A copy of the Keynote presentation

by

Dr Leslie Ramsammy
INTRODUCTION

We are here to advocate for greater action for suicide prevention. It would be remiss of me not to call again for government's legal reforms to decriminalize suicide. One of my major disappointments as a Minister of Health was that in spite of my advocacy for decriminalization of suicide in Guyana, it never happened. My disappointment is even more deeply felt because the Parliament of Guyana at the time, and even now, overwhelmingly supported the decriminalization of suicide. For Guyana, and I suspect, for all those Caribbean countries still with suicide criminalization laws, I believe we stand on weak moral grounds in keeping such an archaic law in our books. Most Ministers of Home Affairs or Public Security, under whom these laws stand, support the decriminalization of suicide, but have been too pre-occupied to bring forward legislations to remedy this great wrong and injustice.

I urge governments in our region and in the world to ensure the total decriminalization of suicide. I am hopeful that this IASP conference would make this call as one of its declarations.

It would be remiss of me not to highlight another injustice - the language of suicide. We loosely declare, far too often, that someone commits suicide, consistent with the criminalization of suicide, exactly as the law prescribes in many of our countries. Suicide kills people; people do not kill themselves. Diabetes kills people. HIV kills people. Cancer kills people. Suicide kills people.

Let us embrace the notion that suicide is a killer, not unlike HIV, not unlike cancer, not unlike diabetes or heart diseases. This conference must emphasize that the language of suicide matters.
I am not an expert

At the very start, a disclaimer is necessary. I can neither present myself as an expert who knows the causes for suicide nor as an expert who has the answers for stopping the next suicide death or suicide attempt. I do know, however, the suicide problem is real. We face, at this very moment, as we have for many decades, a genuine global crisis. I do know that suicide is not inevitable, it is palpably preventable.

The IASP at almost 60

I am eternally grateful that the IASP invited me to this important meeting. In a world that has become a little fatigued with development meetings, I consider this meeting one of the important ones. I am grateful for the opportunity to join you in a fierce advocacy for greater visibility and greater prominence of a global crisis, the suicide crisis, that, in my view, is still a neglected global crisis.

When the IASP was formed almost 60 years ago, suicide was a major problem, but national, regional and global developmental agenda totally ignored the suicide crisis, as well as the larger mental health crisis. Because of the work of organizations like the IASP, because of the work of NGOs at national levels, the advocacy of many individuals, the landscape is quietly and gradually changing. There is some recognition now that suicide is, indeed, a public health challenge, it is a public health crisis. In its 6th decade, the IASP can take solace in that it has contributed mightily to the elevation of the problem from total neglect to acknowledgement that suicide is a genuine public health challenge and global action is required NOW.

Suicide takes too many lives and affects the lives of too many people around the World for us to maintain status quo. It is a big problem. Anytime 800,000 lives are lost and 20M others survive death, facing an uncertain future, the world is diminished. By a business-as-usual approach, not recognizing these deaths and these survival stories as the crisis it is, we further diminish our world, aiding and abetting grave injustice. The world has an imperative to do more to stop the suicide pandemic.
In a hopeful sign, the UN bodies, like the WHO, have shown greater interest in the suicide crisis in the last decade. For this reason, I am hopeful that the WHO will make suicide a special subject for one of its sessions in an upcoming World Health Assembly. Since the WHO Prevention of Suicide Strategy had established 2020 as a milestone year for a 10% reduction of suicide from the 2015 rate, the 2020 WHA would be a good time for a special session at the WHA to deliberate on suicide prevention. Since the countries of the British Commonwealth include several countries among the highest rates for suicide deaths, I believe that the Annual Commonwealth Health Meeting which usually preceded the WHA should consider a special session on Suicide also. In the Caribbean, there should be a special health COSHOD to deal with a genuine Caribbean public health problem.

I want, therefore, to challenge this IASP Meeting to approve a special resolution to be known as the Port of Spain Stop Suicide Resolution calling on COSHOD, the Commonwealth Health Desk and the WHA to include a special session on Suicide Prevention in their 2020 meetings.

**Should public health lead the fight?**

I find it ugly, depressing, appalling that, even with the stunning numbers we are confronted with, there are those that pose the question - is suicide a genuine or manufactured global public health crisis?

We will hear many times during this conference of the more than 800,000 lives prematurely lost each year, the more than 20M people around the world traumatized after surviving suicide and the many millions tormented each day by the temptation of suicide. We do not know the numbers of people whose lives are tormented by suicidal thoughts, but one study shows the number of persons at risk for suicide in the US alone is 80M. It is estimated that almost 1B people around the world are at risk.

According to the Burden of Disease Studies, almost 1B people (973M) each year requires healthcare because of injuries in the world. While 29% of these injuries are because of vehicular accidents, more than 17% are because of self-harm.
Suicide accounts for 18% of the 4.8M deaths caused by injuries and for 1.4% of all deaths in the world. Only traffic accidents exceed the impact of suicide on injury-caused deaths. In fact, suicide causes more deaths than wars, natural disasters and homicide combine. In terms of YLLs (Years of Life Lost), suicide causes an annual loss of 35M years, compare to 23M YLLs caused by wars, disasters and inter-personal violence combined.

Globally, suicide accounts for more than 8.5% of all deaths among youth 15 - 29 years, second only to vehicular accidents.

How could this not be a public health problem. Public health would have abrogated its responsibility if it disowns suicide as its responsibility.

In the Caribbean, suicide ranks in the top 10 causes of death in many countries and, overall in the Caribbean, ranking in the top 3 causes of death for persons 14 - 35 years old. In several Caribbean countries, suicide ranks number 2 for deaths among persons 14 to 35, only behind traffic accidents.

Just in case, we doubt that suicide is a genuine public health crisis in the Caribbean, the last Global Burden of Diseases study revealed that more than 4,000 persons die annually because of suicide in the Caribbean. On an average, in the Caribbean, the annual number of years of life lost (YLL) because of premature deaths due to suicide amount to 174,000 years.

This, the suicide crisis, sisters and brothers, is a public health crisis that we cannot afford to ignore any longer, that we ignore at great peril, that its continued invisibility is morally depraved.

**Suicide Invisibility is inextricably linked to the Neglect in Mental Health**

In 2013, the 66th WHA formally adopted the first ever Mental Health Action Plan 2013-2020. Suicide prevention is an integral part of this action plan, with the goal of reducing the rate of suicide in countries by 10%. Reduction of suicide deaths is an indicator/measure for SDG 3.4 - the overall reduction of deaths due to NCDs be reduced by 30% by 2030. But a careful review will show that suicide is only identified as an indicator; there is no specific target. In addition, there is no
mention of mental health in this goal. Some argue that it is understood to be part of the NCDs.

Given the invisibility of mental health in the global development agenda and the even more egregious invisibility of suicide before 2015, the reluctant listing of suicide prevention as an indicator in the premier global development treaty is progress in the same way we proclaim "thank god for small mercies". Still, I am grateful that our voices were heard, even if not fully. I am not persuaded that anything substantial beyond recognition has been accomplished. We must continue to raise our voices and advocate for action beyond recognition only. We need specific global target and indicators for mental health and we need specific action and targets for suicide prevention, beyond the generic indicator for suicide reduction, hopefully at the same rate one-third reduction for the NCDs.

In the most recent Global Burden of Disease study, it is concluded that less than 3% of countries are presently on target to achieve the suicide prevention indicator for SDG 3.4. In a World Bank Study, progress in suicide reduction is already off-track and we are likely to achieve less than 15% of the target by 2030.

Some people have questioned the legitimacy of suicide being placed within the mental health realm. The Burden of Disease studies, however, unequivocally rebut this assertion and reveal that mental health and substance use disorders account for 23M DALYs (Disability-Adjusted Life years lost) out of the 35M caused by suicide, meaning at least 66% of suicide DALYs are directly due to mental health issues. In some regions, mental health account for more than 84% of suicidal DALYs. Incidentally, major depressive disorders (MDD) account for fully 20% of all suicide DALYs.

In verbal autopsy studies (follow-back studies), as much as 84% of suicide deaths are for people who had one or more mental health illnesses.

In the Caribbean between 60 and 80% of all suicidal DALYS were caused by mental health problems, with an average of about 66%.

There is, therefore, an unequivocal link between mental health and suicide.
Indeed, suicide and mental health as a whole suffer from the same forms of stigma and discrimination. The neglect of suicide prevention in our health and national development strategies parallels the neglect of mental health.

Despite the huge burden that mental health carries, it receives a fraction of funding that other diseases receive. In LMICs, less than 1% of the annual health budgets is allocated to mental health. Indeed, more is spent on takeaway coffee in the UK for one week ($134M) than is given for mental health as development aid ($133M per year). LICs spend 0.5% of national health budgets on mental health, LMICs 1.9%, UMICs 2.4% and HICs 5.1%.

Comparing global development aid and burden of diseases show the disparity. Mental health has a global burden of disease of 184M DALYs, HIV 81.5M. Mental Health Funding is $136M compare to HIV funding of $6.8B. This is not an argument for less money for HIV, but for more money for mental health.

Governments of LMICs must lead a new investment dispensation if they want to stand on good moral grounds for seeking more ODA. Unless governments prioritize mental health and suicide prevention strategies in their development agenda, they cannot expect ODA stakeholders to follow.

An increase in ODA for mental health and for suicide prevention is critical. Most ODA presently is technical support. The average annual ODA of $136M, with $40M for the WHO, distributed among 150 countries is unconscionable. The present ODA for mental health at 5 cents per capita is disgraceful.

LMICs must, at least, endeavor to meet the per capita investment in mental health as proposed by Lancet - $2 (LICs), $4 (LMICs) from the present 20 cents. Private sector foundations and Philanthropies must become more involved in mental health funding. The IASP and others must lobby for the private sector foundations and philanthropies to invest in mental health and suicide prevention. Although, these charitable organizations have contributed about $42B between 2007 and 2016, less than 0.1% was spent on mental health. We need to lobby for more tangible donations for mental health and for suicide prevention.
Those who deny the legitimacy of suicide as a public health problem should learn lessons from the fight against HIV. In the middle of the 1980s and up to the early 1990s, there were those who advocated that HIV should not be dealt with as a health issue, and for that reason, in many countries, HIV Prevention Strategies became a part of the Prime Minister's office. It was realized later that it was a mistake to restrict the role of the Ministries of Health.

England now has a Minister for Suicide Prevention, recognizing that suicide has become a national crisis. But this should not mean that the Minister of Health has no responsibility for mental health and for suicide prevention. In fact, the Suicide Minister in England is more of an advocate and an ombudsman. The prevention and treatment actions are responsibilities that still reside in health.

Health Ministries have a responsibility to lead the engagement of other ministries, as well as stakeholders beyond the government sector, as part of a comprehensive multi-sector effort.

Ministers of Health must not simply be the person with responsibilities for mental health and for suicide prevention, they must be the lead advocate for stronger, more effective suicide prevention investments. Every Ministry of Health should have a formal Department for Mental Health, like the National AIDS Program which is present in every CARICOM country. This department must have a dedicated Director for Suicide Prevention.

**Lack of National Strategies**

The suicide crisis has been with us for decades. One of the very first recognition at the global level came when the UN in 1996 published its Prevention of Suicide Guidelines for the Formulation and Implementation of National Strategies. At that time, only Finland had a National Prevention of Suicide Strategy. For almost 20 years, this guideline remained on the shelf, while almost 15M people died needlessly.

It is an indictment that suicide prevention strategies are relatively new national development instruments. When the WHO published its Mental Health Action
Plan 2013-2020 in 2013 and, subsequently, when it issued the Preventing Suicide - A Global Imperative Report in 2015, there was a renewed global call for national suicide prevention strategies. At the time, only 28 countries (mostly European) of the 194 WHO member states had a national suicide prevention strategy. At the time, countries like the UK, Japan, Finland and others had shown that national development strategies give recognition to the crisis and spur tangible actions, all of which showed reduction impact in those countries.

The overall state of suicide prevention in the Caribbean and globally is extremely frustrating. The publication of the WHO's Mental Health Action Plan and the Suicide Prevention Report in 2013 and 2015, acknowledged the neglect of mental health and suicide prevention, signaling that the fight for better mental health and suicide prevention dramatically progressed from total neglect and invisibility to, at least, a visible problem. Yet the tremendous efforts, driven by civil society stakeholders, like the IASP globally and like the TCV in the Caribbean, and led by the World Health Organization, still represent a cruel deficit. Governments have failed to respond to the urgency and the magnitude of the crisis. More than 90% of the Caribbean countries lack a national strategy and not one of them has dedicated funding for the fight against suicide.

In fact, among the 194 member-states of the WHO, as of right now, only 38 countries are known to have Suicide Prevention National Strategies. Five years after the 194 Member-States agreed at the 66th WHA for each country to develop and implement a national strategy, and 20 years after the UN first highlighted the suicide crisis, the poor response to this proposal indicates that generally suicide is still on the back-burner, still struggling for attention in national development programs.

Here is the depressing note - most of the countries with national strategies are HICs. The LMICs account for almost 80% of all suicide deaths. But only a handful of these countries have national strategies, most of which sit on shelves. Guyana, Namibia, Bhutan and Iran have made progress in implementing their national programs and I would like to highlight that fact. But even these countries, with the exception of Bhutan, have failed to cost and invest in their national strategies.
Other countries with national strategies in the Caribbean are Suriname, Cuba and the Dominican Republic.

I believe that we must include in this IASP meeting a call for Governments of all Caribbean countries to develop and implement a costed and funded national suicide prevention strategy as part of their SDG response. Further, this meeting must urge CAROM Governments to mandate CARPHA to develop a CARIBBEAN Suicide Prevention Roadmap as we approach the last decade before the SDG deadline to guide the individual national suicide prevention strategies of Caribbean countries. Government must stop shirking its responsibility.

**Lack of Reliable Data is impacting the response**

Up-to-date surveillance of suicides, suicide attempts and suicidal behavior or suicidal thoughts is an essential component of a national and local suicide prevention effort. Unfortunately, a meaningful suicide surveillance system is totally lacking in the world. In the Caribbean, this is a problem.

Among the countries that can claim relatively good mortality data, as part of their national vital registration systems are the Caribbean countries. But, because suicide remains, even in the Caribbean, a highly-stigmatized social problem, suicide attempts and suicidal behavior are totally absent or only weakly integrated into our national data registry.

While Caribbean countries rank highly in terms of vital registration systems, these vital registration systems require urgent reviews and expansion to include DALYs caused by mental health and suicide.

All health reports from the WHO, PAHO, the World Bank etc., and studies such as the GBD, concede that the data for suicide, including for mortality, attempts and behavior represent a weak link. It is possible that the wide range in suicide
statistics between regions in a country and between countries represent an artifact of weak vital registration systems.

In fact, the WHO and the World Bank report that only about 60 countries of the 194 member-States have reliable VRS. But the problem now is that with the recognition of suicide as a global public health crisis, there is also the realization that present VRS do not adequately provide for effective suicide data and measurements of progress. The challenge, therefore, is not just for the more than 100 countries with poor VRS to improve, but for a total revamping of the present VRS to be more consistent with the goals of the SDGs, particularly for SDG 3. The present VRS is not synchronous with the SDGs, with the 2013-2020 WHO Mental Health Action Plan and the various national Suicide Prevention Strategies.

Surveillance systems that recognize suicide as a major public health problem, such as the Multicenter Study of Self-Harm in England, The Hunter Area Toxicology Service in Australia, The Bristol Self-Harm Surveillance Register and the Irish Self-Harm Registry and the WHO 2016 Model Surveillance Guidelines for Suicide Prevention exist and must be used to guide our reviews of existing VRS.

We must implement a national reporting system that can measure suicide mortality, suicide attempts, suicidal behavior, health care access for suicide, stigma and stigma reduction targets, means access reduction, education and awareness, access to mental health services, counseling and research.

In this regards, I urge governments in our region and around the world to mandate reviews of the VRS to integrate the WHO 2016 Model Surveillance Guidelines. Governments must mandate CARPHA to lead the Caribbean effort, adapting the WHO 2016 Model Surveillance Guidelines for use in the Caribbean.

Let us learn lessons from HIV. Surveillance and VRSs in CARICOM and the wider Caribbean countries are now synchronous with HIV and AIDS global and national strategies and goals, such as the 90-90-90 goals and the UNGASS HIV Reporting Format. Outside of the developed world, the Caribbean played a leading role in developing and implementing HIV and AIDS reporting systems, including lifestyle
risk behavior for HIV and AIDS. I believe that Caribbean countries, through our
governments, can provide important leadership to ensure improved VRS to
capture mental health and suicide-relevant data.

With a strong VRS that provides for effective Suicide Prevention measurements
and progress, I urge that Caribbean countries, such as Guyana, Trinidad and
Tobago, Suriname, and others institute an Annual Suicide Prevention Report in
Parliament, with the Minister of Health, presenting a written and an oral report
that can be noted in a parliamentary motion inviting a debate. This is already
done in the UK and we can model the UK example.

Means Reduction and Interventions

Even with weak or missing data systems, we know some of the major means for
suicide. In many developing countries, such as Guyana, Trinidad and Tobago,
Suriname in our Region and countries such as India, China, Fiji etc. the ingestion
of poisonous substances such as pesticides account for the majority of suicide and
suicide attempts. Fully more than one-third of all suicides in the world are
accounted for by pesticides. For other countries, like America, guns represent the
main means.

Means reduction works to reduce suicide but means reduction is also a
complicated task. As Minister of Health, I urged the banning of certain pesticides.
In an ironic move, I became the Minister of Agriculture and found to my great
chagrin this is not so easily done. I, therefore, opted for restriction in the use of
pesticides, supported by an aggressive education and awareness program.

We introduced an aggressive pesticide storage program, but this also required a
surveillance program to monitor the effectiveness. In fact, the pesticide storage
program has been in use in other countries. Does it work? Research must be done
to evaluate the effectiveness of pesticide storage programs. In countries like
Guyana, with easy entry through borders, banning programs can only be effective
if it is done in coordination and with collaboration with other countries. Banning,
in fact, could lead to even bigger problems for countries like Guyana.
I want to call attention to certain interventions that I believe can have a major impact. The Gatekeepers Program is an important program to help identify persons who may have troubled lives. It is a good way to engage the community as part of the comprehensive stakeholder involvement initiative.

We need an aggressive program for educating and making people aware of such challenges as depression. For that reason our gatekeepers were trained in the use of a suspicion index for depression, to identify persons who may be engaged in substance abuse, etc. Let me acknowledge the present work being done to train Gatekeepers in Guyana by TCV.

In this regards, some have questioned and condemned the participation of lay persons in providing services that some claim must be the preserve of only highly trained professionals. That was also a claim made in earlier times when we wanted to bring in lay persons to provide counseling and testing for HIV. But task-shifting was effective in combating the scourge of HIV. Task-shifting is similarly helpful in the fight to stop suicide.

We must recognize the role of alcohol and other substance use. Alcohol plays a significant enabling role in the suicide story. Unfortunately, alcohol and substance use interventions in Caribbean societies are weak. Like with HIV, I believe we underestimate the role of alcohol in the suicide story. I believe the harmful use of alcohol is another global problem we seem more comfortable pushing under the rug. It is another developmental challenge that we must elevate in importance. For today's purpose, the harmful use of alcohol is a means and intervention platform we neglect at our own peril. Even though SDG3.5 targets harmful use of alcohol, the global programs to target this goal is lacking urgency.

I urge our governments to mandate CARPHA to develop and lead the implementation of a regional initiative to reduce the harmful use of alcohol for the Caribbean to reach the targets and indicators of SDG 3.5. I further urge governments to make more effective use of task-shifting to provide universal access to mental health and suicide prevention services.
Importance of a Multi-Sector Approach - the NGOs must be facilitated to play an active role

A successful fight requires meaningful leadership by Governments, with a multi-sector approach led by Ministries of Health. The multi-sector approach must include an integral role for civil society, with government funding for NGOs, community programs such as the Gatekeepers Programs, access to quality mental health care services, support programs for survivors, opportunities for the Voices of Survivors and other stakeholders to be heard. There is a need for a Champions of Change Program in the Prevention of Suicide fight, similar to the Champions of Change that HIV have.

Research

Research in mental health and suicide prevention is a critical battle front. But very little investment has been made in mental health and suicide prevention research. Most of the research is done in HICs. We face what I call the 80:3 conundrum, with 80% of the mental health and suicide burden of disease in LMICs, but only 3% of the mental health and suicide research are done in these countries. We need to change this horrid research dispensation.

The Heads of State are Missing in Action

Given the magnitude of the problem created by mental health and suicide, I am frustrated that Heads of State are missing in action. I am hopeful that in the coming months we will hear more Heads of States acknowledging the prominence of mental health as a requirement for human development and pushing for greater funding in the global AID architecture. I am hopeful that Heads of States will speak of the suicide crisis that is shortening the lives of too many people in our world. Outside of the Prime Minister of Britain, I have not heard too many Heads of State speak on the crisis of mental health and suicide.

Recall it was only when Heads of State spoke of the need to fight HIV and AIDS that the world was able to gain some control against HIV, to the extent that we can reasonably think of the end of HIV and AIDS by 2030. It was only when Heads of States spoke up about the impact of the NCDs on poverty and on overall
development, we were able to put together a serious global fight against the NCDs.

I believe we need Heads of States and Governments to take the lead for the promotion of mental health and for a global strategy to end suicide. Caribbean Heads of States can play a pivotal role in this regards and I am looking forward that at least one of our Caribbean Heads of State will speak on behalf of those of us who believe that mental health deserves more attention and that the fight against suicide is an imperative for development.

In 2000 when the MDGs were announced, it represented a milestone global development treaty and, by 2015, the world was better off than it was in the base-year of 1990. Poverty was reduced, hunger was less, health had improved significantly, with measurable progress in the fight against infant and maternal mortalities and in the fight against HIV, TB and Malaria. The efficacy of the MDGs cannot be discounted and underestimated. The MDGs turned out to be a major success story, even if everything we had hoped for was not achieved.

But the MDGs had a major flaw. I went on record in 2001 with my disappointment that the MDGs completely ignored the importance of the NCDs in human development. It was for that reason in 2001, I called for an MDG+ to include indicators for the NCDs, including for the promotion of mental health and for a fight against suicide. In 2011, the UN met to discuss and agree on a roadmap to address the NCDs. In spite of the advocacy of persons like myself, that roadmap, while addressing NCDs as a major gap in the development agenda, again ignored mental health and suicide. As I have stated before, I am grateful that suicide have been included in the SDGs, but I believed mental health has once again been sidelined.

I am grateful that the SDGs in 2015 recognized suicide as a major public health challenge. I believe that the implied inclusion of mental health in SDG 3.4 and the inclusion of suicide as an indicator and measure for human development, even if these inclusion were reluctant and even if it is watered-down, is a victory for those advocates who for decades insisted that the global development agenda was being shortchanged by the neglect of mental health and the suicide problem.
The Caribbean played a pivotal role in placing the NCDs on the global agenda and the CARICOM SUMMIT of HEADS of States in 2007 was a major step towards the critical 2011 UN Summit. The Port of Spain NCD Declaration served as the pivotal catalytic trajectory towards the 2011 UNGASS on the NCDs. I believe we can similarly play a role in ensuring not merely the recognition that mental health is important, but that we need a vigorous global fight against suicide.

**CONCLUSION**

I believe that we must learn lessons, not only from the more than 50 years of active advocacy and work to stop suicide, but from others. HIV and AIDS, for example, can teach us many lessons. This was a global problem filled with stigma, initially nothing was known or understood about the cause, transmission or treatment and very little investments were being made in the early years. But the community, instead of giving up, united and raised their voices, engaged champions, and obtained large and sustained funding. From a paltry few million dollars annually in the 1980s and 1990s, ODA increased to about $6.8B annually in the period beginning in 2003. The HIV and AIDS Coalition were clear in their goals and clear in linking a public health crisis with the economy and security - saving lives, preventing other losses. While implementing certain actions, active research and strengthening the public health system followed. Today, HIV and AIDS remain a global challenge, but from hopelessness in 1990s, today we realistically talk about the end of AIDS by 2030.

What can we do with what we do know right now to have better results in suicide prevention? What can we do to expand and improve partnerships and collaborations in the fight against suicide? How can we transform the ambiguous
target in the SGD3.4 into a real action plan to stop the next suicide? What if one of our Heads of State offer us today some money, are we prepared to tell him or her what we can do now? Or will we tell him or her we will get back to him?

We have talked a lot. We must now walk the talk. Action is needed now more than ever, so let us push forward together for this change.

Mahalia Jackson sang these words and inspired millions around the world: *Lord, give me strength not to move mountains but to climb them.*

In the continuing story of humanity to create a just and equitable world, we have failed too many people everywhere, and poverty, expressed through persistent inequities and social injustices, remains our major failure as humanity. In this poverty story, mental disorders, with its story of economic hardships to those living with mental illnesses and their caregivers and families, and suicides play a critical role.

Sisters, brothers, in the next few years, not as an option, but an imperative, we need to climb some mighty mountains, mountains that will test our resolve and our mettle as we intensify our efforts to stop suicide.