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# Suicide Prevention in Georgia: Healing and Hope

Rosalynn Carter Georgia Mental Health Forum

May 21, 2002

Atlanta, Georgia

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# Opening Remarks

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Rosalynn Carter  
*Chair, The Carter Center Mental Health Task Force*

Today, we are going to talk about a problem in our state that takes the lives of too many of our citizens, the extent of which most people are unaware. I know I was shocked by the statistics. Eight hundred and fifty Georgians die every year from suicide. Even more disturbing is how many people attempt suicide: 17,000 Georgians end up in emergency centers every year because of injuries due to attempted suicide. These numbers do not include those who attempted suicide and do not go to the hospital, those that go unreported, or those deaths that were actually suicides but classified as death by accident or undetermined causes. Some, as we all know, are not reported because people wrongfully look at suicide as disgraceful or shameful. We need to change the attitude about suicide and learn what we can about it so that we can work to prevent it. There is so much we can do.

I am pleased that this year we chose to focus the Georgia Mental Health Forum on this issue. I have learned a lot just through the preparations. I also am excited that we have state officials here who are going to announce a statewide suicide prevention plan. Georgia will be one of the first states in the country to have such a plan, which is a source of great pride. This plan offers hope for families at risk and can serve as a model for our nation. Welcome to this important forum.



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# A Personal Story: There is a Light at the End of the Tunnel

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Art Buchwald, a native New Yorker, is one of America's great political humorists and columnists. His unique interpretations and clever commentary earned him a Pulitzer Prize in 1982. His twice-weekly column is syndicated in virtually every major newspaper in the world.

You could not have gotten a better speaker today. I have had two depressions and I have thought of committing suicide several times. The only reason I did not do it is I was afraid the *New York Times* might not print my obituary. I had a fear that General de Gaulle would die the same day and he would get all my space.

Like many people who contemplate suicide, I went around planning my funeral. It was going to be big and I had Tom Brokaw, Peter Jennings, and Dan Rather speaking for me. It was a weekday, so all my friends who were there kept looking at their watches. Since I lived in Paris for 14 years, the organist would only play Edith Piaf songs. I do not want you to think that I am taking the suicide subject lightly. It was hell. It was really hell. The fear of it was terrible. Well, I got better and I said to myself that the worst thing about suicide, and I have spoken about it everywhere I have gone, is that you cannot change your mind. This is a message

that I think all of you ought to take with you when you leave here: *Suicide does not work because you cannot change your mind.*

I got interested in coming out of the closet when I went on the Larry King show. It was one of the most successful he ever had done. It dealt with depression. Mike Wallace and I talked about our depressions. As soon as we talked about it, all his telephone lines lit up. It was one of the largest responses he has ever had. I accused him after the show that more than half of his audience was depressed people. Another theory that you can take with you: If you can save just one person you will feel it has not been in vain.

I do not deny that even in depression, humor plays some kind of a role. The two depressions in my life were the same things that made me a funny man. The question I am always asked is, "How do you become a professional funny man?" I always reply, "First you have to have an unhappy childhood." I kept going from one foster home to another. I had the luck to be able to make people laugh. I made the kids in my class laugh. Throughout my life I find that the love that I did not get in my family, I got from the crowd. After all the years of giving it away for free, I discovered society would pay vast sums of money if you make them laugh.

As I mentioned, I had two depressions, both severe enough to require hospitalization. The first depression was 25 years ago and the second one was seven years ago. The interesting thing is that I am a better writer now and a better person for the depressions. I had some sort of catharsis after having had it. The second



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People are much more  
vulnerable than ever before.  
They need to be listened to  
and they need our help.***

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thing I preach is that you get over it. When most people are in it, they see no hope. It is a black pit. But once they get over it, they feel a lot better. What I learned and keep learning is that to help people, you do not have to believe them. They do not believe that there is any hope. I repeat time and time again to people who come out of their depressions, "It is a temporary and extreme

phenomenon, but with therapy, drugs, and time, there is a light at the end of the tunnel." I also learned to listen to people when they are having a depression.

We all are dealing with the terrible reality that the price of drugs and even therapy that can help are out of sight and going higher and higher. We are going to go on with this year after year. As a result of Sept. 11, this country is threatened and the people are threatened. For that reason they are much more vulnerable and much more scared than they ever have been before. They need to be listened to and they need our help.

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## Questions and Answers

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**Q** Do you ever feel worried when you use humor with someone who is in crisis?

**A** No, because I am known as a humorist. As a matter of fact, this is a funny thing, but when I was manic-depressive and in my manic stage, nobody knew it because I was having such a good time. They would say, "He's a humorist." So, no one spotted it.

**Q** When you have a friend or loved one who tells you they want to commit suicide, are they telling the truth or are they just seeking attention?

**A** Either one, it does not matter. You have to take them seriously whether they are or not. You are not one to judge that. Secondly, and this is very sad, people who are committing suicide have relatives and loved ones who had to take the brunt of their depression, and it is very tough. Mary Wallace, who is the wife of Mike Wallace, started an organization for wives and relatives of depressed people because they were not getting any support and they were being treated very badly.

**Q** Were you afraid to let others know of your depression when it first started?

**A** Yes, because I am a humorist. That is how I make my living and I did not want people thinking I was depressed until I decided to base it on whether I could make people laugh or not. At the beginning, I was afraid but finally I got over that stigma and said, "Anything is better than the depression."

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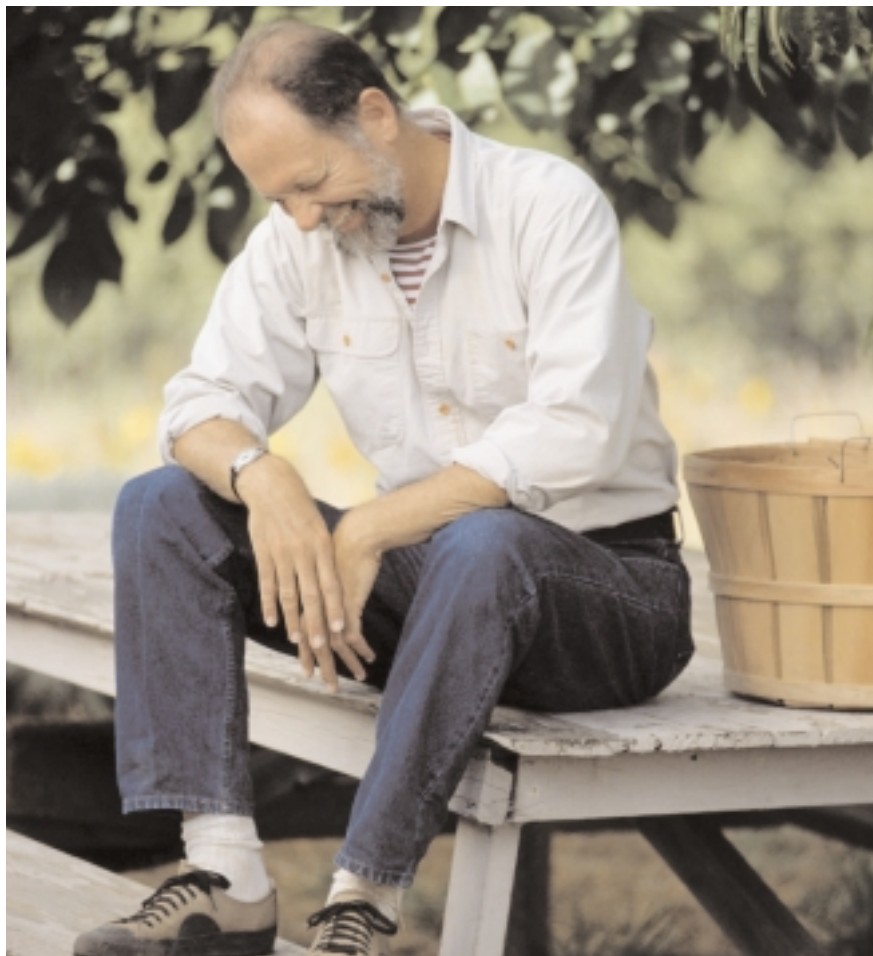
# Using a Public Health Approach to Prevent Suicide

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Mark Rosenberg, M.D., M.P.P., Executive Director, The Task Force for Child Survival and Development. Dr. Rosenberg is board-certified in both psychiatry and internal medicine, with training in public policy and public health. He was educated at Harvard University, completed a residency in internal medicine and a fellowship in infectious diseases at Massachusetts General Hospital and a residency in preventive medicine at the Centers for Disease Control and Prevention. Dr. Rosenberg is on the faculty of Morehouse Medical School, Emory Medical School, and the Rollins School of Public Health at Emory University. He was the founding director of the National Center for Injury Prevention and Control and attained the rank of Assistant Surgeon General.

We are on the verge of a really dramatic change. The question we will focus on today is: How do we get started? I would like to put forward a challenge for all of us and then I will propose the solution and a way that I think we can get started to achieve results that will far exceed our expectations.

The challenge is to look at the rates for suicide from 1938 to 1998. If you start in 1943, about 60 years ago, you see that the rates have not really changed. The rates for Georgia have followed the national rates.



The challenge for us is to cut the suicide rate in half by 2010. A lot of people would say we cannot do that. That is too big. That is too hard. It has not changed for 60 years. Now is the time for us to take on this challenge.

What will it take for us to inspire this change on a national scale? What will it take for us to inspire this change in Georgia? I believe it is within our grasp and we should consider how to approach it. We may be looking hard, but we have the approach in hand. It is the strategy we recognize as the public health approach. Within this approach there are three principles. The first is that our approach is going to be based on science. The second is that we are going to focus on prevention, and the third is that we are going to work together.

## Science

When public health, with its science-based approach, addresses a problem, we say that this is a cause-and-effect world and if we can understand the causes, we can change the outcome. In public health we believe that we can change things for the better. There are four questions that we ask in science: What is the problem? What are the causes? What works to prevent it? And how do you do it? We may not have brought these suicide rates down over the past 60 years, but our understanding of the brain and how it works has seen unbelievable progress. We now understand that there are a hundred billion neurons in the brain. It is a very complex organ.

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Understanding of neuroscience includes questions about what causes depression. What cures depression? What changes it? People used to think that anxiety was one thing and depression another. Our understanding of the brain is starting to show that these two things are very closely linked. Scientists can tell you anxiety is closely related to depression and most people who have an anxiety disorder will suffer an episode of depression in their life. If depression and anxiety occur together, the outcome is worse and the person is at higher risk for suicide. Our understanding of suicide and depression and the risk factors moves from a better understanding of neurons to a better understanding of neighborhoods and how we can change neighborhoods to reduce suicide rates.

## **Prevention**

The next part of the public health approach is prevention. Public health says we need to focus on the future. Public health also says we focus not just on the individual patient who comes to see the doctor, but on everyone's health. Our first reaction is often to comfort those who need comforting. That is very important, but we need to change that focus and start looking at the future.

In 1958, the Public Health Service started funding the first Suicide Prevention Center. In 1966, a Center for Studies of Suicide Prevention was established at the National Institutes of Mental Health, a leader in this field. In 1983, the Centers for Disease Control and Prevention established the Violence Prevention Unit, which started bringing epidemiological analysis and a public health approach to suicide. At that point, suicide prevention consisted of two approaches. One was to focus on crisis centers and hotlines so that someone who is at risk of suicide can call in and we can prevent

it. The other was to find people who are depressed and treat their depression. You had two opposing schools of thought that were quite separate. They spent as much time fighting each other as they did moving the field forward. They were very important starts but our efforts now are more sophisticated.

In 1985, the application of epidemiological analysis to the curves for suicide showed an amazing result. People thought these curves were flat, that they had not changed for years. When we started to break it down by age group, we found that the suicide rate for older people had started to come down and the suicide rate for younger people was going up at epidemic proportions. It engaged people to look at the phenomenon of youth suicide as an epidemic out of control.

There was a Secretary's Task Force appointed to look into the problem of youth suicide that started to focus on prevention and brought science in to gird the prevention efforts. In 1996, there were United Nations and World Health Organization guidelines for the formulation of national strategies. In 1998, the Suicide Prevention Advocacy Network had begun work at a national level. SPAN and founders Jerry and Elsie Weyrauch's boundless energy and work with people at the CDC and the Department of Health and Human Services started to move prevention forward. In 1999, Dr. Davidatcher, the Surgeon General, who is tremendously valuable to this movement, issued a Call to Action to Prevent Suicide. These efforts culminated in a national strategy for suicide prevention and action. This is a great example of the second principle in the public health approach in action.

## **Working Together**

The third principle is integrative leadership. Once you have the science, once you are





focused on prevention, how do you put that into place? How do you take the Georgia Prevention Plan and turn it from a plan into action and change? Georgia is a state with 850 deaths from suicide and 17,000 attempts every year. Somehow there is a system in place here that is producing those results. If we want to change them, we have to change that system. Changing systems is very hard to do one person at a time, but changing a system is something we can do together.

In public health, coalitions are very important. We need to look at how coalitions work and what makes them successful. First we must recognize that not all change leads to improvement, but you cannot have improvement without change. How do

collaboration and change go together? You need a firm base, as with everything in life. Plan, do, study, and act. By going through this cycle, there is a process we can do together. We are going to apply this process to working together to prevent suicide. We have extraordinary amounts of science out there at our disposal that we can use. We are going to stay focused on prevention with our eye on the prize: The prize is to bring the rates down. We are going to provide leadership that unites us and brings us together to increase the resources available in Georgia. I shall close with a quote from Goethe that says, "Knowing is not enough. We must apply. Willing is not enough. We must do." I think if we do, we will achieve success.

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## Questions and Answers

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**Q** In the mental health field, prevention is not funded, especially in the state system. How do we change the focus of funding agencies and state Medicaid insurance companies to realize the importance of prevention?

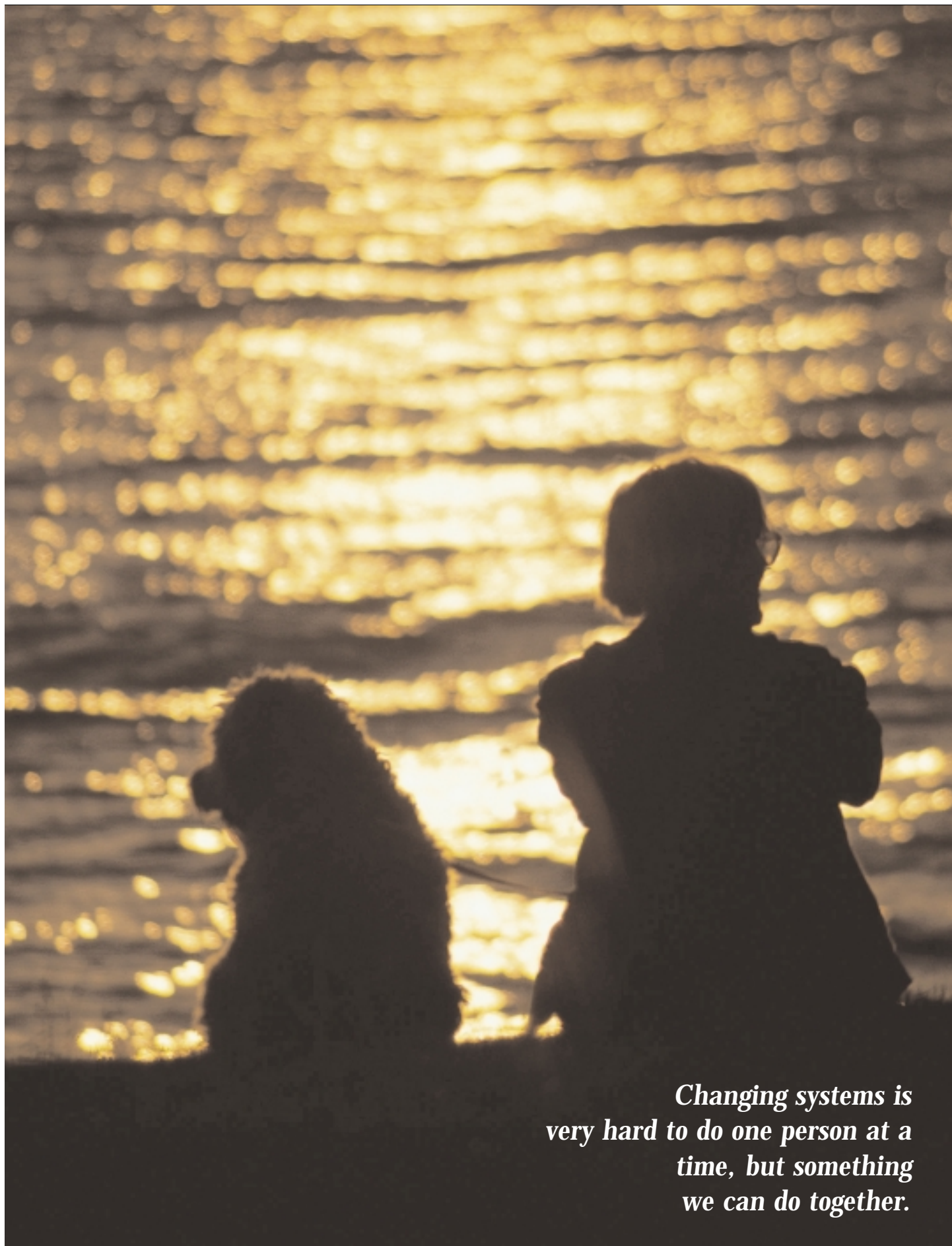
**A** Suicide is not the only field where it is hard to get support for prevention. If you look at AIDS, people were saying 20 years ago there is an unbelievably disastrous epidemic in the making and if we start by focusing on prevention now, we can keep this from happening. It was a human cry as powerful as any you can imagine. What happened? People ignored it and you see what we have today. It is very hard to shift that focus from treatment to prevention. It takes looking forward. It takes looking at people who have not yet been affected. William Foege, M.D., says that when you talk about cancer prevention, most people would not give a dime for prevention until about 10 seconds after they realized they have it, and then they would give everything they have for prevention. I think that we need to build on individual cases. People like Art Buchwald are so important in mounting this and helping people understand where we are. We also have to put in front of policy-makers and the people who control the budget division what we can do. It is no surprise that policy-makers do not see the value in prevention, but we can show it to them and we can convince them. It is not an easy sell, but it is so important. It is the only thing that is going to save lives.

**Q** Are there best practice prevention strategies?

**A** Yes, there is a good deal of information about best practices, including those strategies that have applied a science-based approach. That science base that we talked about is the evaluation of practices that have been put into place. They have been evaluated and can be applied. We need to build on those, but you need to know there are preventive interventions that work in schools. There are preventive interventions that work in a general population or work in psychiatric patients or that work for people with depression or substance abuse. We have a very strong base upon which to build.

**Q** What can be done in the public high schools for the children at high risk for suicide?

**A** You can try to actually identify those students at highest risk and reach out to them actively to get them involved. You also can change the social norms. You can change the norm that says, "Maybe I should not report this because it would get me and him in trouble," to one like that done for drunk driving. Remember when it was funny to see if someone who was drunk could get in their car and make it home? That used to be the norm. Then we had big campaigns about designated drivers, and we changed the laws, and we started putting people in jail. Those campaigns changed the norm to where we do not let someone get into their car when they are drunk. We take away their keys. We put them in a taxi or we put them to bed. That was a very big change and the same thing can be done here. We can change the norm that says, "My friend is suicidal, but I better not tell anyone" to a norm that says, "I am worried about my friend. I am going for help." We can change norms. We can identify the kids at risk. We can put preventive programs in place. We can save those lives.



*Changing systems is very hard to do one person at a time, but something we can do together.*

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# Community Leaders Discuss Suicide Prevention Efforts

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Moderator – Judy Fitzgerald, M.S.W., Executive Director, National Mental Health Association of Georgia.

Ellyn Jeager, Director of Public Policy and Advocacy, National Mental Health Association of Georgia. Ms. Jeager has been a tireless advocate for people with mental illnesses at local, state, and national levels.

Every year, we face a greater challenge at the legislative session and that is the challenge to be heard. What are they going to fund? As a mental health advocate, I firmly believe mental health should be right up at the top of what legislators choose to fund and champion.

It is obvious that I am not in the majority at the legislative session because mental health is always swimming upstream. We are constantly fighting not to move forward but just to hang on. When we look at funding, we know that if you do not move forward, you actually are moving backwards. Therefore, even when we do not have a reduction to our budget, we move backwards. This year we actually took a giant step backward because mental health funding experienced budget cuts. When you add those cuts to the cost of living and when you add those cuts to Georgia's population, which is continuously growing, mental health is rapidly moving backward.

So, what is advocacy? *Advocacy is a voice. It is your voice.* It is everyone's voice that tells the story of why mental health must be

funded. It tells why people must be valued, regardless of what kind of illness they have. It helps reduce stigma. It removes discrimination. It puts you in an arena where you can clearly say out loud, "Here is my story. Here is what will help me. Here is what you have to do." That is advocacy. The word "advocate" means to give voice. We need voices around the state.

So, what else do we need? We need a statewide coalition where all around Georgia people take responsibility for what they believe in. You can be an advocate and never leave your house. Pick up the phone and make some phone calls. The first thing is you have to know who your representatives and senators are. It is important to know what the budget is for the issue and whether it was cut. Advocacy is at your door. It is the one thing that every citizen can do. You do not have to be an expert to know that help is needed and not being provided. My message is that the legislators are people we elect. It is our opportunity, our challenge, and truly our privilege to help educate them. This is what I hope you will do.

Nancy Rithmire, R.N., Chair, Advisory Committee on Student Health and Achievement, Georgia Department of Education.

Nancy Rithmire is a registered nurse certified with Forsyth County Schools. She has been involved in school health for more than 20 years. In the past, she has served as a school nurse consultant with the Department of Education, coordinating school health issues, one of which is suicide prevention.

The Student Health and Achievement panel has been charged by the State Board of Education to determine issues that impact our students in their health and their ability to succeed academically. As a school nurse, I know that there are many components to health and to academic achievement. I

thought we would certainly get the tobacco issues, other kinds of prevention issues, and cardiac issues. I also was hoping we would get the mental health issues. That was one of the first issues mentioned. Even though we are just beginning with this process and the panel will last for 12 to 18 months, I feel

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certain that we will come from that advisory group to the Department of Education with some very specific education, direction, and guidance about mental health issues as well as physical health issues.

The National Association of School Nurses estimates that approximately 80 percent of the visits to a school health room or clinic are related to mental health or emotional issues. Our nurses have been challenged to go well beyond the Band-Aid. Children are suffering emotional problems. We have children coming in every day who have experienced those things that lead to suicide: death of a family member, death of a friend, separation or divorce of parents, pregnancy, or significant illnesses. Changes in residence are frequent. Can you imagine the emotional trauma to

those children who were taken from one school, in which they may or may not have felt comfortable, and then brought to a new school system to learn new friends, rules, structure, teachers, and books? Another thing that occurs, particularly in the teenage years, is breaking up with a boyfriend or girlfriend. So often it is not just the breakup that is involved but also the emotional and

psychological issues that go along. Change in a family's social and financial status also is an issue. We all have experienced the changes that have taken place in our county, with the economy and downturn of finances. That impacts children as well and can result in rejection by peers.

All of this, unfortunately, leads to failure to achieve. Once the spiraling down begins with these issues, grades go down and that creates a situation that children sometimes cannot live with. We have begun trying to do something in our county and are challenging school nurses throughout the state to do the same thing. We are becoming involved with Care Teams, or student assistance programs. The school nurses will lead the Care Teams because the school nurse is most often the person who sees these children. They will call together the counselor, psychologist, teacher, and anyone else who can assist that child. We saw over 84,000 children in Forsyth County last year in our clinics and health rooms. Again, going back to that 80 percent figure, then 80 percent of these children have a mental health issue. That is a significant number of children whom we must help.

My title in Forsyth County is comprehensive school health facilitator. It was changed from school nurse because I know that there is more to the health of a child than just physical health. I know that when those physical health concerns come into the health room there is frequently an emotional or mental health problem we need to address. I promise that I will take our plan to every school nurse in Georgia and challenge them to do as much as they can with emotional and mental health, as they do with physical health.

Ellyn Jeager's comment about the lack of resources is probably the most difficult thing that a school nurse faces. We identify a



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physical illness with the child and do not have the resources to help that child get the follow-up and care that they need. It is even more difficult when you identify a mental health or emotional health issue and there are no

resources there for that child. Former U.S. Surgeon General David Satcher said that we must act now. We cannot change the past, but together we can shape a different future and we will do that.

*Gary Gunderson, M.Div., D.Min., Director, Interfaith Health Program, Rollins School of Public Health, Emory University. Since 1992, Reverend Dr. Gunderson has been director of the Interfaith Health Program, a clearinghouse of the best ideas and strategies that can be adopted by faith groups around the broad range of health and community development. He is an ordained American Baptist minister and was educated at Wake Forest University, Emory University, and Interdenominational Theological Center.*

I would like to offer a way of thinking about congregations and faith communities in Georgia and imagine a way to engage those structures as places of strengths that should be captured and brought into a strategy for suicide prevention. These communities could be brought in, not just for direct service, but in a prevention-oriented strategy, including a political prevention-oriented strategy that should be part of the assets that we have to work with. We need to consider strengths of congregations in that context.

There is something painful in doing prevention and in doing health promotion that pulls away from our focus on the pathologies. As I am now at a school for public health, I am aware that most professional disciplines are formed around a focus on what is wrong. We get enormous self-esteem and funding by elevating the visibility of what is wrong. I want to focus on the other side. In effect, if epidemiology is the study of surprising pathology, or of what is wrong in the wrong places, I want to do reverse epidemiology and talk about what is happening that is right and surprising and against the trend. Let's look at good things that are happening that you might not expect, then follow the lessons from that

positive epidemiology to imagine how it is that we could create a virus of prevention, a virus of health promotion, a healthy virus in our communities.

Elsie and Jerry Weyrauch of the Suicide Prevention and Advocacy Network came to me a year and a half ago with a passion stirred partly by lament for the silence in many of our congregations and hoping for some way to unleash these tremendous assets that rest in the faith communities. I was certain that if we looked, we would find that there are models that exemplify all the strengths of congregations, some with some level of success at demonstrating that these strengths can overcome the challenges of preventing suicide. In April and May, they called my bluff, and we started looking around Georgia and making phone calls. We asked, "What is going on within the faith communities in Georgia that exemplifies models of strengths of congregations in a way that could begin to suggest what it would look like if the faith communities combined their imagination with the opportunity to demonstrate the intentions of God for wholeness and health for all of the people in Georgia, even those considering ending their life?"

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We were able to find a number of strengths that were in place; however, everyone we spoke to had not been thinking about it very much. If you ask the question directly about suicide prevention programs, many will say they do not have them. If you ask them, “Do you have a comprehensive way of engaging and visiting people who are isolated, engaging those who are lonely, and being with those who are sick? Do you have a way of making sure that every kid anywhere within your sphere of influence has

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***Over the past 10 or 15 years, congregations have been building their capacity to do many things relative to suicide prevention.***

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sombody who knows their name, cares for them, welcomes them when they come into the community, and makes sure they are aware when they are

not around groups anymore? Do you have any groups doing that?” They respond that is exactly what their congregation does.

Congregations are primarily groups that congregate. They are social structures that are well designed to engage people who would otherwise be unengaged and include them in the context of something that is going right in their life as a grand story that is positive and indeed a blessing. There have been increasingly, over the past 10 or 15 years, a number of things going on in congregations that are building their capacity to do many things relative to suicide prevention.

The Stephens Ministry has a very specific two-and-a-half-hour model that identifies suicide prevention for lay people so that they are aware. There are about 213 congregations in Georgia that have fully trained and operating Stephens Ministry programs. Many congregations who do not have such a formal structure have visitation programs

that are more informal. You can imagine what it would look like if all the deacons in Georgia had an hour with someone who was knowledgeable to talk about the clues for suicide and the ways in which congregations should be sensitive to the kinds of things that could be done to prevent it.

I also would point to the strength to connect. This is one of the very basic strengths. It is very powerful. Congregations are generally superb at connecting people to resources. This becomes even more critical when there are fewer resources with which to connect. Most clergy already have had the experience of referring people who they are aware are at risk of suicide or who have other mental health challenges. A coalition could be developed between the mental health advocacy groups, the Council of Churches, the Interfaith Council of Metro Atlanta, and other communities that would very simply make some of these connections a higher priority than they might otherwise be.

One of the most powerful strengths that our religious communities have that is not being exercised is the possibility of bringing suicide and suicide prevention into view. I think it is up to the more enlightened clergy to go after their brothers and sisters and give them a new story. Even today, there are fairly enlightened comments upon which more could be built in the denominational formal resolutions and formal materials that are being distributed to clergy. There is a physical faith and health movement that is underway. It is primarily a movement that is animated and led by the lay people in faith communities who are helping their clergy understand the opportunities that they may not have been aware of before.

It is very common in this time to speak about what we do not have, what we wish we had, what is not happening, the resources that are far lower than appropriate, and the money

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that we expected but do not have. If you build a coalition on what you do not have, you end up with a codependent relationship in which you build around the weaknesses of both parties. I think the challenge of our time is, as leaders,

to look for a healthy long-term relationship upon which you can build a powerful coalition. The first step is to appreciate the strengths of our joint partners. This provides the foundation for the kind of building we are trying to achieve.

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## Questions and Answers

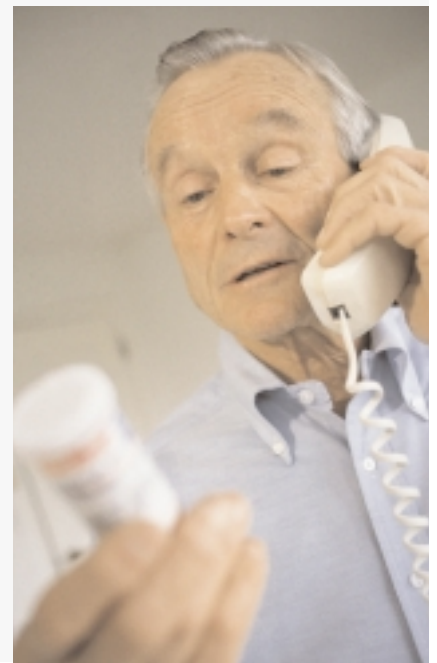
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**Q** Do all counties employ R.N.s as school nurses? If not, do you feel like this is a hindrance to your plan for school nurses?

**A** (Nancy Rithmire) Actually, we have come an awfully long way in Georgia. In 1993, when I was first employed by the Department of Education, we did a school nurse survey and it was rather easy to do. There were only 44 school nurses in Georgia, the majority of them being in Atlanta and Chatham County. No, we do not have a registered nurse in each school. We are fortunate in our county to have a school nurse, a registered nurse, in every one of our schools. We do not have the money to pay them all that we should, so we only have them there six hours a day. If a child comes in with an emotional or physical health situation and they are not there, then unfortunately it is the secretary that takes care of them sometimes. We have been blessed that we got tobacco settlement money two years ago. We were one of only six states in the U.S. that chose to use a portion of that money to hire school nurses. We hope that at some point in the future there will be a school nurse in every school, or at least, the nationally recommended standard of one nurse for every 750 students. One in every school is what we truly need to meet the emotional, physical, and mental health needs of our children in Georgia.

**Q** When does the legislative session begin again and when should we begin contacting our legislators? Also, is there a website where we can get legislators' information?

**A** (Ellyn Jeager) The answer is now, always, and continuously. It does not matter whether the session is in or not. When someone is a legislator, he/she is a legislator for their whole term, which means even when they are not in session they should be available to their constituents, and you are their constituents. You have to develop a relationship. They are more likely to help you if they know you and like you. The legislative session always starts the second Monday in January. It is supposed to run for 40 days, but those are not consecutive days. There are many websites where you can find information about every legislator, including when they vote, how they vote, and if they voted for your issue or against your issue.





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# Challenges for Suicide Prevention in the Public Sector

Moderator – Judy Fitzgerald, Executive Director, National Mental Health Association of Georgia.

Frank Berry, M.S., Director, Office of Behavioral Health, Georgia Department of Juvenile Justice. Frank Berry has been the director of the Office of Behavioral Health since July 2001.

Those of us within the Department of Juvenile Justice talk about the challenges we face. Not many people think about mental health when they think about juvenile justice, yet that is one of our biggest challenges. Citizens of Georgia want a Department of Juvenile Justice to be tough on crime and to provide consequences and punishment. Yet, we have children in our system who have some pretty severe mental health needs. What we are trying to do in our system is train close to 3,000 staff on how to interact with children and teach staff that children are children. Even though some of them may have broken the law and are “in trouble,” they are still children.

Many are aware that the Department of Juvenile Justice suffered two suicides in a three-and-a-half-week period of time a few months ago. Since then, we have been trying to figure out what to do next. How do we change our system? How do we reform our system? How do we balance consequences

with needs? Yet, as difficult as these suicides have been for us, I cannot imagine what it is like for those parents who lost their children in our system. We are charged with keeping children safe and we did not do that. This remains a huge challenge for us.

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**Even though some children may have broken the law and are “in trouble,” they are still children.**

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The Office of Behavioral Health has been the primary office to handle suicide prevention and yet so many times, these issues relate to safety and security issues or to overall interactions with youth. We are trying to get our staff to understand that the more we develop relationships with children, the more we are going to know that child and the better we

are going to be at identifying when that child may be in need of something like talking to an adult or to a group of other people.

The other issue that we have started looking at is that many of these children are not “juvenile justice” kids. In the juvenile justice system, our staff can get a very strong handle on education. Most people can. We understand education. We have all experienced it. People also understand medical services. They are very tangible. Mental health suicide prevention is something that a lot of people do not understand. What happens when you do not understand something? You either ignore it or you refer it to specialists. We have specialists in the Department of Juvenile Justice. But recognize that our facilities each house 400 children who have broken the law in some capacity. We have two master’s-level clinicians to respond. How do two master’s-level clinicians deal with 400 children? You can imagine how stretched these limited resources are.

The Department of Juvenile Justice is trying to address these challenges by focusing on solutions. Some of the solutions are made possible through collaboration. There are two major groups that have helped us – The Carter Center and the National Mental Health Association of Georgia. Why would we choose those groups to partner with us? There are several reasons. We cannot do it ourselves. The leadership of our department is not convinced that we are the best group of people to provide mental health and suicide prevention training and curricula. We can handle the strong juvenile justice components, including safety and security issues, consequences, and restorative justice models. When it comes to mental health, we need help. In our

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partnership with The Carter Center and the National Mental Health Association of Georgia, we are looking at a training curriculum that does not just touch the mental health staff. It needs to touch every level of staff.

We also are looking at creating smaller units. In that 400-bed facility, it does not matter how much training you give or how many mental health professionals you have; 400 children in a single setting is too many. The way you develop relationships with children is to start with much smaller-scale facilities, such as a 60-bed facility, where every staff member knows every child. How does a mental health professional or a juvenile correctional officer in a 400-bed facility know 400 kids? It is virtually impossible. We also talk about specialty units for those children who are high risk. We are trying to balance the need for specialized treatment with the desire to allow youth to interact with their peers and maintain a normalized type of environment.

As we look at our assessment and screening procedures, we recognize the need to consider re-screening at appropriate intervals to understand and measure the impact of spending time in a Department of Juvenile Justice facility. We are moving toward interdisciplinary teams that have education, medical, mental health, and correctional staff meeting together so that everybody knows what is happening with the child. Historically, correctional staff have not necessarily shared information with medical and mental health staff. We have had strong divisions among those areas. We need to

communicate because everybody is there to help the children.

We also are concerned with those youth we have identified as possible suicide risks who are ready for discharge. They have done well and have shown that they are no longer in that situation. They are ready to go to a lower level of care. Do we release them immediately? Do we release them with follow-up? We are having our psychiatrists and psychologists review them when they go to a lower level of care. One of the challenges we face is that we do not have enough psychiatry and psychology hours in our system. There is potential for a child to remain at a higher level of care even if they do not need it. We would like to avoid such placements.



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Collaboration is necessary for our work inside the facilities, but we also are trying to figure out ways to keep children out of the juvenile

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***The Department of Juvenile Justice is not a hospital or therapeutic setting. We are not a mental health system.***

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justice system in the first place. We are not a hospital or therapeutic setting. As a result of the memorandum of agreement signed between the State of Georgia and U.S. Department of Justice several years ago, we have a mental health system in place that has some substance abuse services, some mental health services, and some sex offender treatment. But we are not a mental health system.

One of the things we need to do is partner with our fellow agencies, the Department of Community Health and the Department of Human Resources. We desperately need their help in figuring out how to handle these children. If we recognize that we have a child we cannot keep safe, there needs to be an agency or a place, perhaps a hospital-type setting, where they can be sent for a mutually agreed-upon stay.

Finally, I cannot imagine what it is like for parents who have lost children and for those who have lost significant others to suicide. As a department, we want to address this issue the best we can.

*James DeGroot, Ph.D., Director, Mental Health/Mental Retardation, Office of Health Services, Georgia Department of Corrections. Dr. DeGroot is responsible for the mental health services offered to inmates and detainees who have serious mental illnesses and for habilitation services offered to inmates and detainees with developmental disabilities. He is a licensed clinical psychologist in Georgia.*

In Georgia's criminal justice system, there are approximately 227,000 people serving time. In state prisons, there are 45,000 inmates, or 20 percent of everyone serving time. In jails, there are 29,000, or 12 percent. On parole, there are 20,000, or 10 percent, and on probation, there are 130,000, or 59 percent.

In 1991, state prisons had 22,945 inmates. Last year, in 2001, there were 44,968 inmates. In 10 years, that is a growth of 96 percent, or almost double. That is an important number that will be revisited. A main message I want to communicate is that inmates in prison are a vulnerable population. They are living in an extremely stressful environment.

How are inmates vulnerable? Most have few protective factors. They have maladaptive coping strategies and limited psychological resources. Most inmates have few, if any, social supports because a lot of them are not

close to people. Their capacity for intimacy is limited by their unwillingness to take the risk of being hurt by being open and honest with someone, and most inmates do not trust anyone. Most inmates have problems controlling both their behavior and their impulses. They have poor problem-solving strategies. A lot of them are concrete, rigid thinkers. When you are in prison, there are not too many opportunities for pleasures. Most of them do not find meaning in relationships because they do not have any intimate relationships.

The second challenge to suicide prevention that is unique to prisons is the high number of risk factors found in most inmates. These include medical problems and mental health problems. The inmate population in general tends to have very poor health. In 1991, we had 1,251 inmates receiving mental health services. Last year, we had

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over 6,000. That is a 382 percent rise. Let us go back to the rate of growth in the inmate population. The general inmate population growth was 96 percent in the past 10 years.

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***Georgia's general inmate population growth was 96 percent in the past 10 years. There was a 382 percent rise in the number of inmates receiving mental health services.***

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Compare 96 percent to 382 percent. This tells us that during the past 10 years, we have incarcerated people with mental illnesses four times

faster than those who do not have mental illnesses. This brings us to an agenda item of the National Alliance for the Mentally Ill: the criminalization of the mentally ill.

When they were on the streets, most inmates dealt with stress by drinking, abusing drugs, and acting out sexually or

violently. Likewise, females who became inmates abused drugs and/or alcohol, got into dependent relationships, or disassociated and withdrew from everyone. Where do these coping styles come from? They come from childhood. They are adaptive ways of defending themselves and protecting themselves, often from abusive homes. Five years ago, we did a study to see the prevalence of abuse in our mental health population. We

discovered 80 percent of the women receiving mental health services in our prison system had a history of physical and/or sexual abuse. Forty-six percent of males receiving mental health services had a history of physical and/or sexual abuse. This is significant because when their traditional ways of coping with stress are denied, many of them turn to self-injury and suicide as a way to relieve pressure.

Most inmates have a limited number of psychological resources, thus they are unable to delay gratification, comfort themselves, tolerate frustration, control impulses, or regulate the intensity of their emotions. Some might appear to be in excellent physical shape, but they are not in excellent psychological shape. They need these resources in the same way a child does.

There also are environmental challenges to suicide prevention in prison. The first challenge is to reduce prison stresses. Prison is an extremely stressful place for anyone, even for people who have a lot of psychological resources. Some of the stresses include a coercive environment, noise, smells, temperature extremes, the rumor mill, neighbors, and a lack of freedom. These stressors overwhelm many inmates who are unable to cope and thus end up hurting or killing themselves and/or other people. We try to make cells as suicide-proof as possible.

Our staff members have an important role to play in managing this population. How are we preventing suicide and meeting the challenge? Obviously, we have a suicide prevention program. It consists of education for both inmates and staff. We have programming to enhance protective factors and reduce risk factors, and we also have services. We constantly monitor our program's effectiveness. Last month we averaged five self-injuries a day or 150 a month. These



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were self-injuries that required medical attention. We averaged four assaults a day or 120 a month, and 46 disciplinary reports a day or 1,380 a month. There were 17 admissions a day to a crisis stabilization unit that could be a hospital. There were eight

seclusion orders written by a psychiatrist daily, two restraint orders a day, and one involuntary medication order a day. In terms of the suicide rate over the past 10 years, we have been averaging 15 per 100,000.

*Kenneth Powell, M.D., M.P.H., Chief, Chronic Disease, Injury, and Environmental Epidemiology Section, Division of Public Health, Georgia Department of Human Resources. Dr. Powell has served as an epidemiologist at the Centers for Disease Control and Prevention in Atlanta.*

The four challenges that I want to mention include bringing suicide into the daylight, knowing when we have made a difference, moving upstream from mental health services, and impeding access to lethal means. For too long, suicide has been veiled in mystery and misunderstanding, feared rather than confronted.

Many people think that nothing can be done to prevent suicide once someone has decided to do it. That thought simply ignores the waxing and waning of suicidal interests and also ignores the many suicidal gestures: those who harm themselves not really

intending to die, although some actually do. Another misperception is that asking about suicide is likely to cause someone to really do it.

This misperception has prevented us from conducting surveys and collecting information about the prevalence of suicidal thinking and planning. The lack of that

information has impeded the progress of our prevention programs. This is what I mean by bringing suicide into the daylight.

The next challenge is knowing when we have made a difference. Too many people have died and too many continue to die. It is time to act, but how do we know when we have made a difference? How can we tell when someone did not die? In an average

Georgia high school of about 400 students, we would expect one student to commit suicide every six years. If we plan ahead, if we clearly describe the objectives of our program and lay out step by step how we expect our program to prevent suicides, we can usually determine if we are moving along the expected path.

The third challenge is moving upstream from mental health resources. As a general rule, suicide prevention programs emphasize identification and referral. Identify people in trouble and send them for counseling. Mental health services are very important, but there are also deficiencies. Our screenings for suicide are notoriously inaccurate. We refer many who would never commit suicide, and we miss many who do. Among youth, about 25 percent who nearly die attempted suicide within five minutes of deciding to do so. This does not leave much time to identify and refer. Another problem is that the mental health services are too far downstream. It is reactive, not proactive. It waits until somebody is in trouble and then tries to help. Moving upstream from mental health services is critical to suicide prevention.

The fourth challenge is impeding access to lethal means. Firearms are a lethal means of suicide. "Means restriction" is a term that usually is applied to this concept and refers to efforts that reduce access to lethal drugs,

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***This refusal to think about and talk about suicide actually prevents us from preventing suicides.***

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***In Georgia, 75 percent of suicides are committed using firearms.***

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high places, firearms, or other common methods of committing suicide.

Of all the methods that have been used to prevent suicide, means restriction is the one with the most

evidence that it really works. Restricting methods by which one can commit suicide either forces a delay in the attempt, providing time for the urge to wane, or forces the use of another, and possibly less lethal, means. It may matter most when the method of suicide is a firearm.

In the United States, 60 percent of suicides are done with firearms. In Georgia, it is 75 percent, or three out of every four. There is no simpler, faster, more lethal method of suicide than firearms, yet we never talk about removing them or making them harder to get. Having the courage to emphasize means restriction, specifically firearm restriction, is a challenge to suicide prevention. These are challenges for both the public and private sectors. Addressing each of these may move us toward meaningful suicide prevention.

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## Questions and Answers

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**Q** How are your systems helping folks back into the community to continue with treatment, if needed, or to prepare to live a more productive life?

**A** *(James DeGroot)* For the past few years there has been a program called the Transitional Aftercare Program for Probationers and Parolees. The program started off as a pilot study about three years ago, and the results were really encouraging. It reduced recidivism significantly within one year. Consequently, within the next year the program was funded for the entire state. The program consists of inmates who are receiving mental health or mental retardation services working with a case manager from the community where they are returning. Ideally, the case manager meets with the inmate prior to being released and does an evaluation. When the inmate is released, the case manager provides wraparound services including transportation, housing, health care, mental health care, and developmental disability services. It has been a winner in terms of reducing recidivism for the mentally ill and mentally retarded in Georgia. Two other sites have programs like this, Massachusetts and the Los Angeles County Jail. We have been collaborating with those two systems and our data is very similar.

*(Frank Berry)* From the juvenile justice perspective, we have had an extremely difficult time getting aftercare and transitional services. We have developed some of those on our own; yet what that does is continue the cycle of us trying to do everything on our own. One idea we have is partnering with one of the public mental health providers to provide services in our facility, in our Youth Detention Center, with the hope they will get to know those children upon entry into the juvenile justice system and then will follow them once they go back into the community. We will be piloting this in July 2002. That will be the first true partnership with a public mental health entity where they actually come into our system and are responsible for aftercare. We are hoping that it will be a pilot project that can be repeated throughout the state.

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# A Personal Story: A Mother's Journey

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Iris Bolton, M.A., Executive Director, *The Link National Resource Center for Suicide Prevention and Aftercare*. She authored *My Son, My Son: A Guide to Healing After Death, Loss or Suicide*, a book about the survival of her family in the aftermath of her son's suicide.

A child was born July 6, 1956, a baby boy adored by his parents and tolerated by his 17-month-old brother. Growing up as a happy child with two younger brothers born several years apart, he was sensitive, a perfectionist, a great athlete, creative, a musician, had a genius-level IQ, but also had a learning disability. The learning disability was a perceptual difficulty for which he had professional help. He was hyperactive. While in grade school, a low dose of Ritalin was prescribed by his doctor who said, "He will grow out of it." He played football, basketball, ice hockey, and Little League. His dad was involved as a coach, and both parents went to all the games.



In high school, he had his own band, played drums, piano, guitar, and wrote music, lyrics, and sensitive poetry. After graduating from Grady High School in Atlanta, he signed a contract with a recording company to do his own music. He told a friend he knew he had one album in him, but he was not sure that he had two. He was afraid of success and afraid of failure. He had four girlfriends and promised to marry three of them. He wanted to be independent and wealthy and to be an instant success with his music, to be a star. Patience was his nemesis.

He was handsome, charming, super-sensitive, and took on the pain of others as his own personal pain, soaking it up like a sponge. He did not know how to squeeze the sponge out. A "sunshine in tears" young man who never got involved in drugs or alcohol because he was a health food advocate. His main vice was drinking an inordinate amount of iced tea. The girlfriend he dated for a year and a half broke up with him, and three weeks later, this talented, creative, beautiful young man shot and killed himself in the bedroom of his home. The date was Feb. 19, 1977.

That young man was my son, Curtis Mitchell Bolton. He was a songwriter and a musician. It was interesting because Mitch wrote a poem, a song actually, and it is so appropriate because of our country, because of where we are today at The Carter Center, and because of Sept 11. I thought I would share this poem because of the pain of losing a beautiful young man like that and the pain that so many of us in this room have survived. We have made the choice to find the courage and the compassion that we have to have in order to go on living.

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These are his words. It maybe is a message for all of us today from his spirit or from the spirit world that he will share through his song. It is called *Love Your Brother*.

*Frustration  
Love our nation  
Seems to be a loneliness  
The years go by  
I wonder why  
The good times come and leave  
Now the youth have to tell the truth  
And no one wants to listen  
Feel the haze of all your days  
Wanting to be wanted  
Youth ignored  
Youth bored  
Seeming not to matter  
Show somebody that you care  
Go on and tell them that you are there  
Why do not you take it from the start?  
Why do not you listen to your heart?  
Everything is the same  
Life's little games  
The kind you are always losing  
The hunger is in your heart  
As the years go by  
Tears will dry  
And you can make another start  
Show somebody that you care  
Go on and tell them that you are there  
Why do not you listen from the start?  
Why do not you listen to your heart?  
Always try to love your brother  
Try to get inside his head  
Because if you cannot love each other  
You are better off dead  
Reach out and grab his hand  
Tell him that you understand  
People try to love your brother  
Love your brother as yourself  
Show somebody that you care  
Go on and tell them that you are there  
Why do not you take it from the start?  
Why do not you listen with your heart?  
Jubilation  
Love our nation  
Love each other as a start*

When Mitch died, I wanted to know why. I struggled with the guilt. I felt it was my fault. The reality is, it is not anyone's fault. A mother came to my office at the Link Counseling Center and said, "I know why my son did it. He was in his 20s, and it was like a cup of water that sits on the table full to the brim. It is so full it is rounded at the top, but it does not spill. But if you add one drop or two drops, it spills over."

Now, we are a culture that wants to blame, so we are going to blame the drops. You can put drops in an empty cup and it does not spill. So it has to be all the other water that is there and the drops. Both and not either/or. All of the pain, humiliation, and maybe the learning disabilities – whatever all that was, whatever his cup was full of, and then whatever happened at the end. The girlfriend breaking up with him did not cause it, but maybe it was the last drop. So I had to learn to live with that but not like it. I had to accept it. That is what our journey has been about: learning to forgive, learning not to judge, learning to try to understand, and, more than that, being a part of this wonderful advocacy effort that the Jerry and Elsie of the world have led us on.

Everyone who has chosen to speak up and find their voice, we are the ones who are going to change what is happening in this world. As was said earlier, if there is one death eliminated or one life saved, then perhaps it has been worth it.

We cannot do it alone. We have to help each other. We need to hold, care for, and talk with each other, to communicate and collaborate so that we can survive and make meaning out of the horror. Someone told me there were four things we had to do to heal. We have to tell the story, because in telling it, you believe it and accept the truth of it. Then we have to express the emotions, whether they are anger, rage, guilt, or



sorrow. Get them out and talk it out. Go to survivor groups and talk it out. The third thing is the reason I am standing here today. It is to make meaning out of the horror. The fourth thing is the transition from the physical presence of that person to another kind of connectedness – memories in my heart that no one can take away, maybe a spiritual connection, or maybe dreams. Somehow we have to survive this and make meaning. The National Resource Center for Suicide Prevention and Aftercare that the Link started has made meaning in my life. It has not made it okay, but it has given meaning to Mitch's life and implicit in that is his death.

I wanted to share another poem. It is called *I Do Not Know Why*.

*I do not know why*

*I will never know why*

*I do not like it*

*I do not have to like it*

*What I do have to do is make a choice  
about my living*

*What I do want to do is accept it and go  
on living*

*The choice is mine*

*I can go on living, valuing every  
moment in a way I never did before*

*Or I can be destroyed by it and, in turn,  
destroy others*

*I thought I was immortal*

*That my family and my children were  
also*

*And that tragedy happened only to  
others*

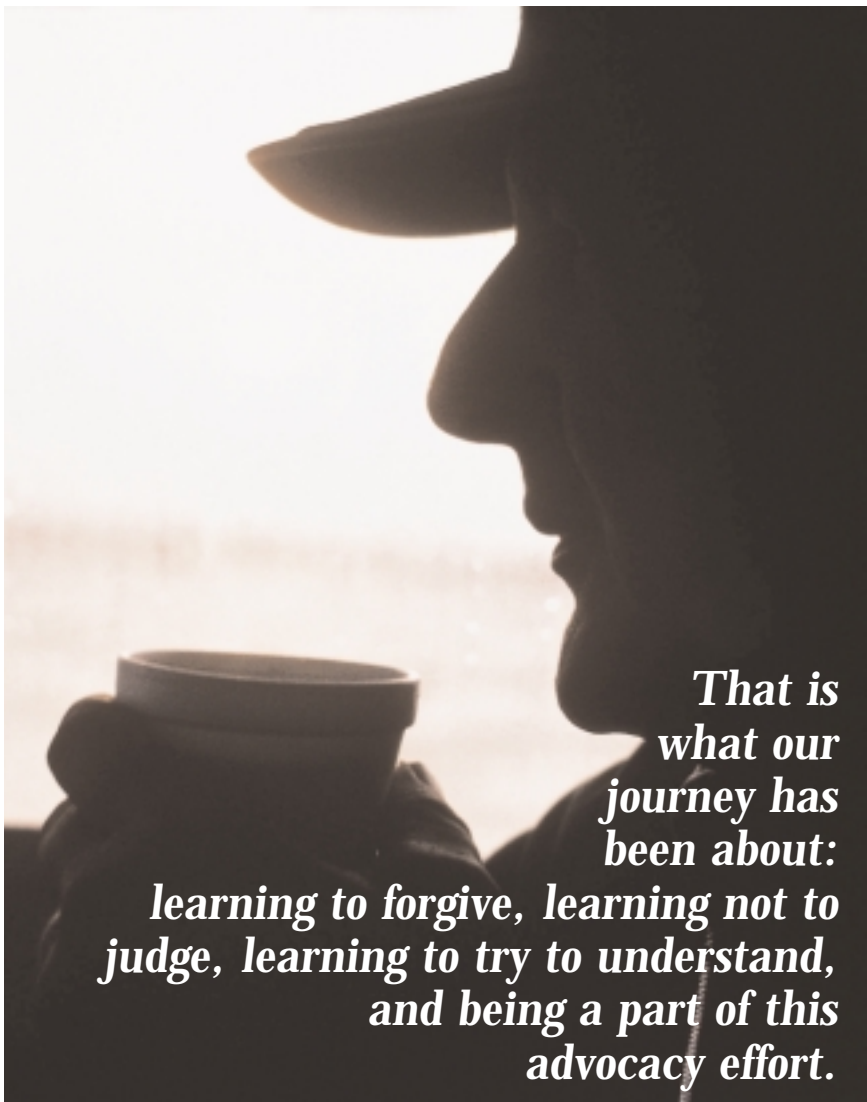
*But I now know that life is tenuous and  
valuable*

*So I am choosing to go on living*

*Making the most of the time I have*

*Valuing my family and friends*

*In a way never possible before.*



***That is  
what our  
journey has  
been about:  
learning to forgive, learning not to  
judge, learning to try to understand,  
and being a part of this  
advocacy effort.***

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# Introduction of the Georgia Suicide Prevention Plan

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*Jim Martin, Commissioner, Georgia Department of Human Resources. He received his bachelor's degree, J.D., and LL.M. degrees from the University of Georgia. He received an M.B.A. from Georgia State University. In 2001, he became the commissioner of the Georgia Department of Human Resources.*

Our audience includes mental health professionals, psychiatrists, primary care physicians, and representatives of state agencies. It also includes family members and survivors who have been instrumental in developing the Georgia Suicide Prevention Plan, and in fact, our emerging national strategy on suicide prevention. I am encouraged by the plan that exists and the fact that we are incorporating within our programs the risk factors and other suggestions in that plan. I hope when the budget situation improves that we can return to a full-scale effort in trying to prevent suicide in our state. Former U.S. Surgeon General David Satcher said in his Call to Action that the nation must address suicide as a significant public health problem and put into place a national health strategy to prevent the loss of life and the suffering that suicide causes.

The plan that has been developed for Georgia received input from public forums and focus groups throughout the state. The plan used data that was developed by the Division of Public Health and the Department of Human Resources. It uses the public health model that was outlined in the Surgeon General's Call to Action. It follows the public model of AIM, in which the "A" stands for awareness, as in promoting awareness that suicide is a

serious problem in Georgia. It kills 848 Georgians every year and results in 17,000 emergency room visits. It also involves awareness that suicide is preventable. The "I" refers to interventions that are developed and implemented by community-based suicide prevention programs. "M" is for the methodology that promotes and supports research and evaluation.

Dr. Satcher said, "Even the most well-considered plan accomplishes nothing if it is not implemented." Each of us, whether we play a role at the federal, state, or local level, must turn recommendations into programs best suited to our own communities. We provide assessment and referral services at the Department of Human Resources for



*The Georgia Faces of Suicide remembrance quilt was provided by the Suicide Prevention and Advocacy Network.*

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suicide risk among school-age children in our public health programs; about 200,000 children are served through those offices. We are making plans to provide technical assistance to Georgia's four Healthy Start sites that will screen for postpartum depression and train staff and providers in best practices in suicide prevention. We collaborate with the Department of Juvenile Justice and the Department of Education to bring about

youth initiatives to deal with the issue of suicide prevention. We also will improve methodology through collaboration with the Department of Education to administer the Youth Risk Behavioral Survey, which will provide good data for planning. We look forward to this work. As the professionals working in these areas, we are charged with learning where we can go in the future to deal with this very important subject.

*Jerry Weyrauch, M.B.A., Co-founder, Suicide Prevention and Advocacy Network. Since the suicide death of their daughter, Terry Ann Weyrauch, M.D., in 1987, Jerry and Elsie Weyrauch, a registered nurse, have worked to prevent suicide at local, state, and national levels.*

A number we believe that people can focus on is 12. We think that every suicide attempt impacts at least 12 people, including family members, co-workers, and members of their communities. Georgia is a leader in formulating a statewide suicide prevention plan. Our plan is not perfect. The challenge is to implement it. From there we can correct it and revise it. In the Suicide Prevention and Advocacy Network logo, our bridge is open-ended because what we do is open-ended. We reach out to everybody and say, "Come join us in this effort to prevent suicide." It is going to take all of us. We want to be partners. We want to collaborate. Collaborative partnerships will get the job done, and then we all can take the credit.

Many are here today because of a personal story. These stories are so important to our message. These stories are the impetus for moving a prevention plan forward.

The Georgia plan has roots, like all of us do. The roots of the Georgia plan come from the 1996 United Nations' National Guidelines for the Formulation and Implementation of National Strategies. Five years and two weeks ago today, the U.S. Senate passed Senate Resolution 84 that,

for the first time, recognized in this country that suicide was a national problem. Out of that one resolution, all of this has come. We now have three million dollars to establish a national suicide prevention technical resource center that will help Georgia implement this plan and evaluate it. We do not have to do it alone. In July, we will hold our second national meeting for state suicide prevention planners who are trying to answer the same questions we are. How do we implement this plan? How do we make it effective? How do we build partnerships?

The answer is through the National Strategy for Suicide Prevention goals and objectives. When the Suicide Prevention and Advocacy Network was organized, we said, "That is our goal." We now have to implement that. The Georgia plan is based on this document, which is evidence-based. We had the CDC involved. There are 11 goals and 68 objectives in the national strategy. The Georgia plan was adapted from this document.

In FY 2001, the governor and the Legislature did provide money for the plan. The final plan is a result of that investment and, this year, we have been working with our steering committee to actually begin

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implementing the plan. This is the partnership and teamwork that we have with the state

of Georgia, our state departments, and our private, nonprofit sectors.

*Laurell Reussow, M.S., Plan Monitor, Georgia Suicide Prevention Plan, Suicide Prevention and Advocacy Network. Ms. Reussow worked as a grief specialist for years and has helped many families cope after a death. In her present capacity, she oversees the implementation of the Georgia Suicide Prevention Plan.*

Governor Barnes chose to support the Suicide Prevention and Advocacy Network in its efforts to reduce suicide after a group of people shared their stories with him. Those people were survivors of suicide, just like me. My dad chose to end his life 17 years ago. No one had to tell me, my family, my friends, or the employees of our family business how tragic it is to lose one life to suicide. Many of us have lived with the aftermath of suicide, but we knew we needed hard numbers to back up what our instincts were telling us, that there were a lot more Georgians just like us. *Suicide in Georgia 2000* provides the information describing the sex, race, and age of those who died by suicide, the methods most commonly used, and the death rates for each county. This is an incredible tool that we have for advocacy.

We recognize that suicide prevention needs to be implemented at the community as well as the state level. The Suicide Prevention and Advocacy Network contracted with Dr. Julie Chamblis and with the National Mental Health Association of Georgia to conduct community-based needs assessments. The data was collected in the form of surveys, focus groups, and key informant interviews. Similar surveys were completed by public health staff and school personnel. This information told us that awareness, education, and funding were among the greatest needs. The needs assessment led us to modify the National Strategy for Suicide Prevention to meet the needs in Georgia. This is a local effort, but it is based on the best thinking

nationally and internationally on suicide prevention. It is written for every Georgian to be able to pick up and find a way to prevent suicides in their own communities. This document is the people of Georgia voicing their belief in the need to prevent suicides.

We thank the governor and the General Assembly for hearing our voices and for recognizing that we are only getting stronger in our determination. The Georgia Suicide Prevention Plan provides a framework for getting everyone in Georgia involved in preventing suicide. The plan is designed for individual people and agencies and organizations in local communities as well as at the regional and state levels. One goal of the plan is to change the individual attitudes and knowledge about suicide. Equally important, the plan seeks to promote suicide prevention in the many systems of Georgia that touch our lives, including, but in no way limited to education, health care, media, the workplace, faith communities, and criminal justice.

The public health approach gives us a foundation for developing and implementing the Georgia plan. It is designed to organize prevention efforts and resources in such a way that they reach large groups, or populations, systematically and effectively.

The keystone of the plan is intervention. It is putting the plan to work. We want it to save lives. We believe that education and training are a good place to start. Who needs training? Everyone. Anyone who comes into regular contact with other people is in a position to

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recognize someone who is having a bad day or someone who might need more help. Everybody needs to be trained to recognize these signs.

There is much work to be done, and we must be willing to overcome barriers and

challenges. Saying there is no funding or manpower is simply not acceptable. It is up to each of us to consider what we can do to make a difference.



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# Best Practices in Suicide Prevention

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*Moderator – Lloyd Potter, Ph.D., M.P.H., Director, Children’s Safety Network, Education Development Center, Inc. Dr. Potter is the associate director of the Center for Violence and Injury Prevention. His current work is focused upon providing assistance to state and local public health officials to develop and implement efforts to prevent suicide, violence, and unintentional injury.*

*Colonel (Doctor) David A. Litts, U.S.A.F., Special Advisor for Suicide Prevention to the Assistant Secretary for Health and the U.S. Surgeon General. In his position, he is the Surgeon General’s representative to ensure completion of the National Strategy for Suicide Prevention and development of an infrastructure to facilitate its implementation. Prior to holding this post, he served as chief of staff for the Air Force surgeon general and executive director of the Air Force suicide prevention program. The program was associated with a 55 percent drop in the suicide rate among Air Force members over four years and is the largest and longest sustained suicide prevention effort associated with significant reductions in suicide.*

**I**n the Air Force community there are 350,000 active duty people. They are all educated at least at a high school level, and most have some college-level education. They are all employed. They all live in decent houses. They have access to unlimited health care, including mental health care, and all speak the same language. They are pre-screened before they come into the Air Force. They have a very low rate of drug use. If they have a serious mental illness, they would not have been accepted into the military, and if they acquire a serious mental illness while on active duty, they are discharged. It is a community in which there are clearly identified community leaders, and a formalized gate-keeper network is already established.

In the mid-1990s, we were in a situation where the Chief of Staff of the Air Force was noticing an increasing number of suicide reports coming across his desk on a daily basis. We brought people together from the different communities. The first issue we had to debate was whether suicide was preventable. The general at the end of the table said it was; therefore, suicides are preventable. If so, then is there some acceptable level? No. One is too many.

We recognized that underneath the issue of suicide were all kinds of problems that people have. There are mental health problems, family problems, relationship problems,

financial problems, legal problems, domestic abuse problems, and violence problems. We recognized that suicide is not a medical problem; it is a community problem. There were no proven approaches. We accepted that we were going to adopt some documents that Lloyd Potter had worked on at the CDC. We would use those guidelines as our best hope for preventing suicide. We recognized that partnerships were a key to success, so we wanted to make sure that all those partners shared a stake in the outcome.

In the Air Force, we had huge cultural barriers, and we recognized that we were going to have to leverage senior leaders to bring about cultural change. The people that we brought to the table included medics, public health people, personnel, human resources, commanders, law enforcement, legal, family ethics, children and youth programs, chaplains, faith community, and criminal investigative services. We also had some researchers from the Walter Reed Army Institute of Research to advise us.

We needed a model to understand how a person changes from a fully functioning individual to someone who is ready to take their life. We adopted a model from Columbia University. We looked at the model and decided at each point what could be done to prevent suicide at that step. We needed a way to take ourselves through this

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very methodically. First we had to assess the incidence of suicide in order to understand the problems and the risk and protective factors. We found out that suicide was the second leading cause of death among people in the military. Relationship problems were predominant. Legal problems, substance abuse, and depression were significantly elevated in those who had died by suicide. We had to educate our commanders, gatekeepers, and first sergeants about relationship problems, mental health problems, legal problems, and financial problems. If we could make people realize that when someone is having these problems, particularly if they are having more than one of them, they need a lot of support.

We emphasized the protective factors and believed if we could strengthen the kind of social support and sense of belonging that people have, as well as improve coping skills, and have policies and cultures that supported people seeking help, it would be very important. We had a lot of people doing preventive work, from the chaplains, child and youth programs, and family support programs, and a lot of resources. None of them were working specifically on suicide prevention. We thought we had the resources, but they were not working as well together as they could. We put an initial assessment together and asked, "What can we do to promote readiness for suicide prevention, and what can we do to implement programs that will decrease risk and increase protection among the Air Force population?"

We leveraged commanders and the Chief of Staff. We had him send out a message to the Air Force on a quarterly basis educating the Force about suicide prevention, highlighting the importance of suicide prevention, and making sure the commanders knew it was their responsibility to take care of their troops by emphasizing the importance

of social support. We have a Chief of Staff who is willing to say things like, "It is a sign of strength when you responsibly take action to seek help."

The Air Force mandated that everyone get annual training in suicide awareness and prevention. There is special training for special people, like commanders and first sergeants. Mental health screenings are given, both on entry into the Air Force and through a questionnaire that is collected once a year as part of a periodic health assessment. We have a behavioral health survey that gives commanders an idea of what problems the people in their unit are experiencing and a database that tracks suicides and suicide attempts so we can learn about what kind of problems people are having who are involved in suicidal behavior.

In post-prevention, there are critical stress management teams established on every installation. Whether it is a traumatic weather event, disaster, or suicide in a unit, we have a team ready to come in and do their best to manage the effects of the trauma. Community services on each base were told to sit down together, look at the risks involving suicide, and come up with a plan to take their collective resources and address those risks in the best way possible, as well as measure the outcome.

Obviously, in 1999, we were celebrating because there was a huge reduction in the suicide rate. Then, it started going up again. We learned that it is hard to sustain a suicide prevention program. Suicide does not go away. From 1987 to 1991, the suicide rate was 12.7; from 1992 to 1996, the rate was 14.3; in the last five years, the rate has been 9.1. We evaluate, we improve, evaluate, and improve.

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This was a case of leadership. Every community in Georgia has someone who, when they speak, things happen. The idea is to get that person logged onto suicide as an

issue that they want to prevent. Consolidate the political will. Then, use the community as the organizing principal. You have got to do everything to change the culture.

*Christle Harris, M.S., Clinical Coordinator, Georgia Teen Screen, National Mental Health Association of Georgia. Ms. Harris earned an undergraduate degree in psychology and a master's degree in counseling psychology.*

The Teen Screen program originated at Columbia University in 1991. They sought to provide early identification of potential mental health disorders in at-risk students around the New York metropolitan area. To date, they have over 24 trained sites across the country. The National Mental Health Association of Georgia has adapted the Georgia Teen Screen program from Columbia's program. It is the first of its kind in our state. In Georgia, suicide is the third leading cause of death among 15- to 24-year-olds and the fifth leading cause of death among 10- to 14-year-olds. These figures give credence to the necessity for continued suicide prevention efforts.

Our main objectives with the program were to reduce the number of suicide attempts and completions among adolescents, as well as to increase resilience and reduce the loss of life through early identification through screening. Stone Mountain High School responded to our request for proposals and put together a wonderful package. Once we reviewed it and visited their site, we decided unanimously that this was the place we wanted to start our prevention program.

Initially we sought to screen the entire ninth grade population at Stone Mountain High School because this grade is a transition period for adolescents. This program was unique because we sought to empower the students and give them a voice in participating in the program. We also wanted to make it a

collaborative effort among the parents and school staff as well as the National Mental Health Association of Georgia.

We pitched the program to the students, sent out parental consent letters, and decided to come up with an incentive to get students to take the form home, have their parents read it, and decide whether or not they wanted the student to participate. We came up with money, and the response was staggering. Regardless of whether the parent agreed, the student still obtained the money.

We screened in excess of 420 students with a three-part screening program. We had a brief survey that sought to identify potential risk factors in the student. If there were any indicators that something was wrong, we referred them on to the Diagnostic Interview Schedule for Children. We used the Diagnostic Interview Schedule for Children to help narrow the focus of the symptoms that students were exhibiting so we could best refer them to the appropriate resources. If a student showed a need and screened positive for any type of mental health disorder, we used case management and notified the parents to inform them of what was going on with the student and to provide immediate referral sources. We tried to narrow down resources that were within their immediate area of DeKalb County.

An important part of the program was to educate the students. Adults often underestimate what students are truly going



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through. We found through this program that the best service we provided was having a safe, healthy environment for students to disclose and have a positive mental

health experience. This helped reduce the stigma of mental health services for these students. We know that reducing stigma can be a key to prevention in the long term.

*Ralph Simpson, Principal, Stone Mountain High School. Mr. Simpson has a degree in criminal justice and has worked as a corrections officer at a maximum-security prison. He is the first African-American principal at Stone Mountain High School and is enrolled in a doctorate program in education, supervision, and leadership.*

I decided to become a part of the solution instead of the problem. In becoming part of the solution, you certainly have to be a problem solver and proactive. As educators we need to be student-centered. When you are that type of individual, the children will tell you every single thing that goes on in a school. Some things you do not want to know, but they will tell you everything. There are students who are having problems in many cases and situations. They will share with me some of the personal prob-

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***I am not going to wait until a suicide occurs to take action.***

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lems and situations that are occurring inside and outside of the home before they will share them with their parents. We have a mentoring program at the school where the students can talk to teachers, counselors, cafeteria workers, custodians, or any adult in the building if there is something occurring in the household or if they need to just vent, share, and get guidance. As educators, this is very critical.

There are some instances where we need assistance. How can we assist others if we are not fully equipped to deal with some of the situations and problems that are occurring? The Children's Defense Fund model is

to leave no child behind. I believe that, at the same time, we do not need to leave any principals or teachers behind.

We are talking about being proactive. I have been at Stone Mountain High School for four years. We have not had the experience, fortunately, of a student or child committing suicide. Am I supposed to wait until that happens?

When the Teen Screen program came along, it was an attempt for me to be proactive and attempt to prevent any such occurrence. If there is a student killed in an accident or for some other unfortunate reason, they send a crisis team of counselors to the school for two or three days. We need these types of individuals in the school on a daily basis.

I can look at my student population daily and see a child who has made attempts or responses that reflect some characteristics of suicide. I know the students who have had to be referred to the counselor's office for making some mention of suicide. It is at that point we get those individuals involved and refer them to the resources. We need the resources to intervene sooner.

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Christine Daley, Ph.D., School Psychologist, Muscogee County Schools. Dr. Daley recently assumed responsibilities as state mental health coordinator for the National Association of School Psychologists.

I want to tell you about a program we have implemented in the Muscogee County School District during the last two years. One purpose of the program is to educate parents, teachers, students, and the community about the signs and symptoms of suicide. Another is to provide a self-screening tool for students and provide a conduit for them to obtain services if they are experiencing symptoms of depression or suicide.

The impetus for the project came from the results of a survey conducted in the Muscogee County School District from 1998 to 1999 by the Search Institute. Out of 8,970 middle and high school students, 19 percent reported being sad or depressed most or all of the previous month and 17 percent reported having

attempted suicide one or more times. Those statistics were scary, especially when compared to national data, which were slightly lower.

In the fall of 2000, the psychology services department received information from the National Screening for Mental Health about National Depression Screening Day in October. We talked to the director of guidance, and it became a bigger project than just screening students. We pulled together

the counselors, psychologists, and community agency representatives and came up with a proposal to bring to our school board and superintendent.

The school board approved the screening and educational materials as a component of our high school curriculum so we would not have to deal with issues of parental consent. The next step was to get people trained as caregivers. We had a toolbox conference at the beginning of every school year and made sure all of our counselors and psychologists who had not gone through the Living Works assessment/gatekeeping program were trained to help identify persons who might be at risk for suicide. We presented the educational and screening materials to the faculties and staff of all of the high school programs. We notified parents we were going to show a video informing them of what was going to be presented to the students, a screening form they could complete on their own children, and a list of resources they could access in the community if they felt their child was at risk for suicide or depression. There was a lot of publicity the first year. Material was posted in the school and shown on the government access channel, and we got support from the local mental health people in the community.

Our teachers were really important and the ones most comfortable after seeing all the material. We screened them first to make sure they were comfortable presenting the information to students. Psychological services staff supported those who were not comfortable. We provided them with a script to introduce the materials to students and a video called *Signs of Suicide* that showed vignettes of high school-age students talking about their own experiences.



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After the students saw the video, the teachers used a manual to discuss some of the things the students saw. After that, students completed the Columbia depression scale and response cards. Students self-referred to talk to a counselor if they felt they needed to. On any given day, as many as 25 caregivers followed up with students who felt they needed to talk to someone. The caregivers used the Living Works model to ascertain level of risk. Any student who demonstrated a moderate or high level of risk was required to sign a contract and, depending on the circumstances, the parents would be called to get involved. In those instances where we felt like a referral was necessary, parents would sign a contract indicating they would follow up with their student, and how, and that they would let the school know once they had done so and what the outcome was.

Last year, we had a program evaluation committee come in. The results are not in yet. What we have learned is that prevention and collaboration are important. I am proud of the Muscogee County School District, school board, superintendent, and building- and district-level administration because they recognized the importance of prevention and were courageous enough to allow us to implement this program in the curriculum. Also, I am proud of our system of caregivers, school psychologists, nurses, social workers, teachers, and community mental health people who were able to set aside differences and recognize that we could accomplish more, and much more effectively, through a collaborative effort.

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## Questions and Answers

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**Q** Do you know any other branches of the armed forces that have suicide prevention programs such as the Air Force?

**A** *(David Litts)* Actually all of the services are doing good and innovative work. What distinguishes the Air Force is that we have been doing it consistently for the last five or six years and with the leadership of the Chief of Staff. That seems to be the thing that is really making a difference.

**Q** How do you get people to collaborate at the local level?

**A** *(Christine Daley)* I was surprised how easy it was. We have a good relationship with our local mental health community because we deal with so many children with medical problems or mental health issues. I think basically it is taking the first step and asking.

*(Ralph Simpson)* I just want the parents in my community to face reality. When we focus on school violence and violence in general, we can see the vast differences between general homicide and teen homicides and suicides. When parents look at the reality, they can become educated and holistically involved with their child's education and life.

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## A Personal Story: Four Lucky Things

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Larry L. Gellerstedt, III, President and Chief Operating Officer, The Integral Group. Mr. Gellerstedt began his career at Beers Construction Company. He was named 1992 Entrepreneur of the Year by Ernst and Young, 1993 CEO of the Year by the Atlanta Business League, and one of the 100 most influential people in Georgia by Georgia Trend magazine.

**I**n June of 1999, I was running an international business that was publicly traded on Wall Street. I was chairman of the board for the Children's Healthcare System and had led the merger. I had just stepped down as chairman of Fernbank Museum. By all standards, I had the world by the tail. In June of that year, thanks to a great therapist, I committed to going into Menninger Institute while suffering from severe anxiety disorder, clinical depression, and substantial thoughts about suicide. I am certainly no authority on mental illness, so I can only share a personal perspective.

My illness led to many ups and downs over the years, but when I went to Menninger, I was absolutely at the bottom. It took me 12 months to substantially recover. During that time, I lost my job. For a period of time, I lost my family. It was the most frightening and terrifying fight of my life. I hope I do not have to fight it again. I made a decision at that time that if I ever got out, I was going to share my story and I was going to do it publicly. I was driven to do that by my experience of 25 years of physical and mental problems when I never would have succumbed to treatment.



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I felt guilt and shame. I felt like I lacked will. I felt like a wimp and a malingerer. To be successful in business, you had to be tough, and I believed I just needed to try harder. By June of 1999, I was working anywhere from 70 to 80 hours per week and was successful by most standards.

I was in a program called Professionals in Crisis at the Menninger Clinic. The program was set up for people in their professional careers who have substantial amounts of responsibility. I had at least four huge advantages over most of the other patients I was with. Without these advantages, I do not know that I could have made it. Most of my fellow patients did not have all that I benefited from.

First, I was able to pay for my care regardless of what my insurance company did. While running businesses all my life, I had never taken the time to look at the back of the policy. The business insurance did not provide any mental health coverage. Most of the patients that were with me at Menninger had \$10,000 lifetime mental health coverage. It took about seven days at Menninger to go through \$10,000.

Second, I had a therapist that I trusted. He became my quarterback and directed me through the maze of mental health opinions and medicines and all that was thrown at me at a time when I really was not in a good position to evaluate it.

Third, I had the ability to quit work and not fail in supporting my family. Last, I had the most incredible friends and family support base. I am convinced that, although depression was brutally hard on me, it pales in comparison to the people who lived with me on a daily basis through 25 years of suffering.

I remember when I finally went in. I think the only person on earth who was more tired, frustrated, and sad than me was my wife, Carol,

but she stuck with me. I made a commitment to go public so that someone, just one person, would get treatment sooner than I did. That is the only reason I decided and wanted to go public. The response has been overwhelming. I feel helpless when someone calls. I tell them I had four lucky things.

Currently, I think the mental health system is pretty dysfunctional since you have got to steer yourself through it and have the ability to pay for what you need. I think the system of care is dysfunctional in response to the payer system. I saw people who had circumstances at least as hard as mine and were in very bad shape get kicked out of Menninger in six days due to money.

I also saw an institution – and I only have the perspective of one – in decline. I was in Menninger for five months and was out for 10 days when I figured I needed to go back. I saw programs getting closed every day. I saw staff cutbacks. It was an institution trying to survive, but in surviving, whose care gets compromised? Those of us who are out there. It is not easy. The key to me is: People need to have access to treatment. Without that, I do not think we can ever get over the stigma of the disease. If you are going to admit that you have got it and there is no place to get better, then the pressure and risks are too great.

Is the business world ready to acknowledge mental illness? I do not think the business world is ready, and I do not think it ever will be unless people start speaking out. It is risky to speak out. The risks pale in comparison to the satisfaction and joy you get when you see there is one person that you touch. That makes all the risk worthwhile.

Now that I am back in the business world, I see the risks every day. People do not want you to talk about it. They do not want to mention it to you. They are not sure they can



trust you in a pressure-packed situation. I cannot blame them. They do not understand the disease. I do not understand the disease. I know that I have a regimen of weekly therapy, 225 mg of Effexor every day, and a Clonopine in my pocket in case I get too anxious. I have been on a steady path and I plan to stay healthy. There is a stigma and there is a risk, but there is a bigger risk. Based on the response I have seen from the two newspaper articles we have done, there are a huge number of people out there crying for help in an environment that is very unforgiving for those who admit they have the disease.

There are no easy answers, but every long journey starts with a single step. I know what I can do is tell my story and, hopefully, that will help somebody out there. It helps me periodically to tell my story. A good friend of mine said I was just supposed to

say I went away because I was tired. Five months is a long time to go away because you are tired. One of them said, "For God's sake, Larry, do not become the poster boy for mental illness." I do not want to be the poster boy for mental illness. I just want to be Larry Gellerstedt.

I also know that this disease does not segregate itself from business people and professionals. David Litts talked about when you can give responsibility back to people who have suffered from mental illness. It is a painful story to hear, but we have got to talk about it. I applaud what professionals and advocates do because I know they do not get thanks, but their efforts are the foundation of the safety net for people like me. Each of us desires to get better, become healthy, and become contributing members of our families and communities.

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## In Summation

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Pat Strode, Director, Family Education, National Alliance for the Mentally Ill – Georgia. Ms. Strode also serves as co-chair for the 2002 Rosalynn Carter Georgia Mental Health Forum.

This statewide forum has underscored the importance of listening: listening to our children, listening to our co-workers, and listening to those who are in our custody and in our care. We must listen so that we can learn what is going on and can recognize symptoms. This listening also is critical for coalition building.

We have heard about science-based treatment and the link between mental illness and physical illness. Research can be used to help us focus on the future. All of this points to the need for advocacy and the importance of letting our legislators know what our needs are. This advocacy must be practiced with our schools and faith communities. These are tools that we can use to

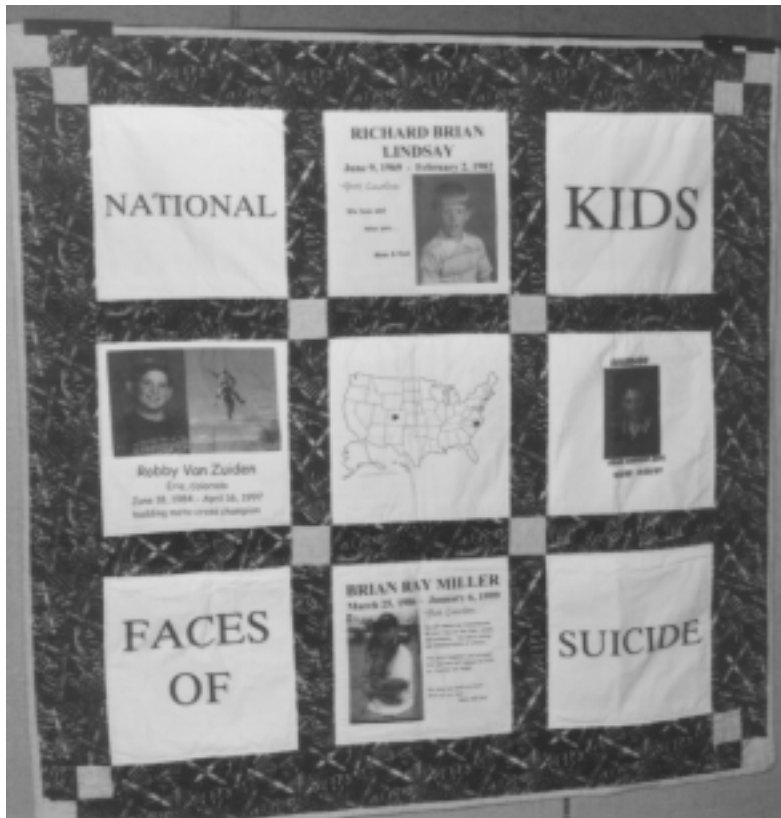
influence our respective communities and prevent suicide. The challenge is to implement them effectively.

Education is the key. We must learn more about the stressors, the symptomology of suicide, and about mental illnesses. The lack of adequate services has resulted in an increase in the population of people who have mental illness in the jails. Please let your legislators know we need community-based mental health treatment centers and we need programs that work. The jails should not have to be treatment facilities, and it is up to us to change that.

We have heard inspirational stories. You can do something, talk to somebody, listen to somebody, and let somebody know that you care. The Georgia plan is a tool, and I implore all of us to use it. There is something in the plan that anyone can do to help prevent suicide.

There are some wonderful best practice programs that are available. What they are doing at the Air Force is remarkable. We want the Teen Screen in our schools. We want to focus on the teens and to focus holistically on our youth. At the same time, we want measurable results. Results are essential for replicating intervention and prevention programs.

We must continue to tell the stories and put faces on mental illness, the victims of suicide, and the survivors. We need to let people know we are here, that we believe in treatment, and that we are not going to sit back and relax. The suicide prevention plan for Georgia must be implemented all over the state so that we can see those suicide rates drop. Our lives depend on it.



*The National Kids Faces of Suicide remembrance quilt was provided by the Suicide Prevention and Advocacy Network.*

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## In Closing

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Rosalynn Carter  
*Chair, The Carter Center Mental Health Task Force*

*I*t has been a wonderful, emotional event – wonderful because so many people came together to work on preventing suicide. I hope that we can continue the work begun here and successfully bring suicide rates down in our state. It also has been wonderful because the state announced its suicide prevention plan. I am proud of Georgia, one of the first in the country to have such a plan. It has been wonderful because we learned about best practices and good ideas that we all can take away with us. It has been emotional because of the personal stories, which brought tears to our eyes. Larry Gellerstedt will never know how many lives he has touched because he was willing to go public with his anxiety disorder and depression. His story illustrates the importance of parity for mental health insurance coverage and the need for all mental illnesses to be covered.

We have learned that we all can do something to prevent suicide and that we can get our state and communities involved with us. So I thank you again for a wonderful day.

*Rosalynn Carter*