:

There are tools available for assessment of children’s social and/or emotional strengths. One that is designed for infants and young children is the ASQ/SE (Ages and Stages Questionnaire), which is available through the Follow Along Program administered by County Public Health programs in 84 of Minnesota’s 87 counties and two reservations.

Has this strategy been implemented in Minnesota?

Yes, the ASQ/SE is being utilized by several Follow Along programs in Minnesota. All Child and Teen Checkup programs review mental health issues as appropriate.

Indicators for this Strategy:

- < Numbers Reduce the difference in responses between children with special health needs and their peers who have no special health concerns on the Minnesota Student Survey.

For more information contact:

MDH, Minnesota Children with Special Health Needs program, at (800) 728-5420 or (651) 215-8956 (metro).