The Committee on Energy and Commerce

Memorandum

September 16, 2014

TO: Members, Subcommittee on Oversight and Investigations

FROM: Committee Majority Staff

RE: Hearing on "Suicide Prevention and Treatment: Helping Loved Ones in Mental Health Crisis"

On Thursday, September 18, 2014, at 11:30 a.m. in 2123 Rayburn House Office Building, the Subcommittee on Oversight and Investigations will hold a hearing entitled "Suicide Prevention and Treatment: Helping Loved Ones in Mental Health Crisis." This hearing is part of the Subcommittee's ongoing examination of mental health programs and resources with the aim of ensuring that Federal dollars devoted to mental health are reaching those individuals with serious mental illness (SMI) and helping them to obtain the most effective care. In particular, this hearing will examine the connection between SMI and suicidal behavior and ideation, with a view towards dispelling harmful, commonly-held myths and identifying promising evidence-based treatments as well as effective strategies for suicide prevention targeting the most vulnerable populations.

I. WITNESSES

Statement by:

- The Honorable Lincoln Diaz-Balart, former Member of Congress.

Panel:

- Rear Admiral Boris D. Lushniak, M.D., U.S. Acting Surgeon General;
- David A. Brent, M.D., Endowed Chair in Suicide Studies and Professor of Psychiatry, Pediatrics, Epidemiology, and Clinical and Translational Science, University of Pittsburgh;
- Christine Moutier, M.D., Chief Medical Officer, American Foundation for Suicide Prevention; and
- Joel A. Dvoskin, Ph.D., Assistant Professor of Psychiatry, University of Arizona.

II. BACKGROUND

Suicide takes an enormous number of lives and devastates the family, friends, and communities of those who fall victim to it, both in the U.S. and globally. Approximately 40,000

Americans commit suicide annually, making it a more likely cause of death than motor vehicle crashes, homicide, or drug use.[1] For over 90% of suicides, the victim had been diagnosed with a mental illness.[2] Efforts to reduce this startling number of suicides must therefore involve serious attention to the nation's provision of mental health services.

Suicide is a particularly significant threat for certain demographics. It is the third leading cause of death for young people ages 15-24 (a rate that has nearly tripled during the past 40 years),[3] and the second leading cause of death for adults ages 25 to 34.[4] Suicide was the tenth leading cause of death for all ages in 2010.[5] Suicide rates among elderly white men are increasing at a significant rate.[6] America's veterans also are experiencing increased losses of life due to suicide. A Federal study found that veterans under the age of 24 are more than three times more likely than civilian males in the same age group to commit suicide.[7] Across gender and age groups, veterans comprised 22.2% of suicides in the past two years, while they comprise only 13% of the U.S. population.[8]

These alarming statistics still do not convey the extent of the suffering brought on by suicide. For every person who commits suicide, 25 attempt suicide (or approximately 1 million Americans) annually. A full 1% of the U.S. adult population (or 2.2 million adults) have reported making suicide plans in the past year, and 3.7% of the U.S. adult population (or 8.3 million adults) have reported having suicidal thoughts in the past year.[9] In fact, these numbers underestimate the problem. Many people who have suicidal thoughts or make suicide attempts never seek services.[10] Furthermore, suicides affect the families, friends, and communities of its victims. As conveyed to the Director of the National Institute for Mental Health by a father who lost his son to suicide, "suicide has at least 11 victims: the person who dies and at least ten others who will never be the same."[11]

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[1] *Deaths: Final Data for 2011*, CENTER FOR DISEASE CONTROL AND PREVENTION, Tables 9-13 (2011), *available at:* http://www.cdc.gov/nchs/data/nvsr/nvsr63/nvsr63_03.pdf.

[2] *Suicide Fact Sheet*, NATIONAL ALLIANCE ON MENTAL ILLNESS (reviewed January 2013), *available at: http://www.nami.org/factsheets/suicide_factsheet.pdf;* This percentage is comparable in countries other than the U.S. *Preventing Suicide: A Global Imperative*, WORLD HEALTH ORGANIZATION 40, *available at:* http://apps.who.int/iris/bitstream/10665/131056/1/9789241564779_eng.pdf?ua=1&ua=1.

[3] *Suicide Fact Sheet*, NATIONAL MCH CENTER FOR CHILD DEATH REVIEW, *available at:* http://childdeathreview.org/causesSUI.htm.

[4] *Suicide: Facts at a Glance*, CENTER FOR DISEASE CONTROL AND PREVENTION (2012), *available at:* http://www.cdc.gov/violenceprevention/pdf/Suicide_DataSheet-a.pdf.

[5] Id.

[6] Matthew Nock et al, *Suicide and Suicide Behavior*, 30 EPIDEMIOL. REV. 133-154 (2008), 134-35.

[7] Bill Briggs, "Young Male Vets Have Triple the Suicide Risk of Other U.S. Men, Study Shows," NBC NEWS (Jan. 10, 2014), *available at*: http://usnews.nbcnews.com/_news/2014/01/10/22257614-young-male-vets-have-triple-the-suicide-risk-of-other-us-men-study-shows.

[8] Janet Kempt and Robert Bossarte, *Suicide Data Report, 2012*, DEPARTMENT OF VETERANS AFFAIRS, MENTAL HEALTH SERVICES- SUICIDE PREVENTION PROGRAM 15 (2012), *available at:* http://www.va.gov/opa/docs/Suicide-Data-Report-2012-final.pdf.

[9] See supra n. 4.

[10] *Understanding Suicide: Fact Sheet*, CENTER FOR DISEASE CONTROL AND PREVENTION (2012), *available at:* http://www.cdc.gov/violenceprevention/pdf/suicide_factsheet_2012-a.pdf.

[11] Thomas Insel, *Director's Blog: A New Research Agenda for Suicide Prevention*, NATIONAL INSTITUTE OF MENTAL HEALTH (Feb. 5, 2014), *available at:* http://www.nimh.nih.gov/about/director/2014/a-new-research-agenda-for-suicide-prevention.shtml.

Nonetheless, popular myths and misconceptions about suicide remain widely held, including that those who begin thinking or speaking about suicide are merely seeking attention, will always be suicidal, can never again be healthy, and cannot benefit from – or will not be willing to seek – treatment. Public awareness about suicide is crucial to strengthening the social and familial bonds of potential victims and bringing them out of their sense of isolation.

Achieving reductions in both attempts at, and thoughts of, suicide also requires the improved delivery of mental health services. The Subcommittee has heard how effective care continues to elude many of the 11.4 million American adults suffering from SMI.[12] The Substance Abuse and Mental Health Services Administration estimated that in 2009, 40% of adults with SMI reported not receiving any treatment.[13] This needs to be corrected, whether these adults are not receiving treatment due to lack of awareness of their condition, the stigma associated with receiving SMI treatment, or a feeling that that treatment will not improve their condition.

In 1997, Congress passed two resolutions that recognized suicide as a national problem and suicide prevention as a national priority.[14] In 1999, then-U.S. Surgeon General David Satcher released a *Call to Action to Prevent Suicide*, which emphasized the need to improve the quality and quantity of treatment programs through, among other efforts, the creation of a National Strategy for Suicide Prevention.[15] The National Strategy, released in 2001, called for the establishment of a public-private partnership, which was launched in September 2010 as the National Action Alliance for Suicide Prevention (NAASP).[16]

Despite increased awareness and improved programming, these initiatives have not reduced the number of suicides committed or attempted, which have remained relatively constant since the 1950s.[17] In 2012, the U.S. Surgeon General, in collaboration with the NAASP, released an updated National Strategy. The 2012 National Strategy describes goals and objectives for advancing four different but "interconnected strategic directions" for preventing suicide: (1) healthy and empowered individuals, families, and communities; (2) clinical and community preventive services; (3) treatment and support services, and (4) surveillance,

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[12] *Committee's Investigation of Federal Programs Addressing Severe Mental Illness*, SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS MAJORITY STAFF 2 (May 15, 2014), *available at*: http://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/letters/MentalHealth/051514MH-Staff-Memo.pdf.

[13] Id. Although the vast majority of Americans with SMI are nonviolent (and themselves are often the targets of violence) lack of treatment can put those with SMI, and those with whom they interact, at risk. The Director of NIMH informed the Subcommittee that treatment can reduce the risk of violent behavior 15-fold in persons with SMI. Id.

[14] *2012 National Strategy for Suicide Prevention: Goals and Objectives for Action*, U.S. SURGEON GENERAL, NATIONAL ACTION ALLIANCE FOR SUICIDE PREVENTION 96 (Sept. 2012), *available at:* http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/full-report.pdf.

[15] *The Surgeon General's Call to Action to Prevent Suicide*, DEP'T OF HEALTH AND HUMAN SERVICES, U.S. PUBLIC HEALTH SERVICES 6-7, *available at:* http://profiles.nlm.nih.gov/ps/access/NNBBBH.pdf.

[16] *National Strategy for Suicide Prevention: Goals and Objectives for Action*, U.S. DEP'T OF HEALTH AND HUMAN SERVICES 1, 22 (2001), *available at:* http://www.sprc.org/sites/sprc.org/files/library/nssp.pdf.

[17] For a graph of the rate of suicides over the past sixty years, see supra n. 12, *2012 National Strategy for Suicide Prevention* at 16.

research, and evaluation.[18] Aligned with the various objectives are "priority areas" of the NAASP, meant to complement and further advance the strategic directions described by the National Strategy.[19]

In 2014, the NAASP's Research Prioritization Task Force (RPTF) released an action plan with the aim of reducing suicides by at least 20% over 5 years and at least 40% over 10 years.[20]

III. ISSUES

The following issues may be examined at the hearing:

- Why do people become suicidal?
- How can we better predict risk?
- What prevents individuals from engaging in suicidal behavior? What interventions or services are most effective for treating the suicidal person and preventing suicidal behavior?
- Would greater dissemination of evidence-based treatments lead to significant decreases in suicides or suicidal behavior? How would such dissemination be achieved?
- Are Federal resources targeting the treatment of SMI properly allocated to reach individuals at greatest risk of suicidal ideas or behavior?
- Since the suicide rate has not decreased over the last 60 years, why does HHS believe the RPTF action plan will achieve significant decreases in suicide rates over the next 10 years?

IV. STAFF CONTACTS

If you have any questions regarding this hearing, please contact Sam Spector or Alan Slobodin of the Committee staff at (202) 225-2927.

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[18] See supra n. 14, *2012 National Strategy for Suicide Prevention* at 24. Four "interconnected strategic directions" marks a slight departure from the framework adopted by the 2001 National Strategy: "AIM" (Awareness, Intervention, Methodology). Id.

[19] Id. at 25-26.

[20] *A Prioritized Research Agenda for Suicide Prevention: An Action Plan to Save Lives*, NATIONAL ACTION ALLIANCE FOR SUICIDE PREVENTION- RESEARCH PRIORITIZATION TASK FORCE 7 (2014), *available at:* http://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/Agenda.pdf.