Prevention's Legislative Pioneer

As a survivor of the suicide loss of his father, Sen. Harry Reid calls on a very personal tragedy to influence mental health policy in our nation

A public Senate hearing is a unlikely venue to hear a deeply moving story of loss, especially when a seasoned politician takes the microphone. Yet during a Senate Aging Committee meeting in 1996, Sen. Harry Reid did just that by revealing that his father completed suicide in 1972.

Since then, the Nev. senator has become a chief proponent of suicide public policy, introducing groundbreaking legislation that spurred the 2001 National Strategy for Suicide Prevention. "He gave the nation the permission to speak about suicide by sharing his story," said Jerry Reed, former legislative assistant to Reid and now executive director of SPAN USA, a suicide prevention advocacy group. "His legislation led to the first coordinated effort among states, municipalities and local governments to address suicide as a preventable public health problem and lift its veil of secrecy."

Reid also championed the Garrett Lee Smith Memorial Act, legislation named for Oregon Sen. Gordon Smith's son who completed suicide in Sept. 2003. The legislation provides federal funding for states, tribes and colleges to combat youth suicide and includes provisions to improve youth behavioral and mental health treatment.

ASP recently interviewed Reid and found him eager to discuss suicide prevention policy, calling it "encouraging," yet adding, "we have much work remaining to do." He also talks about the loss of his father and how it impacted his politics and his life: "Personal tragedy can serve as a catalyst for change."

Senator, recent evidence suggests that providing enhanced insurance coverage for behavioral health does not lead to exploding insurance costs. Would you reflect on your views on providing equal insurance coverage for both mental and physical conditions?

Given the close relationship between mental health and suicide, it's essential to eliminate the barriers to seeking and receiving effective mental health treatment. After all, good mental health is integral to overall health, as well as a key protective factor against suicide. In contrast, mental disorders and poor access to mental health services are substantial risk factors. In fact, the Institute of Medicine reports that the overwhelming majority of those who die by suicide has a diagnosable mental disorder. Yet, most suicide victims do not have their disorder diagnosed or adequately treated at the time of suicide.

Even today, I can still recall the moment in 1972 when I received the tragic news about my father having taken his own life.

As such, I believe that achieving parity in health insurance coverage of mental health services is critically important to the overall suicide prevention effort. Health insurance plans that cover mental health services should do so under the same terms and conditions as general medical and surgical services.

Recognizing this, the majority of states has already passed mental health parity legislation for state-regulated health plans.

As a member of the Senate, I have long sought to enact mental health parity legislation at the federal level. In the last Congress, I was pleased to see the primary legislative vehicle for this proposal, Paul Wellstone Mental Health Equitable Treatment Act, receive majority, bipartisan support in both chambers of Congress. Unfortunately, the legislation did not pass.

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In the 109th Congress, the Paul Wellstone Mental Health Equitable Treatment Act was reintroduced in the House of Representatives. As before, I strongly support this measure and will work to move a companion bill forward in the Senate when it is reintroduced there.

If we are to achieve mental health parity nationally, we must also resist proposals that would dismantle the hard-won victories in the states. Recent defeat of Senate bill 1955, the Health Insurance Marketplace Modernization Act (HIMMA) was a victory for mental health care for millions of Americans. This seriously flawed legislation would have wiped out a wide range of state coverage protections, including those requiring coverage for mental health services. It ultimately would have led to greater market fragmentation in a system in which too many Americans already cannot get the mental health services they need and deserve.

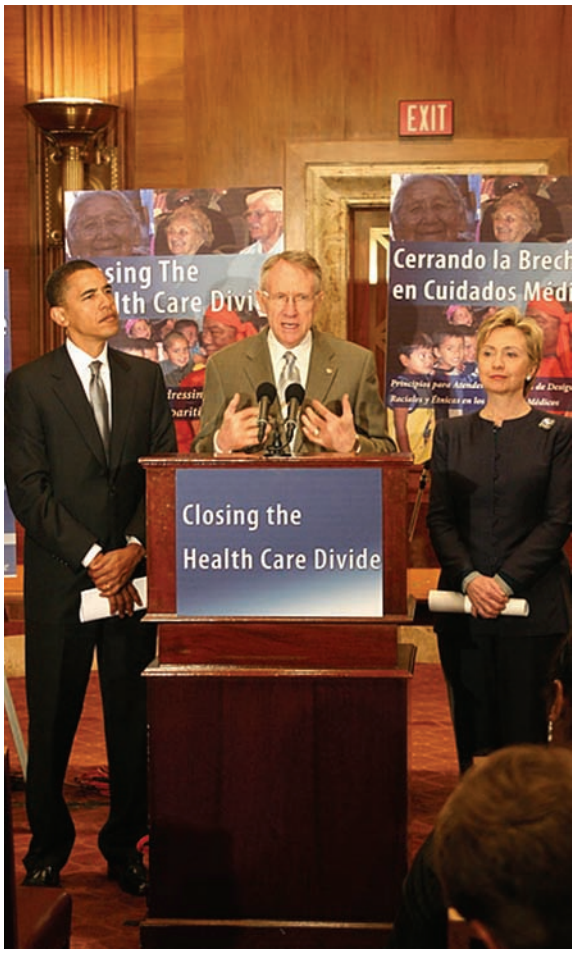
Senator, given the strong bipartisanship support for the Garrett Lee Smith Memorial Act and given that one of the top 10 resolutions from the 2005 White House Conference on Aging addressed mental health needs of older adults, what can we all learn from this for suicide prevention legislation to address these vulnerable populations? Anyone can be affected by suicide, but certain populations are especially vulnerable. The suicide statistics for the young, in particular, are deeply troubling. For young people 15-24 years old, suicide is among the three leading causes of death. More teenagers and young adults die of suicide than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia and influenza, and chronic lung disease combined.

At the other end of the age spectrum, the elderly are disproportionately hit hard by suicide. In fact, the highest suicide rates of any age group occur among persons age 65 years and older. And, as many ASP readers know, the risk factors for seniors differ from those of the very young.

What do these figures tell us about effective suicide prevention and intervention? In a compelling and clear way, they point to the need for selective programs that address specific at-risk groups. I believe that was one of the key driving forces behind Congress passing the Garrett Lee Smith Memorial Act with strong bipartisan support.

The vast majority of seniors have medical insurance under Medicare, yet under current Medicare co-payment or co-insurance requirements, Medicare beneficiaries pay two-and-a half times as much for outpatient psychiatric services. I support changing this to equalize Medicare co-payment requirements for psychiatric services with other physician services. Older adults seeking treatment for mental disorders should not have to face yet another barrier to care.

While the goal is to ultimately reach everyone who would benefit from suicide prevention, it can be easier to move forward legislation that reflects the needs of a subset of the American population. Fortunately, the two measures I just described ultimately



Sen. Reid has been a champion for health care in America for all Americans. Here Sen. Barack Obama (D-IL) and Sen. Hillary Clinton (D-NY) joined him in 2005 to spotlight racial and ethnic disparities in our nation.

benefit everyone, even though they call for action in a limited way, because the resulting gains build momentum and increase overall awareness of suicide as a serious but preventable public health challenge.

Senator, since the launch of the National Strategy for Suicide Prevention, what do you think is the greatest achievement made so far in moving NSSP recommendations and suicide prevention in our nation forward?
Crafted to provide a comprehensive framework for decisive action, the National Strategy for Suicide Prevention is the nation's foundation for a suicide prevention agenda. When it was first published in May 2001, the NSSP was lauded as representing both the work accomplished and the progress yet to be made. The blueprint advances the cause of suicide prevention in many ways, but as we all know, fulfilling its main purpose ultimately takes implementation at the state, local and community levels.

All 50 states now have a statewide suicide prevention strategy in place, under development or recognized as a major public health goal. I am very heartened by this milestone, and I am hopeful that those states that have begun, but not yet completed, their own statewide plan will accelerate their efforts.

Senator, given the progress made thus far in suicide prevention, what do you feel is the next priority in this arena, the one that could have the greatest return on investment and impact on saving lives?
With suicide still needlessly claiming more than 30,000 lives each year, and attempted or seriously contemplated by millions, widespread adoption of a clear and comprehensive strategy could not be more timely. Under such a plan, the organized collaboration between various stakeholders—including health care professionals, government, health and policy experts, and grassroots members—would strengthen the overall mental health care infrastructure, raise public awareness and lead to better use of limited resources. Each individual step forward builds momentum, ultimately contributing to the work of everyone else involved in the national effort.

At the same time, we should not allow the lack of a formal statewide plan to be a barrier itself. We should be pressing forward with existing initiatives and examining what is working and why, keeping in mind that suicide is the outcome of a complex mix of risk and protective factors taking effect in a cultural, social, and economic context.

Our knowledge base about suicide is also still limited, whether it draws from existing programs or research studies.

Clearly, despite the encouraging progress made so far, we have much work remaining to do.

Senator, we applaud your courage in coming forward to share you own personal loss. Would you be willing to share with us a bit about how this loss continues to impact your life, your career, and your approach to public policy today?
Even today, I can still recall the moment in 1972 when I received the tragic news about my father having taken his own life. I had just returned to my Las Vegas law office after spending a memorable afternoon with the legendary Muhammad Ali when I was given an urgent message to call my mom in Searchlight, Nev., immediately. That was when I learned that my father had killed himself.

The years following my father's death, my family didn't talk about →

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his suicide. We were left alone and carried this experience in a very private way.

It wasn't until 1996, 24 years later, when I spoke publicly for the first time about my father's suicide. Shortly thereafter, my office was inundated with calls and letters from people around the country who had also lost a loved one to suicide. I quickly learned that suicide is a national problem, and one that is particularly severe in my home state of Nevada.

Senator, what do you feel are some of the best ways to increase interest in the field of suicide prevention among your colleagues?

No one should have to personally experience the tragedy of suicide to realize that it is not "something that happens only to other people."

Rather than something that we turn away from, suicide is something we should turn towards and work together to eradicate. With this in mind, I introduced Senate Resolution 84 on May 6, 1997, to call for a national strategy to address suicide in America. All senators agreed to its passage that same day, turning the resolution into a remarkable beginning for suicide prevention efforts nationally.

When our esteemed colleague from Oregon, Sen. Gordon Smith, lost his 21-year-old son, Garrett Lee Smith, to suicide, my Senate colleagues and I were again reminded that suicide truly can affect anyone. Like many other suicide survivors, Sen. Smith and his wife Sharon thus began their tireless work to advance the cause of suicide prevention, leading to the passage of the Garrett Lee Smith Memorial Act in 2004.

As you can see, personal tragedy can serve as a catalyst for change. It can even become a persuasive instrument of public policy.

In the case of suicide prevention, it is perhaps also the most powerful way of transcending personal loss to making an enduring difference in the lives of countless others.

Elected to the U.S. Senate in 1986, Sen. Harry Reid (D-NV) was unanimously elected as Democratic Leader by his fellow Senate Democrats after winning a fourth term to the U.S. Senate in 2004 by a wide margin. For more, see reid.senate.gov.