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President's New Freedom Commission on Mental Health: Campaign for Mental Health Reform Suicide: A National Priority March 29, 2006

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MICHAEL HOGAN, Ph.D.: I will just say, as we are doing this, this is to make a transition between the challenges faced by returning veterans and the problem of suicide. We have just heard, in Michael Pelkey's story, how strong the connection is. Science is pretty clearly established now that those kind of extraordinary stressors that men and women might face in combat have the same effect on the brain as stressors that are faced by other victims of extraordinary trauma, whether it is rape or sexual abuse, and therefore how this extraordinary need that has been spoken of so well here – that is faced by members of the military who are exposed to these stresses - is faced by a much broader segment of our nation as well, many of whom do not have access to a system of care, that although the VA system may be deficient is more integrated and more comprehensive than that available to many other individuals who wrestle with these challenges.

So this is indeed a good transition and introduction to our next panel, which will focus on suicide and suicide prevention. I was just reflecting, as Stefanie was talking, of a statistic that I carry around in my mind that illustrates the scope of this problem, which is that, in my one state of Ohio, since the War in Iraq began, we have lost as many lives to suicide as all the military casualties faced by our nation's military in Iraq. Some of those deaths by suicide are deaths

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like Michael Pelkey's, of people in the Guard, as well as in active duty, who have been over there, come back and have not been able to live with the wounds, as Stefanie put it, that they have suffered.

We have got an extraordinary panel here as well and I think I will just, once again, introduce them in order and then ask you to proceed. We start with a presentation from Marley Prunty-Lara, who is one of our nation's leading young mental health advocates, as so many young people are these days, wrestling with the challenge of bipolar disorder since she was 15 years old, and obviously wrestling with it, given her presence here today, with a good deal of success, yet at the same time, drawing from that challenge to speak out to educate others, including policy makers, about the depth of these problems.

Marley will be followed by Dr. Arias, who is the director of the National Center for Injury, Protection and Control at CDC in Atlanta, who is a clinical psychologist, very well published, in areas that are closely related to this, particularly in the areas of intimate partner and family violence.

Dr. Arias will be followed by Jerry Reed, who is the executive director of the Suicide Prevention Action Network, probably the foremost advocacy entity nationally, advocating about suicide and suicide prevention efforts. Jerry brings

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work on he Hill to this effort, having served as deputy chief of staff for Senator Harry Reid before he moved into the arena of suicide prevention.

And finally, we are pleased to have with us Calvin Nunnally, who is on the frontlines directing suicide prevention programs for the State of Virginia in the Department of Health in Virginia. And in that effort, he both coordinates a statewide network of trainers to talk about these issues, but also gives considerably of his own time to train people about the risks of suicide and suicide prevention. We are really happy to have this panel to educate us about the scope and dimension and challenges of suicide.

Marley, let me welcome you and turn this over to you to start us off.

MARLEY PRUNTY-LARA: Hello. Thank you for this opportunity to share my experiences. As both a young person with bipolar disorder, and as a suicide attempt survivor, speaking before you today, I am a testament to the power of medicine, perseverance and personal resilience.

Some of you may be surprised to learn that I live with a mental illness. What I want to impart to you is that with the help of others, I am effectively managing and controlling my illness. As 21, I am successfully attending college at the University of Minnesota in Minneapolis. I devote many hours as a volunteer advocate for those with or at risk of mental

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illness.

Just a few short year's ago however, a mental illness controlled me and nearly claimed my life. My struggle did not begin with the diagnosis of bipolar disorder at age 15; rather, it was merely made more evident. By the time I was diagnosed, I was already lost and consumed by the quest to find my voice and control my madness. Not having my bipolar disorder under control was like knowing I was dead and still breathing.

No matter how hard I tried, I felt this illness-induced mania, sucking the life out of my body and forcing me to stay awake and watch. My manias were unrelenting. Hours would be lost to extravagant shopping sprees and my mind would race with grandiose ideas of helping the world. Then I would crash, falling deep into depression, only to begin the cycle again. Suicide, seductive in its power to seem rational and plausible, often felt like the only way to stop both the physical and psychological pain I endured as a result of my illness. For me, suicide was not about dying, it was about attempting to rid myself of my disease.

As a Mexican-American growing up in South Dakota, a rural state with limited resources, I often felt alone in my struggle with bipolar disorder. I would scour magazines, books and the internet, hoping that being the first one didn't mean I was the only one. Being the first one at my high school known to have a diagnosis of bipolar disorder, I often struggled

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against other's opinions that my illness wasn't real. I struggled to maintain ties to my school in the face of inpatient hospitalizations and unavoidable absences.

Despite federal and state requirements intended to enable me to get the help I needed to succeed in school, I became the first one – the only one – of my high school friends to drop out of school. I was so disabled by my illness that by my junior year, my loan option for attending school was a special education classroom, located on the same floor as the mental health ward of a local hospital. The stigma I experienced as a result of that option left me with what felt like little choice. I became a high school dropout.

For me, dropping out of high school meant giving up on a dream I had focused on during my darkest of days. Rather than feeling as if my school system had failed to adequately meet my needs, I felt as if I had failed to meet their expectations. The hardest part, knowing I was smart enough to graduate high school and ill enough for that goal to be unattainable.

In my struggle for survival against my disease, I not only had to overcome the racing thoughts and ominous lows, but I also had to rise above the seemingly endless obstacles in order to attain adequate health care. As suicide became an evermore enticing option for me, my mom searched for a psychiatrist available to treat me in South Dakota. We were

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told we would have to wait four to five months before I could get an initial appointment. I did not have that long to live.

I found help 350 miles away, in another state and was hospitalized for two months. However, the residential treatment facility was not covered by my mother's insurance, forcing my parents to take a second mortgage out on their home in order for me to receive the care I urgently needed to stay alive. After returning home, I again struggled to maintain continuity of care. That struggle continues today.

My story is not unique. In advocating for improved access to mental health care, I have met many amazing people from both rural and urban America, who share similar stories of struggling, not only to live with a mental illness, but also to find and afford adequate care. In rural states like South Dakota, where shortages in the number of practicing psychiatrists, available hospital beds and community services, continue to exist.

Most who suffer from mental illnesses do not take the proactive steps to wellness that my family and I have taken. I was fortunate that my family had the option of mortgaging their home in order to be able to afford the care I desperately needed. Many do not have such options and if they have any health insurance, routinely face discriminatory insurance barriers that deny them the coverage necessary for recovery.

The desperation that exists in places like my home

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state, was evidenced to me when I participated on a panel, televised statewide on South Dakota Public Broadcasting. In a large portion of South Dakota, PBS is the only station people receive in their homes, particularly on the Reservations. During the call-in portion of the program, I was struck by the number of people who called from the least populated and most underserved portion of our state. They called looking for answers and for hope. Many recognized the symptoms I described, in their family member's friends and sometimes themselves. Even after the show had aired, my mother and I received calls from those with limited resources, wanting what I have achieved for their loved ones.

I have come to understand the moral obligation we have as citizens to not only care for, but also to empower, the most vulnerable around us. As I have reflected on the question of obligation, I believe it is vital that we continue to heed the words, findings and recommendations of the New Freedom Commission on Mental Health. Perhaps its most important message for me is this: Our nation must make mental health a real priority. Surely we can do no less, as we consider that mental illness claims more than 30,000 lives annually. And, as the Commission highlighted, that loss is a largely preventable public health problem.

I came perilously close to suicide and I fear that. But for a dedicated family with the financial means to assure

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that I got needed treatment, I may have succumbed to my illness. My own experience is powerful evidence that with effective treatment, a person with bipolar disorder can lead a full, healthy, successful life. Recovery should not be something only the lucky experience.

Thank you for allowing me the privilege of telling my story. Let it not end with me. While bringing awareness to this issue is an important step, it is not enough. More direct and immediate action, such as the passage of comprehensive mental health parity at the federal level must be taken. Millions are waiting. [Applause]

MICHAEL HOGAN, Ph.D.: Marley, thank you. On the contrary, we are privileged to listen to you. And I think that one thing that I will say before we move to other members of the panel, is that those of us in our generation have a great deal of optimism about the courage and competence of people in your generation, who are much more upfront about this than, frankly, we are or were. And maybe based on your example, much less willing to take "no" for an answer. We feel that the future is in good hands, which is your hands. Although, we would like to turn it over to you a little better than it is functioning right now. [Laughter]

I think to help us understand the depths of the problem, as I said before, we are privileged to have Dr. Ileana Arias with the CDC, who will give us a primer of the realities

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of suicide in America.

ILEANA ARIAS, Ph.D.: Thank you Mr. Chairman, members of the Commission, Marley and my fellow panelists. Suicide is a significant threat to the health of Americans and CDC is committed to preventing it in the same way that it addresses other issues in order to meet its mission, which is essentially to promote wellness and to protect the health of Americans.

We essentially address suicide very similar to the way that we do with more traditional CDC concerns, such as infectious diseases. And that is, we are very careful to monitor the problem, find out as much as we can so that we can develop effective strategies for the prevention, and then once they have been discovered, engage in widespread dissemination and education in order to be successful in those prevention efforts.

What I would like to do today is basically highlight some of the activities that we have been supporting and developing in an effort to prevent suicide at the CDC – those involving essentially data collection and monitoring of the problems, some advances in intervention, evaluation and research, and then focus on where it is that we would like to go in the future in order to improve on the work that we have accomplished in the past.

Unfortunately, it is the case that injuries generally are the number one cause of death for Americans between the

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ages of 1 and 44. And although the majority of those deaths are associated with motor vehicle crashes, violent-related death and suicide specifically, are a significant concern. In fact, it is the second cause of death for individuals in America between the ages of 25 and 34.

In 2003 in the United States, there were more than 31,000 people who died by suicide. In order to put that in context, I would like to point out that that's about 85 people a day. It is about three to four people every hour who are dying by suicide and in fact it is approximately the population of the Yukon territory dying by suicide. We have a significant problem.

Not only do we have a significant number of people who are dying by suicide every year in the United States, we also have individuals who are hurting themselves, non-fatally, but suffering in myriad ways as a result of those self-inflicted wounds. Over 410,000 people were treated in emergency departments for suicidal behavior. Again, to make those numbers real, it is the equivalent of about four to five division I football stadiums filled with fans. That is the problem that we are dealing with and we are trying to prevent.

I would like to focus a little bit about data collection methods, in that in order for us to be effective in the prevention of suicide; we have to learn about individuals who engage in suicidal behavior, individuals who die by

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suicide. We have to find out who they are and how they got to where they are so that we can then design and implement programs in order to prevent future occurrences of those behaviors.

We essentially are interested in finding out about suicidal ideation. We are interested in learning about non-fatal suicides and then of course, death by suicide. And the data systems that we are primarily relying upon are the Youth Risk Behavior Survey, the National Electronic Injury Surveillance System and the National Violent Death Reporting System. And I will talk a little bit about each of those in turn.

The Youth Risk Behavior Surveillance System is a national school-based survey of high school students. That is grades 9 through 12 and it is conducted every two years. In 2003, which is the latest most recent information that we have, 17% of our high school students – 17% of our children in grades 9 to 12 - reported that they had seriously considered attempting suicide. Seventeen percent of our children reported making a specific plan to attempt suicide. And unfortunately, nine percent of our kids actually attempted suicide in that year.

The National Electronic Injury Surveillance System, or NEISS, is a surveillance system that relies on emergency department data. It generates information from a

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representative sample of hospitals across the United States. In the year 2000, self-inflicted violence module that we use in that system, indicated that there were 264,000 non-fatal self-inflicted injuries; 60% of those were probable suicides. These are individuals who wanted to hurt themselves, who intended in killing themselves. Most of these injuries we know are the result of poisonings and then cutting and piercing.

We have, in 2003, expanded the assessment that is done in NEISS, for suicide and getting additional information. We are specifically getting additional information about the characteristics of individuals who are self-inflicting injuries and also trying to track information about substances that are being used and access to substances in the home for self-infliction of harm. And we hope to be able to use the information that we have been traditionally gathering from NEISS and then, more recently, in the expansion of this new module to guide intervention efforts.

Finally, I would like to share a little of the information that we gather through our National Violent Death Reporting System. This is a system that was begun in the year 2002. We eventually would like to have such a surveillance system in all 50 states and all territories in the United States. Currently, we are only able to support the existence of this system in only 17 states.

Essentially what the surveillance system does is it

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links information from police, coroner, medical examiner, crime labs and death certificates, to gather as much information as we can, again, in one source, on all violent related deaths in the United States, including suicide and firearm deaths.

The novelty of the system is that we can get information significantly quicker than we ever have on violent deaths, and not only are we able to get then a more complete picture of what is going on in the United States in any given year, since we have expanded the elements that are available in that report, but in addition, we get the information soon enough that we can start detecting the possibility of changes in trends – that is, increases – and be able to intervene before those become real.

Some of the information, not surprisingly, from the National Violent Death Reporting System, is that almost half of the deaths that are being captured are suicides. And in fact, this comes from the first six states that we funded and most of those states have been using the information that is being generated by NVDRS to engage in suicide prevention planning in their states. Again, one of the things that it is being used to suggest is that suicide is a significant problem and more of a problem than people even had hypothesized prior to the release of these data.

I would like to draw your attention also to the 25% of deaths that are being quoted as undetermined. One of the

things that we are also trying to examine and get more information is the extent to which, with the proportion of those deaths, that should be classified as suicides or that were suicides that are not being classified that way by coroners and medical examiners for a number of different reasons.

The NVDRS also supplies information on the characteristics of decedents in those situations and then of the circumstances surrounding those deaths. As you can see here, again, for the initial six states that we funded, over 38% of individuals who were categorized as dying by suicide, were depressed at the time of their death. Approximately 40% also had a current mental health problem. A significant proportion of those - the preponderance of those individuals having been reported as having a major depressive disorder.

Over 50% were currently being treated. There also was a high rate of mental illness in the history of these individuals, and unfortunately, consistent with other literature that is available, alcohol and substance abuse being significant problems. We also have information suggesting the kinds of stressors that are risk factors for suicide, not surprisingly, relationship disruption being a significant one of those. And by relationship disruption, we mean either the death of a close other or relationship dissolution.

All the information that we gather, whether it is

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NVDRS, the YRBS, NEISS, or any other system, we try as much as we can to translate that into programs that can be used that we can support and that others can support for the prevention of suicide. The work that we do, all of the research that we support in the development of those programs – and currently the research that we are supporting in terms of prevention of suicide – is primarily focused on identifying one of the most effective ways of preventing suicide.

One of the most exciting developments in that work that we have supported is a very innovative approach to the prevention of suicide, developed by Dr. Aaron Beck at University of Pennsylvania. Most of us who have been trained in mental health, most of us who have been trained to deal with suicide, often times treat suicide as a symptom or an outcome of another condition. We treat the primary condition, whether it is depression, schizophrenia, bipolar disorder or something else, as a way of having an impact on depression.

The program that has been developed and shown to be significantly effective, rather than seeing suicide or suicidal ideation and behavior as an outcome, it treats it as the primary symptom – the primary concern in the individual. Essentially, the focus of the treatment is on coping and finding alternative ways of responding to suicidal behavior, without necessarily referring to any preexisting or any other underlying conditions that may account for those faulty coping

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mechanisms.

What these researchers have been able to show is that approach has been significantly more effective than treatment as usual – that is, both medical treatments and psychological treatments for individuals who have presented at emergency departments subsequent to an attempt to kill themselves. As you can see, these are survival rates. Individuals who have been treated in this new way are significantly more likely to be alive 18 months after participating in treatment than individuals who have been treated with usual care.

One of the things that we are very interested in doing now – we are actually supporting this application of this program in a community setting – want to see the extent to which the same significant effects of this program that were gathered or that were accomplished in a controlled laboratory setting, could actually be accomplished in a naturalistic community health setting.

In addition, we are also very excited in the future of exploring this as a possibility of engaging in primary prevention of suicide. The program has been developed and has been applied to individuals who have already attempted suicide, who would like to see the ability of using this program as a way of dealing with suicidal behavior and suicidal ideation prior to attempts.

In addition to this research, we also have been

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interested in helping others identify what are effective ways of preventing. We are collaborating with SAMSA – with the Substance Abuse and Mental Health Services Administration – and expanding the evaluation of three programs that are being supported by the Garrett Lee Smith Memorial Act. We are primarily interested in documenting exactly what is being implemented in those programs, how it is being implemented, the impact and the idea is to be able to document exactly what was done so that if the impact is favorable, we can then duplicate that in other settings. The choice was made, again, given our interest and our mandate, to choose programs that are addressing primary prevention of suicide as much as possible and taking more of population-based approach to prevention than an individual approach.

In conclusion, we know that suicide is a critical public health issue. We need better data to prevent suicidal behavior. We need to know more about what individuals are thinking and what leads them to make a choice to hurt themselves. In addition, and what we need that data for, is to be able to develop and support effective interventions for the prevention of suicide.

One of the areas that we would like to do a little bit more of and where we are moving to in the future – and sort of concurrent with some of the work that we are doing – is addressing social norms, essentially addressing the stigma

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associated with suicide. We can collect a lot of information. We can develop a lot of programs. The information is only good to the extent that we actually get it from individuals and the programs are only effective to the extent that they are implemented and actually supported.

One of the things that we are interested in doing is using the expertise that CDC has developed in other areas in health communications to address how it is that people are thinking about suicide, not just in terms of themselves, but in a community setting. We want to make sure that communities are willing to address the issue of suicide prevention, support the programs that are necessary in order to prevent suicide. And then we also want to be able to change norms about suicide so that individuals do not feel any hesitation in accessing whatever services and resources are available to them in the event that they start experiencing suicidal ideation.

We are hoping, and we are learning from the experiences that the Air Force had, in changing the culture with which suicide was addressed and in changing the culture of how suicide was responded to, not only by service providers and command, but by also individuals who are experiencing those symptoms. Thank you very much. If there are any questions that I can answer, I would be more than happy to do that, either now or later, as the Chairman sees fit.

MICHAEL HOGAN, Ph.D.: Thank you Dr. Arias. I am sure

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there will be questions when we conclude the panel. I will say that the numbers about suicide, whenever they are brought forward, are really stunning. People have no idea that this takes many more lives than murder and then that the lives that are lost are only the tip of the iceberg, given the attempts that are made and so on. To have CDC begin to connect these dots with respect to data and to look at accidents and injury reports and so on and knit those things together, is really a wonderful step.

This is one of many areas in health care, and probably in mental health care, where the real leadership to begin to make change – and we have only begun – actually came from survivors and people who had direct experience, not from us professionals. We hope that we are starting to catch up, but in that context, it is particularly nice to welcome here from Jerry Reed, the executive director of the Suicide Prevention Action Network.

JERRY REED, M.S.W.: Good afternoon Chairman Hogan, fellow commissioners and fellow panel members. My name is Jerry Reed and I am the executive director of the Suicide Prevention Action Network USA, otherwise known as SPAN USA. SPAN is the nation's only suicide prevention organization dedicated to leveraging grassroots support among those who have lost a loved one to suicide and to advance public policies that help prevent suicide.

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The organization was created to raise awareness, build political will and motivate action for a national strategy to address the prevention of suicide. Since SPAN USA was founded in 1996, grassroots volunteers and staff have worked in communities, in state capitols and in Washington, DC to advance our public policy goals.

In our work over the past decade, we have found the issue of suicide is not one that is easily acknowledged. In part, because many people do not realize how widespread it is. It is estimated that each day, 85 Americans die by suicide and another 1600 make suicide attempts. This translates, as Dr. Arias said earlier, to 31,000 suicides per year and 650,000 suicide attempts. More people die by suicide in the U.S. each year, than by homicide. But it is homicide that captures attention. No one hesitates to devote resources to reduce homicide rates, but the stigma and silence surrounding suicide masks the dire need for suicide prevention strategies.

But while there is much to be done to address the public health problem of suicide, it is heartening to see the progress that has been made over the past few years, including the Commission's report to the President. Although the data is yet to be published, I would like to share with you the results of a new *Parade* Research America health poll that was supported by SPAN USA and others.

Ninety-two percent – ninety-two percent of Americans

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strongly agree or somewhat agree that mental health services are fundamental to overall health. Eighty-nine percent feel that mental health and physical health are equally important. When asked, "What is treated with greater importance?" 66% report that physical health is treated with more importance and only 24% believe that mental and physical health are treated with equal importance.

And for the first time this year in our survey, Americans were asked if they agreed or disagreed that with appropriate research, interventions and services, many suicides and suicide attempts could be prevented. Seventy-eight percent agreed or somewhat agreed that many suicides and suicide attempts can be prevented. Thus, Americans confirm our current commitment to suicide prevention is on track and we must continue our efforts to provide help for those who struggle.

I would like to thank the Commission for highlighting the importance of suicide prevention in your report to the President. Specifically, I applaud Objective 1.1, which recommends the advancement and implementation of a national campaign to reduce the stigma of seeking care and a national strategy for suicide prevention. Your recommendation has inspired much needed action across the nation. Since the report was issued, a series of regional suicide prevention conferences around the country enabled every state to bring together members of suicide prevention coalitions to plan

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effective strategies for addressing suicide. Today, all but a few states are actively engaged in suicide prevention efforts. Whereas, a decade ago, only a handful were.

Additionally, the nation's hotline continues to serve those in crisis. By simply dialing a 1-800 number, a caller is seamlessly connected to the closest certified crisis center. The National Suicide Prevention Resource Center, appropriated by Congress and administered by SAMSA, continues to assist communities and states in developing and implementing suicide prevention programs and strategies and is working to advance the capacity of the workforce to prevent suicide through awareness and training.

Just this year, 22 colleges, 13 states and one tribal organization received the first ever youth suicide prevention and early intervention grants under the Garrett Lee Smith Memorial Act, Public Law 108-355. I am pleased to report that the appropriations bill for 2006 – this program was fully funded – fully funded – at 27 million dollars, which will allow our National Resource Center to increase its capacity and allow additional states and colleges to receive funding for youth suicide prevention and early intervention.

The Commission made two specific recommendations that I will comment on briefly. First, the Commission urged swiftly implementing and enhancing the national strategy for suicide prevention to serve as a blueprint for communities and all

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levels of government. This plan continues to receive attention nationally. In addition, a large number of states have used this plan as a model to develop their own plan for suicide prevention. Many state programs are receiving funds now, either from their own state legislatures or through federal grant initiatives.

The Commission also recommended forming a national public-private partnership to advance the goals of the national strategy for suicide prevention. This voluntary public-private partnership would involve local community, business and education leaders and representatives of the faith community to address suicide prevention at the grassroots level.

SAMSA recently announced that as part of its mental health agenda, the Department of Health and Human Services will launch this public-private partnership at the national level. What is more, Congress affirmed in its support by including language about the public-private partnership in the fiscal year 2006 Labor/HHS appropriations bill. So as you can see, I think we are moving in the same direction for the right reason.

SPAN USA will do everything it can to support SAMSA's launch of the partnership in the coming months. This partnership, the Action Alliance for Suicide Prevention, will provide a unique opportunity to focus attention on the national strategy by defining priorities, ensuring that appropriate individuals and organizations are engaged, and by monitoring

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and reporting on progress and success in achieving objectives.

As an advocate who has been active in suicide prevention for many years, I am encouraged by our progress, but recognize that much more needs to be done. The Commission's report has helped underscore the role of the national strategy for suicide prevention. Now it is incumbent upon all of us in this room today to do all we can to ensure that the strategy is implemented and its objectives achieved.

We are still in the early stages; we are removing stigma, challenging barriers and obtaining mental health care coverage are essential. We must take concrete steps to remove the stigma associated with seeking help and address the inequity that exists between coverage for physical and mental health care. How, for example, can we allow our Medicare program to have a policy that requires a 50% co-payment for mental health care, and only a 20% co-payment for physical health care? [Applause] Considering that older adults have the highest rate of suicide among all age groups, it appears we are not connecting all the dots. This type of discrimination in our health care insurance programs must be rectified. Many suicides are preventable. There are treatment and services, and it is in our national interest to help those in need.

As Dr. Arias said, our data collection systems must also be improved. We must support expansion of the National Violent Death Reporting System, which allows us to link several

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data systems to keep us better informed about the circumstances surrounding violent deaths, including suicide. And we must promote research and encourage the implementation of programs and interventions that have proven effective.

Suicide is a national problem and it will take all of us working together to achieve the goals of the national strategy. No one commission, no one branch of government, no one state, and no one individual can prevent suicide alone. Rather, the national government, state governments, survivors, advocates, clinicians, researchers and the private sector must all do their part to help us make progress.

Let me share just a few examples of how groups are working together to advance the cause of suicide prevention. SPAN USA works with many federal and state partners, foundations and organizations, such as the National Council for Suicide Prevention, the Campaign for Mental Health Reform, the Mental Health Liaison Group, the National Coalition on Mental Health and Aging, and many others, to ensure that the topic of suicide prevention is part of our national dialogue and included in our nation's mental health reform agenda.

This kind of collaboration has resulted in some major developments. For example, in recent weeks, a landmark conference on suicide prevention amongst indigenous communities was held in Albuquerque, New Mexico. I attended and learned a great detail. In October 2005, for the first time, a national

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conference brought together professionals, advocates and those who have attempted suicide to ensure we learn more effective ways to prevent suicide. And in December of 2005, one of the top 10 resolutions at the White House Conference on Aging addressed the mental health needs of older adults, an important advancement, given that elderly males have a very high rate of suicide.

As you can see, the dialogue is active, and from this dialogue, action will follow. Therefore, I urge all of us in this room today to commit to doing all that we can individually and collectively to, one, end the discrimination between mental health and physical health coverage offered through our health care insurance programs. Health is health and without mental health, full health evades us all.

Two, eliminate the stigma associated with mental illness and help seeking by encouraging and supporting national awareness campaigns that promote health and help seeking. Three, urge Congress to provide full funding for the Garrett Lee Smith Memorial Act in the coming year and target attention to other high-risk populations as well. Four, ensure that the National Strategy for Suicide Prevention serves as our national blueprint and is fully implemented and supported at both federal and state levels of government. And five, ensure accountability from all of us – from those entrusted with advancing suicide prevention efforts. We must report on

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progress and take steps to make our delivery systems more person-centered with a focus on recovery.

Working together over the past decade, we have made real progress in suicide prevention. By continuing this partnership on all levels and formulating the public-private partnership to oversee advances, I am really confident that we will implement the 11 goals and 68 objectives of the National Strategy for Suicide Prevention and achieve our ultimate goal of saving lives.

Thank you for the opportunity to speak with you this afternoon. And thank you again for your leadership on suicide prevention. [Applause]

MICHAEL HOGAN, Ph.D.: Jerry, thank you. It is really helpful to me anyway, and I am sure to the rest of us, to hear you illustrate an area where we actually are making real progress. And it really is gratifying. At the same time, as all these things need to happen, I am struck by the length that comes back to Marley's testimony and to what Stefanie Pelkey had said – how the thoughts of suicide or considering it, is an act that is often private or it takes place in families and therefore, the challenge of reaching out to everybody who might be able to intercept this is an extraordinary challenge.

The leadership in doing that, I think it has to start at the national level, but it is really carried out at the state level. So we are really pleased to hear from Calvin

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Nunnally, Sr., who leads those efforts in the State of Virginia.

CALVIN NUNNALLY, SR.: Thank you Mr. Chairman, former commissioners. My name is Calvin Nunnally and I am the suicide prevention manager with the Virginia Department of Health. I would like to thank the Campaign for Mental Health Reform for inviting us today just to share a few thoughts about what is going on in Virginia and sort of give an idea of probably what is happening in a lot of states as a result of recent initiatives.

In Virginia, we actually lose one teenager every week to suicide. In 2004, the latest year for which data are available, there were 805 suicides in the Commonwealth, or about two suicides per day, for an adjusted rate of 10.8 suicides per 100,000 persons. Suicide was the eleventh leading cause of death among all Virginians and the third leading cause of death for youth between the ages of 10 and 19. Almost twice as many youth die from suicide in Virginia as compared to homicides.

The Virginia Department of Health provides leadership, resources and training to allow communities to provide suicide prevention awareness and response training and public awareness activities to decrease the number of self-inflicted injuries and deaths due to suicide. As with everything, funding turns out to be a very important issue. And we are no less immune to

that in Virginia.

At the time the suicide prevention plan was proposed, the Virginia Department of Health and the Department of Mental Health/Mental Retardation and Substance Abuse Services were allocated a whopping $75,000 each to provide suicide prevention activities. The original estimate to implement the youth suicide prevention plan was actually $800,000. Due to the much smaller amount allocated to VDH, the agency restricted its implementation of the plan's recommendation to the delivery of gatekeeper training – suicide prevention awareness training – and development and dissemination of youth suicide prevention information throughout the Commonwealth.

At that time, the Department of Mental Health had part of a full-time equivalent staff person to coordinate its efforts around developing a network of trainers, providing training to community service boards, and supporting a statewide conference on youth suicide prevention. As a result of budget reductions, the $75,000 that was allocated to the Department of Mental Health was reduced to $21,000. And I have to pause when I say that.

This limited the activities of the youth suicide prevention activity greatly at the Department of Mental Health – that goes without saying. In addition to General Assembly funding, the Virginia Department of Health received federal funding for youth suicide prevention through a targeted injury

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cooperative agreement from the Centers for Disease Control and Prevention. This program began in 2002 and provided $900,000 annually for three years. This funding has enabled the Virginia Department of Health to have one full-time equivalent staff position to manage its suicide prevention program and to evaluate its youth suicide prevention training, provide funding and technical assistance to suicide crisis centers and provide public awareness campaigns to target communities.

Funding under the Garrett Lee Smith Memorial Act, which Virginia received $4,000 annually for three years, is a key component enabling Virginia to enhance existing statewide infrastructure for youth suicide prevention early intervention and to establish four geographic pilot areas in the state to become models for youth suicide prevention early intervention.

This funding will help ameliorate the deficiencies in Virginia's youth suicide prevention system as enumerated in both of the Commonwealth suicide prevention's plans. This funding will also enable Virginia to take its prevention efforts to the next level, developing prevention, early intervention models beyond simply providing training on the early recognition of warning signs to ensuring a continuum of care that extends to completed recovery.

Suicide prevention trainings have traditionally been a large part of Virginia's initiatives. Prior to funding under the Garrett Lee Smith Memorial Act, suicide prevention training

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was the core suicide prevention strategy utilized by the Virginia Department of Health. Two gatekeeper training models are used: Question, Persuade, Refer – QPR – is a session designed to be presented in one to three hours and is suitable for general audiences of just about anyone interested in suicide prevention. People trained in QPR learn how to recognize the warning signs that a person may be having thoughts of suicide and how to question, persuade and refer that person to help.

Applied Suicide Prevention Skills Training Assist is a full two-day training, usually taken by professionals and other caregivers, such as counselors, social workers, nurses, crisis line workers and others who may become directly involved in the treatment of the one who is potentially suicidal.

As of November 2005, over 94% of the state's school divisions have hosted one or both of the training models. Nearly 1,000 QPR and 630 Assist sessions have been provided. To date, nearly 50,000 people have been trained in one or both of the gatekeeper training models.

VDH is able to complete so many training sessions because it has a statewide network of over 300 individuals who are certified as QPR and Assist gatekeeper trainings. In June 2005, we actually – in order to meet demand or to keep pace with demand – had to train an additional 26 certified trainers. I am in the process currently of training an additional 26

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trainers. And that training will occur this coming June.

Dr. Hogan, you also mentioned that it was incumbent upon states to make the public aware or to de-stigmatize help seeking. And that is something that we have been really working at in the Commonwealth. We do that by providing various public awareness campaigns with brochures, with radio, with television. Annually, the Department of Health distributes over a quarter of a million brochures to human service providers. We provide many of these to schools and with agencies that work in after school programs with schools. We have several brochures that we distribute on a regular basis. On any given week, I will send out 2,000-3,000 of these to schools and other agencies that request them.

We have a brochure that is aimed directly at teens. It is called *What Are Friends For: Suicide is Not the Answer.* We have a brochure called *Depression: Learn the Facts*. As you have heard several times, it is really difficult to talk about suicide without seeing the word "depression" come into the conversation. We have a brochure called *Young People and Suicide: What You Should Know.* One called *What Every Parent Should Know About Preventing Suicide*. And another, *What Every Teacher Should Know About Preventing Suicide.* And as I said, these are distributed annually to the tune of about a quarter million brochures.

Additionally, each year we distribute about 6,000

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copies of the revised State Board of Education Suicide Prevention Guidelines. We have reprinted those each year and continue to distribute those to schools. The Department of Health also maintains updated information on activities related to youth suicide prevention, as well as links to national prevention resources on its www.preventsuicideva.org website.

In 2005, as in previous years, that we contracted with the Virginia Association of Broadcasters to air two times each year, in May generally and in September, suicide prevention radio spots aimed at teens. The 30 and 60-second spots were produced by the American Foundation for Suicide Prevention and have four basic messages. One, that suicide is a serious public health problem; that suicide is a preventable public health problem; that there are things that can be done to contribute to suicide prevention. We also make available the suicide prevention hotline number – 1-800-273-TALK. The national suicide number is given repeatedly during these messages.

I am currently in the process of negotiating contracts to air those spots again in June of this year and in early August. And we try to time those at a time when teens are out of school, when they are most likely to hear the radio messages.

We also realize at the Department that in order to have these initiatives have a lasting effect, they must be sustained

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at the local level, far beyond any grant funding or anything else that is occurring. So we contract each year with the local crisis centers – and we have five that we work with in Arlington and Dumfries and Lynchburg and Bristol and in Norfolk – to provide training and other region-specific suicide prevention activities designed to promote awareness, education, resource sharing and linkages with mental health and substance abuse services.

In 2005, these contracts provided for the development of community awareness events, hosted by the local crisis centers and generally attended by anywhere from 75 to 100 people per session. And these attendees represented a variety of individuals and organizations from local communities in an effort to inform them about suicide as a public health problem and to garner support for local suicide prevention initiatives. The events featured keynote speakers, prevention breakout sessions and presentations by prevention specialists, as well as suicide prevention gatekeeper training themselves.

Collaboration with community groups interested in suicide prevention continues to be a strategy in Virginia's program. In many areas, what began as local coalitions have grown to be really the hallmark of suicide prevention activities at the local level, and we continue to develop these coalitions. In fact, it is really uplifting because most of them are started at the suggestion of just local citizens who

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want to reduce suicide. In fact, one such coalition which is very active now in Bedford County, Virginia, was started by a retired teacher and when we met, she told me simply, "I am simply tired of reading about my students committing suicide and we want to do something about it." The coalition has been up and running for two years and has just done a lot of marvelous things in terms of suicide prevention in the local communities and we are very pleased that that continues to happen.

Virginia has also developed and presented to the state legislature a Suicide Prevention Across the Lifespan Plan. Although we emphasize youth suicide prevention, we realize that it is a problem that exists across the lifespan and we want to make sure that those in the middle of the continuum, and those at the very end, are not neglected. So suicide among the elderly is something that is very important to us and something that we take very seriously.

In conclusion, our program in Virginia continues to provide leadership through public and professional awareness building, gatekeeper training, supporting communities in their prevention efforts and funding reasonable suicide prevention initiatives through local suicide crisis centers. By sustaining public awareness about suicide and suicide prevention, youth suicide service providers who are in a position to identify those youth at risk of suicide, providing

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counseling and referral, self-inflicted injury and loss of life due to suicide, can be greatly reduced. As mentioned above, funding provided by the Garrett Lee Smith Memorial Act will enable Virginia to extend its prevention efforts to the communities located within the four pilot sites and eventually set the standard for suicide prevention early intervention initiatives throughout the state, which can be sustained well into the future. I thank you for your attention. [Applause]

MICHAEL HOGAN, Ph.D.: Thank you Mr. Nunnally. I really am heartened again. I would like to say on behalf of the Commission for all these presentations, to see that this is an area where we really are starting to make some progress. And I think that what Virginia is doing is probably a benchmark in terms of what other states are doing, but it is challenging. There is so much to do at the same time.

We know from the evaluation of the Air Force's program, which reached every person in the command structure and involved a tremendously broad effort, that something like a 40% reduction in suicide was achieved and we have a way to go to reach that benchmark. Although it is also interesting to note that that program received about a 50% reduction in DUIs and about a 50% reduction in domestic violence reports so we know that these issues are interrelated.

I would like to ask my fellow members if they have questions for the panel. Yes, Judge Lerner-Wren.

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JUDGE GINGER LERNER-WREN: First of all, to all the panelists, this is an issue that I do recall that when we were collapsing, prioritizing and trying to really frame where to begin, obviously this and the anti-stigma issues was felt twofold. One, I think I can speak on behalf of the Commission that obviously they were significantly compelling of import, first and foremost. And secondly, I think there was a shared consensus. I hope it was a shared consensus that of all of the overarching goals that we framed out, that quite frankly, this one was probably one of the ones that we would get ahead of the curve on sooner, if you will, than many of the other noted goals, simply because the action could be quicker. It did not necessarily take legislative types of coordination and action and all of that. So really compelling, I have to say, in terms of the need to really get out front on this issue.

I too join Mike in terms of sharing the relief that we have come so far. But I also have to share, on a personal note, that since the issuance of the report of the Commission, I really felt, quite frankly, that we could have, similar if you will, to the campaigns against domestic violence. Even in terms of our understanding, I think our consensus now, the awareness of the effects, if you will, of bullyism [misspelled?] in school that certainly our education could have, I think, come further, come more swift in terms of

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reaching and just educating the public. And easy, if you will, simplified models of campaigning like we have done in terms of domestic violence. I do not think there is anybody now, whether it be in the court system, in the public health system, in the community anywhere who does not understand what domestic violence is, that it crosses over all strata and that it is a significant, unacceptable problem in this country. I think we really could get much further, if you will, in terms of the issue of suicide if we just start to really act.

The studying, I have to tell you, are significantly important. The data, the population relationships, the linkages – all of that are absolutely important. But I just really feel we have to start the conversations. We have got to start the dialogues. We have to talk about it and start to desensitize our children and our parents and our family so that they could all be on the lookout. I do not think that takes a lot of data to start the conversation on the ground and in the schools and in the beauty shops and in the pediatrics' offices and wherever else we are at the dinner table, as uncomfortable as those conversations, quite frankly, could be. I do it every single day in the courtroom. When I am doing my particular mental health division, I say is loud and I say it clear and I ask the question to every individual I see and that is, "Have you thought and/or attempted to hurt or kill yourself?" We have got to ask the questions and we have got to be brave

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enough to speak the talk instead of keeping it locked up in taboo.

The other point that I wanted to raise that has not been raised - we talked about it somewhat during the Commission, but I think it is relevant. And that is the interface with corrections, the interface with law enforcement and how suicide attempts are treated within our jails and prisons. We recognize very, very well - certainly within the framework of the Commission of the criminalization problem; obviously the tragedy in our country with mental illness. I can tell you firsthand that the treatment of individuals within the jails and prisons of our country who speak or threaten suicide are absolutely draconian. They are stripped, they are isolated, they are placed on often times steel bedding and really borderline, if you will, in terms of the kinds of inhumane way to address issues of suicide within our correctional systems. And so within the framework of the campaign, I hope that the criminal justice sector - law enforcement and correction's medical services - are integrated in those conversations.

CALVIN NUNNALLY, SR.: Might I comment on that Chairman? That has been a real integral part of what we have done in Virginia. In fact, two week's ago, I personally did a training with the staff at a juvenile detention center. On the 14th, I will train about half of the staff for the Department of

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Corrections Education. We have an interagency board and we have people from corrections, from law enforcement, on those boards.

One of the things that we are really pleased about with the funding from the Garrett Lee Smith Memorial Act is that our plan is to move – I mentioned in my paper – beyond just gatekeeper training and we want to connect all of those dots, with law enforcement, with people who respond on the scene, first responders, emergency medical services people, emergency rooms, in each of the coalitions that we have started in the communities, we began almost immediately with the clergy, law enforcement and the school system people. Because we realized as we looked at what was going on in local communities, that the dots were not connected; that people did not respond properly.

My dad was a police officer and I knew how he would respond to a suicidal person and I do not want that to happen to any person. Because I know what he would say, "You want to use my gun?" And that is what we are trying to do. We have actually done this training with all of the police officers in the City of Lynchburg. We try to train as many police officers, as many juvenile probation people we can because we realize that they are a factor in the equation as well, and that is something that we are really working on.

MICHAEL HOGAN, Ph.D.: Thank you. I think we had a

comment from Dr. Fisher and it will be the last word. The break is starting now, but we won't actually take it until we hear from you. [Laughter]

DANIEL FISHER, M.D., Ph.D.: This is going to be a very short comment if the break is starting now. [Laughter] First of all, I want to thank you all very much. I was particularly moved by Marley, your presentation. I would like to say that hope is really a central aspect in combating suicidality [misspelled?]. The more people that can speak about their recovery and the more the system is transformed to give hope, the less suicidality, I think, will be pervasive.

I give one little vignette. I was in Oregon a few month's ago, and there was a 13-year old boy in the audience, right in the front row, and I could see him fidgeting around and I was not sure whether he really wanted to be at the talk. I was talking about recovery. I was talking about some of my own recovery and recovery of other people from mental illness. After their break for lunch, his mother came back and said, "My son really got a lot out of your talk." She said, "He has been suicidal since he was 10, when he was first diagnosed with bipolar disorder. This was the first time he heard that he could recover. It is the first time that he heard that he could have a future."

So the transformation of our system and suicide prevention are really interrelated. And I hope there will be

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more integration of the suicide prevention aspects with the overall transformation in the mental health system, so that they are not seen as parallel tracks. But they are very, very closely related. I hope that every mental health official, every mental health practitioner will give hope, despite a diagnosis of mental illness and they will say, "Yes, this is a very severe problem that you have, but you have a future and I will introduce you to other people who have been through it and they will show you through peer support and self-help that you can have a future, as well as through treatment."

MICHAEL HOGAN, Ph.D.: Dan, thank you. That is an extraordinary statement. I think to end on, I want to add one item to this because it was mentioned in the presentation and because the meeting here is going to be webcast and possibly somebody watching it will be thinking and wondering what they are going to do with their future. To repeat the number that has been established for the National Suicide Prevention Hotline, which is, 1-800-273-TALK. If you are watching this on the computer and have any of these concerns about yourself, please call that number.

We will take a short break. Let's be back at 3:45 to hear another area of inspiring progress, which is looking at health and mental health issues in the workplace. Thank you very much for members of both of our first two panels.

[Applause]

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