

**SUICIDE AWARENESS AND
PREVENTION**

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BEFORE A
SUBCOMMITTEE OF THE
COMMITTEE ON APPROPRIATIONS
UNITED STATES SENATE
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SUICIDE AWARENESS AND PREVENTION

TUESDAY, FEBRUARY 8, 2000

U.S. SENATE,
SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN
SERVICES, AND EDUCATION, AND RELATED AGENCIES,
COMMITTEE ON APPROPRIATIONS,
Washington, DC.

The subcommittee met at 9:30 a.m., in room SD-192, Dirksen Senate Office Building, Hon. Arlen Specter (chairman) presiding.
Present: Senators Specter, Reid, and Wellstone.

OPENING STATEMENT OF SENATOR ARLEN SPECTER

Senator SPECTER. The hour of 9:30 having arrived, the Subcommittee on Labor, Health and Human Services, and Education will proceed with this hearing.

Our subject today is suicide awareness and prevention. The hearing has been convened at the special request of our distinguished colleague, Senator Harry Reid, who has had a personal family involvement with the matter and offered a Senate resolution which called for a national suicide prevention strategy.

Suicide certainly is a major problem in the United States, claiming some 31,000 lives annually, contrasted with homicide which claims 20,000 victims. There is a very high incidence among juveniles and it is an issue which has not been adequately addressed either in terms of national awareness or a strategy for prevention.

Dr. David Satcher, our distinguished Surgeon General, has done extensive work in the field, as has Dr. Steven Hyman, Director of the National Institute of Mental Health. And the Surgeon General's recommendations last year in a Call to Action listed some 15 recommendations focused on the general topics of awareness, intervention and methodology.

We have, in addition, a distinguished panel of scientists, and we have Ms. Danielle Steel, best-selling novelist, whose 19-year-old son committed suicide in 1997, and Ms. Jades Smalls, first runner-up to the 1999 Miss America Pageant. So, the combination of our witnesses provides both a scientific background and the so-called human face on the problem to create awareness which should lead to a strategy for prevention.

We have a very long list of witnesses, and we are going to have to conclude the hearing shortly in advance of 11 o'clock this morning because this is a very crowded schedule. Our custom is to allow witnesses to testify for 5 minutes. Our professionals, Dr. Satcher and Dr. Hyman, are used to that even though they bring learned

treatises with them for insertion into the record, but they are masters of the summary at this point in their professional careers.

I know a number of my colleagues will be joining us in due course, but we will proceed at this time because of our tight schedule and commitments.

STATEMENT OF DAVID SATCHER, M.D., Ph.D., ASSISTANT SECRETARY FOR HEALTH AND SURGEON GENERAL, OFFICE OF PUBLIC HEALTH AND SCIENCE, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Senator SPECTER. Our first witness is Dr. David Satcher, 16th Surgeon General of the United States, only the second person in history to simultaneously hold the positions of Surgeon General and Assistant Secretary of Health. Before joining the administration, he was president of Meharry Medical College of Nashville, Tennessee for more than a decade, 1982 to 1993.

The biographical sketch does not include the observation of Dr. Koop who said that the Surgeon General was the only individual who was both a general and an admiral.

I think you prefer the title Dr. Satcher, and the floor is yours.

Dr. SATCHER. That is fine. Thank you.

Thank you very much, Senator Specter, for this opportunity to testify and for holding this very important hearing on suicide.

Let me just say, as you have pointed out, that suicide is, indeed, a very serious public health problem in this country. It is the eighth leading cause of death and the third leading cause of death among youth and young adults. The highest rate of suicide is among men, in fact, men over 75 years of age.

But it is important to point out that suicide is a problem that affects all ages, all races, and all ethnic groups. For example, while it was once thought that suicide was not a problem with African Americans, very clearly that is not true and has never been true. The rate of suicide in young black males has doubled between 1980 and 1996. So, the concern for suicide in all of our populations, I think, is a very real one.

As you pointed out also, most people are surprised to hear that for every two people who are killed by homicide in this country, three people take their own lives.

I think the stigma that is associated with suicide has kept us from addressing this issue directly until now, and that is why this hearing is so important.

I want to thank people like Dr. Kay Jamison and especially Elsie and Jerry Weyrauch and SPAN, Senator Reid, and other members of your panels today who have been willing to speak out about their own tragic experiences. And I know it has been painful because I have heard from many survivors of suicide the struggles that they go through. So, their willingness to speak out and to provide leadership is really making a difference in this area.

The Nation is now engaged in an open dialogue on suicide, and through this hearing we hope to gain a better understanding of the public health problem, but also to gain support for completing a national suicide prevention strategy.

The national strategy that we are proposing is closely linked to international efforts. Work by the World Health Organization, the World Bank, and the Harvard School of Public Health produced

data in 1996 pointing out that mental health problems were the second leading cause of disability and premature deaths in the world for industrialized countries, the second, second only to cardiovascular diseases. WHO called on countries throughout the world to develop strategies to address the problem of suicide.

Because of this and because of the backing of organizations like SPAN, we called a meeting in Nevada in October 1998 to look at the problem of suicide, and we called together experts in the field, clinicians, survivors, and advocates to spend 3 days in Reno, Nevada discussing this problem. As a result of that, we developed the Surgeon General's Call to Action for Suicide Prevention.

Basically, the recommendations in the Call to Action are divided into three areas.

One, we think it is critical that we increase the awareness of suicide in this country as a first step toward de-stigmatization, and not only suicide, but the awareness of the mental health problems which lead to suicide. So, a major set of recommendations relate to increasing awareness.

The second area is intervention. We believe that there are tremendous opportunities to improve the services and the programs in this country that could lead to a reduction in suicide. These are programs to enhance the mental health infrastructure, which starts with educating people in general.

The third category is methodology. We believe that we must continue to advance the science of understanding of suicide but also of suicide prevention.

So, out of this Call to Action, we have been busy within the Department. A team of people have been working over the last several months developing recommendations for a national strategy. There are at least 20 States in the country that are working on plans for their own strategy for suicide prevention. We have been able to visit many of these States, many local programs in the country, and people are working very hard to develop strategies.

Of our recommendations, we believe the most important one is this recommendation for the development of a national strategy that actually calls for a public/private partnership. It calls for not a Federal program but a national program, a program in which we relate to different levels of government, but we also look to communities throughout this country and organizations in communities like churches and schools and fraternities and criminal justice programs and others to work together to develop the infrastructure requirement for a prevention program.

There are two basic approaches.

One, we have to reduce the barriers to the effective identification and treatment—

Senator SPECTER. Dr. Satcher, I am sorry to interrupt you, but we are going to have to observe the time very meticulously. So, if you would finish your current thought, we are going to move on.

Dr. SATCHER. OK.

This is the Surgeon General's report, mental health report, and basically it recommends reducing the barriers to effective identification.

The second this is CDC is funding many efforts and partnering with many groups for suicide prevention using a model that has been used by the Air Force that has been very successful.

PREPARED STATEMENT

So, we are recommending, of course, that we move forward. We have a meeting scheduled in March of outside experts to meet with us and give their input, and then later in the year we will have a major meeting of partners throughout the country to see where we are. We hope by the end of the year to be prepared to present a recommendation for a national strategy for suicide prevention.

[The statement follows:]

PREPARED STATEMENT OF DAVID SATCHER

Chairman Spector, Senator Reid, I am pleased to be here today to participate in this historic hearing, advancing the discussion of suicide prevention in America.

Suicide is a serious public health problem. It results in over 30,000 premature deaths each year. In 1997, the most recent year statistics are available, suicide was the eighth leading cause of mortality in the United States and the third leading cause of death among youth and young adults [10–24 year olds]. Men aged 75 years and older actually had the highest rate of suicide of any group. Indeed, suicide is a national problem that affects people of all ages, races and ethnic origins.

When we compare the incidence of suicide with that of homicide, most people are surprised to learn that suicide is by far the greater killer. In fact, for every two deaths by homicide in the U.S. there are three deaths due to suicide. And if a person dies by a firearm, that death is one-third more likely to have been a suicide than a homicide.

Because of the stigma too long associated with mental illness and suicide, we, as a nation, have been reluctant to talk openly about this threat to our health and well being. We owe a great debt of gratitude to concerned individuals, such as: Dr. Kay Redfield Jamison, author of *Night Falls Fast*; important groups such as SPAN, the Suicide Prevention Advocacy Network, and its founders Elsie and Jerry Weyrauch; you, Senator Reid, as a leader on this issue in the Senate; and to many others who have stepped forward to speak out about their own personal loss to suicide; and more importantly, to take action to prevent loss of life due to this terrible killer. I am extremely pleased that we are now engaging in an open national dialogue on the issue of suicide. The goal of the discussion, of course, is an outcome we all desire—measurable and significant decreases in deaths and suffering due to suicide and suicidal behavior—decreases which will be sustainable over the long term.

I trust that through this hearing today, we will all gain a greater understanding of the scope of suicide as a public health problem and garner significant, official, and broad support for the work of completing a National Suicide Prevention Strategy.

WHY A NATIONAL SUICIDE PREVENTION STRATEGY?

Our goal of developing a National Strategy is linked closely with international suicide prevention efforts. In 1996, the World Health Organization, recognizing that mental illness, including suicide, ranks second in the burden of disease in established market economies, urged member nations to address suicide [WHO document: "Prevention of Suicide: Guidelines for the Formulation and Implementation of National Strategies."] In the past few years, Australia, Denmark, Finland, Norway, Sweden, New Zealand, and the UK have developed national suicide prevention strategies. The WHO has established its own suicide prevention task force to encourage national policies promoting suicide prevention around the world and to evaluate WHO efforts to reduce mortality associated with suicide. This progress in the international community has contributed momentum to the considerable efforts already underway in our own country.

We now understand that many suicides and intentional, self-inflicted injuries are indeed preventable. Just over six months ago, I issued a National Call to Action to Prevent Suicide. In that Call, I introduced a blueprint for addressing suicide represented by the acronym A-I-M, which stands for Awareness, Intervention, and Methodology.

—"Awareness" signifies our commitment to broaden the public's awareness of suicide and its risk factors.

—“Intervention” means we will enhance services and programs, both population-based and clinical care to reduce suicide.

—And “Methodology” compels us to advance the science of suicide prevention.

Awareness, Intervention, Methodology—AIM—this framework for suicide prevention stems from work begun through a significant public-private partnership involving the Department of Health and Human Services, which brought together researchers, clinicians, survivors and advocates, and various federal and state agencies in Reno, Nevada, a little over a year ago. Empowered by that first-of-its-kind meeting, grassroots organizers—many of whom are suicide survivors—have joined with state public health officials and others in at least 20 states to begin planning state level prevention efforts. Many are now working with their state legislatures in the appropriations process for these programs.

I can think of no other issue with which I’ve been involved that has produced so large and so positive an outpouring of public support. Since issuing the Call to Action, countless people have spoken or written to me, sharing their grief from their own experiences with suicide and telling me how they are getting involved in the suicide prevention movement.

I think it is critically important for those of us working this issue at the Federal level to fully appreciate this passionate groundswell for suicide prevention. Today, we have a tremendous opportunity to provide national leadership that will guide this outpouring of energy to productive ends.

The AIM blueprint identifies 15 key recommendations that will do just that. Perhaps the most important of AIM’s recommendations is the mandate to complete a comprehensive National Suicide Prevention Strategy. It is this comprehensive Strategy that will direct the Nation at the federal, regional, state, tribal, and community levels to a collaborative, comprehensive, coordinated response to suicide.

Our National Suicide Prevention Strategy will outline a conceptual framework and courses of action to guide, promote, and support culturally appropriate, integrated programs for suicide prevention among Americans.

I should stress that a National Strategy is not a federal-only or even a federally-driven project. To the contrary, a National Suicide Prevention Strategy must foster the myriad public-private partnerships necessary for effective suicide prevention in every community. We envision a Strategy that will define and produce an infrastructure that supports communities in their prevention efforts through consultative services, sharing of best practices, data gathering, and perhaps most important, program evaluation. With these supports in place, community level agencies and organizations will collaborate in new and more effective ways to mitigate the risk factors associated with suicide, as well as strengthen putative factors that protect people from suicidal risk.

Research shows that many people who kill themselves have a mental or substance abuse disorder, or both. For this reason, removing the stigma associated with mental illness and its treatment must play a central role in the Strategy. In December, I released “Mental Health: A Report of the Surgeon General”, the first report ever released by a Surgeon General addressing mental health. The report identified critical gaps between those who need mental health services and those who actually receive them. It also identified significant gaps between optimally effective treatment and what many individuals receive in actual practice settings. Clearly, we have much work to do to remove the barriers to optimal mental health service delivery in the United States.

Suicide has multiple intersecting causes and risk factors, so effective prevention programs must be comprehensive in addressing individual, family and community-level factors. It will require engagement by dozens, and in some instances literally hundreds of stakeholders in each community: schools, faith-based groups, social and housing services, law enforcement, justice, youth and civic organizations—just to name a few. In addition to reducing risk factors, these community agents will play significant roles in enhancing the protective factors to which I just referred. These protective factors may be those pertaining to the individual, like resilience, resourcefulness, help-seeking, respect, and nonviolent conflict resolution skills, or those pertaining to communities, like interconnectedness, social support, and social services.

We now have one example of a large-scale community-based program that appears to have been successful in reducing suicides. For the past five years, the United States Air Force has consciously promoted these protective factors among Air Force members and the Air Force community. During those same five years, the suicide rate among airmen has declined each year, from 16.4 down to 5.6 per hundred thousand—a decline of over 65 percent. The 1999 suicide rate in the Air Force was 40 percent lower than any level recorded in the past two decades, and about one-fourth the national suicide rate when corrected for age, sex, and race. Similar declines did

not occur in the other military services. We need to evaluate this program further to understand the contribution of its various components.

CDC, working closely with states, communities, universities, partners in the private sector and others, has contributed in a number of areas to improve our understanding of suicide prevention efforts such as this one. For example, CDC is supporting the development of a suicide-prevention research center that will describe the magnitude of suicidal behavior, promote research, and identify prevention activities. In addition, CDC has funded two suicide prevention evaluation projects: one to enhance awareness, increase utilization, and assess the efficacy of telephone crisis intervention services for teenagers and the other to develop intervention services for adults over 65. CDC has also conducted a study of nearly lethal suicide attempts to investigate, among other things, the role of alcohol use and abuse, the results of which indicate that alcohol use within the three hours before an attempt are important risk factors for suicidal behavior.

SAMHSA, through its Centers for Mental Health Services and Substance Abuse Treatment, is providing grants to schools and community organizations that have provided a plan to build consensus around and pilot an evidence-based program to promote healthy development and prevention of youth violence, including suicide. Last year funds were granted to 40 such organizations across the country. A new Guidance for Applications (GFA) will be out this spring for School Action Grants that will have a special emphasis on the prevention of youth suicide.

By coupling public health interventions with disciplined research in the primary prevention and treatment of mental illness, we can reasonably expect to prevent premature deaths due to suicide throughout the life span, while reducing other suicidal behaviors, such as attempts and gestures, as well. And consequently, we will reduce the trauma these suicidal behaviors inflict upon families, friends and others in significant relationships with the suicide victims. But it will do still more. I believe investments in suicide prevention are really investments in human and social capital. The social scientists teach us that these investments produce wide-ranging dividends throughout society and achieve improvements in overall function, resiliency, safety and health that would not otherwise be possible.

At this point, I'd like to talk about the progress we are making toward completing the National Strategy. Since releasing the Call to Action, a cross-cutting team of suicide prevention experts from several agencies within the Department of Health and Human Services has mapped out a systematic process that will ensure timely completion of the strategy. With leadership from SAMHSA, we will be bringing together the most knowledgeable people from outside the federal government to work with our DHHS team on the issue. These are experts with vast experience in not only suicide prevention, but also the clinical and social sciences, criminal and juvenile justice, public policy, business, and occupational health. Their primary responsibility will be to help translate the 15 recommendations in the Call to Action into specific goals and measurable objectives. Following this, a process to gather inputs from major stake-holders at the national, state, and local levels will identify activities to ensure each objective is achieved. At every step, we will draw on the collective expertise and wisdom of persons from many backgrounds and life experiences: scientists, prevention experts, survivors, program planners and evaluators, consumers of mental health services, justice experts, clinicians, public health leaders, educators, social services professionals, and religious leaders. Diversity among prevention partners should produce a Strategy that ensures continued investment and collaboration throughout the implementation phase. I am proud to tell you that we are on schedule to have a strategy ready for the American people before the end of this calendar year.

Before I conclude, I should point out that most of the activities in the National Strategy will be implemented at the community level through existing structures. Settings such as schools, workplaces, clinics, physician's offices, correctional and detention centers, eldercare facilities, religious institutions, recreational centers, and community centers are natural venues for integrated suicide prevention activities. In fact, in many communities, several of these formal agencies are already committed to preventing suicides. The National Strategy will ensure each of these community components assumes an effective role in preventing suicides, and does so in a fashion that is tailored to the unique characteristics of their community. When this happens, we can expect further improvements in health and well being to emerge in every segment of the American population. I believe this collaborative community effort will have an exponential effect; that is, the overall improvements in community health will be far greater than the sum of the contributions of the individual agencies, programs, or interventions.

Am I optimistic? Yes, I am. We are witnessing a convergence of research, practice, recognition, political will and strong grassroots commitment that has the potential

to produce historic public health breakthroughs in suicide prevention. Since the mid-90's, we are seeing small but steady declines in suicide rates among some of our highest risk populations: males, both Caucasian and African-American, among both the elderly and youth. Interestingly, these declines appear to be almost entirely attributable to declines in firearm suicides. Still, nearly 60 percent of all suicides are attributable to firearms, and in men over 65, that figure is an astonishing 77 percent. These small declines in suicide rates, though encouraging, pale in comparison to the steep increases seen between 1980 and 1996 among young males, when for instance, the suicide rate among black males aged 15-19 increased 105 percent.

I would like to conclude by saying that the time is right—the opportunities are plentiful. The National Suicide Prevention Strategy will chart the course for the fruitful collaboration of government, advocates, communities and families, energized by the opportunity to realize what for many has been a long-cherished dream—real and sustainable decreases in the devastating consequences of suicide in our society.

Thank you Mister Chairman, Senator Reid, and members of the committee. Again, it is very gratifying to be participating in this hearing today. This concludes my remarks.

Senator SPECTER. Thank you very much, Dr. Satcher.

STATEMENT OF STEVEN HYMAN, M.D., DIRECTOR, NATIONAL INSTITUTE OF MENTAL HEALTH, NATIONAL INSTITUTES OF HEALTH, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Senator SPECTER. Our next witness is the distinguished Director of the National Institute of Mental Health, Dr. Steven Hyman. He has a bachelor's from Yale, masters from Cambridge, an M.D. from the Harvard Medical School. Prior to coming to NIMH, Dr. Hyman was professor of psychiatry at the Harvard Medical School and director of psychiatry research at Massachusetts General.

I might note that the increase for the National Institute of Mental Health went up by some more than \$123 million to an excess now of \$633 million. In the last 3 years, Senator Harkin and I have taken the lead to add more than \$5 billion to NIH funding, and yesterday we introduced a resolution with many cosponsors to raise National Institutes of Health funding by some \$2.7 billion. We believe NIH is the crown jewel of the Federal Government. That may be the only jewel of the Federal Government.

Dr. Hyman, the floor is yours.

Dr. HYMAN. Mr. Specter, you even understated the number that you have been generous enough to give us. We now have a budget, including AIDS research, of about \$975 million, and for that we thank you and your colleagues for your support and we hope to be worthy of that.

I also want to thank you because it was clear in a series of meetings that you conducted last year that you have taken an important role in putting such subjects as youth suicide and youth violence in the proper public health context, and this is very much appreciated.

I also want to thank David Satcher who is the first Surgeon General to take these issues with this kind of very important seriousness, and it is a privilege to be here with him.

We are all going to talk a little bit about the numbers in suicide, but they are absolutely staggering. I have put up a chart here just charting youth suicide rates because my colleague here emphasized, just due to the time, rates in the elderly.

But what you can see is that since the mid-1960's rates of youth suicide have doubled until they have more recently plateaued, and since the 1950's—the chart just was not long enough—rates of youth suicide have actually tripled. It is now the case that among

youth suicide is responsible for more than two times as many deaths as all natural causes combined. So, this indeed is an enormous national tragedy and national public health problem.

I also want to acknowledge Senator Reid who, of course, has had an enormous impact on our suicide focus.

In addition, in some populations, such as Alaska Natives and some Native American tribes, the suicide rate among youth is 10 times the national average, so there are some extraordinary problems here.

Now, suicide is a complex phenomenon. We know—and I am not going to dwell on this—it involves genes as well as experience, but these genes are not fate. In other words, there are things that we can do to intervene in the course of mental illness and genetic predisposition to prevent and make a difference in suicide.

NIMH and other research has shown that, in the United States and in many other countries, more than 90 percent of suicides reflect a mental illness, especially depression, often together with alcohol abuse, manic depressive illness, and also schizophrenia and borderline personality disorder. Just by naming these diagnoses, it suggests that there are interventions. But unfortunately, there are obstacles to interventions.

In children, we have inadequate knowledge as to the safety and efficacy of antidepressant treatment. The NIMH is trying to address this. We initiated a year ago a very large scale, multi-center trial in the treatment of adolescent depression, but we still do not have in the United States an adequate research infrastructure to study antidepressants in younger children when depression often begins and we are working on this.

In addition, there are other obstacles. Many studies of depression have actually excluded suicidal individuals because of ethical issues and liability issues, and we want to be working with some of the foundations represented here to come up with ethical and legal guidelines so that people who are suicidal will be included in treatment trials so that we will have precise knowledge as to how to intervene best when people are suicidal.

Even where we have knowledge, however, there are tragic gaps. I think it is well known that more than 70 percent of elderly males who commit suicide saw a primary care physician in the last month of their life. Clearly, there is an enormous disconnect. We have been attempting, through research, to understand how to close this gap. One important multi-center trial called PROSPECT which is being conducted at the University of Pennsylvania, the University of Pittsburgh, and at Cornell—sorry, one is outside of Pennsylvania, Senator—is looking at having a mental health professional in primary care clinics and in closing the educational gap with providers.

In addition, we are aware that the issue of depression in the medically ill is often very much under-attended to. There is a sense that, well, if you had a heart attack, would you not be depressed or if you had cancer? But in fact, we are leaving depression very much untreated in these individuals and also pain, and people should never wish for death in the context of a medical system that could, in fact, provide them with adequate treatment.

In youth again we have many prevention programs. Very few of them have actually been subjected to research, and indeed we know from studies of some prevention programs that if anything is powerful enough to make a difference, it is also powerful enough to have side effects. And some well-intentioned programs aimed, for example, at de-stigmatizing suicide have actually had—and I will sum up—some adverse consequences. We want to de-stigmatize mental illness so that people get treatment and de-stigmatize the idea that you can ask for help, but we want to keep the barriers to suicide high.

PREPARED STATEMENT

We have a number of announcements out and we are supporting research, a good deal of research, on suicide prevention and evaluation. And we want to work closely with the Surgeon General, with other Federal agencies, and also with foundations and non-Government partners to ensure that we have well-tested prevention measures out there that are being appropriately evaluated.

Thank you.

[The statement follows:]

PREPARED STATEMENT OF STEVEN E. HYMAN

Mr. Chairman and Members of the Committee, thank you for the opportunity to discuss the tragic public health issue of suicide and the urgent, challenging questions associated with its prevention.

To those not suffering from depression or another mental illness, suicide is fundamentally an incomprehensible act—but for others it is all too real, and it claims the lives of some 30,000 Americans each year: people of every age, both men and women, within every group of our population. The World Bank/World Health Organization-sponsored, Global Burden of Disease study reveals that suicide was the 9th leading cause of death among developed nations in 1990. What happens to these people? How do the neurochemicals and electrical impulses that account for the function of one's brain translate into a decision about death over life? Do the methods and messages of media contribute as precipitants of suicide, or are they potentially useful tools in its prevention?

Studies from the U.S., Finland, Sweden, and the U.K., all find that 90 percent of people who kill themselves have depression or another diagnosable mental or substance abuse disorder. From studies of the prevalence of depression—that is, the number of new and existing cases of depression over a given period of time—and data on the treated prevalence of depression, we can infer that as many as one-third to a half of those individuals with depression who die by suicide likely are undiagnosed or are not receiving adequate and appropriate treatment for this potentially lethal disorder. Although I have specified clinical depression, high rates of suicide also are associated with bipolar disorder, or manic depressive illness, with schizophrenia, and with other mental disorders. Estimates of the number of suicide victims who have had psychiatric treatment in their lifetimes range from 30 to 75 percent. These estimates vary depending on gender, age, their primary psychiatric illness, and where these people lived. A smaller group, 20 to 45 percent, was receiving psychiatric treatment at the time of their deaths that, for many was inadequate. Some suicide victims who were not receiving psychiatric treatment were in contact with primary health care providers. This is particularly true for elderly persons who committed suicide; studies have shown that 70 percent of these individuals were in contact with a primary care provider within a month of their suicide.

Suicide is always tragic; but because it is, in my view, potentially preventable through timely recognition and treatment of mental illness, the tragedy is compounded.

NIMH ACTIVITIES

I have been asked to describe for you what NIMH is doing to find effective ways of dealing with this very complex behavior. I will describe to you what we have

learned about suicidal behavior, and tell you what directions we are heading with regard to suicide prevention efforts.

Before I discuss NIMH's efforts, however, I would like to thank you, Senator Reid, for your unwavering support of suicide prevention efforts for the Nation. Your disclosure of your own family's experience with suicide, your introduction of Senate Resolution 84 a few years ago, your Senate Resolution 99 designating November 20, 1999 as National Survivors for Prevention of Suicide Day, and your support of the first National Suicide Prevention Conference in Reno, which set the stage for our being here today.

I also would like to thank Senator Specter for his leadership in fostering inter-agency collaborations to deal from a public health perspective with mental health concerns of youth, including violent behavior directed at others and self in the form of suicide.

We appreciate your foresight and determination to tackle these tough, yet approachable, problems. And let me add that I deeply appreciate Dr. Satcher's having taken the initiative to issue his Surgeon General's *Call to Action to Prevent Suicide*. The credibility of his office and of his own voice has done and will do much to call our Nation's attention to the largely silent epidemic of suicide.

WHAT WE KNOW ABOUT SUICIDE

Obstacles to understanding and preventing suicide notwithstanding, we are continuing to learn a great deal about it.

- We have made substantial scientific progress by determining that almost all suicidal behavior occurs in the context of a mental disorder. The risk is elevated further when mental disorders are complicated by substance use. These well-documented findings carry significant implications for prevention strategies.
- We have known for some time that suicide rates vary dramatically by gender and ethnic group in this country. We are just beginning to understand how other risks and protective factors interact with mental disorders and substance abuse in these groups—again, information that is critical to targeting interventions more effectively. Last summer, in conjunction with an NIMH-sponsored statewide conference in Alaska, I traveled to an Alaskan Native village in an effort to better understand the conditions leading to lack of availability of mental health services. More than 95 percent of all rural villages in Alaska cannot be accessed by road and are several hours flying distance from the more populated cities of Alaska. Often, it is impossible to reach these communities due to weather conditions. High rates of unemployment, low education, and poverty render many villages in rural and frontier Alaska vulnerable to family and community violence, suicide and other health and mental health problems. It is not entirely surprising, therefore, that Alaska has the second highest rate of suicide in the nation. In fact, the State ranked second among the 50 states in suicide rates and perennially records nearly double the overall U.S. suicide rate. American Indians/Alaskan Natives, who account for about 16 percent of the state's population, are among the racial/ethnic groups that have the highest suicide rates in the United States. Among American Indian and Alaskan Natives, suicide rates are 70 percent higher than overall U.S. rates. This is an issue that demands our attention.
- Perhaps most importantly, our knowledge that mental disorders and substance abuse contribute to suicide risk has helped raise awareness that adequate detection and treatment of mental disorders can truly be a life or death issue. The Surgeon General's "Report on Mental Health" emphasizes correctly that we must intensify our efforts to address the stigma that surrounds mental disorders in order to get individuals the help they need before it is too late.

WHAT WE KNOW ABOUT RISK FACTORS

Despite the 30,000 lives that suicide claims each year, and despite the searing intensity of the act of suicide—for family members and other survivors, as well as for the victim of an attempted or completed suicide—the relative infrequency of suicide in the population at large was long believed to have stymied attempts to identify specific, reliable risk factors. In fact, we know a considerable amount about risk factors for suicide.

- The first and most profoundly important risk factor was cited already but bears repeating: From psychological autopsy studies in which a suicide victim's medical, psychological, social history are systematically studied, we have learned that the vast majority—estimated at more than 90 percent—of suicide victims have had a mental and/or substance abuse disorder.

—Follow-up studies of adults with mental or substance abuse disorders reveal the inordinately high risk of suicide associated with these disorders. Some 30 years ago, Guze and Robins documented that patients who had been hospitalized for affective disorders had an alarmingly high rate of suicide and subsequently estimated that persons with depression had a lifetime risk for suicide of 15 percent. Since their work, numerous other studies have followed other patients with depression—including less severely ill patients who had been treated in outpatient as well as inpatient settings—for longer periods of time. Although the revised estimates from this research are less dismal, the lifetime risk for suicide is still 6 times higher for persons with a diagnosable depression than for a person without the illness. Among persons with schizophrenia, over the typically life-long course of this illness, the risk for suicide is between 4 and 6 percent (Inskip et al, 1998; Fenton et al., 1997), but with risk higher earlier in the course of illness (Inskip et al, 1998). Approximately 7 percent of those with alcohol dependence will die by suicide. Persons with mental disorders who attempt suicide are at significantly elevated risk—3 to 7 times greater than others with the same illnesses—for eventually completing suicide. In the U.S. population at large, an “average” American, has less than a 1 percent likelihood of dying by suicide.

Clinical risk “profiles” vary by age and gender. For example, among adolescent male suicide victims, the most common profile is depression, complicated by a pattern of problematic behavior at home and in school, including alcohol or other substance abuse, that often leads to isolation and rejection. Among adolescent females, a mood disorder is most likely, with conduct problems and substance abuse less likely. Among older white males—that is, men 55 and older, who comprise the group with the highest rates of suicide, at six times the national average—alcohol use is very infrequent, and a moderately severe, late onset depression is most common. More so than among other age groups, depression in the elderly is often obscured by symptoms of physical illness, and by loss and loneliness that all too often mar late life; thus depression is not recognized or treated adequately.

ONGOING SCIENTIFIC EFFORTS

Efforts by NIMH-sponsored investigators to find proven and safe prevention efforts are a work in progress, and one that we strive to promote and nurture. The obstacles to such research are formidable. For one, it is challenging to convince researchers to pursue careers in suicide prevention, given the difficulty of showing a reduction in suicidal behaviors over the typical, 5-year funding period of an intervention study. To demonstrate effects, particularly within this time frame, would require trials of very large size. Also, most researchers who received funding from NIMH for clinical trials traditionally have excluded suicidal patients from clinical trials, as does the pharmaceutical industry, because these patients are seen as too “high risk” and represent potential legal liability. All of these barriers leave little opportunity to judge how effective our treatments are for persons who are suicidal.

Fortunately, attitudes are changing, and clinical researchers appear more optimistic about identifying effective ways of treating suicidal patients. This reflects, in part, remarkable gains in the safety and efficacy of treatments for severe mental disorders such as depressive illness and schizophrenia.

Perhaps more importantly and more critical to the progress that research is making, is the willingness of brave individuals to participate in treatment studies and the unwavering focus of advocacy groups made up of families and friends who have suffered the devastating loss of a loved one to suicide.

We at NIMH and in the larger research community are aware, too, of ethical problems inherent in not studying persons who are suicidal. Thus NIMH is seeking innovative ways to assist and encourage willing researchers and research participants by identifying useful measures of suicidal behavior that can be used in clinical trials, as well as developing some guidelines for consent, monitoring, and crisis protocols.

I am genuinely heartened that leaders such as the members of this Committee and the Surgeon General endorse and actively promote a public health-oriented approach to treating mental disorders. Not only is this the reasonable and effective thing to do, but it also provides the research community with opportunities to look more broadly and over longer periods of time at treatment outcomes, which should improve our assessment of how effective treatments and preventive efforts are at reducing suicidal behaviors.

DIFFERENT RISK FACTOR PROFILES

Because different age and gender groups seem to have different risk factor profiles, I will describe our current treatment and prevention efforts for reduction of suicidal behavior within specific age groups.

Youth Suicide

In the area of school-based suicide awareness programs, we have learned a very important lesson: That it is critical to evaluate prevention programs. Despite good intentions to raise awareness of suicide and its risk factors among youth in schools, few programs have been evaluated to determine if, indeed, they are effective at reducing suicide. And more to the point, of those relatively few programs that were evaluated, none has proven to be effective. In fact, some programs have had unintended negative effects by making at-risk youth more distressed and less likely to seek help. By describing suicide and its risk factors, some curricula may have the unintended effect of suggesting that suicide is an option for young people who have some of the risk factors and in that sense “normalize” it—the very opposite of what we should be trying to do. Many school districts, worried about liability issues, are purchasing suicide counseling packages from entrepreneurs seeking “quick fixes” to prevent suicides. Unfortunately, most of these programs have not been evaluated, and we are very concerned about potential risks associated with participation in suicide prevention programs that have not been subject to rigorous evaluation. Because of the tremendous effort and cost involved in starting and maintaining programs, we should be certain that they are safe and effective before they are further used or promoted.

There are a number of prevention approaches that are less likely to have negative effects, and to have positive outcomes beyond that of reducing risk for suicide. One approach is to promote overall mental health among school-aged children by addressing early risk factors for depression, substance abuse and aggressive behaviors. In addition to the potential for saving lives, many more youth benefit from overall enhancement of academic performance and healthy peer and family relationships.

A second approach is to detect youth most likely to be suicidal by identifying those who have depression and/or substance abuse, combined with serious behavioral problems. Events such as recent tragic shootings in schools and other settings that capture public attention and concern are not typical of youth or adult violence, including suicide, but have focused the nation’s attention on these important issues. By focusing research attention on high-risk groups, researchers have learned much about depression, substance abuse and frequently co-occurring aggressive and violent behavior. Studies have shown that all of these problems share similar risk factors and processes—that is, the same experiences and influences act to increase risk for these problems. One might reason that comprehensive programs designed to reduce these risks also will reduce the often tragic outcomes, including suicide, that often are associated with such problems. Community efforts, involving parents, school systems, law enforcements officials, and other resources must communicate and work together to provide supportive, seamless treatment for youth with mental disorders. A report of preliminary findings from one NIMH grantee who is refining a family-based treatment approach for reducing conduct disorder in adolescents notes a reduction in suicidal behaviors—both suicidal thoughts, or ideation, and actual attempts—as well as reductions in aggression towards others.

Adult Suicide

Most of the prior and current research on suicide prevention in adults has focused on those with the highest risk of suicide—those who have made repeated suicide attempts. A few clinical research groups in the U.S., Europe, and Australia have evaluated interventions that include both medications and psychotherapy, but many of the studies did not have adequate numbers of patients to determine with any degree of certainty whether the intervention was truly effective. Fortunately, increasing numbers of researchers are becoming interested in developing treatments for such high-risk patients. Adults in the treatment system who report high rates of suicide attempts include women with borderline personality disorder; men and women with depression who also abuse drugs or alcohol; and men and women with bipolar depression. At present, NIMH is collaborating with the Centers for Disease Control and Prevention (CDC) to support a treatment trial with suicide attempters who appear at an inner city emergency room. In this study, specially trained therapists will work immediately with these individuals to address their hopelessness and depression, and also to help them obtain necessary treatments for their substance abuse disorders. This immediate, on-the-spot, high-intensity intervention will be compared to the treatment such individuals normally receive. If proven effective, our next step will be to disseminate the intervention strategy widely.

As you may be aware, NIMH has embarked on several large, clinical trials—for bipolar disorder, treatment resistant depression, adolescent depression, and best use of new antipsychotic medications. The reason for these efforts is to improve our knowledge about treatments for patients in the “real world”—those with co-occurring mental and substance abuse disorders and other, general medical illness; young and older people; and other persons who typically are encountered in diverse treatment settings. All of the trials will involve large numbers of participants—from about 430 for the study of adolescent depression, to more than 2,000 patients who will be involved in the evaluation of sequenced treatment alternatives for resistant depression. It is highly likely that there will be patients in these trials who will become suicidal. NIMH is assisting the researchers to plan and provide a high level of monitoring and care for such patients; our hope is that with adequate safeguards, fewer of these potentially suicidal patients will be excluded from the trials, more patients will be helped with the treatments being tested, and in the end, more will be learned about effective treatments for these patients.

Up to two thirds of all patients who commit suicide have seen a physician in the month before their death. However, in few adult suicide victims is a mental disorder detected, and among those, treatment is usually inadequate. Training health care professionals, particularly those in the primary care sector, to treat recognize and treat or refer mental disorders appropriately is an urgent order of business if we are to reduce suicides. No less important—and, again, a challenge to the Nation that Dr. Satcher issues most compellingly in the Surgeon General’s “Report on Mental Health”, is to combat the stigma attached to mental disorders and to encourage persons to seek treatment for mental disorders.

SUICIDE AMONG OLDER ADULTS

Among older adults—and, particularly, among older white males—late onset depression is the mental disorder most commonly associated with suicide. This form of depression, which typically is uncomplicated by substance abuse, is among the more readily treatable depressive disorders. Yet older persons at risk for suicide, like the majority of older adults in this country, tend not to seek mental health treatment. Rather, most have seen their primary care provider within the month, if not the week, of their death.

In response to this finding, NIMH issued a request for applications (RFA) for grant support to test more effective approaches to detecting and treating depression in older adults in primary care settings. I am pleased to report that we have awarded a grant for a very promising collaboration involving three of our clinical intervention centers. Termed PROSPECT, for “Prevention of Suicide in Primary Care Elderly: Collaborative Trial”, this project will assess the degree to which physicians can be trained and assisted to improve detection and treatment of depression in 6 primary care clinics, and compare them to 6 “usual care” clinics. This study complements a multi-site trial supported by the John A. Hartford foundation, where comparable outcome measures will be used across all sites.

Several researchers who are involved in the PROSPECT study also are participating in a collaborative study of Aging, Mental Health, Substance Abuse and Primary Care. This cross-agency initiative involves the Substance Abuse and Mental Health Services Administration, the Health Resources and Services Administration, and the Veterans Administration. The design and nature of our collaboration allows comparable measures to be used across many primary care sites. Results from this research should lead to a clearer picture of why and when older adults slip through the system without obtaining the care they need for mental disorders.

WHAT REMAINS TO BE DONE

Although we yet have an immense amount to learn about risk reduction and prevention of suicide, we should be encouraged, I feel, by the fact that we can spell out with some certainty next steps in research. Let me suggest several of these.

One, we are increasingly hopeful that we will find effective treatments for persons at greatest risk for suicide (those who have already made a suicide attempt). But we have much more to learn about how effective treatments—both medications and psychotherapies—may reduce both the short- and long-term suicide risks for persons with depression, schizophrenia, and anxiety disorders. Early findings suggest, for example, that the new antipsychotic medications appear to reduce suicidal ideation in some treatment trials for persons with schizophrenia. Greater numbers of prescriptions of newer antidepressant drugs have been associated with lower rates of suicide in Sweden.

Two, we must encourage more investigators in more treatment studies to include more—and consistent—measures of suicidal behavior. Resulting data will help in-

investigators think through treatment strategies that allow patients who become suicidal to be treated safely and returned to study trials.

We need to be more creative in devising tools and strategies to detect those at risk for suicidal behavior. Persons outside the mental health treatment system—for example, those who engage in domestic violence, who are failing in school or social relationships, or who are substance abusers—may benefit from consultation with a trained professional and, in some instances, may benefit from treatments at a time when they will be most effective.

Three, we need to better understand if and how prevention efforts aimed at preventing or reducing aggression, hyperactivity, depression, psychoses, and substance abuse also reduce the risk for suicidal behavior. This information is desperately needed by schools and communities with limited resources. We need to understand the most efficient, effective, and sustainable approaches to meet these goals.

Fourth, we need to encourage more minority investigators to pursue research in this area, in part to help us to understand better how “protective factors” work. For example, African American women have among the lowest rates of suicide, although they have mental disorders at rates comparable to those experienced by white women. It is important to understand the factors that protect one from suicide. We also need to examine differential suicide rates among other ethnic groups. As I mentioned earlier, American Indians/Alaskan Natives, who account for about 16 percent of Alaska’s population, are among the racial/ethnic groups that have the highest suicide rates in the U.S. Among American Indian and Alaskan Natives, suicide rates are 70 percent higher than U.S. rates.

CONCLUSION

Mental disorders and substance abuse disorders—alone and co-occurring—are the major risk factor for allowing human beings to overcome one of nature’s most compelling instincts—the urge to survive. Why do people kill themselves? We urgently need to know more. We are grateful that with the support of many people, our society is increasingly willing to address and resolve the legal and ethical issues surround clinical investigations on this topic and that for too long have been permitted to unduly complicate knowledge development. With the help of dedicated scientists, wise policy leaders, the courage of those affected by mental and substance abuse disorders, and the committed advocacy of those who genuinely care about these tragedies, we have learned a tremendous amount, and we will continue to learn more.

Senator SPECTER. Thank you very much, Dr. Hyman.

I want to yield now to my distinguished colleague, Senator Harry Reid, who I said at the outset had requested this hearing specially because of his own family involvement in the issue. Senator Reid?

OPENING STATEMENT OF SENATOR HARRY REID

Senator REID. Senator Specter, thank you very much. I appreciate your holding this hearing. You have a tremendously busy schedule with all of the budgetary hearings. Your subcommittee is responsible for most of the work because you cover so many different areas. I cannot say how much I appreciate your working this hearing into your schedule. You have approached this really professionally, and I am so grateful to you.

I have a statement that I would like to be made part of the record.

Senator SPECTER. Without objection, it will be made part of the record.

Senator REID. I apologize for not being here, but I had to open the Senate for the minority this morning.

Dr. Satcher, thank you very much for being here. You have done so much for suicide prevention by adding the weight of your office and the stature you have on this issue. We have had very few people who are willing to step out in front. You have been willing to do that, for which I am grateful.

I also say I appreciate every one of the witnesses being here, but some come at a little greater risk than others. I want to express my appreciation to Danielle Steel for being here. This is always very difficult when you have to talk about a loved one that has been lost, and when you are someone as well known as Danielle Steel, that makes it doubly difficult. Again, like Dr. Satcher, we appreciate very much your being here because the more attention we focus on this, the more we are going to learn.

PREPARED STATEMENT

During the time that this hearing started till now, someplace in the United States someone killed themselves, and as a result of that, there are husbands and wives and children and friends at a total loss as to why someone would take their own life. That is what this hearing is all about.

Thank you very much, Mr. Chairman.
[The statement follows:]

PREPARED STATEMENT OF SENATOR HARRY REID

Good morning Mr. Chairman and distinguished guests. I would like to extend my gratitude to Senator Specter for convening today's hearing. As one of the many Americans who has lost a loved one to suicide, this hearing holds special significance for me.

Suicide is not something that only happens to other people. It is the 8th leading cause of death in the United States, and is ranked as the 3rd leading cause of death among our youth. More young adults die from suicide than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia, influenza and chronic lung disease combined.

Suicide claims the lives of 31,000 Americans annually—this means that every day we lose 85 people to suicide. In this country, there is one suicide every 17 minutes. For every suicide, there are survivors left to cope with tragic loss and to struggle with unanswered questions.

The best place to start a story is at the beginning, so allow me to take a moment to bring you back a few years so you may understand my interest in suicide prevention.

The year was 1972, and I had just spent a memorable afternoon with the legendary Muhammad Ali. When I returned to my Las Vegas law office, I was given an urgent message to call my mother at our home in Searchlight, Nevada. That is when I learned my father had shot himself.

Prior to this moment, I had never thought of suicide as something that would affect my life. Suicide was something that only happened in other people's families.

Over the years that followed, my family simply did not talk about my father's suicide. In retrospect, I guess I was somewhat embarrassed and even ashamed. My family and I were left alone and carried this experience in a very private way—the same private and lonely way that many families across this country carry their pain today.

Thankfully, through hearings like this one today, many who previously suffered in silence are now able to turn today's grief into hope for the future. Suicide is a preventable tragedy and by addressing this public health challenge we can change the course of the future for so many Americans.

A few years ago, I was contacted by Jerry and Elsie Weyrauch from SPAN—The Suicide Prevention Advocacy Network. They knew I had lost my dad to suicide and asked if I would speak at their second annual suicide awareness event here in Washington. I agreed, and on the day of the SPAN event, I introduced a Senate Resolution that would focus attention on the issue of suicide in America. My resolution calling for a national strategy to address suicide in America passed in the Senate the same day it was introduced. This marked a promising first step towards the establishment of a national strategy for suicide prevention.

In October 1998, a national conference on suicide prevention convened in Reno, Nevada. One result of this conference was the publication of the Surgeon General's "Call to Action to Prevent Suicide." This is a blueprint for suicide prevention and I am pleased that the Surgeon General is here to tell us more about this effort.

Our next step is to translate the Surgeon General's framework for suicide prevention into action and to increase direct spending for suicide prevention. We need to establish a way to ensure the money allocated to suicide prevention is spent wisely and in accordance with our national strategy. We must ensure that every dollar we spend makes a difference.

Suicide is a public health challenge. It is not a topic we can afford to sweep under the rug and silently hope it will improve over time. Instead, we must dedicate ourselves to eradicating the staggering rate of suicides in this country. We have already begun to make a difference and I am optimistic about what we can accomplish through a National Suicide Prevention Strategy.

We have an outstanding panel of witnesses here today. I would like to thank everyone for participating in this hearing, and I look forward to hearing from all of our distinguished guests. Thank you.

Senator SPECTER. Thank you, Senator Reid.
Senator Wellstone.

OPENING STATEMENT OF SENATOR PAUL WELLSTONE

Senator WELLSTONE. Thank you, Mr. Chairman. I know we are under time constraints, so let me just thank Dr. Satcher and Dr. Hyman for their leadership. It is much appreciated.

Let me thank you and Senator Reid for your engagement with this issue.

Let me thank all the people that are here, all the panelists. I want to mention to Dr. Jamison that I read your book and it was a very, very important book to me and I think many people in the country.

Then finally, let me just thank one organization back in Minnesota, Save, which is an organization that both Sheila, my wife, and I have done a lot of work with. As you know, Mr. Chairman, I am very interested in this area and I look forward to hearing from all the panelists.

And that is as brief as I can be.

Senator SPECTER. Thank you very much, Senator Wellstone.

Just a couple of questions. Dr. Satcher, what advice would you give to someone who was thinking about suicide?

Dr. SATCHER. Well, someone who is thinking about suicide—as a physician, of course, I would want to talk with that person at length to learn more about why that person is thinking about suicide.

Senator SPECTER. Would you give that person some advice as to seeking professional help?

Dr. SATCHER. Yes. I am starting with myself because I am a professional. But, yes, I would recommend that all primary care providers ask their patients about depression and anxiety and the other mental health problems that lead to suicide and, when indicated, refer them to specialists in the field. But one of our big problems, as you know, in this country is we need the primary care sector more involved in identifying people who are at risk for suicide. So, I am sorry. When I referred to myself, I was speaking as a physician.

Senator SPECTER. Would you think it useful to try to set up a hot line, an 800 number, or is there any such mechanism now in effect where the thought is running through somebody's mind, however tentatively, however tenuously, to seek help?

Dr. SATCHER. There are 800 numbers. Let me just say they are not well evaluated. Dr. Hyman might want to speak to that. CDC

is now evaluating the use of crisis hot lines for teenagers, for example, and hopefully over a period of time, we will learn more about the impact that these have.

One of the concerns, of course, is that many of the people who are at greatest risk for suicide do not call those numbers. Of course, Dr. Jamison has written about that. The problem we have is that the people who are at greatest risk of suicide are usually not the ones that call numbers seeking help. So, we have got to learn more.

That is why we need programs in communities. We need ministers and teachers and others who are leaders in communities to be aware of the fact that there are many people who are depressed, and when we identify these problems, we need to make sure that people get the help they need. We have got to be more supportive. We have got to have a stronger infrastructure, and that is what we hope to do with this national strategy.

Senator SPECTER. Dr. Hyman, picking up on those who do not seek help—and we know the heavy incidence of suicide among teenagers—what advice would you give to parents or teachers or anyone who has extensive contact with teenagers as to what danger signals to look for and what sort of precautionary suggestions or advice to teenagers especially?

Dr. HYMAN. I think what is really critical is the difficulty of telling the difference between a passing stage and something that is really serious. I think the advice to parents and teachers is that if somebody's behavior changes, if their grades go down, if they become disinterested, and it is pervasive and it lasts more than a few weeks, it is a time to talk to the child and perhaps bring them to a professional.

Teachers I think would like—and we have talked about this before—more training in understanding warning signs both for depression and suicide and also for risk of violence. But Dr. David Satcher at Columbia has also pointed out that again many of the most suicidal youth actually hide very well these feelings.

One of the things that has been suggested through research is actually screening tools that can now be administered, perhaps using a computer, so there is very little embarrassment, that might identify kids who would not otherwise come forward or who are not giving outward signs, and these screening tools then could be used to make clinical referrals.

Senator SPECTER. Thank you very much, Dr. Hyman. Thank you very much, Dr. Satcher.

I would like to call now our second panel: Dr. John Mann, Dr. John Fildes, Dr. Kay Redfield Jamison, Dr. Admiral Susan Blumenthal.

While the second panel is stepping forward, let me acknowledge the presence among our very many distinguished visitors Senator Bob Packwood, a colleague, distinguished chairman of the Finance Committee, and an expert squash player.

Senator PACKWOOD. The only experience I have in self-destruction is playing squash with you.

Senator SPECTER. Would you stand and be heard, Senator Packwood? I would not catch all of that.

Senator PACKWOOD. I told him the only experience I have in self-destruction is playing squash with him.

Senator SPECTER. He is ordinarily a good squash player except for the six stitches which appear under my left eye.

STATEMENT OF JOHN MANN, M.D., CHAIRMAN, SCIENTIFIC COUNCIL OF THE AMERICAN FOUNDATION FOR SUICIDE PREVENTION

Senator SPECTER. Our first witness today on the second panel is Dr. John Mann who heads the Department of Neuroscience at New York State Psychiatric Institute and is professor of psychiatry and radiology at Columbia University which runs the clinical research center for the study of suicidal behavior. Thank you for joining us, Dr. Mann, and the floor is yours.

Dr. MANN. Thank you very much, Senator Specter, for the opportunity to present here today.

I am here in my academic capacity as well as in my capacity as chairman of the Scientific Council of the American Foundation for Suicide Prevention. That Scientific Council comprises 50 of the most distinguished experts in suicide throughout the country, and the foundation, which represents a large body of survivors, is the only private foundation in the United States dedicated to the funding of suicide research, over 200 projects in the last few years, education and support for survivors.

These survivors have placed their faith in scientific approaches to the identification of the causes and risk factors for suicide and in the identification and development of effective treatment interventions. And I would like to focus my remarks on the latter, what can we do about this problem.

We have made enormous progress in trying to understand causes and risk factors of psychiatric illnesses and suicide is a complication of psychiatric illnesses. It is not a result of social problems. It is a compilation of factors which fundamentally stem from psychiatric illness.

But in trying to develop better treatments for psychiatric illness—and we have been enormously successful with the support of Congress in doing that—we have made relatively little progress in denting the tremendous toll due to suicide. The reason for that is that almost all of the clinical trials that have been conducted have specifically addressed general psychiatric patients and not specifically those who are feeling suicidal. In fact, most studies have actually excluded those patients. So, when the clinician is asked the question, what should I use for the suicidal patient, they have to extrapolate from other types of studies. This is really a shocking deficiency in our clinical armamentarium, given how sophisticated we are in other respects.

The American Suicide Foundation does not have the funding to support these kinds of studies. Many private foundations are in the same situation. The only approach that will make a dent in the situation will be a partnership between Government and private foundations.

The American Suicide Foundation has partnered, for example, with the Soros Foundation to conduct a treatment intervention study on suicide in Hungary. Hungary has three times the suicide rate of the United States. Certain provinces of Hungary are par-

ticularly vulnerable. We believe that this kind of model in Hungary will potentially be usable in other places. We, in particular, have in mind the State of Nevada which, like Hungary, has a very high suicide rate, double that of the United States, a small population, a place where we can conduct a manageable, affordable intervention that could be a model for the rest of the country.

The second proposal that the American Foundation for Suicide Prevention wishes to put before the committee is a proposal for a national network of treatment evaluation centers akin to the kinds of national networks that we have for surgical cancer, for heart disease, and so on, centers that specialize in the identification, the assessment, and the treatment of suicidal patients. This national network would then be the infrastructure or the vehicle for conducting controlled, clinical, scientific treatment trials to develop strategies for treating suicidal patients.

For example, we know there are medications that may work better than other medications in depression and manic depression for preventing suicide. In other words, these drugs do have properties that are valuable to these patients for their psychiatric illness, but they have an additional property, such as lithium, which may reduce the risk of suicidal behavior independent of improving the psychiatric condition.

An analogy is when you are driving a car recklessly or very fast or you hit some ice or there is an accident, you need your seat belt system to save your life. When you develop a psychiatric illness, what determines whether or not you act on the suicidal feeling is not just the psychiatric illness but an inherent predisposition or vulnerability to act on powerful feelings. There are treatments that may well improve this restraint system that we all have to varying degrees and may help us help patients live through the crisis of the psychiatric illness while we are waiting for the treatment to work.

There are promising treatments in the area of mood disorders and in psychoses and we would like to propose that funds be set aside for this kind of national treatment research network to evaluate these kinds of promising treatments as the step forward to actually giving clinicians the tools to save lives in the United States as soon as possible.

Senator SPECTER. Thank you very much, Dr. Mann.

STATEMENT OF JOHN FILDES, M.D., MEDICAL DIRECTOR, UNIVERSITY OF NEVADA MEDICAL CENTER TRAUMA UNIT

Senator SPECTER. We now turn to Dr. John Fildes, medical director of the University of Nevada's Medical Trauma Center, where he developed the Suicide Prevention Research Center responsible for more than 100 physicians who treat more than 9,000 admitted patients. Thank you for joining us, Dr. Fildes, and the floor is yours.

Dr. FILDES. Thank you very much, Senator.

As a surgeon, I became interested in treating patients with suicide after years and years of tending to their wounds and knowing that I could only master part of the problem. I have been involved in a broad number of injury control projects throughout our State and region and felt that suicide prevention was a paramount issue.

Senator Reid has been instrumental in supporting us in that effort, and we were fortunate enough to open up the Suicide Prevention Research Center through funding provided by the CDC.

Nevada, as many people know, has the highest per capita suicide rate in the United States and has so for the past 10 years. This only tells part of the problem. In the Intermountain Western States, 8 of these States make up the top 12 highest suicide rates in the Nation, placing us in the center of an endemic region and being the natural home for this sort of research.

The Suicide Prevention Research Center has been charged to fill in some of the gaps with regard to creation of tools to take a public health approach for injury control.

All the information that we know about suicide and everything that you have heard today only tells about the number of deaths. There is no real-time, on-line surveillance system in the United States or in any individual State that can record the number of attempts that actually take place, and these outnumber completions by a large number. In order for us to implement effective programs and know whether those programs are making things better or making them worse or just remaining the same, we need to have an ongoing, on-line, real-time measurement of suicide activity, both attempts and prevention, throughout the United States.

We are pioneering that task in Nevada and will spread it to six of the eight Intermountain States during the 3-year program that we have with the CDC.

In addition, we require the need to standardize nomenclature. When you try to meta-analyze and compare studies done by different research groups at different times, it is not always entirely clear what is being described or how these studies are comparable. And operationalizing a language for suicide research is the second objective that we hope to accomplish.

The third is to create a standardized inventory tool, one which can be self-administered throughout the rural and frontier of the Intermountain West, to follow back the intimate acquaintances of those who have committed suicide, as well as to be used on attempters and to try to characterize some of the risk factors, the behavioral issues, and other external forces that have caused these acts to take place.

Fourth, we would hope to create an inventory of research-proven prevention programs from around the globe so as not to recreate the wheel, to make these prevention programs available to communities that have demonstrated the highest rates, and to aid their implementation by identifying local experts who are willing to embrace and to longitudinally propagate these activities within their home communities with the support of the center.

And finally we hope to do this by creation of an educational task group to help disseminate our findings, as well as our interventions, and to guide us through their implementation.

Dr. Satcher has said that even the most well considered plan accomplishes nothing if it is never implemented. What I have shared with you today is the model of an evidence-based, outcome-driven, injury control model applied to the problem of self-directed intentional injury and death. It utilizes the Surgeon's General Call to Action by expanding the awareness, by implementing intervention

programs that are practical and readily available, and using methodology based on public health and epidemiologic principles. In order for this work to be implemented on a broad scale, it will continue to require support and the attention of public and private sources.

Suicide is not an irrational or an inevitable act. It is a public health problem of ever-growing proportion and requires the same level of commitment provided to other diseases. As a trauma surgeon and as a specialist in injury control and injury prevention, we see it as one form of intentional injury which can be worked on effectively and which can be reduced.

Thank you.

Senator SPECTER. Thank you very much, Dr. Fildes.

STATEMENT OF KAY REDFIELD JAMISON, Ph.D., PROFESSOR OF PSYCHIATRY, JOHNS HOPKINS UNIVERSITY

Senator SPECTER. Our next witness is Dr. Kay Redfield Jamison, professor of psychiatry at the Johns Hopkins University School of Medicine and co-author of the standard medical text on manic-depressive illness. Her list of accomplishments is very extensive, but one of the most significant is that she is the recipient of the American Suicide Foundation Research Award for her more recent book, "Night Falls Fast: Understanding Suicide." In the jacket of the book, a matter of some sensitivity, but in the public domain, is the comment at the age of 28, after years of struggling with manic depression, she attempted to kill herself.

Dr. Jamison, thank you for joining us.

Dr. JAMISON. Thank you. I am a psychologist and professor of psychiatry at the Johns Hopkins School of Medicine, and I thought this morning I would talk more personally since my colleagues will be and have been addressing the science of suicide. Thank you very much for the opportunity to speak here today.

Suicide has been a professional interest of mine for more than 20 years and a very personal one for very much longer. I have a hard-earned respect for suicide's ability to undermine, overwhelm, outwit, devastate, and destroy. As a clinician, researcher, and teacher, I have known or consulted on patients who hanged, shot, or asphyxiated themselves, jumped to their deaths from stairwells, buildings, or overpasses, died from poisons, fumes, prescription drugs, slashed their wrists, cut their throats. Close friends, fellow students from graduate school, colleagues, and children of colleagues have done similar or the same. Most were young and most suffered from mental illness. All left behind a wake of unimaginable pain and unresolvable guilt.

Like many who have manic-depressive illness, I have also known suicide in a more private, and awful sort of way, and I trace the loss of fundamental innocence to the day that I first considered suicide as the only solution possible to an unendurable level of mental pain.

I was 17 when, in the midst of my first depression, I became knowledgeable about suicide in something other than an existential and adolescent way. For much of each day, during several months of my senior year in high school, I thought about when, whether, where, and how to kill myself. I learned to present to others a face

at variance with my mind, ferreted out the location of two or three nearby tall buildings with unprotected stairwells, discovered the fastest flows of morning traffic, and learned how to load my father's gun.

The rest of my line at the time fell into a fast and black night. Everything seemed a ridiculous charade to endure, a hollow existence to fake one's way through as best one could. But gradually, layer by layer, the depression lifted, and by the time my senior prom and graduation came around, I had been well for months. Suicide had withdrawn to the back squares of the board and become once again simply unimaginable.

Over the years, though, my manic-depressive illness became much worse and the reality of dying young from suicide became a dangerous undertow in my dealings with life. Then when I was 28 years old, after a particular damaging and psychotic mania, followed in turn by a prolonged and violent siege of depression, I took a massive, lethal overdose of lithium. I unambivalently wanted to die and I nearly did. Death from suicide had become a possibility, if not a probability, in my life.

This time it was not a very long walk from personal experience to clinical and scientific investigation. I was a young assistant professor in a department of academic psychiatry. I studied everything I could about my disease and I read all I could about the psychological and biological determinants of suicide. As Dr. Satcher and Dr. Hyman have made clear this morning, there is a great deal known about these psychological and biological determinants, but there is a terrible gap between what we know and what we do about it. And this gap is lethal.

And there is, in fact, much we know about suicide that is strangely heartening. As a clinician, I believe there are treatments that can save lives. As one surrounded by scientists whose explorations of the brain are elegant and profound, I believe our basic understanding of the brain's biology is radically changing how we think both about mental illness and suicide. And as a teacher of young doctors and graduate students, I feel the future holds out great promise for the intelligent and compassionate care of the suicidal mentally ill.

All of these things I deeply believe. The science is of the first water. It is fast-faced and it is laying down pixel by pixel, gene by gene the dendritic mosaic of the brain. Psychologists are deciphering the motivations for suicide and throughout the world, from Scandinavia to Australia, public health officials are mapping a clearly reasoned strategy to cut the death rate of suicide. We are fortunate—and I cannot say how fortunate we are—in this country to have had and continue to have the superb leadership of the Surgeon General, Dr. David Satcher.

Still, the effort seems remarkably unhurried. Every 17 minutes in America someone commits suicide. And I will wrap up. Where is the public outrage? Where is the public concern?

I have become more impatient—and I am generally impatient—and more acutely aware of the problems that stand in the way of denting the death count. I cannot rid my mind of the desolation, confusion, and guilt I have seen in the parents, children, friends, and colleagues of those who kill themselves. Nor can I shut out the

images of the autopsy photographs of 12-year-old children or the prom photographs of adolescents who within a year's time will put a pistol in their mouths or jump from the top floor of a university dormitory building.

Like many of my colleagues who study suicide, I have seen time and again the limitations of our science and been privileged to see how many good doctors there are and appalled by the callousness of others. Mostly, I have been impressed by how little value our society puts on saving the lives of those who are in such despair as to want to end them. It is a societal illusion that suicide is rare. It is not rare. Certainly the mental illnesses most closely tied to suicide are not rare. They are common conditions and unlike cancer and heart disease, they disproportionately affect and kill the young.

We need to do more, far more, and now. Thank you.

Senator SPECTER. Thank you very much, Dr. Jamison, for sharing your personal experiences.

STATEMENT OF SUSAN BLUMENTHAL, M.D., M.P.A., ASSISTANT SURGEON GENERAL AND SENIOR SCIENCE ADVISOR, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Senator SPECTER. We next turn to Dr. Susan Blumenthal, Rear Admiral, Assistant Surgeon General, and Senior Science Advisor, Department of Health, national expert in suicide research and prevention and has written extensively on the health concern, including a major volume, "Suicide over the Life Cycle." From 1982 to 1985, Dr. Blumenthal served as head of the suicide research unit at the National Institute of Mental Health, and as the Nation's first Deputy Assistant Secretary for Women's Health, she is credited for putting women's health on the national policy agenda.

Thank you for joining us, Dr. Blumenthal, and we look forward to your testimony.

Dr. BLUMENTHAL. Good morning and thank you, Chairman Specter, Senator Reid, Senator Wellstone, for your outstanding leadership and commitment throughout your careers in Congress. You have worked tirelessly to raise awareness and to convene members of the Federal Government and private sector to work on major public health problems like violence and suicide. It is an honor to participate in this hearing today.

I also want to commend the work of our Surgeon General, Dr. David Satcher, and Dr. Hyman, Director of the NIMH, for their work and to the scientists here, the grassroots advocates, and families who contribute so much to raising awareness about this public health problem.

I am here today in my private capacity.

Senator Specter, it is over 15 years ago that I first testified before you on this issue in 1985 when I was head of the suicide research unit at the National Institute of Mental Health. At that time several clusters of youth suicides had occurred in communities across our Nation, including Westchester County, New York and in Plano and Dallas, Texas, running through these communities like a lethal, infectious disease, leaving the Nation heartbroken and perplexed about the reasons for these tragedies and urgently in need of strategies to help prevent future loss of life in ways not unlike our communities have been ravaged recently by school violence

where young people have killed their classmates and then killed themselves.

You see, as you have heard, since 1950 there has been a tripling in suicide rates for our Nation's young people, ages 15 to 24, but the sharp upturn in rates of suicide among adolescent and young adults in the United States that began in the 1950's and emerged as one of the most highly visible and alarming public health trends of the 1980's perhaps obscured also the fact of the pervasiveness and persistence of suicide and suicidal behavior in all other age groups of the population throughout the course of the 20th century and the fact that risk factors for suicide appear to differ across the life cycle.

Suicide is a complex human behavior. It reflects many determinants, biological, psychological, and environmental, present in the absence of protective factors. Thus, preventing suicide requires multifaceted interventions, individual, medical, community-based and environmental. Suicide occurs across the life cycle and its risk increases with age. It occurs in both men and women and across racial and ethnic groups. Yet, many people who commit suicide have exhibited warning signs to friends, parents, teachers, colleagues, and doctors, but their symptoms have not been recognized and they have not received appropriate intervention. Thus, as concerned citizens, educators, legislators, and health care professionals, we all have a critical role to play in suicide prevention.

In the testimony today, you are hearing what we have learned over the past 15 years about suicide and how to prevent it and the challenges ahead if suicide rates are going to be reduced further in the future.

Perhaps the most significant achievement during this time period has been the important progress made in our ability to diagnose and treat mental and addictive disorders that are so disproportionately represented in the life histories of those who commit suicide. You see, research tells us that as many as 90 percent of people across the life cycle who end their lives by suicide are suffering from a mental and/or addictive disorder.

But as Dr. Jamison underscored, unfortunately what we know from best practices does not get translated into ordinary practice in our communities around the Nation, that people are not getting detected, that they are not being referred for appropriate treatment, and because of the shameful stigma that exists in our society that treats mental illnesses like personal weaknesses or character flaws rather than real, disabling illnesses just like heart disease or diabetes, for which there are extremely effective treatments.

Over the past decade, we have finally witnessed an opening of understanding about these illnesses that has resulted in more effective treatments and in people seeking help. Over the past century, the rates of suicide have remained remarkably stable, although in the past decade we have seen about a 10 percent drop in suicide rates.

To put a framework around what we know and to stimulate collaborative actions to prevent this tragic loss of human lives, in the 1980's we fostered a public health approach to suicide prevention, saying that it was not a result of just social and environmental factors. It encompasses a strategy to maximize the benefits and efforts

and resources for prevention across this Nation, and this is the approach that has been taken by our Surgeon General's Call to Action.

The public health approach has been used widely to respond to epidemics of infectious disease and over the past decades has been used to address other challenging health problems such as chronic diseases like the fight against heart disease. In public health, there are three levels of prevention, primary, secondary, and tertiary.

Primary prevention is like vaccinating for the prevention of infectious disease—and I will wrap up in a minute—doing community-based interventions, for example, to prevent smoking, encourage a healthy diet and physical activity for heart disease. To prevent suicide, it means de-stigmatize mental illness and educating the public and health care providers about mental illness and substance abuse. It means providing every child with a healthy start, promoting mental health across the life span, including school-based interventions to foster problem solving skills, conflict resolution, and resiliency.

Secondary prevention means identifying high risk people and intervening.

Senator SPECTER. Dr. Blumenthal, are you summing up now?

Dr. BLUMENTHAL. I am.

In heart disease, it means detecting those with high blood pressure or cholesterol. To prevent suicide, it means detecting those who have suffered a loss who are at high risk, who are depressed, and intervening.

And tertiary prevention means intervening with people who have exhibited suicidal behaviors, as we would with people with heart disease. And again, studies are underway to find the most effective treatment strategies.

We also must promote better surveillance of the problem, avoid inadvertently glamorizing suicide in educational programs and in the media. We need to establish community task forces to respond before a crisis occurs. We need to build coalitions between grassroots, between the public, between policymakers, health care leaders. We need to decrease access, easy access, to lethal methods in our homes.

Well, in closing, Voltaire has said that the man—let us also make that the woman—who, in a fit of melancholy, kills himself today would have wished to live had he waited a week. Our understanding of suicide is benefitting from rapid advances in the neurosciences and the behavioral sciences from the kind of public awareness that is coming from this hearing, from the Surgeon General's Call to Action to Prevent Suicide, and hopefully with it will come hope in the future, hope that we will further reduce suicide, an untimely loss of human life, in the 21st century.

Thank you for the opportunity to be here today.

Senator SPECTER. Thank you very much, Dr. Blumenthal.

Senator Reid.

Senator REID. Thank you very much, Mr. Chairman.

Coming here today, in addition to this being a unique opportunity to have our first congressional hearing of this magnitude dealing with suicide, has been personally very rewarding for me because over here on the wall—and I did not know it was going to

be here—is a quilt that had a number of people from Nevada who committed suicide, and one of those is my father. Just walking over there and visiting with my dad for a few seconds was important to me.

And also it brought to my mind, even though my father was uneducated—he didn't graduate from the eighth grade not because he was not smart enough; he just did not have the opportunity—maybe in his death there was some meaning because I am sure that he would be surprised if we had all these eminent scientists here talking about one of his problems or talking about his problem—and that is, in effect, what you are doing. So, in his death, today maybe I see the benefit of speaking out on this subject because we are talking more about it.

I think the question I would like to ask this panel, Mr. Chairman, is in my opinion the biggest problem with suicide is there needs to be public awareness that it happens all the time. Suicide always happens to someone else. Since my dad killed himself, I really focus on suicide. It is all around us. Well, it happens every 17 minutes here in America, four times as much, we were told earlier today, in Hungary. It is a real problem in America and the world.

So, my question is what can we do, what should we do to allow the American public know that 31,000 people die every year? Do you have any ideas, any of you?

Senator SPECTER. Dr. Blumenthal.

Dr. BLUMENTHAL. Well, I think that we need to do more educational campaigns, but I think we have to start with educating about the incredible prevalence of mental and addictive disorders in America because one out of five Americans will have a mental illness in any year-period.

I think our Surgeon General's Call to Action about suicide and mental health is an important step forward. We had a White House conference on mental health. That is an important step forward. We need to educate our health care providers to understand that suicide is the most tragic complication of undiagnosed and treated mental illness.

But shamefully in our country there are disparities in terms of coverage for mental illness that treats them like they are not other physical illnesses. And I think we have to rectify that. We have to encourage people to seek help, but we have to ensure that help is state of the art, and we have to ensure that all Americans have access to lifesaving treatment and health care.

Senator REID. We have public service announcements about wearing seat belts. Not nearly as many people are killed every year by virtue of not wearing seat belts as die from suicide. I personally have not seen any public service announcements about suicide.

Dr. MANN. I think that is a very important point. People who are feeling suicidal need to understand that there is help out there, and we need to focus specifically on this group because this is the group that is at risk for dying. Patients who have psychiatric illnesses but do not have suicidal thoughts are at extremely low risk in terms of suicide. So, the ones who are at risk are having these thoughts. Somehow we have to reach out to them and we have to

reach out to their families because they tell their families about the fact that they are feeling suicidal.

At the same time, it is a bit like World War II. The first thing we have to do is stop retreating. The next thing we have to do is to build enough tanks so that we can go on the offensive, developing treatment strategies that are shown to be specifically beneficial for the suicidal patient in the main conditions that are associated with suicide like manic depression or bipolar disorder, unipolar disorder, schizophrenia, and substance abuse.

We have to give the clinician the tools. We talk about educating the public. We talk about educating the clinician, but the clinician knows that they need specific tools for this problem, and to get those tools, we need factories that make those tools. The factories that make those tools are specialized centers that know about suicidal patients, that are used to looking after them, that conduct, in the safest possible way, the treatment trials to determine what treatments work best for them.

Senator REID. Thank you, Mr. Chairman.

Senator SPECTER. Thank you very much, Senator Reid.

Senator Wellstone.

Senator WELLSTONE. Mr. Chairman, I will try and be brief.

Let me, first of all, just say to Dr. Jamison your words: "that there is a gap between what we know and what we do and that gap is lethal" I think sort of rings out to me and I hope to the country.

I want to sort of talk about two issues. It is less in the form of a question, but just a comment.

First of all, on the whole issue of discrimination. We have gone through this in my own State. The Governor of Minnesota, Governor Ventura, said in an interview, "I've seen too many people fight for their lives. I have no respect for anyone who would kill themselves. If you're a feeble, weak-minded person to begin with, I don't have time for you." So, we have a ways to go in terms of just dealing with some of the insensitivity or lack of knowledge. I can think of other words. But I think that that is one challenge.

But, Mr. Chairman, I want to make a comment first about Senator Reid and then about you.

First on Senator Reid, you were talking about your dad. I think what your father might be most proud of is not the experts that are here, but that you are here as U.S. Senator. I think that is what he is looking down from heaven and seeing, especially with your outspokenness and your courage to talk about your own family and the way in which you have brought that before the country.

And, Senator Specter, everybody has said this. Dr. Blumenthal said it. Everybody has said it in one way or another. Dr. Satcher said it. Dr. Hyman. There is a direct connection also between suicide and people who are struggling either with mental illness or with substance abuse or addiction. You, Mr. Chairman—and very few people have been willing to do this—you have now been willing to cosponsor the Fairness in Treatment Act which essentially says when people are struggling with substance abuse, we have to treat this. You cannot view it as a moral failing. You have been the one who has been willing to step forward, and I appreciate your effort to do this with me.

Senator SPECTER. Do not forget yourself. It is your bill.

Senator WELLSTONE. I usually do not pass bills here. I always need some help.

Senator Domenici and I are working together on this Mental Health Equitable Treatment Act.

My point is, first of all, what we are not doing goes back to what Dr. Jamison said, the gap. There is too much discrimination. We are not covering this with health insurance. We are not getting the treatment to people, especially children, especially minorities, especially poor, especially rural areas, especially seniors. At the minimum, we ought to end that discrimination and make sure there is the coverage for the treatment.

Then the second point is even if you end the discrimination, for those who cannot afford any coverage at all, we have got to make sure there is some coverage.

Then finally, even if you have got the coverage, quite often there are communities where we do not have the infrastructure of the men and women and the people to deliver the care.

To me, we can do this. We can do this. We have to. That is my statement.

Senator SPECTER. Thank you very much, Senator Wellstone.

Dr. Jamison, my first question is for you. We thank you specially for sharing with us your own personal experiences, which are very, very powerful. As Senator Reid has, it has unique meaning when you come forward and tell us what happened to you. That is very, very authoritative, obviously.

Your statement has much to commend it, but I would like you to amplify on one line where you said, referring to suicides, "Most were young and suffered from mental illness. All left behind a wake of unimaginable pain and unresolvable guilt." Would you amplify that?

Dr. JAMISON. Yes. Actually I had no intention of writing a book about suicide because I thought it would be, from a scientific point of view, overwhelming and, from a personal point of view, something I just did not want to do.

I did a book tour for a book I had written about my manic depression, and every single place I went, someone came up to me—and usually four or five people would come up with photographs of 15- or 17- or 20-year-old kids who had killed themselves. The cumulative effect of that was—it is one thing to read the statistics and another thing to go to town after town, city after city across the United States and see the death toll and see the guilt, the unresolvable guilt, 20, 30 years later. What could I have done differently? What ought I have done? What can I do to protect my other children? It just seemed to me an appalling indictment of somewhere in society, given what we know about the scientific basis, the biological basis of the illnesses that are responsible for suicide, that people would feel so personally accountable for them.

I just think that unless you have been there, there is no way of knowing the kind of guilt that people feel because there is always something that somebody could have done differently. I mean, that is just a given. Whether it is a friend or a colleague or a family member, we all know we could have done something more or different.

You are asking about what can people do. One of the things I am struck by is people will send their kids off to college, and they will go check out the libraries. They will go check out the graduate record scores. They will go check out the admissions into law school rates. They will check out everything. But they will not check out the mental health facilities at the campuses. They will not sit down and talk with their kids about, look, we have got depression in our family, or your uncle committed suicide. You are a little bit at risk. What can we do about it? Let us talk about it. There are things that people can do now within families and communities that are not being done, much less at the government level. That is what I find, I guess, so awful.

Senator REID. Mr. Chairman, would the chairman yield just for a brief statement?

Senator SPECTER. Sure.

Senator REID. We talk about every 17 minutes someone killing themselves. Those are the reported suicides. The automobile accidents and the many other things that happen that are not counted as suicides that really are would increase that number. Would you agree?

Dr. JAMISON. Yes, absolutely. I spent a fair amount of time with medical examiners over the last several years, and they talk about a child who was 17 years old and had a gunshot wound to the head, wrote a suicide note. The parents will still say it was an accident because they cannot bear to live with the fact that it was a suicide and put pressure on the medical examiner's office to classify it as an accident.

Senator SPECTER. Thank you, Dr. Jamison.

Dr. Mann, you talk about studies which you would like to undertake. What response are you getting from the National Institute of Mental Health on your applications? The \$5.2 billion increase in the last 3 years ought to have given some extra leeway. Are you having much luck?

Dr. MANN. Well, thanks to your leadership and your colleagues', there has been a very significant increase in funding at the NIMH.

Senator SPECTER. Is it filtering down?

Dr. MANN. Yes. In fact, we have had a meeting with Steve Hyman not so long ago, and he has been very supportive and forthcoming in terms of creative funding mechanisms and arrangements to try and implement the kind of treatment trials that we have been talking about today. So, we are very optimistic, with your support and working with the NIMH, that we will see some of this bearing fruit in the very near future.

Senator SPECTER. Dr. Hyman is still here. He liked that comment.

Dr. HYMAN. Yes. This is a very well-funded man speaking.

Senator SPECTER. Perhaps even better in the future.

Dr. Fildes, what would you recommend to a parent who sees some danger signals in his or her child?

Dr. FILDES. I have the opportunity to actually treat patients like this, and we have these patients and their families talk about the problem and do so with the help of professionals.

There are many, many times when I treat a young patient, or even an elderly individual, who has had a very serious, serious sui-

cide attempt and saved their lives, only for a few days later for them to say, oh, I cannot believe what I have done. I do not understand what I have done, but I will never do it again. In that moment, that crystallizes the elements of the cure that we are talking about, that we are all trying to find and apply across the numbers of patients around the United States.

Senator SPECTER. Dr. Blumenthal, the red light is on. I do want to ask you one final question for this panel. You were here, as you noted, 15 years ago. What has been the extent of the progress on dealing with suicide, if any progress in fact has been made? And is it adequate?

Dr. BLUMENTHAL. Well, I think we have seen progress. We have seen recent declines in some of the suicide rates over the past decade for certain populations, although others have gone up, for example, young black males. We have seen more systematic research being conducted at the NIMH and at CDC, the testing of new intervention trials in SAMHSA. But clearly, much more needs to be done.

I just want to underscore that suicide is a complex human behavior. It requires interventions that are multiple, targeted to those risk factor domains. For example, most people who commit suicide have a mental illness, but most people with mental illness do not commit suicide. Therefore, we need to strengthen the protective factors for people. We need to increase social supports, decrease access to lethal methods in the homes, such as guns. We need to promote resiliency and educate young people about mental health in the schools, and we need to, again, increase access to mental health services in our country.

Senator SPECTER. Thank you very much, Dr. Blumenthal, Dr. Jamison, Dr. Fildes, Dr. Mann. We appreciate very much your being here.

We now go to our final panel: Ms. Danielle Steel and Ms. Jade Smalls. Congresswoman Nancy Pelosi will introduce Ms. Danielle Steel.

STATEMENT OF HON. NANCY PELOSI, U.S. REPRESENTATIVE FROM CALIFORNIA

Senator SPECTER. First we will call on Congresswoman Pelosi for the introduction. She is serving her seventh term in the House, representing California's 8th congressional district, won her last election by a narrow margin, with 86 percent of the vote. She is a member of the House Select Intelligence Committee and is a member of the House Appropriations Committee and serves on the Subcommittee of Labor, Health and Human Services, where we have all collaborated on a great many appropriations matters.

Congresswoman Pelosi.

Ms. PELOSI. Thank you very much, Mr. Chairman. Thank you for your leadership on this issue, to you, to Senator Reid, to this committee, for facing this issue head on. There is so much denial about it in the country.

Senator Wellstone extended his regrets in having to go to another meeting, but you pointed out his tremendous leadership, in addition to Senator Reid's and yours, on this issue.

Mr. Chairman, Senator Reid, I am here this morning as a proud Representative of San Francisco, proud of my constituent, Danielle Steel, and delighted that I can say that she is a personal friend for many, many years.

She is a household word in many homes in America, but she is a very private person.

When I think of Danielle Steel, I think of one word: mother. She is first and foremost a mother of a beautiful family. Many of her children are with her today at this hearing.

This is a real act of courage on the part of Danielle Steel. She is a very, very private person although, as I say, well known. She shared her apprehension with me about facing this committee, and I told her she had nothing to fear, that it would be painless. But that is the small part of the courage. The larger part of the courage is her being here to tell the personal story of Nick Traina. It is in that spirit of Danielle as a mother that I am proud to sit with her and present her to the committee.

Thank you, Mr. Chairman.

Senator SPECTER. Thank you very much, Congresswoman Pelosi.

STATEMENT OF DANIELLE STEEL, BEST-SELLING NOVELIST AND AUTHOR OF "HIS BRIGHT LIGHT"

Senator SPECTER. Ms. Steel, as noted, is a world-renowned author, 77 books. The Guinness Book of World Records noted that one of her books was on the New York Times Best Seller List for 381 consecutive weeks. Her most important piece of work perhaps is the one she wrote in honor of her son Nick who committed suicide at the age of 19. The book, entitled "His Bright Light," was written to remove the stigma associated with mental illness.

She is the mother of nine children and comes before us today to comment about her very extensive and tireless efforts to help other children who suffer from emotional distress.

Thank you for joining us, Ms. Steel.

Ms. STEEL. Thank you very much, and thank you for the lovely introduction.

I would like to thank the ladies and gentlemen of the Senate Appropriations Committee for having me here today. I do not ever speak publicly, but it was an honor and an invitation that was impossible to resist.

I also feel better being here today because all of my children assured me that I am not famous.

I was asked to speak about my son Nick. It is a huge challenge to paint a portrait of him for you in so little time. Brilliant, charming, wonderful, loving, talented, funny, outrageous, tormented, unforgettable.

Senator SPECTER. Ms. Steel, we have moved rather expeditiously. Senator Reid has weighed in in your favor for an extra 5 minutes, and we have the time. So, take 10.

Ms. STEEL. Thank you very much. I was frantically crossing things off before I sat down.

He was a magical child, an extraordinary boy. He suffered from manic depression all his life and committed suicide at 19.

As a baby, when people would ask his name, he would answer, I'm incredible. Because people said it of him so often, he thought

that was his name. He was a remarkable child and became an even more remarkable young man.

By the time he was 2, I knew something was wrong with him. He was like a record playing on the wrong speed, way, way too fast. By 4, I know now that he was manic. I feared even then that he was sick. At 7, I was convinced of it. He was brilliant, had good grades, but was moody, troubled, easily enraged. I turned to doctors and psychiatrists throughout his early childhood and was always told that he was fine. I felt in my heart that was not true, although I wanted it to be true. I sensed that there were terrible demons lurking deep within. I cannot even tell you how I knew, but I knew.

At 12, his best friend died in an accident. Nick was doing well in school, but he began dabbling in drugs and he was deeply depressed much of the time, sitting in the dark in his room. He was full of contrasts. Sometimes he would be jubilant. He was loving and funny. Sometimes he was too depressed to move. Often he was awake all night, sometimes till 8 a.m. Nonetheless, the psychiatrists we saw insisted he was fine. They were charmed by him.

By 13, Nick's life began to fall apart. From then on, his life was a constant merry-go-round of schools where he could not conform, psychiatrists, special programs for emotionally disturbed kids, and brief stays in mental hospitals to evaluate him. They said he was difficult and blamed it on his high IQ.

He remained undiagnosed and unmedicated until 15 when I was told he had attention deficit disorder. By 15, I believed he was suicidal, although he never put it in words. My instincts were right. When I read his journals after his death, I discovered that from the age of 11 on, he wrote about killing himself every single day.

At 15, he became more and more impossible to manage. He spent 5 months in mental hospitals, and we could not get him functional enough to come home. Yet, through it all, he was brilliant, charming, affectionate, angry, confused. We tried three different hospitals in 1 year. No one was able to do anything for him. By the end of that time, he was curled in a ball, terrified and sick.

At 16, he was finally diagnosed bipolar and put on lithium. Within 3½ weeks, he was sane, whole, functional, and back in school getting straight A's.

Life began for Nick at 16. He said that on lithium he felt normal for the first time in his life. He did well in school. He began in earnest a music career that he had longed for and worked towards for years. Music was his passion and his joy. He had huge charisma and talent, and in the next 3 years, he released nine CD's, played hundreds of concerts, did two national tours with his band, appeared on MTV, and was scheduled to tour Europe and Japan. He was a lyricist, composer, musician, and lead singer of an increasingly successful punk rock band.

He became then the boy I knew and loved so fiercely who was not only my son, but became my best friend. He had compassion, wisdom, joy, and a sense of humor about others and himself. He worked tirelessly. He had a quick tongue and a big heart, and where he saw pain, he would reach out a hand.

His hospital stays then were to readjust his medications. He had two psychiatrists, a live-in psychiatric counsellor, and took three

medications daily, upon which his life and well-being relied. He had nurses from the age of 14 to accompany and protect him from his lack of impulse control. Once on lithium, he was virtually drug-free.

From 16 on, Nick lived in a cottage of his own with his nurses and the psychiatric counsellor who oversaw everything he did.

He graduated from high school and did one term of junior college, and his life in his late teens was a whirlwind of rehearsals, concerts, and road tours. Wherever he went, he was accompanied not only by his fellow musicians and his equipment, but by his nurses, his counselor, his medications, and his disease. Wherever he was, even on tour, we checked his lithium levels, with blood tests weekly, to make sure that they were high enough. We tested him daily for drugs to make sure that he was not dabbling, and with rare, rare exceptions he was not.

We thought we were home free. Only in reading his journals later did I realize how constantly tormented he still was and how close to the abyss he always lived. On medications, he appeared balanced and happy most of the time. He insisted, and we wanted to believe, that he was fine. That outward appearance of fineness even fooled him.

At 18, Nick decided he no longer needed medication. He felt great. He stopped taking lithium, became almost instantly manic, and within 5 weeks attempted suicide by taking a virtual arsenal of drugs. It left him with damaged kidneys, liver, spleen, heart, temporarily deaf, briefly incoherent, and paralyzed both his legs.

Before he had even recovered, 10 days later he tried again in a locked suicide ward while on suicide watch. And he attempted suicide yet again for a third time 2 months after that.

We got him back on Prozac and lithium and he finally accepted the seriousness of his disease. From then on, he handled his illness and medications extraordinarily well, with maturity and responsibility, telling us if he did not feel right. When that was the case, we would put him in the hospital for a few days to readjust his meds.

Five months after his third suicide attempt, Nick was on medication, healthy, strong, in great spirits, the best he had ever been. On a 3-month tour with his band, exhaustion set in and he began to get depressed and spiral down. Ten days before the end of the tour, he knew he had to leave. He was too sick to stay. He knew his health and life were in jeopardy, and in despair, he left the tour and quit the band. He flew home and took to his bed for 5 weeks. I had never seen him as down.

Determined to rise from the ashes, he started another band immediately and, in a short time, played two local concerts and recorded a new CD. But he still did not feel right and asked to be put in the hospital. Two hospitals refused to admit him, said there was no reason to, that he was fine.

Ten days later, Nick took a massive overdose of morphine, a substance to which he knew he was fatally allergic, and this time his attempt was successful. He died at 19.

I believe he did it because he could not bear to sink to the depths again and knew he would one day. He did it because he knew he could no longer tour and was not strong enough to endure the rig-

ors of his musician's life, which he loved so much. He felt he had no other choice. It was his only way out. His final freedom from pain.

Nick taught me to let go of every preconceived idea I ever had. He forced me to be open and creative in new ways every day of his life. He taught me to focus on what he could do rather than what he could not, to celebrate and value his accomplishments and accept his defeats with grace. He was a lesson in accepting people who are different and loving them as they are. Even with his illness, he accomplished more than most people I know. His life was a victory in so many ways.

I tell you his story not so you can mourn him or pity me, but because his story needs to be heard. He was not alone in his illness or his outcome. He is unusual perhaps only because he had a family which was so fiercely devoted to him. He had loving parents and eight siblings who adored him and a team of supporters who worked tirelessly to keep him happy and alive. We had enormous resources and energy with which to support him. For as long as we could, in every way we could, we would not let Nick die. I no longer feel that we lost him early, although his life was certainly far too short, but I feel that we kept him alive for 8 years longer than he planned.

A great number of manic depressives attempt suicide and many of them succeed. What we need to think of now is how to best serve others like him. The question is: How do we rouse psychiatrists to diagnose and medicate bipolars early enough to make a difference to save lives?

Five years ago, it was a rarity for Nick to get lithium at 16. It is a miracle if children are being diagnosed and medicated now, and if so, I believe it will improve and maybe even save their lives. If Nick had been treated at 5 or 6, he would have been spared 10 years of agony and might perhaps be alive today. I believe that early diagnosis and medication are crucial to the well-being and survival of kids like Nick; and to give them a better chance.

I am turning to you now, asking you to open eyes in this country, the eyes of the public, the eyes of the doctors who treat them. Open not only eyes but hearts. You have the power to affect how and when and in what ways mental illness is treated. Together we can change how it is perceived. Each of us in some way is touched by a life like Nick's. Use us, use me, use Nick as an example. Use others like him to cast a bright light into the dark abyss where people like Nick live. It is no longer good enough to diagnose bipolars in their 20's, as was the tradition. They are sick long before that. They need help long before that. They need medication long before that. They die long before that.

PREPARED STATEMENT

Nick Traina is one boy, one child, one life lost. But he speaks for an army of people out there who need your help, not only people who are themselves sick, but people who love them and care about them, mothers, brothers, fathers, sisters, husbands, wives, friends, daughters, sons. Let us all reach out to help. Let us make a difference for even one life. And may God bless you for your courage, your wisdom, and your kindness. On behalf of Nick and my family

and those of us who have lost loved ones, and particularly those who are still struggling with them, I give you my thanks for the lives you will touch and save.

[The statement follows:]

PREPARED STATEMENT OF DANIELE STEEL

I would like to thank the ladies and gentlemen of the Senate Appropriations Committee for having me here today. I do not ever speak publicly, but it was an honor and an invitation that was impossible to resist.

I was asked to speak about my son Nick. It is a huge challenge to paint a portrait of him for you in so little time. Brilliant, charming, wonderful, loving, talented, funny, outrageous, tormented, unforgettable. He was a magical child, an extraordinary boy. He suffered from manic depression all his life, and committed suicide at nineteen.

Nick spoke English and Spanish fluently before he was one. He walked at eight months, loved disco music before he could walk, and when people would ask his name, he would answer, "I'm incredible!" because people said it of him so often, he thought that was his name. He was a remarkable child, and became an even more remarkable man.

By the time he was 2, I knew something was wrong with him. He was like a record playing on the wrong speed, way, way too fast. By four, I know now that he was manic. I feared even then that he was sick. At seven, I was convinced of it. He was brilliant, had good grades, but was moody, troubled, easily enraged. I turned to doctors and psychiatrists throughout his early childhood, and was always told he was fine. I felt in my heart that that was not true, although I wanted it to be true. I sensed that there were terrible demons lurking deep within. I cannot even tell you how I knew, but I knew.

At 12, his best friend died in a car accident. Nick was still doing well in school then, but he began dabbling in drugs, and he was deeply depressed much of the time, sitting in the dark in his room. He was full of contrasts. Sometimes he would be jubilant, he was loving and funny, sometimes he was too depressed to move. Often he was awake all night, sometimes til 8 a.m., nonetheless, the psychiatrists we saw insisted he was fine. They were charmed by him.

In his early teens, Nick's life began to fall apart. By 13, Nick's demons were in full swing. From then on, his life was a constant merry go round of schools where he couldn't conform, psychiatrists, special programs for emotionally disturbed kids, and brief stays in mental hospitals to evaluate him. They said he was difficult, and blamed it on his high IQ.

He remained undiagnosed and unmediated until 15, when I was told he had Attention Deficit Disorder. He was put on Prozac then. By 15, I believed he was suicidal. He never put it in words, but was so often depressed and so isolated that I was afraid to go into his room, sure that I would find him dead, by his own hand. I know now that my instincts were right. When I read his journals after his death, I discovered that from the age 11 on, he had written about killing himself every single day. It took another eight years to accomplish it.

At 15, his life was a shambles. He became more and more impossible to manage. He spent five months in mental hospitals, and we couldn't get him functional enough to come home. Yet through it all, he was brilliant, charming, affectionate, angry, confused. We tried 3 different hospitals in one year. No one was able to do anything for him. By the end of that time, he was curled in a ball, terrified and sick.

At 16, we took him to UCLA, and he was finally diagnosed bi-polar, and put on Lithium. It was a miracle drug for him. Within three and a half weeks, he was sane, whole, functional, loving, funny, and back in school, getting straight A's.

Life began for Nick at sixteen. He said that on Lithium, he felt normal for the first time in his life. He did well in school. He began, in earnest, a music career that he had longed for, and worked towards for years. Music was his passion and his joy. He had huge charisma and talent, and in the next three years, he released 9 CD's, played hundreds of concerts, did two national tours with his band, appeared on MTV, and was scheduled to tour Europe and Japan. He was a lyricist, composer, musician, and lead singer of an increasingly successful punk rock band. And he became then, the man I knew and loved so fiercely, who was not only my son, but became my best friend. The depths to which he had been gave him an understanding, compassion, wisdom, joy, and a sense of humor about others and himself. He worked tirelessly. He had a quick tongue and a big heart, and where he saw pain, he would reach out a hand, he could never pass a homeless person without

buying them a meal. And despite the angelic qualities we see so clearly now, there were undeniably times when, much as we loved him, he drove us up the wall.

His hospital stays then were only to readjust his medications. He had two psychiatrists, a live-in psychiatric counsellor, and took three medications daily, upon which his life and well-being relied. He had constant nurses from the age of fourteen, to accompany and protect him from his lack of impulse control, which could cause him to walk across a freeway, or hang too far out a window. Once on Lithium, he was virtually drug-free. But there was a fragile quality to Nick, an ephemeral sense that he could break easily, or his life could instantly slip away.

From 16 on, Nick lived in a cottage of his own, with his nurses, and the psychiatric counsellor who oversaw everything he did.

He graduated from high school and did one term of junior college and his life in his late teens was a whirlwind of rehearsals, concerts, and road tours, driving endless hours across the country in a van to play with his band. Wherever he went, he was accompanied, not only by his fellow musicians and his equipment, but by his nurses, his counsellor, his medications, and his disease. Wherever he was, even on tour, we checked his Lithium levels with blood tests, weekly to make sure that they were high enough. We tested him daily for drugs, to make sure that he wasn't dabbling, and with rare, rare exceptions, he was not. We thought we were home free. Only in reading his journals later did I realize how constantly tormented he still was, and how close to the abyss he always lived. On medications, he appeared balanced and happy most of the time. He insisted, and we wanted to believe, that he was fine. That outward appearance of "fineness" even fooled him.

At 18, Nick decided that he no longer needed medication. He felt great. He stopped taking Lithium, became almost instantly manic, and within five weeks attempted suicide by taking a virtual arsenal of drugs. It left him with damaged kidneys, liver, spleen, heart, temporarily deaf, incoherent briefly, and paralyzed both his legs. Before he had even recovered, ten days later he tried again, in a locked psychiatric ward, while on suicide watch. And he attempted suicide yet again, for a third time, two months after that.

We got him back on Prozac and Lithium, and sometimes a third medication. He himself finally accepted the seriousness of his disease, and that it would be not only a life-time battle, but a lifetime maintenance issue for him. I compared it to diabetes, which made sense to him. From then on, he handled his illness and medications extraordinarily well, with maturity and responsibility, telling us if he didn't feel right. When that was the case, we would put him in the hospital for a few days to readjust his meds.

Five months after his third suicide attempt, Nick was on medication, healthy, strong, and in great spirits, the best he had ever been. And he left on a 3 month tour with his band. But with the rigors of the tour, exhaustion set in, and he began to get depressed and spiral down. Ten days before the end of the tour, he knew he had to leave. He was too sick to stay. He knew his health and life were in jeopardy. And in despair, he left the tour and quit the band. He flew home and took to his bed for 5 weeks. I had never seen him as down.

Determined to rise from the ashes, he started another band immediately, and in a short time, played two local concerts, and recorded a new CD. But he still didn't feel right, and asked to be put in the hospital. Two hospitals refused to admit him, and said there was no reason to. Ten days later, Nick took a massive overdose of morphine, a substance to which he knew he was fatally allergic, and this time his attempt was successful. He died at nineteen.

Nick committed suicide in the 90 minute window in his nursing schedule at 4:30 a.m. On the only night in five years that his counsellor in charge, who loved him dearly, had gone away. I believe he did it because he could not bear to sink to the depths again, and knew he would one day. He did it because he knew he could no longer tour, and was not strong enough to endure the rigours of his musician's life, which he loved so much. He felt he had no other choice. It was his only way out. His final freedom from pain.

Nick taught me to let go of every preconceived idea I ever had. He forced me to be open and creative in new ways every day of his life. He taught me to focus on what he could do, rather than what he could not, to celebrate and value his accomplishments, and accept his defeats with grace. He was a lesson in accepting people who are different, and loving them as they are. Even with his illness, he accomplished more than most people I know. His life was a victory in so many ways.

I tell you his story not so you can mourn him, or pity me, but because his story needs to be heard. He was not alone, in his illness, or his outcome. He is unusual perhaps only because he had a family which was so fiercely devoted to him. He had loving parents and 8 siblings who adored him, and a team of supporters who worked tirelessly to keep him happy and alive. We had enormous resources and energy with

which to support him. For as long as we could, in every way we could, we would not let Nick die. I no longer feel that we lost him early, although his life was certainly far too short, but I feel that we kept him alive eight years longer than he planned.

A great number of manic-depressives attempt suicide, and many of them succeed. What we need to think of now is how to best serve others like him. The question is: How do we rouse psychiatrists to diagnose and medicate bi-polars early enough to make a difference to save lives? There are other questions as well: How do we offer mental health care to people who cannot spend what we did? How do we reach out among the homeless and figure out who is mentally ill, and give them the medical attention they need? How do we erase the stigma of an illness so vicious, so brutal, and so costly, so that people will no longer be embarrassed or afraid to get help, either for themselves, or the people they love?

In the two years since Nick has been gone, I have heard of a few early diagnoses, of children as young as 5 or 6 being diagnosed bi-polar, and being given Lithium. Five years ago, it was a rarity for Nick to get Lithium at 16. It is a miracle if children are being diagnosed and medicated now, and I believe it will improve and maybe even save their lives. If Nick had been treated at 5 or 6, he would have been spared 10 years of agony, and might perhaps be alive today. I believe that early diagnosis and medication are crucial to the well-being and survival of kids like Nick; and to give them a better chance.

I am turning to you now, asking you to open eyes in this country. The eyes of the public, the eyes of the doctors who treat them. Open not only eyes, but hearts. You have the power to affect how and when and in what ways mental illness is treated. Together we can change how it is perceived. Each of us, in some way, is touched by a life like Nick's. Use us, use me, use Nick as an example, use others like him to cast a bright light into the dark abyss where people like Nick live. It is no longer good enough to diagnose bi-polars in their twenties, as was the tradition, they are sick long before that. They need help long before that. They need medication long before that. They die long before that.

Nick Traina is one boy, one child, one life lost. But he speaks for an army of people out there who need your help, not only people who are themselves sick, but people who love them and care about them, mothers, brothers, fathers, sisters, husbands, wives, friends, daughters, sons. Let us all reach out to help, let us make a difference, for even one life. And may God bless you for your courage, your wisdom, and your kindness. On behalf of Nick, and my family, and those of us who have lost loved ones, and particularly those who are still struggling with them, I give you my thanks for the lives you will touch, and save.

Senator SPECTER. Thank you very much, Ms. Steel, for that very powerful testimony, and thank you for the book about Nick and sharing it with so many other people. We thank you.

Congresswoman Pelosi, we know of your busy schedule, so whenever you feel like departing, you are obviously free to go.

STATEMENT OF JADE SMALLS, EVANSTON, ILLINOIS, FIRST RUNNER-UP, 1999 MISS AMERICA PAGEANT

Senator SPECTER. We next turn to Ms. Jade Smalls, currently taking a year off from her studies as a senior at Northwestern University to serve as Miss Illinois. At the Miss America Pageant where she was first runner-up, she promoted youth suicide prevention as her platform, and she continues to speak statewide and nationally on the topic. She has conducted research in the area of suicide prevention with institutions such as the National Institute of Mental Health and the Center for Disease Control. Thank you very much for joining us, Ms. Smalls, and we look forward to your testimony.

Ms. SMALLS. Thank you and I am definitely honored to be here amongst all these experts and humbled by the courage of the survivors. I will be honest and let you know that I tend to run about 22 to 34 seconds over. I hope that you can forgive me for that in advance.

Senator SPECTER. That is fine. Thank you.

Ms. SMALLS. About 5 years ago, I did lose a classmate in a very unnecessary way, and it began with her dating an older boy who was a bad influence and suddenly turned into the two of them going on a cross-country crime spree that left an innocent bystander dead. In the end, it ended in a tragic double suicide where my friend and her boyfriend ended their own lives. Five years ago, this would have been an isolated incident, but here we are today and can we even count the number of times that we have seen suicide and homicide combine within our schools?

As Miss Illinois, I have been blessed with the amazing opportunity to speak in schools about suicide prevention. And I have to tell you that not so long ago, I would have never been allowed there because we thought that suicide should not be discussed with students. But now things are changing, and if anything good has come from these recent tragedies in our schools, it would have to be the newfound willingness now of these administrations to address issues that they had either pretended or had not realized existed.

Of course, there is still some hesitation on the part of school administrators, and who can blame them? But that does not mean that they do not want to be a part of the solution. I am here to ask for the funding that is going to provide them with the resources they need to help them become the lifesavers we know they can be. And I am here because I have seen the faces of children affected by suicide and I have heard the voices of teens that are crying out for help not only for themselves, but for their peers around them. Most importantly, I am here to make sure that we use this opportunity wisely. Right now our schools are eager to help and because of the Surgeon General's initiatives, our Government has the means and the research now more than ever to bolster the spread of information.

I think you have heard every single panelist here talk about suicide having a stigma, being a silent killer. When I go to schools, sometimes I ask the kids to raise their hands if they have ever broken an arm or a leg before, and they all raise their hands. Then I ask them if they were ashamed to have to wear a cast or if their first reaction was to pretend like nothing was wrong or did they try to fix their broken leg by themselves. And, of course, they look at me in disbelief because they know that when they are hurting, they are supposed to ask for help. But why is it so different for mental illness? Students agreed that mental illness and depression were often viewed as things to be ashamed of or issues that they should work out by themselves. But we do not tell cancer patients to snap out of it or we do not tell AIDS patients to get over it.

In one high school with an audience of over 2,000, a girl raised her hand and shared that she had been diagnosed with manic depression. She had suffered for years by herself and had in her own words experienced the shame attached to her illness. Right there that day in her own school she broke down so many walls of stigma that had been built up, and she told her student body that it was okay to ask for help. Her comments brought forth confessions of past suicide attempts, opened doors to healing for survivors of suicide in her school, and helped to close the gap between the student

body and the faculty. But she should not have to bear this burden alone.

My work in the schools has convinced me that the need is great and the tools of solution are few. I think we should provide funding that will institute, as we heard said before, self-check opportunities and depression screening in our schools so students can be diagnosed early. Let us provide funding to develop mental health curriculums for school aged children to teach the language of mental health and to bring awareness to the signs of depression and suicide.

Only 1 percent of suicide prevention curriculum has actually reached the schools. Nevertheless, we have organizations like the Ronald McDonald House Charities who has already created a suicide prevention CD-ROM to give out to schools. But they are only one organization in the private sector and they cannot possibly reach the countless numbers of schools. I suggest that maybe our Government agencies like the Department of Health and Human Services, the Department of Education, and the National Institute for Mental Health collaborate to create mental health cd-rom's that will provide in-school resources and, of course, could be distributed on a faster and farther scale. Schools also need funding initiatives to support behavior modification programs aimed at breaking stereotypes that are inhibiting our children from seeking help.

I am really here to let you know that young people want to help their peers. YM magazine, a young women's magazine with a readership between the ages of 13 and 19, recently ran an article on suicide, and they listed the toll-free number for SPAN for anyone interested in fighting the war against suicide. I spoke with Elsie Weyrauch, founder of SPAN and survivor of suicide, and she told me of the overwhelming response by young people under the age of 25 who wanted to help. But in particular, there was one girl, and she wanted to learn how to help a friend who had repeatedly attempted suicide. Elsie told me that that little girl was only 12 years old, and that said so much. She is obviously younger than the average readership of YM magazine.

When we think of little children, we associate them with things like Disney or bicycles and Barney, but through my research, I learned of a 5-year-old boy. He committed suicide and he left his note in crayon. I am trying to imagine this little guy who had probably only begun to learn how to write, and there he was forming his little fingers around that crayon, writing those final words. We cannot wait any longer.

So, the reason I am here is to stand before you representing that 5-year-old little boy and that 12-year-old little girl and the thousands of kids that we have lost this week alone to suicide. I also represent the thousands of living young people who want to be a part of the solution.

PREPARED STATEMENT

I want to make sure that that little girl will never again have to call Marietta, Georgia to find out how she can help her loved ones. So, I am here to call you to action and ask you for the funding that is going to allow these initiatives to become not yet another document that is one of those ones that sit on the shelves and

collect dust, but one that is going to help save many, many lives. And I believe the time to act is now.

[The statement follows:]

PREPARED STATEMENT OF JADE SMALLS

About five years ago, I lost a classmate in a very unnecessary way. It began with her dating an older boy who was a bad influence and suddenly turned into a real life nightmare. The two of them went on a cross-country crime spree that left an innocent bystander dead. After finally being cornered by police, my friend and her boyfriend refused to surrender and instead they killed each other inside of the car they had stolen. Five years ago, this would have been an isolated incident. But here we are today and can we even count the number of times we have seen suicide and homicide combine within our schools?

As Miss Illinois, I am blessed with the amazing opportunity to speak in the schools and spread the message of suicide prevention. Not so long ago, there would have been no place for me in these schools because it was thought that suicide was not a topic to be discussed with students. Now things are changing. If we can find that anything good has come from these recent tragedies in our schools it would have to be the newfound willingness of these schools and their administrations to address issues they had pretended or had not realized existed.

Of course, there is still some hesitation on the part of school administrators and who can blame them? But that does not mean that they do not want to be a part of the solution. I am here to ask for the funding that will provide them with the resources they need to help them become the lifesavers we know they can be. I am here because I have seen the faces of kids who have been effected by suicide. I have heard the voices of teens that are crying out for help not only for themselves but for their friends as well. Most importantly, I am here to make sure that we use this window of opportunity wisely. Right now our schools are eager to help and—because of the Surgeon General's initiatives—our government has the means and the research now more than ever to bolster the spread of information on suicide prevention to our nation's youth.

Some of you have heard suicide previously referred to as the "quiet epidemic". Suicide is such an effective silent killer because of the stigma that surrounds it. I often ask students to raise their hands if they've ever broken an arm or a leg before. Many hands go up. When I ask them if they were ashamed to have to wear a cast or if their first reaction was to pretend like nothing was wrong, to hobble around with a dislocated joint, or to try and fix the bone themselves they look at me in disbelief. They know that when they are hurting they are supposed to ask for help. So why is it so different for mental illness? Students agreed with me that mental illness and depression were often viewed as things to be ashamed of, issues that should be worked out within the individual himself. Yet no one tells a cancer patient to "snap out of it" or an Aids patient to "get over it".

In one high school, with an audience of two thousand, a girl raised her hand and shared that she had been diagnosed with manic depression. She had suffered for years by herself and had, in her own words, "experienced the shame attached to her illness". She wanted her student body to know that it was okay to ask for help. That day she broke down walls of stigma that had been built up in her own life and in her own school. Her comments brought forth confessions of past suicide attempts, opened doors to healing for survivors of suicide in her school, and helped to close the gap between the student body and the faculty. But she should not bear that burden alone.

My work in the schools has convinced me that the need is great and the tools of solution are few and far between. Let us provide funding that will institute self-check opportunities and depression screening in our schools so students can be diagnosed early enough to receive proper care. Let us provide funding to develop mental health curriculums for all of our school aged children to teach the language of mental health, to help students become aware of the signs and symptoms, and to provide educators with links to those agencies available to save our children. Sadly, only 1 percent of suicide prevention curriculum has reached our high schools. The Ronald McDonald House Charities has taken a step in the right direction by creating a suicide prevention cd-rom, called "Team Up to Save Lives", to be distributed in schools. They are doing their part in many communities but as one private sector foundation they cannot possibly reach the countless number of schools in need. I suggest that our government agencies such as the Department of Health and Human Services, the Department of Education and the National Institute for Mental Health collaborate to create mental health cd-roms that will provide in-school

resources, information and prevention strategies that could be distributed faster and farther on a national scale. Schools also need funding initiatives to support behavior modification programs aimed at breaking stereotypes that inhibit our children from seeking help.

I am here to let you know that young people want to help keep their peers alive. YM magazine—a young women’s magazine with a readership between the ages of 13 to 19—recently ran an article on suicide and listed the toll free number for SPAN, the Suicide Prevention Advocacy Network, for anyone interested in fighting the war against suicide. I spoke to Elsie Weyrauch, founder of Span and survivor of suicide, and she told me of the overwhelming response from young people who wanted to know how they could help. She remembered one particular call from a little girl who said she wanted to help a friend who had repeatedly attempted suicide. That little girl was only 12 years old. She was younger than the average readership for YM magazine.

When we think of little children we associate them with Disney, bicycles and Barney. Through my research I learned of a little boy, who was only 5 years old. He committed suicide and he left his note in crayon. I am trying to imagine this little guy who had probably just learned to form his fingers around that crayon. Yet, there he was writing those final words. We cannot wait any longer! That is why I am standing before you, speaking for that 5 year old boy, the 12 year old girl and the young people who have died this week and over the years by suicide. I also represent the thousands of living young people who want to be a part of the solution.

Let us make sure that that little girl will never again have to call Marietta, Georgia to learn how she can help a friend. We are calling you to action, asking you to fund the initiatives set forth by the Surgeon General to assure that this document does not become yet another article that collects dust, but a living breathing one that saves lives. The time to act is now.

Senator SPECTER. Well, thank you very much, Ms. Smalls.

The request that you have made is work in progress. We are seeking to increase NIH funding by \$2.7 billion. It is now right at \$19 billion. It has come up \$5 billion in 3 years. Those are astronomical increases because we believe that the National Institute of Mental Health and other agencies require that kind of help.

As Dr. Hyman commented, a special initiative was put into effect last year reallocating more than \$700 million for school violence which is very closely associated with these kinds of problems.

Senator Reid, we are going to have to close within the next 2 minutes.

Senator REID. Mr. Chairman, I just wanted to again express my appreciation to you. I do not think that we need to ask questions to these witnesses. They are here because of who they are. And you have focused attention on an issue that needs focusing. We are grateful to you and we look forward to working with you down the road to make sure that some of the things we talk about become realities to stop suicides every 17 minutes.

Ms. SMALLS. Thank you.

Ms. STEEL. Thank you so much.

Senator SPECTER. Senator Reid, thank you very much, and thank you very much, Ms. Steel and Ms. Smalls. Your testimony is very powerful, obviously.

Ms. Steel, as you recounted the sequence of events with your son, you did so very much. I do not know what more you could have done. When you bring the insight about starting at the age 5, I think that is a very telling factor.

Ms. STEEL. I think we wait too long very often and people hesitate to brand children with the label “mental illness,” and I think that is the issue of stigma, as Ms. Smalls says. We need to treat it like diabetes or any other physical condition.

Senator SPECTER. And when Miss America runner-up puts her fame, fortune, and beauty on the line, that speaks eloquently and loudly.

This hearing is only one step of many activities which this subcommittee and the full committee and the Congress will undertake.

So, we thank you very much.

Ms. STEEL. Thank you very, very much. Thank you, Senator.

CONCLUSION OF HEARING

Senator SPECTER. Thank you all very much for being here, that concludes our hearing. The subcommittee will stand in recess subject to the call of the Chair.

[Whereupon, at 11:02 a.m., Tuesday, February 8, the hearing was concluded and the subcommittee was recessed, to reconvene subject to the call of the Chair.]

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