

Suicide Prevention and Youth: Saving Lives

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Witness:

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Director

Testimony

Laurie Flynn is the director of The Carmel Hill Center for Early Diagnosis and Treatment in the Division of Child and Adolescent Psychiatry, and the national director of Positive Action for Teen Health (PATH). Ms. Flynn has been instrumental in the improvement of services for children and adolescents with serious mental disorders. Before joining Columbia University in 2001, Ms. Flynn served as the executive director of NAMI (National Alliance for the Mentally Ill) for 16 years. NAMI is the nation's leading grassroots advocacy organization dedicated solely to improving the quality of life for people with severe mental illnesses and their families. Ms. Flynn is a member of many national advisory boards and professional association committees concerned with the care of the severely mentally ill, the quality of mental health care and family support, as well as research and ethical aspects of the treatment of mental illness. She is also the recipient of many service awards and commendations from national foundations and associations, including three from the American Psychiatric Association. Ms. Flynn is the author of several articles, books, and book chapters on health services for the mentally ill and family support. LAURIE M. FLYNN CURRICULUM VITAE CONTACT INFORMATION Columbia University Division of Child & Adolescent Psychiatry 1775 Broadway, Suite 715 New York, New York 10019 Tel: 646-443-8191 Fax: 646-443-8190 Email: FlynnL@childpsych.columbia.edu EMPLOYMENT Director, The Carmel Hill Center for Early Diagnosis & Treatment, 2002 – present National Director, Positive Action for Teen Health, 2002 – present Senior Research & Policy Associate, Columbia University College of Physicians & Surgeons, 2001 – 2002 Executive Director, National Alliance for the Mentally Ill, 1984 – 2000 Director of Public Policy, National Adoption Center, 1983 – 1984 Executive Director, North American Council on Adoptable Children, 1979 – 1983 Conference Director, Delaware Valley Adoption Council, 1978 – 1979 Consultant to child welfare organizations, federal, state and county governments and non-profit family organizations, 1978 – 1985 BOARDS & PROFESSIONAL ORGANIZATIONS Clinical Trial Advisory Group, National Institute of Mental Health, 2000 – present Expert Panel, Forecast for Mental Health 2010, Institute for the Future, 2000 – present Intramural Research Program, IRB, National Institute of Mental Health, 1998 – 2000 Member, Executive Session on Medical Error and Patient Safety, Harvard University Kennedy School of Government, 1998 – present National Advisory Board, Research Center on Managed Care for Psychiatric Disorders, University of California, Los Angeles, 1998 – present Board of Directors, Health Care Quality Alliance, 1998 – present Chair, Board of Trustees, Foundation for Accountability, 1996 – 1999 (current member) Presidential Appointee to National Bioethics Advisory Commission, 1996 – present Advisory Board, Center for Mental Health Services Research, University of California, Berkeley-San Francisco, 1994 – present American College of

Neuropsychopharmacology, Committee on Ethical Considerations in Clinical Research, 1994 – present American Psychiatric Association, Committee on Human Subjects in Research, 1994 – present National Expert Advisory Panel, Schizophrenia PORT, University of Maryland, 1993 – 1999 Executive Committee member, Johns Hopkins and University of Maryland Center for Research on Services for Severe Mental Illness, 1992 – present Appointed by Gov. William Donald Schaefer to Maryland Commission on Women's Health, Chair, Mental Health, 1992 – 1993 Editorial Board, Association for Health Services Research, 1991 – present National Advisory Board, Center for Research on the Organization and Financing of Care for the Severely Mentally Ill at Rutgers University, 1990 – present Appointed by H.H.S. Secretary Louis Sullivan to the Federal Task Force on Homelessness and Severe Mental Illness, 1991 – 1992 National Mental Health Leadership Forum, 1989 – 1992 Child Welfare Institute, Atlanta, Georgia, 1989 – 1993 Interdisciplinary Advisory Board for Hospital & Community Psychiatry Journal, 1988 – present Governing Council, Section for Psychiatric Services, American Hospital Association, 1987 – 1990 National Advisory Committee for Young Adults with Serious Mental Illnesses: National Association of State Mental Health Program Directors 1987 – present Committee on Problems of Public Concern Co-chair, American College of Neuropsychopharmacology, 1986 - present SELECTED PRESENTATIONS The Columbia University TeenScreen Program - Presentation to the Idaho Psychiatric Society and First Lady of Idaho. June 2003. The Columbia University TeenScreen Program - Presentation to the State Capitol, Madison, Wisconsin. June 2003. The Columbia University TeenScreen Program - Presentation to the United States Secretary of Education. Washington, D.C. June 2003. The Columbia University TeenScreen Program – Presentation to the Education Research and Development Institute. New York City. 2003. Health Service Needs for Persons with Severe Mental Illness. Lecture to John's Hopkins University, Bloomberg Department of Public Health. Baltimore, Maryland. April 2003. The Columbia University TeenScreen Program - Plenary Speaker for the 16th Annual Research Conference: A System of Care for Children's Mental Health— Expanding the Research Base, Florida Mental Health Institute. Tampa, FL. March 2003. Dealing with Fragmentation in the Service Delivery System – Presentation to the President's New Freedom on Mental Health. Arlington, VA. December 2002. Reaching Youth at Risk for Suicide: Prevention, Legislation, School Screening. Symposium at the American Academy of Child and Adolescent Psychiatry Annual Conference. San Francisco, California. October 2002. Screening Adolescents for Suicide and Depression. Workshop at the Alliance for Children and Families Annual Conference. Philadelphia, PA. October 2002. The Columbia University TeenScreen Program: Making it Happen. Symposium at the Annual Convention of the National Alliance for the Mentally Ill, Washington, D.C., July 2001. Institute on Psychiatric Services, Philadelphia, PA. Invited Lecture, 2000. Department of Health Policy and Management, Johns Hopkins University, Lecture, 2000. Department of Psychiatry, Maryland University Grand Rounds, 1999. Department of Psychiatry, State University of New York Health Science Center at Brooklyn, Grand Rounds, 1999. Hospital & Community Psychiatry Institute, San Diego, CA, 1994, 1996, 1999. Eleventh Annual Pittsburgh Schizophrenia Conference, Keynote, 1994. Hillside Hospital, Long Island Jewish Medical Center, Commencement Address to graduates in Psychiatry, 1993. Hospital & Community Psychiatry Institute, Baltimore, MD, 1993. Department of Psychiatry, University of California, San Diego, 1993.

Columbia University Psychiatric Residency Training Program, 1992. Yale University CMHC 75th Anniversary Lecture, 1991. Friends Hospital, Philadelphia, 1991. Sheppard-Pratt Hospital, Baltimore, MD, 1991. American Psychiatric Nurses Association, Keynote, Baltimore, MD, 1991. NIMH Biannual Conference on Mental Health Economics, 1990. New York Medical College Department of Psychiatry, 1990. University of Pennsylvania School of Nursing, Dean's Lecture, 1990. PUBLICATIONS ARTICLES: "Saving Lives in New York: A Plan To Prevent Suicides - Suicide and Populations at Risk: Recipients of Mental Health Services." New York State Office Of Mental Health. (In Press). "Mental Health Screening Can Prevent Youth Suicide." School Board News, National School Board Association. July 2003 "Implementing Evidence-Based Practices for Persons with Severe Mental Illness," Psychiatric Services, co- author, January 2001 "Blaming the wrong Villain," Taking Issue Column, Psychiatric Services, November 2000 "The Role of the National Alliance for the Mentally Ill in Reversing the Economic burden of Mental Illness," The Economics of Neuroscience, co-author, 2000 "A New Image of Mental Health," Health & Health Care 2010, Institute for the Future, 2000 "Mental Illness: A Legacy of Stigma, A Future of Hope," Journal of Practical Psychiatry and Behavioral Health, 1998 "Political Impact of the Family-Consumer Movement," National Forum, Phi Kappa Phi Journal, 1994 "Patients' Families Say No!" essay, part of "Dialogue: Can Managed Behavioral Healthcare Plans Serve the Severely Mentally Ill?," Behavioral Healthcare Tomorrow, 1994 CHAPTERS: "Role of Advocacy, Self-help and Career Groups and Voluntary Organizations" chapter in New Oxford Textbook of Psychiatry, 2000 "Consumer and Family Concerns About Research Involving Human Subjects," chapter in Ethics in Psychiatric Research by American Psychiatric Association, Pincus HA, Lieberman JA, Ferris S, 1999 "Patterns of Health and Social Service Use Among People with Severe and Persistent Mental Illness," Flynn LM, Kasper JD, Steinwachs DM. 1996 "Social and Economic Costs of Schizophrenia" chapter in From Mind to Molecule: Review of Schizophrenia Research by American Psychiatric Association, 1994 "Managed Care: A Family Perspective," chapter in Allies or Adversaries: Mental Health and Managed Care, American Psychiatric Association, 1994 "Forming A National Family Organization: What NAMI Has Learned. " Chapter in Advocacy for Emotionally Disturbed Children, Florida Research & Training Center for Children With Severe Emotional Disturbances, Charles C. Thomas, Publisher, 1989 "The Stigma of Mental Illness" chapter in Families of the Mentally Ill: Meeting the Challenge, Agnes Hatfield, editor New Directions for Mental Health Services Series, Jossey-Bass, 1987 BOOKS: Using Client Outcomes Information to Improve Mental Health and Substance Abuse Treatment, co-editor, 1996 Criminalizing the Seriously Mentally Ill: The Abuse of Jails as Mental Hospitals, by NAMI and Public Citizen's Health Research Group, co-author, 1992 A Foster Parent's Guide to Mental Health Services for Children, Child Welfare Institute, 1990 Care of the Seriously Mentally Ill: A Rating of State Programs, co-author, 1988 and 1990 editions HONORS • The CNS Award for Outstanding Service to Humanity, Comprehensive NeuroScience, Inc., 2000 • Albert B. Sabin Hero of Science Award, Americans for Medical Progress Education Foundation, 1999 • Decade of Brain Award, National Foundation for Brain Research, 1998 • Public Service Award, American Association for Psychosocial Rehabilitation, 1996 • Patient Advocacy Award, American Psychiatric Association, 1995 • Presidential Commendation Award, American Psychiatric Association, 1994 • Mental Health Section Award,

American Public Health Association, 1993 • Award for Distinguished Service, American Psychiatric Association, 1988 and 1991 • Selected as a Switzer Scholar by the U.S. Department of Education and the National Association for Rehabilitation, 1988 • Certificate of Commendation, presented by Margaret Heckler, U.S. Secretary of HHS, 1983 • Award for Meritorious Service to the Children of America, presented by the National Council of Juvenile and Family Court Judges, 1981 EDUCATION Mary Washington College University of Virginia, BA, Philosophy Testimony of Laurie Flynn Director Carmel Hill Center for Early Diagnosis and Treatment Division of Child and Adolescent Psychiatry, Columbia University Hearing on “Suicide Prevention and Youth: Saving Lives” Senate Health, Education, Labor and Pensions Committee Subcommittee on Substance Abuse and Mental Health Services March 2, 2004 Good Morning Mr. Chairman and Members of the Subcommittee; as Director of the Carmel Hill Center for Early Diagnosis and Treatment within the Division of Child and Adolescent Psychiatry at Columbia University, I am honored to participate as a witness at today’s hearing on youth suicide prevention. The Carmel Hill Center administers the Columbia University TeenScreen® Program, a mental health screening and suicide prevention initiative for youth. The issue of youth suicide prevention is personal to me; my daughter made a suicide attempt during her senior year of high school. She had deteriorated inexplicably and rapidly, moving quickly from severe stress to depression with few warning signs. At the time, there was no reliable way for youth to be screened for mental illness or suicidal tendencies and parents had no reliable way of knowing their child was in danger. Thankfully my daughter was successfully treated and went on to college and graduate school. Last year she was married. My family’s story has a happy ending, but thousands of parents and teens are not so fortunate. The Evidence Base for Mental Health Screening as a Means of Youth Suicide Prevention Since my daughter was first treated for mental illness, evidence-based youth mental health screening programs have been researched, developed, proven to work, and made available for use. These suicide prevention initiatives, which include not only the Columbia University TeenScreen Program but also other programs such as the Signs of Suicide Program developed by our colleagues at Screening for Mental Health, Inc., have undoubtedly helped improve, if not saved, the lives of thousands of teens. Had the TeenScreen Program been available in my daughter’s high school, I most likely would have had a year or more warning that she needed help. There exists a growing body of scientific research that has found screening to be an effective way to find those who are suffering from mental health problems and are at risk for suicide. Screening provides a way to find these youth before their lives have been permanently derailed by related poor academic achievement, substance use, self injury and suicide attempt. Screening is especially important because many conditions, especially adolescent depression, do not always exhibit easily identifiable symptoms. Universal screening, when linked with referral to appropriate services, can significantly reduce the devastating impact of mental health problems on young lives. The move to offer mental health screening to every teen in the United States is based on the findings of a psychological autopsy study published in 1996 by Dr. David Shaffer, Chairman of the Department of Child and Adolescent Psychiatry at Columbia University. The study provided information about teenagers who commit suicide and how suicides could be prevented, revealing that teen suicide is not the unpredictable event we had once thought it to be. In fact, teens that commit suicide suffer from a very specific range of mental

illnesses. Dr. Shaffer found that 91 percent of the teens that committed suicide had a psychiatric disorder at the time of their deaths. This finding has now been replicated in several national and international studies. In Dr. Shaffer's study, the majority of boys who committed suicide suffered from depression, abused alcohol or drugs, and/or had made a prior suicide attempt. Most girls who committed suicide either suffered from depression or had made a prior suicide attempt (Shaffer et al., 1996a). The original study of the TeenScreen Program on 2,004 high school students revealed the program's unique ability to uncover youth at risk for suicide, but unknown to have problems and not receiving professional help for them (Shaffer et al, 1996b). Only 31 percent of those with major depression, 26 percent of those with recent suicide ideation, and 50 percent of those who had made a past suicide attempt were known by school personnel to have significant problems and receiving help. This indicates that the majority of students who are suffering from a mental illness and are at risk for suicide are currently not detected. Dr. Shaffer hypothesized that if youth were screened for these disorders and those found to be at risk were treated, most suicides could be prevented. As a result of Dr. Shaffer's research, the Columbia University TeenScreen Program was developed. The Columbia University TeenScreen® Program The TeenScreen Program has a simple purpose: to screen youth for mental illness and suicide, identify those who are at risk, and link them to appropriate treatment. In 1999, we were able to take the available research and apply it in the real world with the launch of the national TeenScreen Program. As part of our initiative to ensure that every teenager receives a mental health screening before leaving high school, we have trained 108 screening sites in 34 states, Guam, Canada and Panama. We currently have over 200 sites in development. In 2003, we were able to screen approximately 14,200 teens at these sites; among those students, we were able to identify approximately 3,500 youth with mental health problems and link them with treatment. This year, we believe we will be able to identify close to 10,000 teens in need, a 300 percent increase over last year. The TeenScreen Program works by creating partnerships with communities across the nation to implement early identification programs for suicide and mental illness in youth. We work with communities to develop screening programs that are based on the TeenScreen Program, yet adaptable to accommodate the specific needs and resources of each community. Most screening programs take place in schools, but the program can also be implemented in residential treatment facilities, foster care settings, clinics, shelters, drop-in centers and other settings that serve youth. Once a screening partner has been identified, we ask that the potential screening site complete some basic requirements. The site must submit a plan for screening youth and agree to identify a site coordinator, agree to screen a minimum of 200 youth per year, commit to routinizing screening in their community, and provide biannual reporting of screening results. We do not require data collection for research purposes, and we work with potential sites through the application process to help them fulfill each requirement to the best of their ability. In fact, many of our current sites began screening as part of a one-year pilot and, once they felt comfortable with the process and obtained further community resources and support, have since advanced to screening routinization. It is important to note that we require both parental consent and participant assent before a youth can take part in the screening process, thus making screening a completely voluntary activity. In the first stage of the actual screening process, all youth who consent to screening and obtain parental consent complete the Diagnostic Predictive Scales

(DPS). The DPS is a 10-minute self-administered questionnaire that screens for social phobia, panic disorder, generalized anxiety disorder, major depression, alcohol and drug abuse, and suicidality. Youth who report no mental health problems on the DPS are dismissed from the screening, and youth who require further attention are advanced to the second stage where they are assessed by a mental health clinician to determine if further evaluation or treatment would be beneficial. If professional services are recommended, the youth and his or her family are assisted with the referral process. At a time of budget shortfalls at both the federal and state levels, I am aware that the subcommittee is particularly interested in the costs associated with our screening program. I am happy to report that as part of our new campaign to ensure that every teenager receives a mental health check-up before leaving high school, we are offering 400 communities across the nation free individually tailored screening projects, including free screening instruments, materials, and software; free pre-training consultation; free training; and free post-training technical assistance. Most sites incur a minimal cost for implementing a screening program. The primary cost associated with screening is staff; other costs include computers and supplies. Many schools and communities can implement their programs at no additional cost by utilizing resources that are already in place (e.g., the school social worker conducts the screening and uses the school's computer lab to do so) or by securing volunteers and interns to staff the program. Schools that do not have these resources in place have been able to find grants to support the screening staff, which can be as small as one person, and supply needs. Because the program is flexible and can be implemented in a variety of ways, it is able to fit into any budget. State Efforts Through our outreach efforts and community partnerships, we have been enormously pleased to work with several states that have taken the initiative to implement statewide youth mental health screening and suicide prevention strategies. Among these states are Ohio, Florida, Nevada, and New Mexico; in addition, recent activity in Pennsylvania and Iowa have put those states on the path to a statewide strategy. For example, in the Chairman's home state of Ohio, we have been fortunate to work with Mike Hogan, PhD, Director of the Ohio Department of Mental Health, Chair of the President's New Freedom Mental Health Commission, and a member of our National Advisory Council. In February 2002, Commissioner Hogan initiated a statewide TeenScreen effort by soliciting five county mental health boards to be part of a pilot program. Over the next 10 to 18 months, the development of these screening sites was supported by staff at the TeenScreen Program as well as through a grant of \$15,000 from the Department of Mental Health to each mental health board who is participating in the pilot program (Cuyahoga County, Clermont County, Butler County, Stark County, and Wayne/Holmes Counties). In Senator Ensign's home state, the Nevada Department of Education recently announced plans to create a new office within the department, the Center for Health and Learning. Our partnership with Nevada began 2 years ago in the Clark County Health District, which maintains 3 school-based health centers serving ten schools in Las Vegas and North Las Vegas. During this time, health district staff has used the TeenScreen Program in 3 of the area schools. Due to the success of the program in Clark County, and through the continuous outreach and collaborative efforts of the county's health district staff, the Nevada Department of Education has taken an interest in the TeenScreen Program, resulting in the creation of the Center for Health and Learning. The development of the Center has been led by Gary Waters, State School Board President, and strong supporter

of the TeenScreen Program. The Center will, among other activities, be responsible for setting up a statewide program to oversee the TeenScreen Program in interested schools and districts. The Center's oversight will include the development, start-up, and implementation of TeenScreen sites as well as ongoing support, including planning support, coordination of provider services, and quality assurance guidance, for these new sites. In New Mexico, home to Senator Bingaman, a collaborative relationship with the New Mexico Department of Health's Office of School Health and the University of New Mexico's Department of Psychiatry has led to successes on many fronts. Our partnership in the state began two and a half years ago with a TeenScreen Program pilot in 5 school-based health centers (including Silver City SBHC, Ruidoso SBHC, Acoma-Laguna SBHC, and Bernalillo SBHC). This pilot has led to the stationing of a TeenScreen Program Western Regional Coordinator in Albuquerque, integration of the TeenScreen Program into several Robert Wood Johnson funded research grants, and the adoption of screening by several frontier schools, including Newcomb, Clovis, and Lovington. Youth mental health screening is also at the forefront of issues to be included in New Mexico's behavioral health restructuring plan, and have a great deal of support across state agencies. As the Senator is aware, recent suicides in Pojoaque schools have prompted that community and others to seek out solutions that better address the unique challenges that New Mexico communities face, and the TeenScreen Program is one of the approaches being considered. In Iowa, home to a member of the full committee, Senator Harkin, a tragedy occurred just this past October. A student at Lincoln High School in Des Moines committed suicide, and subsequently parents and school officials became suspicious of a suicide pact. In response to the suicide and the suspected suicide pact, and with the help of former Governor Terry Branstad, a member of our National Advisory Council, TeenScreen Program staff offered our assistance and our program to Lincoln High School and the Des Moines school district. This incident coincided with a groundswell of interest in screening from school social workers, most of who had heard about TeenScreen at a conference, and in the State Department of Education. Ultimately, we were able to convene two important meetings; the first was with representatives of the State Department of Education and school social workers from around the state; the second was with the principal of Lincoln High School, members of the school board, and representatives of the Des Moines School District, among other attendees. As a result of these two meetings, we are on our way to implementing youth mental health check-ups not only in the Des Moines School District, but across the state as part of a statewide TeenScreen Program pilot. In Florida, our partnership is an example of the relationship between youth suicide, mental illness, and substance abuse prevention. TeenScreen Program staff has been working with Governor Jeb Bush to help achieve his goal of reducing suicides in the state. We have specifically collaborated with Jim McDonough, Director of the Office of Drug Control and the state Suicide Prevention Task Force. In partnership with the University of South Florida we are piloting district wide mental health screening of 9th graders in Hillsborough and Pinellas counties. Staff has met with mental health professionals and community leaders, elected officials, advocates, the business community, and family organizations to build a base of support for media outreach and awareness. The Case for Expanded Mental Health Screening Research has established that evidence-based screening programs are one of the most effective means of youth suicide prevention. Research has also shown that one of the best times to catch

youth at risk of suicide is in high school, with suicide rates among teens rising dramatically around age 14 to 15. While we are proud to have trained 108 screening sites in the use of the TeenScreen Program, only a fraction of our nation's secondary schools currently offer students a mental health screening. The need for increased availability of youth mental health screening is evidenced by the fact that close to 750,000 teens are depressed at any one time, and an estimated 7-12 million youth suffer from mental illness. While treatments are available for these severely disabling disorders, sadly, most children do not receive the treatment they need. Among teens that are depressed, 60-80 percent go untreated. Among all teens with mental illness, two out of three do not receive treatment. It has been established that the failure to adequately care for the mental health of our youth is connected to youth suicide. Suicide continues to be the third leading cause of death among our youth. In fact, more adolescents die by suicide as die from all natural causes combined. This does not even take into consideration the 19 percent of teens who contemplated suicide, the 9 percent who made a suicide attempt, and the 3 percent who made an attempt requiring medical attention, as identified by the CDC in 2001. The good news is that in the past year, there has been a wave of support for youth mental health screening, led by the final report of the President's New Freedom Commission on Mental Health. One of only 6 reported goals of the commission is that "Early Mental Health Screening, Assessment, and Referral to Services Are Common Practice." The commission found that among children such screening, assessments, and referrals "can prevent mental health problems from worsening." The commission's final report also states that "schools are in a key position to identify mental health problems early and to provide a link to appropriate services." I am especially pleased to report that the commission named the Columbia University TeenScreen Program a model program for early intervention. National Support for Mental Health Screening In addition to the endorsement by the President's New Freedom Commission on Mental Health, to date, 21 national mental health, education, and other organizations have endorsed the goal of offering every American teen receives a mental health check-up before high school graduation. A list of these organizations has been provided for committee members. We have also found success in Congress and among state legislators. Language in fiscal year 2004 omnibus appropriations bill calls on the federal government to report on what it is doing to encourage mental health check-ups for youth, including school based screening. We see this as a first step towards identifying one or more federal funding streams in the Department of Health and Human Services and the Department of Education to support screening. Last September, Congresswoman Rosa DeLauro introduced the Children's Mental Health Screening and Prevention Act, H.R. 3063, bipartisan legislation to fund a federal demonstration program encouraging diverse sites to implement and evaluate youth mental health screening. The legislation, which currently has 37 cosponsors in the House but no companion legislation in the Senate, would authorize up to \$7.5 million a year to enable up to ten interested communities to participate. At the state level, the Pennsylvania, Georgia, and Illinois state legislators have introduced resolution specifically encouraging the use of mental health screening as a means of identifying youth at risk for suicide. In Pennsylvania, this resolution was followed-up by a joint hearing on youth suicide prevention at which we were honored to testify. Challenges for the Subcommittee The challenge to the subcommittee is clear. There now is a proven way to find young people before they make an attempt on their lives. Families are counting on

your leadership. Fortunately, the subcommittee, the committee, the Senate, the Congress, and the entire federal government are in a position to ensure that every teen in America is offered a mental health screening as a means of suicide prevention. More leadership is needed, not necessarily more money. Our experience shows that the government can support youth mental health screening by redirecting existing resources. For example, state and local education agencies can use Safe and Drug Free Schools and Communities dollars to support school-based mental health services and suicide prevention activities. Both the federal and state governments must do a better job of encouraging local school districts to include mental health check-ups in their grant applications. Looking back at the example set by Nevada, I would encourage the federal government to support the appointment of a state leader on suicide prevention. Currently, suicide prevention activities are administered by a myriad of state agencies and councils, sometimes in coordination with mental health services, sometimes in coordination with health services such as injury and violence prevention, and sometimes in coordination with education services. This leader can be a person currently working on youth suicide prevention at the state level, but who would now be responsible for coordinating and disseminating available information on youth suicide prevention and youth mental health screening. Finally, Congress will soon consider reauthorization of the Substance Abuse and Mental Health Services Administration. I know the subcommittee joins me in thanking the agency for their leadership on the issue of youth suicide prevention. I encourage Congress to ensure that the agency has the resources it needs to continue its work and to increase its support of youth mental health screening. I am grateful for the subcommittee's leadership on and support for youth suicide prevention and am ready to work with you to ensure that all children are on the path to lead happy and healthy lives. I would be more than happy to take any questions from the subcommittee members.

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