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RPTS BURDETTE

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SUICIDE PREVENTION AND TREATMENT: HELPING LOVED ONES IN MENTAL HEALTH CRISIS

THURSDAY, SEPTEMBER 18, 2014

House of Representatives,

Subcommittee on Oversight and Investigations

Committee on Energy and Commerce

Washington, D.C.

The Subcommittee met, pursuant to call, at 11:33 a.m., in Room 2123 of the Rayburn House Office Building, Hon. Tim Murphy [Chairman of the Subcommittee] presiding.

Present: Representatives Murphy, Burgess, Blackburn, Gingrey, Griffith, Johnson, Long, Ellmers, Upton (ex officio), DeGette, Braley, Schakowsky, Castor, Tonko,

Yarmuth, and Green.

Staff present: Gary Andres, Staff Director; Leighton Brown, Press Assistant; Karen Christian, Chief Counsel, Oversight; Noelle Clemente, Press Secretary; Brad Grantz, Policy Coordinator, Oversight and Investigations; Brittany Havens, Legislative Clerk; Sean Hayes, Deputy Chief Counsel, Oversight and Investigations; Robert Horne, Professional Staff Member, Health; Emily Newman, Counsel, Oversight and Investigations; Mark Ratner, Policy Advisor to the Chairman; Macey Sevcik, Press Assistant; Alan Slobodin, Deputy Chief Counsel, Oversight; Sam Spector, Counsel, Oversight; Jean Woodrow, Director, Information Technology; Peter Bodner, Democratic Counsel; Brian Cohen, Democratic Staff Director, Oversight and Investigations, and Senior Policy Advisor; Lisa Goldman, Democratic Counsel; Hannah Green, Democratic Policy Analyst; Elizabeth Letter, Democratic Professional Staff Member; and Nick Richter, Democratic Staff Assistant.

Mr. {Murphy.} Good morning. I now convene today's hearing: ``Suicide Prevention and Treatment: Helping Loved Ones in Mental Health Crisis,'' a fitting topic during this National Suicide Prevention Month.

In recent weeks we have read what I think were thoughtless, uninformed, and at times callous commentary on the tragic death of Robin Williams. Words describing his death as ``selfish,'' ``heathen'' and ``coward.'' The Academy of Motion Picture Arts & Sciences tweeted out a picture from the movie Aladdin with the caption, ``Genie, you are free.''

Now, denigrating the man who died or glorifying suicide as an escape sends the entirely wrong message and trivializes the loss and the pain felt by both the deceased and his or her family.

Today, we take the conversation of suicide out of the dark shadow of stigma and into the bright light of truth and hope.

Suicide is the deadly outcome of mental illness. Suicide is what happens when depression kills. Suicide is an

epidemic and its impact is staggering.

Now, I know some have come to me and asked if we could have a hearing on Ebola, and some day we will. It is a deadly infectious disease. But to date, no American has died from Ebola virus.

But in 2013, 9.3 million Americans had serious thoughts of suicide; 2.7 million Americans made plans of suicide; 1.3 million Americans attempted suicide; and nearly 40,000 died by suicide.

Suicide is an American public health crisis. It is a world health crisis, and that results in more lost lives than motor vehicle crashes, homicide, or drug use. As we will hear today, it is the third leading cause of death for young people between ages 15 to 24, and the second leading cause of death for adults ages 25 to 34, and each day, we lose 22 veterans to suicide.

In 90 percent of suicide, an underlying diagnosis of mental illness was a contributing factor. Suicide is the very definition of a ``mental health crisis.'' The problem is clear and the need for action is urgent. But our national response to this crisis has been tepid and ineffectual at

best. The age-adjusted death rates for heart disease, cancer, stroke, and diabetes are all trending downward as the result of a focused public and political will to address them. Yet in that same period, the suicide rate has climbed a stunning 16 percent, despite substantial federal spending over the past 60 years and the development of federal programs and strategies meant to reduce suicide.

We have randomized clinical data supporting the effectiveness of certain treatments to prevent suicide. However, it is unclear what we are doing to ensure that evidence-based treatments are reaching out to our loved ones in need.

Suicides, and suicidal behavior, remain underreported, undertreated, and cloaked in a stigma that infects our discussion of all aspects of serious mental illness. The existing data collection instruments we use are weak, our research is lagging, and evidence-based treatments often fail to reach those who can be helped. People do not report suicides because of stigma, worry about insurance claims issues or misattribution of causes.

Following the December 14, 2012, elementary school

shootings in Newtown, Connecticut, this subcommittee has been reviewing mental health programs and resources across the Federal Government with the aim of ensuring that tax dollars reach those individuals with serious mental illness and help them obtain the most effective care. I thank all members of this committee for their dedication to this difficult but important subject.

Helping families in mental health crisis remains my highest legislative priority, and if have the courage to confront mental illness head-on I am certain we can save precious lives.

Now, as I have been traveling the country meeting with people to talk about mental illness, I have found that some still grossly misunderstand mental illness. They don't argue for the right to be well but I hear judges say that it is not illegal to be crazy. I hear public officials say that they have the right to be mentally ill even when we know that there are genetics and neurological components that cause this illness. It is a brain disease. It is not an uncomfortable way of life. It is not a non-contentious reality. Mental illness is not a state of mind. And people

who believe those concepts, that we can just will it away with awareness, I say that such thoughts are unscientific, that it is uninformed, it is immoral, it is unethical, and it is wrong.

This subcommittee is dedicated to fight for the right of people to get treatment and the fight for them to be well, and I think all members on both sides of the aisle have been so dedicated in this cause.

So today, to provide some perspective on serious mental illness and suicidal behavior, and to begin to dispel the most persistent and pervasive myths and as well as effective strategies for suicide prevention, we will hear from a number of witnesses. First will be the Hon. Lincoln Diaz-Balart, our colleague and our friend who formerly represented Florida's 21st District in Congress; Rear Admiral Boris Lushniak, the Acting Surgeon General; Dr. David Brent, the Endowed Chair in Suicide Studies at the University of Pittsburgh, and Director of the STAR Center, a suicide prevention program for teens and young children; Dr. Christine Moutier, Chief Medical Officer of the American Foundation for Suicide Prevention; and Joel Dvoskin of the

University of Arizona. I thank them all for joining us this morning, but I especially appreciate the courage shown by our former colleague, Lincoln Diaz-Balart.

Lincoln, by being here today and sharing your story, I know you are helping to save lives. We talk about statistics and numbers. For you it is from the heart, and you give help and hope to those families at risk. So on behalf of all those, quite frankly, of us who have lost a friend or family member to suicide, we thank you for being the voice of all of us.

[The prepared statement of Mr. Murphy follows:]

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Mr. {Murphy.} And now I would like to give Ranking Member Diana DeGette an opportunity to deliver remarks of her own.

Ms. {DeGette.} Thank you very much, Mr. Chairman. Your dedication to this issue shows, and I want to commend you for trying to work in a bipartisan way to actually do something about it.

Suicide takes the lives of about 40,000 Americans every year, and of course, that leaves behind millions of devastated parents, children, spouses, and friends. So if there is anything that we can do in this committee to help suicide prevention efforts, we should do so, and I want to thank all the witnesses for coming over today and talking to us.

I particularly want to thank our former colleague, Lincoln Diaz-Balart, who is going to talk today about his son, Lincoln Gabriel Diaz-Balart, who suffered from mental illness and committed suicide last year. I can't imagine as the parent of two young women how you could come do this, and I want to thank you for coming, and I want to let you know

that our hearts and sympathy go to you and your family.

We also have Dr. Boris Lushniak, the Acting Surgeon General; Dr. Christine Moutier, who is the Chief Medical Officer from the American Foundation of Suicide Prevention; David Brent, a Professor in Psychiatry from the University of Pittsburgh; and Dr. Joel Dvoskin, a Clinical and Forensic Psychologist, and member of the University of Arizona faculty who is here today. All of you should give us a really diverse view on what we can do to begin to deal with this.

We have talked a lot of time in this subcommittee this past year about mental health issues. We have learned a lot of important things. We have learned about the need to appropriately target mental health funding and the need to adequately fund mental health research. We have learned about the importance of health insurance that provides coverage for people with mental illnesses and why the mental health parity of the Affordable Care Act has made such a big difference for those patients and their families. I think that the testimony that we will take today will only help us expand our understanding.

Some of these issues I know are politically sensitive,

and Mr. Chairman, I know how badly you want to pass comprehensive mental health legislation. I support that goal. We have been working assiduously to try to come up with a bipartisan bill that can be accepted by the leadership on both sides of the aisle, and we have Democrats who stand willing and able, as you know, Mr. Chairman, who have sat down with you, who have sat down with other members on both sides of the aisle to put this bill together, and so I really think it is precisely because we have spent so much time on the issues that if we didn't put the lessons that we had learned in these oversight hearings to practice in legislation, then it may all be for naught.

This subcommittee has limited time and resources, and frankly, these mental health issues are one of the very important issues that we have tackled in this Congress, but we have also done a lot of other productive work this Congress on drug compounding that led to bipartisan legislation. We have had some high-profile hearings on the GM debacle. I am hoping that that will result in legislation to improve motor vehicle safety.

And I am also disappointed because I do think there are

a couple of other issues that we could look at even before the election but certainly before the end of this Congress. The first one I have requested a hearing on is the Ebola outbreak, and I am sure, Mr. Chairman, you did not mean to imply that simply because no American lives have been lost that we shouldn't look at this because there have been hundreds of lives lost in Africa and with the potential of a pandemic if we don't address this issue. And so I think it would be very useful to have a hearing before the end of the year on Ebola in this subcommittee, and I think we could really help see what our public health system is doing to help address these issues.

The second letter that you have, Mr. Chairman, and I have talked to Chairman Upton about this, is a letter asking this subcommittee to look at the way that the NFL and the other sports leagues are addressing domestic violence. This committee has oversight over major league sports, and frankly, the way that domestic violence has been minimized in the NFL and other sports leagues deserves investigation by this committee. There is still time to do this, and I would hope that we could work in a bipartisan way to make this

happen.

I also hope that we can make progress on the goals of today's hearing, which is reducing suicides and improving suicide prevention efforts.

So Mr. Chairman, thank you for calling this hearing. I look forward to working with you on this issue and all of the many issues that we face, and most importantly, retaining our committee's jurisdiction over all of these issues. I am trying to channel Mr. Dingell today. Thank you very much.

[The prepared statement of Ms. DeGette follows:]

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Mr. {Murphy.} Thank you. I appreciate it. The gentlelady yields back. I now recognize the chairman of the full committee, Mr. Upton, for 5 minutes.

The {Chairman.} Well, thank you, Mr. Chairman, and I appreciate your statement at the beginning and Ms. DeGette's as well.

So today we are here to examine the domestic, and indeed global, public health crisis that is suicide. It has been noted that 40,000 Americans every year commit suicide. This hearing is a natural outgrowth of this subcommittee's groundbreaking investigation of federal programs addressing serious mental illness following the December 2012 tragedy in Newtown, Connecticut, and I know for a fact that probably every member here on this committee but our colleagues and our friends and neighbors at home in fact have been impacted with someone who has committed suicide.

No discussion of the full burden on our society of serious mental illness is complete without a discussion of suicide. For over 90 percent of them, the victim had been diagnosed with, yes, a mental illness. And tragically, our

Nation's vets are one of the populations hardest hit by the crisis. While one in ten Americans has served our country, sadly over the last couple of years, one in every five suicides has involved a vet.

Like other areas covered by our committee's work on 21st Century Cures, success will depend on our ability to close the gaps between advances in scientific knowledge about treating serious mental illnesses, which have been extensive, and how the Federal Government prioritizes and delivers these treatments to the most vulnerable populations. Our delivery of mental health services must keep up with the impressive pace of research and innovation in the field.

There is significant public misunderstanding and misperceptions for sure regarding suicide. We hope that our ongoing work will educate the public about the many treatments available to address serious mental illnesses and help correct misconceptions that stand in the way of access to life-saving mental health care for many of the most vulnerable of our friends, family, and neighbors. The Federal Government has spent billions of dollars on the worthy effort of minimizing the impacts of mental illness

over the last couple of years; we need to ensure that these investments can make a difference.

I appreciate the witnesses that are here, particularly our good friend, Mr. Lincoln Diaz-Balart.

[The prepared statement of Mr. Upton follows:]

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The {Chairman.} I yield to Dr. Burgess, who will yield to Ms. Blackburn.

Dr. {Burgess.} Thank you, Mr. Chairman, and thank you for bringing us here during Suicide Prevention Month. My thanks to the witnesses for presenting today. Thank you, Mr. Chairman, for correctly outlining that suicide amongst veterans that have recently attracted national headlines, and appropriately so. Perhaps this morning we will learn something about what has been learned and what is being done.

I also want to highlight a particular population that is often overlooked when we discuss suicide and suicide prevention, and that is the Nation's physicians. America's doctors, the people on the front lines of suicide prevention, are some of the most at risk of suicide and having suicidal thoughts. This is troubling, and I hope we can hear how it is being addressed. Physicians and dentists are the most likely occupations to take their own lives. Physicians are more than twice as likely, and as it turns out, female physicians are more than three times likely to commit suicide, and it also affects a disproportionate share of

young doctors. Dr. Brent's testimony states that insomnia is the single most significant predictive symptom for suicide, and what I would be interested in hearing, is that because a symptom of worsening depression or is in fact a causative factor that exacerbates some of the things that lead one to contemplate taking their own life. The medical profession deals with many challenges. Perhaps the most prominent challenge is that not every patient can be fixed. Watching patients suffers can be very isolating and it can take a toll.

We are here today to begin a discussion about why this is the case and how Congress can help, and I look forward to hearing our witnesses, and yield to the gentlelady from Tennessee, the vice chair of the full committee.

[The prepared statement of Dr. Burgess follows:]

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Mrs. {Blackburn.} I thank you, Dr. Burgess, and I do welcome our witnesses.

I want us to think about this: 105. That is the number of individuals that will take their life today: 105. Many more will attempt it, and as we have prepared for the hearing, one of the things that I have found interesting and of note is that through the decades with all the research, with millions of taxpayers' spent, what we have not seen is a reduction in the suicide rates, the number of suicides that are attempted and committed, and I know we are all seeking to find answers to this. We each have been touched by those that have attempted or have committed suicide, and it is a very tender issue.

I have the Centerstone Research Institute in Nashville that has done tremendous work on the issue of youth suicide and is working with the juvenile justice system, and Mr. Chairman, I would like to submit a letter for the record from Centerstone.

Mr. {Murphy.} Without objection, yes.

[The information follows:]

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347 ********** COMMITTEE INSERT **********

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Mrs. {Blackburn.} And with that, I thank the witnesses and yield back.

[The prepared statement of Mrs. Blackburn follows:]

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Mr. {Murphy.} Thank you. I now recognize Ms. Schakowsky for 5 minutes.

Ms. {Schakowsky.} Thank you, Mr. Chairman. I want to thank you for holding this hearing. Suicide affects many, many people. It has been close to me as well, and it is entirely appropriate that we address this topic.

I want to tell you, our dear former colleague, Lincoln Diaz-Balart, how much I appreciate, I think we all appreciate, your coming here today. It takes a special kind of guts to come here and talk about your son Lincoln, who suffered from mental illness, committed suicide last year, and I can only imagine the pain of losing a child to suicide. My heart goes out to you.

Mr. Chairman, I applaud your legislative and oversight efforts this Congress on mental health issues, and I know that you are really trying to make a difference, but I am disturbed by what appears to be a growing disconnect between the facts we hear at oversight hearings and our failure to heed those facts when it comes to writing legislation. We have heard a few ongoing themes at this Congress's mental

health hearings and forums. We have heard about the importance of high-quality health insurance coverage for those with serious mental illness. Individuals suffering from mental illness need broad coverage. They need continuity of care. They need to be able to afford their treatments. Witness after witness has told us the same thing, and we will hear the same thing today. Earlier this year, the president of the American Psychological Association said that the availability of this coverage under the Affordable Care Act represented ``a watershed moment in the effort to prevent suicide.''

But Mr. Chairman, some of the Republican legislative approaches have ignored this evidence. Your colleagues have voted over 50 times to dismantle Obamacare and take health insurance away from millions of Americans. And Mr. Chairman, we have also heard about the importance of adequately funding mental health research. We hear the same about funding for suicide prevention efforts today. But Mr. Chairman, the Republican legislative approach has ignored this evidence. Again and again, your colleagues have voted on funding on an appropriations bill including sequestration and the Ryan

budget that have resulted in stagnant budgets for mental health research. And today, Mr. Chairman, we will hear about the availability of guns as a risk factor for suicide. Dr. Brent's testimony says that among healthy youths, and I quote, ``The only factor that differentiated suicides and controls was the presence of a loaded gun in the house.'' But Mr. Chairman, when we talk about legislation to improve mental health outcomes, prevent mass violence, prevent suicide, your Republican colleagues refuse to even consider guns as part of the problem.

The purpose of our oversight hearings ought to be to inform the legislative process, but in this committee, that is not happening. Over and over again, our witnesses tell us one thing but the Republican majority does something else. That is a shame, Mr. Chairman. I hope we can listen carefully to our witnesses today and finally act on what they tell us.

And I would like to yield the remainder of my time to Congresswoman Castor.

[The prepared statement of Ms. Schakowsky follows:]

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Ms. {Castor.} I thank my friend, Congresswoman Schakowsky, for yielding the time, and I want to thank you, Mr. Chairman and Congresswoman DeGette, for continuing to focus on the challenges families have all across this country with mental health issues, and I would like to welcome our former colleague, Lincoln Diaz-Balart from Florida. Lincoln, you are representing families all across this country in speaking out on their behalf, and I want to thank you for your courage in talking about your son and his depression and suicide last year, and thank you for encouraging improvements in public policy when it comes to suicide prevention, and here is why this is so important. In America, the rates of suicide are going up, particularly among young people and veterans. There is some distressing news that yes, as Congresswoman Schakowsky summarized, there have been budget cuts to the National Institutes of Health, the Centers for Disease Control, substance abuse and mental health treatment, and it is going to be much more difficult to tackle these problems if we remain in this atmosphere of devolution.

But the good news is that the Affordable Care Act is now

434 providing courage to millions of previously uninsured
435 Americans requires that all new individual and small group
436 insurance plans cover mental health and substance abuse
437 disorder services as one of the ten essential health
438 benefits. Plans are required to coverage these services at
439 parity with medical and surgical benefits, significantly
440 expanding lifesaving services. A February 2014 report by the
441 American Mental Health Counselors Association found 6.6
442 million uninsured adults with serious mental health and
443 substance use conditions will be eligible now for health
444 insurance coverage including coverage for mental health and
445 substance abuse through the new Affordable Care Act
446 marketplaces and exchanges.
447 The president of the Psychological Association of
448 American said that notwithstanding the politics of the
449 Affordable Care Act, the prospect that millions of Americans
450 will have health insurance covering mental health benefits at
451 a level comparable with their physical health care is a
452 watershed moment that could truly destigmatize mental health
453 care and suicide prevention services.
454 Thank you. I yield back.

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[The prepared statement of Ms. Castor follows:]

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Mr. {Murphy.} Thank you.

I would now like to introduce our first witness. He is the Hon. Lincoln Diaz-Balart, an attorney and consultant based in Miami, Florida. He is a former Member of Congress, where he served with great distinction between 1993 and 2011. He is here today to share for the first time a moving and personal story about Lincoln Gabriel. I greatly appreciate you being here, Lincoln. Normally at this time we would swear in a witness, but after consulting with the chairman and the ranking member, we all agree that an oath to be sworn is not necessary today because you speak from the heart, and the heart binds a voice to the truth far greater than a mere oath would.

So with that, I will now give you time for your opening statement.

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^TESTIMONY OF HON. LINCOLN DIAZ-BALART, FORMER MEMBER OF CONGRESS

} Mr. {Diaz-Balart.} Mr. Chairman and Ranking Member DeGette and members of the committee, when you called, Mr. Chairman, last week and graciously asked if I would consider speaking here today, I consulted with my son Daniel. He and his older brother, our dearly beloved Lincoln Gabriel--LG--were very close, and I have ultimate trust in Daniel's judgment. I explained to Daniel what you had told me, Mr. Chairman, with the subcommittee, the experts, the Surgeon General, who will testify here, will consider helping loved ones in mental health crisis. Daniel's words were, ``Of course LG would want you to be there. If one person who might not otherwise get help is able to get treatment because of that hearing and its aftermath, LG would be happy.''

My son Lincoln Gabriel was a blessing to all who got to know him. He was all love. His was not a theoretical love. It was a constant, practical love demonstrated by his daily actions, and above all by his deep respect for all human

beings. LG was ultimately generous. He was intelligent, courageous and of profound religious faith. He never allowed his illness, his deep depression, for which he took medication, to stop him from demonstrating his respect and his love for all human beings he came across.

Christina, Daniel and I miss him dearly, and we will continue to miss him for the rest of our days in the hope of our ultimate reunion with him.

Congress honored Ukraine today by receiving its president in a joint meeting. After their Orange Revolution, I went to Ukraine in December 2005, and the First Lady at the time, Mrs. Yushchenko, asked if my community would be able to help some of Ukraine's most severely handicapped, physically handicapped, children. I said yes, so in October 2007, 10 children arrived in south Florida from Ukraine needing prosthetics for arms or legs, or both. Our community and some south Florida firms responded admirably. Nine of the ten children were fitted with prosthetics. But I remember my then-chief of staff, Anna Carbanel, calling me from the airport when the children arrived explaining we have so much work to do with one particular young woman, 18-year-old

Natalia. Natalia, a beautiful young woman, was born with extremely small arms and legs, and her back structure did not allow her to sit up. Hers was not a case for prosthetics. It was much more serious. She lived each day on a small wooden platform with wheels face down. The First Lady of Ukraine had been very impressed by the fact that despite her physical disability, Natalia is an artist. She paints with a brush she holds with her teeth.

But Natalia's dream was to be able to sit in a wheelchair and face life sitting up. She had had multiple surgeries in Ukraine but they had failed. A south Florida surgeon, Dr. Hadi Barvataneni, volunteered to operate. The community donated the funds to pay for her hospital stay. Natalia's surgery was successful. After her surgery and rehabilitation, she was able to sit upright and live independently in her new wheelchair.

She stayed in south Florida for months for her rehabilitation. Anna Carbanel and her husband, Gus Munghill, opened their home to her. During those months, LG became Natalia's friend. He was so proud of what our community had done for those children. LG's first and his last Instagram

posts were photographs of Natalia's paintings. I carry his last Instagram post with me. Some friends of LG's wrote ``This is pretty cool. Who painted it?'' ``A family friend from Ukraine named Natalia,'' LG answered.

I have never met anyone more respectful of all human beings than my son Lincoln Gabriel. As I said, he was all love. I must admit I believed that all you need is love. I never thought our tragedy of May 19, 2013, was possible, but it was possible. Sometimes love is not enough.

Assertive proactive intervention is sometimes required to get needed treatment to those in mental health crisis, and thorough discussion of their illness with those who are sick.

I have come before you today to thank you for focusing on this painful issue and to thank the mental health experts, the physicians, those in the NGOs, in the Executive Branch, the Surgeon General, all those working to prevent tragedies such as the one my family experienced. Please, find common ground. Overcome differences in order to make progress.

As my son Daniel said, if one person who might not otherwise get help is able to get treatment because of this hearing and its aftermath, LG would be happy.

Thank you.

[The prepared statement of Mr. Diaz-Balart follows:]

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Mr. {Murphy.} We thank our friend and our colleague for his words of motivation and challenge, and we will heed that challenge.

Now, as our next sit of witnesses is coming to the table, I will read your introductions. Please have a seat as your nameplate is put down.

We are going to be joined today by Rear Admiral Boris Lushniak, who is the Acting United States Surgeon General. He oversees the operation of the U.S. Public Health Service Commissioned Corps comprised of approximately 6,800 uniformed health officers. Also, Dr. David Brent is the Endowed Chair in Suicide Studies and Professor of Psychiatry, Pediatrics, Epidemiology and Clinical and Translational Science at the University of Pittsburgh. Dr. Christine Moutier is the Chief Medical Officer of the American foundation of Suicide Prevention, and Dr. Joel Dvoskin is an Assistant Professor of Psychiatry at the University of Arizona and is here today on behalf of the American Psychological Association.

I will now swear in the witnesses. You are aware that the committee is holding an investigative hearing, and when

so doing has the practice of taking testimony under oath. Do any of you have an objection to taking testimony under oath? Seeing none, the chair then advises you that under the rules of the House and the rules of the committee, you are entitled to be advised by counsel. Do any of you desire to be advised by counsel during your testimony today? You all say no. In that case, if you would please rise and raise your right hand, I will swear you in.

[Witnesses sworn.]

Mr. {Murphy.} And all have answered affirmatively, so you are now under oath and subject to the penalties set forth in Title XVIII, Section 1001 of the United States Code. I am going to ask you each to give a 5-minute opening statement. We will begin with Dr. Lushniak.

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^TESTIMONY OF REAR ADMIRAL BORIS LUSHNIAK, M.D., U.S. ACTING SURGEON GENERAL; DAVID 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, ASSISTANT PROFESSOR OF PSYCHIATRY, UNIVERSITY OF ARIZONA

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^TESTIMONY OF BORIS LUSHNIAK

} Admiral {Lushniak.} Thank you so much, Chairman Murphy, Ranking Member DeGette and members of the subcommittee.

What a way to start in terms of hearing the words of the Hon. Lincoln Diaz-Balart. Oftentimes in public health we get caught up, certainly in subcommittees we get caught up. We get caught up in numbers, we get caught up in programs, we get caught up in initiatives and successes and failures. I submit to you, sir, starting off with a personal and poignant such as presented to us really sets the tone for what all

this about, that this ends up being that one life at a time, and yet we know that although he came here very heroically to discuss the story of his son and their family's tragedy, the repercussions of that spread out, and each and every year, as we already heard, almost 40,000 people have stories like that. Let us remember those 40,000. Let us focus on the public health impact of this terrible scourge in our land.

I want to share with you the opening dedication of this, the 2012 National Strategy for Suicide Prevention, and it goes like this. To those who have lost their lives by suicide to those who struggle with thoughts of suicide, to those who have made an attempt on their lives, to those caring for someone who struggles, to those left behind after a death by suicide, to those in recovery and to all those who worked tirelessly to prevent suicide and suicide attempts in our Nation.

This is one of those quintessential components of any program, of any initiative, certainly initiatives out of the Office of the Surgeon General that it is not one person, it is not one group. It is incredible clinicians as I have to the left of me. It is incredible political structures and

leaders that I see in front of me. It takes that proverbial village to have success in public health.

For over a decade, the Office of the Surgeon General has led in this topic matter. This has been a priority. Surgeon General David Satcher back in 1999 put out the first call to action, and in 2001, the National Strategy for Suicide Prevention. Most recently, my predecessor, the former Surgeon General Regina Benjamin, in partnership with the National Action Alliance for Suicide Prevention updated this U.S. National Strategy for Suicide Prevention.

I am here as an Acting Surgeon General. I am a career officer in the U.S. Public Health Service, but here committed to demonstrate the commitment of the Office of the Surgeon General to continue to be visible and a long-term supporter of our Nation's work in suicide prevention. I don't come to you as a psychologist, psychiatrist, behavioral science expert. These are people to the left of me here. We have that expertise behind me. My chief of staff, Captain Robert DeMartino, also a member of the U.S. Public Health Service, is a psychiatrist by training. He is there embedded within the immediate Office of the Surgeon General. I come to you

as a person trained in family medicine, preventive medicine and dermatology. I bring my commitment to a public health approach and public health expertise to these issues.

Let me define this public health approach. What is the problem? We define the problem through surveillance and data. Why did it happen? We identify the causes and understand the risks and protective factors. What works? We develop and evaluate innovations, programs and policies. How do you do it and accomplish the goal? We implement and ultimately disseminate interventions that work, evidence-based interventions.

While the Office of the Surgeon General doesn't direct or have oversight over specific programs or agencies within the Department of Health and Human Services, the ability of that title of Acting Surgeon General or the Surgeon to bring the Nation's attention and focus onto important public health issues remains an important and necessary part of our efforts to prevent suicide in our Nation. We play a leadership role to bring together federal and non-federal partners, inspire them to identify the solutions, take collection action to address these key issues. That collaborative leadership was

fundamental to creation of this, the national strategy.

Incidence of suicide, as we have heard, in spite of an encouraging trend between 1995 and 2005, has sadly remained largely undisturbed. Many people will ask why. The unsatisfying answer is, suicide is a complex problem that defies a simple solution. Still, there are many clues out there in the international realm. The United Kingdom's steady, significant reductions in suicide rates included access to 24-hour crisis care, assertive outreach for people with severe mental illness. In Taiwan, follow-up aftercare after suicide attempts led to a 63 percent reduction. Means reduction has been successful in international settings. Regardless of the means, those who die by suicide are far from being the only ones affected by that tragedy.

We have this as a catalyst, the National Strategy for Suicide Prevention, work together by HHS agencies and outside partnerships, 13 goals, 60 objectives, reducing suicides over the next 10 years. We work together with the National Action Alliance for Suicide Prevention, a public-private endeavor. We have many examples of successes, and yes, sir, many examples of failures in this.

With the emphasis on effective treatment to prevent suicide and reattempts, one of our goals, we have various therapies that are out there that are available and need to be utilized in this evidence-based world. We are engaged in a long-term effort to change how our society thinks about serious mental illness and suicides. We have to work on those change.

Mr. {Murphy.} If you could wrap up?

Admiral {Lushniak.} While much has been done, we know more needs to be done. I applaud you for bringing attention to this issue. I urge your continued support for suicide prevention.

Thank you, Mr. Chairman, Ranking Member DeGette and members of the subcommittee, and I look forward to further discussion.

[The prepared statement of Admiral Lushniak follows:]

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Mr. {Murphy.} Thank you, Doctor.

Dr. Brent, you are recognized for 5 minutes.

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^TESTIMONY OF DAVID BRENT

} Dr. {Brent.} First, I would like to thank you and your staff for inviting me. It is an honor to be here.

I would like to make a few points about what I think are things that we can do now that can decrease the suicide rate, and it starts with the premise that the single most important risk factor for suicide remains mental disorder, and there is evidence that if you improve the quality of treatment of mental disorder that you can decrease the suicide rate. This has been demonstrated regionally in studies based in primary care. There are pharmacoepidemiologic data that show that there is an inverse relationship between prescriptions for antidepressants and the suicide rate, and one of the ways that we think about how mental illness contributes to the risk for suicide is that it affects a balance between distress and restraint and that when you have low restraint against suicide and high levels of distress, that is when suicide ensues, and this is why insomnia, I think, is one of the most important risk factors for suicide. It is

underrecognized. Many people are not well trained in its treatment. The way that it contributes is that it tends to increase disinhibition and dysphoria, which is a really bad combination and something that can either precipitate or exacerbate suicidal thoughts.

There also are efficacious treatments for suicidal behavioral, and the issue is really one of dissemination at this point, and I will just mention one of them, dialectic behavior therapy, but there are several others, and what they have in common is that they have a clear model for suicidal behavior. They collaborate with the patient, and they have a safety plan that the patient can implement when they have suicidal urges.

Another barrier to prevention of suicide, I believe, has to do with the inadvertent effects of the black-box warning of the FDA, which warns against suicidal events that may occur with antidepressant treatment, and what we have seen as an untoward consequence of that is a decline in the rate of diagnosis of depression and even a decline in referrals for psychological treatments for depression in adolescence, and although it is controversial, there are some studies showing

752 that that is correlated with an uptick in suicide.

753 Another thing that I think should be in our portfolio
754 has to do with evidence-based prevention. The Washington
755 State Institute for Public Policy has done cost-benefit
756 analyses on different prevention programs and showed that
757 there are certain ones that are evidence-based and yield a
758 very high return for investment, and I think that some of
759 these could decrease risk factors that we know are related to
760 suicide such as aggression and substance abuse.

761 The issue of lethal agents in suicide--guns in the
762 United States--having a gun in the house greatly increases
763 the risk of suicide, and it is not only in people who have
764 mental illness, although that is the most concerning issue,
765 but in our studies, we found that individuals where there
766 wasn't a clear mental disorder, the only factor that
767 differentiated between suicide victims and people in the
768 community was having a loaded gun in the home, and so we know
769 that there are interventions that can be done in primary care
770 that can at least encourage people to store guns in a secure
771 manner so that a disinhibited or impulsive act won't lead to
772 a fatality, and we would urge that this be considered as an

important public health measure.

There are service system changes that can lead to improvement in the suicide rate, and Dr. Lushniak alluded to this, but in England, they showed that implementation of care coordination, 24-hour beds, crisis beds, assertive outreach if people don't show up for their appointments, and dual diagnosis treatment, that is, substance abuse and mental disorder combined. When they implemented these recommendations, it was associated with a decline in the suicide rate.

And so to conclude, I just wanted to share what I think are some recommendations that may help us to reduce the suicide rate, which has to do with improved recognition and treatment, and I think the most promising area, and this is in collaborative care where mental health treatment is collocated in primary care, dissemination of evidence-based treatments that have been shown to reduce suicide, coordination of care and the mental health service systems, innovations that have been shown in England to reduce suicide, and I think that there are some research areas that could have relatively high payoff quickly. One is whether

better recognition and treatment of insomnia could have an effect on the suicide rate, safety counseling in primary care, whether restriction of availability of lethal means could reduce the suicide rate, and I think research on trying to find agents that have a more rapid onset of antidepressant effect than the ones that we are currently using, and I think that--and finally, evidence-based prevention judiciously used, and I think these recommendations, many of them are partly in place now, I think could make a favorable impact on the suicide rate.

Thank you.

[The prepared statement of Dr. Brent follows:]

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Mr. {Murphy.} Thank you, Doctor.

Now, Dr. Moutier, if you would pull the mic close to you and turn it on. We appreciate your testimony.

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^TESTIMONY OF CHRISTINE MOUTIER

} Dr. {Moutier.} Mr. Chairman and members of the committee, thank you for inviting the American Foundation for Suicide Prevention, AFSP, to testify today. I am Christine Moutier, and I am AFSP's Chief Medical Officer. I would like to submit my full written statement for the record, and Mr. Chairman, thank you for your longstanding leadership in mental health and suicide prevention.

The magnitude of suicide's toll on our society is immense, but my message today is hopeful and actionable. While suicide's roots are complex with biological, psychological and social determinants at play, clearly oftentimes suicide is the result of an unrecognized or untreated mental illness, and when one in four Americans have a diagnosable mental health condition but only one in five of those are seeking professional help, we have a lot of work to do. We must elevate the layperson's understanding of how mental health problems are experienced or what they look like in loved ones, and we must highlight help-seeking as the

smart, responsible thing to do when you sense a change in mental health just like you would be proactive with any other aspect of your health.

Suicide risk tends to be the highest when multiple factors come together or precipitating life events in a person with a mental illness. We can start by better recognizing and effectively treating those health problems. On a population level, we can implement more upstream approaches such as shoring up community and peer support, teaching students social and emotional skills, making mental health care accessible and available to all, and addressing the health care system's failures, training frontline citizens like teachers, first responders and clinicians, and limiting access to lethal means.

The good news is that suicide is preventable, and thanks to a grassroots movement catalyzed by both suicide loss survivors and the emerging voice of those with their own history of suicide attempts, the fight against suicide is reaching a tipping point. I believe we need to focus on three key policy areas to bend the curve of our Nation's suicide rate, and these areas include suicide prevention

research, suicide prevention programs, and support programs for those who are touched by suicide.

Research is vitally important to understanding what actually works to prevent suicide. Suicide research must focus on the gaps in the science, which, if understood, would have the greatest potential impact on reducing suicide burden.

AFSP uses a strategic approach to fund the best science with an eye toward impact. One AFSP-funded study, for example, trained primary care physicians in a region of Hungary that happened to have one of the world's highest suicide rates and found that their training led to a reduction in suicide rates in that region at least until the effect of the training had passed a couple years later. Studies of bridge barriers dispel the myth that people bent on suicide will find a way since suicide rates for the whole region diminished following their construction, and, as you have heard, clinical intervention studies have found promising results for those at highest risk for suicide such as people who have had a suicide attempt.

AFSP believes that the Federal Government must

substantially increase funding of suicide research in the hopes of obtaining similar reductions in mortality that have come from strategic investments in other major public health problems like heart disease, HIV/AIDS, and cancer. Federal funding of research is far from commensurate with suicide's morbidity and mortality toll.

Suicide prevention needs to encompass a broad range of the issues that put people at risk for suicide and conversely, prevention needs to emphasize the conditions that provide a protective effect against suicide. The best strategies are multidimensional and sustained. They use education, media campaigns, targeted screening, resilience building, system changes that treat mental health problems as health issues and not disciplinary ones, and they address access to lethal means.

Prevailing cultural perceptions about suicide and mental health keep 80 percent of people with a mental health problems from getting help. To address this appalling level of mental health illiteracy, we must provide education universally to eradicate stigma and shatter the real and perceived barriers that keep people suffering in silence.

Suicide touches many, many lives, but only recently as more and more people are speaking out about their experiences has the need for action become so apparent. Ten years ago, our organization had only a handful of people banding together. Today we have over 100,000 people walking and raising awareness for suicide prevention every year. It is time to wage war on suicide and put a stop to this tragic loss of life. I believe we can accomplish a goal of reducing the suicide rate in our country 20 percent by 2025. This is our organization's goal. Science can provide a clear roadmap, and I believe the American people are ready for a greater understanding of the issue. If we push hard with an effective strategy, we can save lives.

Thank you.

[The prepared statement of Dr. Moutier follows:]

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Mr. {Murphy.} Thank you, Doctor.

Now Dr. Dvoskin, you are recognized for 5 minutes. Make sure the microphone is on and pull it close to you.

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^TESTIMONY OF JOEL A. DVOSKIN

} Mr. {Dvoskin.} Chairman Murphy, Ranking Member DeGette and members of the committee, my name is Dr. Joel Dvoskin. I am a clinical and forensic psychologist. I am a faculty member at the University of Arizona College of Medicine. I also serve as Chairman of the Governor's Advisory Council on Behavioral Health for the State of Nevada. I thank you for holding this hearing, and I am appearing today on behalf of the American Psychological Association, which is the largest scientific and professional organization representing psychology in the United States. APA supports the committee's focus on ensuring that our Nation does all it can to prevent suicide.

As you have heard, suicide is a complex and multifaceted problem. It is also a form of violence, but with access to appropriate treatment, it can be prevented, and that is probably one of the more important things I want to say to you today, and you have heard from other people is that we know how to prevent suicide; we just don't do it.

Any act of interpersonal violence including mass homicides, which have gotten a lot of attention, are suicidal acts. The majority of people who commit mass homicide die. They either kill themselves, they are shot by police, or their life as they know it is over because they go to prison or hospital for the rest of their life. So if we prevent suicide, we will prevent mass homicide; we will just never know it because you never know which person would have decided to end their life at the expense of many others.

APA views suicide prevention as an essential part of violence prevention. As you have heard from Dr. Brent, suicide is an impulsive act, especially angry impulsivity, where an individual is desperate to relieve their suffering and can't figure out another way to do so.

Suicide risk can be reduced through identifying and providing support to address the factors that drive a person to consider suicide as well as the factors that disinhibit people and allow them act on those drives.

Much of my current work is--I am a board member of the National Association to Protect Children, and one of the important points I want to make is that child abuse and

trauma is an important risk factor for suicide among a whole bunch of other bad life outcomes. Programs such as the National Child Traumatic Stress Network are essential to our efforts to prevent suicide.

Much of my own work is focused on jails and prisons. I was glad to hear you mention DBT. Just yesterday, I spent all day in the women's prison in Huron Valley in Michigan, where they have done, to my knowledge, the first DBT program in a prison in America as a large part of their effort to prevent suicidal acts among their inmate population.

By using a public health and prevention approach, experience shows that we have reduced jail suicides by about two-thirds in every jail that had implemented a public health approach to suicide prevention. It is very simple. You ask people at the front door if they are thinking of killing themselves, and if they say yes, which they often do, you keep them alive until the crisis passes.

You have heard about interagency collaboration and programs. One example is the crisis intervention teams, which I know that Chairman Murphy has been supportive of, a program that has been developed with law enforcement, but CIT

is worthless if the police don't have anybody to refer the person to. So in the absence of good mental health care, CIT, which is a tremendously valuable program, loses a lot of its effectiveness.

One of the most important things I want to share with you today is the fact that we have completely neglected to use the most important behavioral change agent in America to fight suicide, and that is television advertising. Television got everybody in America to put deodorant on every morning, but we have never tried to use it to change behavior on a much more important thing, and I think the committee could use its power to get some cooperation from television advertisers to fight stigma and to get people to tell us when somebody they care about, their life is in danger suicide to suicide. We know what works but not all Americans have access to the effective treatment and crisis intervention is necessary.

We need to have more trained professionals including people who have been through problems with mental illness and are very effective peer service providers. I very much agree with the chairman's push to at least revisit the Medicaid IMD

expansion, which will hopefully make more acute crisis beds available for people who are now choking emergency rooms where people can't get lifesaving treatment, and it is bad treatment for a serious mental illness or a psychiatric crisis as well.

My time is almost done. I just want to add a couple of other things. One of them is that the National Violent Crime Reporting System currently only exists in 16 States, and I urge you to consider expanding that nationwide so that we can do some of the research that you have heard about before.

I want to express my deep appreciation of the committee's work and its ongoing attention to the prevention of suicide and the treatment of serious mental illness in America. Over my many years in this field, I have seen tremendous progress in figuring out how to fight suicide. We just don't implement these tools broadly enough. Suicide, like so many tragedies, is the direct result of despair, and there is only one cure for despair, and that is hope. It is my hope that our political parties can join together in a bipartisan effort to give people in the most acute despair some measure of hope for a better life by improving the

services that are provided to people experiencing emotional crisis and psychological pain. This can happen to any of us, and we must ensure that help is there in time of crisis.

Can we afford to do this? I would propose to you that given the costs of each suicide, we can't afford not to.

Thank you very much.

[The prepared statement of Mr. Dvoskin follows:]

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Mr. {Murphy.} Thank you. I thank all the panelists for your important testimony. Let me open up questions here for 5 minutes, and we will alternate with other questions.

Surgeon General, in 2010, a progress view on the National Strategy on Suicide Prevention prepared by the Suicide Prevention Resource Center identified the ultimate policy goal behind the national strategy as reducing the morbidity and mortality of suicide behaviors. Is that the aim of the national strategy as you understand it as well?

Admiral {Lushniak.} It is to a large extent, and morbidity, I have to clarify here. Morbidity is the world of attempts, right?

Mr. {Murphy.} We all know that within the realm of suicide, there is a whole spectrum and it starts with the concept of, you know, suicide ideation, suicide planning attempts, and then suicide, and so ultimately within the national strategy is really a concerted effort across multiple government agencies and with the private sector components to be able to say, as already stated here, to reduce that incredible burden on our society, the number of

ultimate suicides that do occur.

Mr. {Murphy.} Thank you. Also, in September of this year, in a blog post, NIMH Director Tom Insel noted that despite increased availability of mental health care and medications for depression, the U.S. suicide rate has remained largely unchanged and of, course, we also know in some areas, it has gone up. Would you agree that this data suggests that our national strategy dating back to 2001 has not been effective in reducing the number of deaths by suicide and we need to make some changes?

Admiral {Lushniak.} Well, I think the changes are in progress of being made. I think going back to 2001, we realized in 2001 was the first strategy. This most recent strategy came out under Surgeon General Benjamin back in 2012. So actually this is second anniversary of the release of this strategy. So it is too early, in my view, to say that things are not successful, yet I realize we are all frustrated with the fact that success, if it is going to be there, is coming rather slowly, and so there is frustration.

Now, built into this are multiple other changes that are going on including the idea of, you know, one of the

objectives of this, objective 5.4, which focuses on efforts to increase access to and delivery of effective behavioral health services. Now, that certainly has changed with the Affordable Care Act. The Mental Health Parity and Addiction Equity Act will give 60 million people extended access to mental health and substance use disorder services, and depression screening, alcohol misuse screening and counseling are now covered as pre-preventive services under ACA. So my sense is that to be able to go back to 2001 saying things aren't working, my sense is, I am going back to 2012 and re-analyzing it.

Mr. {Murphy.} It is clear we have to do something, and as I have talked with former Congressman Lincoln Diaz-Balart, he told me that access was not a problem, and I am sure we would agree that for Robin Williams, insurance and money was not a problem.

But Dr. Brent, you have seen considerable success in some of your research, in particular, the STAR Center. How has the STAR Center performed? And I think it is the only one of its kind in Pennsylvania, and is it serving as a model for other States in terms of ability to have positive

results?

Dr. {Brent.} Well, I don't know how unique it is, but our program is funded by the Commonwealth of Pennsylvania and it allows us to do things that often clinicians don't do because it is not billable, but I would say that the things that we do that I think lead to our effectiveness, we spend a lot of time on supervision and training using evidence-based treatment. We work as a team, and so decision-making is shared and you are less likely to make a mistake than if you have multiple opinions. We spend time coordinating with other institutions so our clinicians will go to schools, inpatient units and so on. This is not reimbursed currently but we feel that it is important. And I would say that we have a sense of mission and discovery, and I think we are critical about our own work, and we are always looking to improve.

Mr. {Murphy.} And we hope you will continue to share much of that research with this committee because it is an exemplary program.

Dr. Moutier, the Washington Post ran an article in its August 12, 2014, issue quoting you extensively in the media

treatment of Robin Williams' suicide. In particular, you took issue with a tweet by the Academy of Motion Pictures Arts and Sciences which you argued ran contrary to a healthy dialog. I don't know if we have that tweet available. Right there. And it says, ``Genie, you are free.'' How can the American Foundation of Suicide Prevention and similar groups bring the myths and facts about suicide and suicide prevention to the attention of organizations and commentators acting on social media? Could you please comment on how we need to change that?

Dr. {Moutier.} Yes. I think that speaks exactly to the disconnect and the level of ignorance that is out there. Obviously they meant well with that statement, and little did they realize that to a vulnerable individual, especially a young, vulnerable person, that really presents an idea that suicide is being idealized and it is a solution and makes it more acceptable, and I am sure they did not mean to do that but that kind of messaging is being done still to this day quite frequently.

My organization partners with other organizations. We have already produced media guidelines for safe messaging,

and actually maybe even effective prevention messaging about suicide after an event has occurred that has the public's attention. We are doing things like working with the media. We just attended a conference this week to try to raise this level of education. We have friends in the Associated Press who are working to, for example, get the term, the phrase ``committed suicide'' banned from the AP Style Guide, which would be a measure of progress as well so that it is not associated with a criminal act.

Mr. {Murphy.} Thank you very much. I now recognize Ms. DeGette for 5 minutes.

Ms. {DeGette.} Thank you very much.

Dr. Lushniak, access to treatment is going to be a key part of any efforts we make in suicide prevention and reduction. Is that correct?

Admiral {Lushniak.} Yes. I think it is a key feature.

Ms. {DeGette.} Thank you.

Admiral {Lushniak.} Let me back up just--

Ms. {DeGette.} Okay. I need to keep moving.

And Dr. Brent, in your testimony, your written testimony, you say, ``Access to good quality mental health

treatment can reduce risk.'' Is that correct?

Dr. {Brent.} Yes.

Ms. {DeGette.} And I would assume, Dr. Moutier, you agree with that as well, that people have to have access to quality treatment, right?

Dr. {Moutier.} Yes.

Ms. {DeGette.} And Dr. Dvoskin?

Mr. {Dvoskin.} Yes.

Ms. {DeGette.} Okay. So going back to you, Dr. Lushniak, what were you going to clarify?

Admiral {Lushniak.} Well, it is interesting because I think access to be able to diagnose appropriately severe mental illness--

Ms. {DeGette.} Right.

Admiral {Lushniak.} --and being able to treat it appropriately is the key feature.

Ms. {DeGette.} Yes.

Admiral {Lushniak.} One of the disturbing factors that we have seen in terms of the data that come in is that the majority of suicides that do occur have had access to medical care.

Ms. {DeGette.} Right.

Admiral {Lushniak.} They--

Ms. {DeGette.} But they don't necessarily have access to psychological care.

Admiral {Lushniak.} But also the issue here is--

Ms. {DeGette.} Is that right?

Admiral {Lushniak.} --whether that issue--whether as you are having your blood pressure taken, whether--

Ms. {DeGette.} Whether they are asking about that?

Admiral {Lushniak.} Exactly.

Ms. {DeGette.} That is correct. And Dr. Dvoskin, part of the thing is that we haven't had high-quality psychological care, particularly for adolescents. Isn't that correct? I mean, what we have heard in all these things this year that we have been having is that we don't have nearly enough trained mental health professionals for adolescents, and that pediatricians and others who are treating these young people don't have the psychological training. Would you agree with that?

Mr. {Dvoskin.} Some do and many don't.

Ms. {DeGette.} Okay. And Dr. Brent, in your written

testimony, one of--and actually, Dr. Dvoskin, you talked about this too in your testimony. You were talking about DBT, which is dialectic behavior therapy. Is that right?

Dr. {Brent.} Yes.

Ms. {DeGette.} And dialectic behavior therapy is a very intensive and expensive therapy. Is that correct?

Dr. {Brent.} Yes.

Ms. {DeGette.} But it seems to have shown through the studies that it works. Is that right?

Dr. {Brent.} Yes. Can I--

Ms. {DeGette.} Yes. Turn the mic on, please.

Dr. {Brent.} There are briefer versions and there are other treatments like cognitive behavior therapy.

Ms. {DeGette.} Right.

Dr. {Brent.} There is one study--

Ms. {DeGette.} Right.

Dr. {Brent.} --in nine sessions, they were able to cut the suicide rate in half.

Ms. {DeGette.} Right, but still, the cognitive behavior study, that costs money too and it needs trained professionals to administer. Is that right?

Dr. {Brent.} Yes.

Ms. {DeGette.} Yes? Okay. Thanks. So the reason I am asking these questions is because, of course, one thing we tried to do when we passed the Affordable Care Act is, we tried to give people mental health coverage as a result, and in fact, there was a report earlier this year by the American Mental Health Counselors Association that nearly 7 million uninsured adults with serious mental health and substance abuse conditions are now eligible for health insurance coverages under the ACA marketplaces and for 27 States through Medicaid, and so Dr. Dvoskin, I wanted to ask you, do you think that it is important that we expand mental health coverage to people as we are expanding our health care in general?

Mr. {Dvoskin.} Mental health coverage crisis response is terribly important, so even if someone is in treatment, if there is--many suicidal crises occur late at night when crisis response teams, fire and rescue, police agencies are the responders, and a competent crisis response has suffered very badly from the decreases in mental health funding in the public mental health system over the last 15 years.

Ms. {DeGette.} Right. So even though we are giving people more access to mental health in the ACA, we still need to fund that crisis treatment, and we have heard that loud and clear.

Mr. {Dvoskin.} Yes, ma'am.

Ms. {DeGette.} Dr. Lushniak, I want to ask you if you can talk about what has happened that you have seen since the Affordable Care Act has given increased coverage of mental health services and what that will mean in your efforts for suicide prevention.

Admiral {Lushniak.} Well, certainly, I think it is too early to see whether we have a success or a failure here. The success is, we do have coverage. As I mentioned already, both the Affordable Care Act as well as the Mental Health Parity and Addiction Equity Act will give 60 million, 6-0 million people expanded access to mental health and substance use disorder services. So the idea here is that access, will access bring us success? Certainly, I think access is going to be a positive influence.

Ms. {DeGette.} But it is not the only thing.

Admiral {Lushniak.} But right now it is not the only

thing. It is helpful. It is heading in the right direction but it really dovetails into what I think all of our messages was. We are dealing with a very complex public health issue here, a very complex mental health issue here, and it is multifactorial with multifactorial resolutions. There is not going to be one simple answer saying access will solve the whole problem.

Ms. {DeGette.} Thank you. Thank you very much, Mr. Chairman.

Mr. {Murphy.} Thank you. I now recognize Mr. Griffith of Virginia for 5 minutes.

Mr. {Griffith.} Thank you very much. I appreciate that.

I will let any of you jump in on this. One of the things that we haven't discussed in detail but is a part of that multi--and I am not going to pronounce the word right, but multi reasons why someone might commit suicide. I noticed an article that I read indicated that there are families who suffer from depression who have multiple members who have committed suicide and other families who suffer with a history of depression who do not have suicide, not a single

one, and I am wondering what the thoughts are. Do you all believe--and everybody can answer this. Do you believe that there is a gene that we might be able to identify that would say these folks with depression are more likely to commit suicide than other folks, and do we target or do we put special attention on those who have a family history both of the mental illness of depression and a resulting suicidal act in the family?

Admiral {Lushniak.} And I will start, and then we can open it up to the panel. Certainly, there are genetic influences on a variety of conditions--substance use, abuse of substances. Alcoholism obviously has a genetic predisposition. There are also mental health disorders, severe mental health disorders that do have a genetic connection there as well. We know a definite risk factor is having a family member who has committed suicide. We know that is a risk factor, and the whole idea of genetics and its tie-in with suicide I think is still to be determined in our research world, and I will pass the microphone on to the clinicians here to further give their opinion on this.

Dr. {Brent.} Well, there is definitely a genetic

influence to suicide, and the families that you were describing, the two types of families, is strong evidence for that, but that doesn't mean that it is caused by a single gene, and I think that when we deal with families where there has been a completed suicide, we have to tell people actually that you are at increased genetic risk but genetics isn't destiny. If you have a risk that is 40 per 100,000 instead of 10 per 100,000, the odds are still with you, and so I think it is important not to oversell that. At the same time, we are chasing what might be some genetic factors that could be contributing to suicide risk but it is not going to be one gene.

Mr. {Dvoskin.} I would just add that looking at this through a public health lens, it is very easy to identify the people who are deserving of extra attention, who is at higher risk, people who have tried before, people who have close families who have killed themselves. So we don't lack for an ability to identify the at-risk population.

Mr. {Griffith.} Did you want to add anything?

Dr. {Moutier.} Well, I think I will just say, as you heard, we have things that we can implement now. Research is

fine and good, but if it doesn't translate into something that is actionable to actually help people, I think in many cases what you are hearing is that we have evidence-based strategies and now we have growing access to care. Now we have to link the two. So I think there are things that we need to do now, and continuing to more robustly fund research is very important. We are probably some years away from that genetic answer for predicting suicide risk but it could be there, absolutely.

Mr. {Griffith.} Well, I appreciate that and hope that while I know that is just one piece of the puzzle, I would hope that the researchers and both private and governmental areas would continue to look into that.

Switching gears, I would ask the Surgeon General if he could comment on the possibility of using the U.S. Air Force's suicide prevention program as a possible model for the other branches because obviously we are all concerned with the high increase and the large numbers of our armed forces who returned from combat.

Admiral {Lushniak.} Certainly. I think it is a discussion that I can certainly have and will have with the

other Surgeons General of the Army and Navy as well as the Air Force, my fellow surgeons, if you will. That being said, I think the Air Force is a great model. The Air Force has two components to their program. One component is the wingmen component, which is servicemen watching out for other servicemen. The other component is actually built into a youth prevention program.

I think the bottom line to all of this, and it really goes back to this public health model that I described earlier, ultimately, we are looking for what works. Part of what works is to be able to look at innovations, look at changes and properly evaluate them because ultimately as we go further to implement this, whether it is across the armed services or whether it is across the Nation, I have to have proven systems that work before nationwide implementation goes. But I think we are on that pathway to find out what is working and to see how it is implementable, even in terms of further pilot studies.

Mr. {Griffith.} And Mr. Chairman, if you all will indulge me, I am going to go back to the first question because something came to my mind.

One of the factors is also substance abuse, and I am wondering if there are any programs out there--we talked earlier about educating people on what you might do and why television--we have learned, you know, everybody should use deodorant but we haven't how to deal with suicide. For those families that have a history of both substance abuse and suicide, I wonder how much work is being done on encouraging those families to be abstinent when it comes to both alcohol and other substances.

Admiral {Lushniak.} I think certainly we look at all the risk factors, and I think we sort of described it earlier. We know a lot of the risk factors that exist out there. Now, how all these are bundled together, which is the family history component in addition to the substance use or abuse component, we certainly look and try to strengthen our specific prevention activities within those populations, but in essence, we sometimes break them apart. In other words, the substance use is treated differently than the family history one. But again, I will turn to the clinicians here who do this on a daily basis.

Dr. {Brent.} So substance abuse prevention is an

interesting issue because it is so prevalent, especially in adolescents and young adults, that there is argument that a universal prevention actually makes more sense than targeting people that are at high risk, and in that policy institute I mentioned, the Washington State Policy Institute, they have identified several intervention programs that are low-cost that are, you know, relatively brief that have shown to reduce substance abuse by about a third in communities where it had been implemented.

Mr. {Murphy.} The gentleman's time is expired but if you could get us copies of--any time any of you reference any study, I hope you will get us copies. That is valuable.

Mr. {Griffith.} Thank you, Mr. Chairman. I appreciate the committee's indulgence.

Mr. {Murphy.} Thank you. Now Ms. Castor is recognized for 5 minutes.

Ms. {Castor.} Thank you, Mr. Chairman, and thank you to the panel.

I don't think it is an understatement to say that there is a suicide crisis among America's veterans. The Department of Veterans Affairs estimates that 22 veterans commit suicide

every day. I am not going to use that, I have learned. What is the proper way to say it then?

Dr. {Moutier.} Died by suicide.

Ms. {Castor.} Twenty-two veterans die by suicide every day, about 7,000 per year. Veterans are three times as likely to die by suicide as non-veterans. The number of suicides among veterans is outpacing the number of combat deaths. So this is a real national tragedy.

Dr. Lushniak, why are we seeing these trends. I think people kind of understand the stresses, but what can you tell us?

Admiral {Lushniak.} Well, again, you know, the big question is why, why we see such trends. I mean, we certainly know one of the risk factors is serving in military. Certainly in military during wartimes, the stressors increase. The issues as, you know, Chairman Murphy well knows by going on--he was sharing with me his experiences going to Walter Reed twice a month to be able to treat and to diagnose and to assist in individuals who are coming back with traumatic brain injuries, who come back with PTSD. We are in a time where there are more such service

members who are coming back. That is part of the issue. The other issue also is the issue of serving in any of our uniformed forces brings with it its stress, its separation from family, its separation from one's normal environs. So there are multiple reasons for that.

Let me tell you to some extent sort of the cooperation that is going on right now, to a great extent the cooperation that is going on right now, and this specifically goes back to a question we had earlier in terms of the surveillance. Part of the way we get risk factors is being able to monitor what is going on out there, and we heard a little bit about the National Violent Death Reporting System, that it is only in 18 States right now. I can tell you today that the CDC has awarded new grants to expand this from 18 to 32 States. But on top of that, there also now is an expansion to actually both CDC and NIH working with the Department of Defense and working with the Veterans Administration system to link their data sets or the data across their data sets. Now, why is this important? Ultimately, I am still looking, you know, for further information about risk factors, and if I can get more precise information from VA databases, if I

can get more information from the Department of Defense databases, for those individuals who have died from suicide, this is very helpful for us to plan the next series of strategies.

Ms. {Castor.} I represent the Tampa Bay area, and in Tampa we have the Haley VA Hospital. It is known as the busiest VA in the country and it is home to one of the five polytrauma centers, so we see the most severe cases of TBI and spinal cord injury, but I was there a couple of weeks ago talking to a veteran that had been deployed about three to four times and was from Fort Bragg and was a tough guy and was known as a leader, and he said to me, let me tell you my story, you know, I am a tough guy and I came back and I had my wonderful family and they are supportive and things were going all right, and then a couple of months later something just snapped, and he said I recommend that the VA system and all of you do a better job up front when folks come home, even if we say, oh, we are fine and we are okay, and they are physically healthy, to not just accept it, and I think the Congress has put a lot of resources into this but Dr. Lushniak, what can you tell us now about what the Federal

Government is doing? We have heard a good summary, but how it is really working? Oh, I am sorry. I mean Dr. Dvoskin.

Mr. {Dvoskin.} I think that the--I agree that the Federal Government could profit from better coordination of its efforts, and I also think the efforts needed to be targeted along the lines that you have heard today from my colleagues, but just to give you one example, access to care doesn't mean very much if you can't get to a psychiatrist or a psychologist, and there aren't nearly enough mental health professionals in the United States, not nearly enough. There are wonderful clinicians in the VA but there aren't enough of them. It takes 5 years to expand a residency program in psychiatry, and medical schools are loathe to go into the process, so we are automatically something we have done to ourselves 5 years behind the curve to increase the number of psychiatrists that are being trained at some of these wonderful medical schools, and you can't bill for a resident. You can't bill Medicaid for the services provided by a resident. Well, this is something we are doing to ourselves. There is no reason in the world for that rule, but it is something that we do.

So there is a lot of ways that the Federal Government could streamline existing programs, coordinate existing programs and add the kind of evidence-based practices that my colleagues have talked about today.

Mr. {Murphy.} Thank you. The gentlelady's time is expired. And now Dr. Gingrey is recognized for 5 minutes.

Dr. {Gingrey.} I thank Chairman Murphy, Dr. Murphy, for the hearing. This legislative hearing of course is extremely important and I commend him for his bill, H.R. 3717. I gave him the thumbs-up just a second ago that I absolutely want to be signed on as cosponsor of this legislation. It is a hugely important issue, and I thank him for that.

Let me, Dr. Moutier? Is that--

Dr. {Moutier.} Moutier.

Dr. {Gingrey.} Moutier. Yes. Let me ask you a few questions and then maybe the time remaining, the other panelists, the Surgeon General.

Dr. Moutier, in addition to the factor of age, ethnicity also plays a role in the incidence of suicides, why has there been a consistently high suicide rate for elderly white men relative to all other groups? Any information on that?

Dr. {Moutier.} Sure. I can speak to that while we also speak to the largest rise that we have seen in suicide rates perhaps ever, which is in middle-aged men actually, 35 to 64 years old. Over the last decade, their rates of suicide rose almost 50 percent. I would speak to a number of things including all the basic things that you have already heard about the prevalence rates of mental health problems and distress and what happens when we don't take proactive care of ourselves. I would cite the role of culture that we have had in particular segments of society and we think about military veteran, physician and first responder populations, what they all have in common is higher rates of suicide than the general population and a very tough macho sort of can't acknowledge being a human being type of culture.

Dr. {Gingrey.} Well, let me just interrupt you. Thank you for that, and I just intuitively think, you know, the pressures of life as you get a little older and the financial pressures are greater and maybe the children and the grandchildren didn't turn out quite the way you wanted them to and you get a little depressed, and so that leads--well, not a little depressed. That leads to my next question, and

if you would comment on the statistic that 90 percent of the people who commit suicide were previously diagnosed with mental illness. Is it known what percentage of these diagnoses are comprised of--well, would quality as a serious mental illness?

Dr. {Moutier.} That is a really good question, and it is actually that in greater than 90 percent of the cases of suicide that have been studied through this method of psychological autopsy had a diagnosable mental health condition. In most cases, they actually had not necessarily been diagnosed or treated. So that method is a little bit tricky.

Among those who had a diagnosable mental health condition, the majority of them it was substance abuse combined with a mood disorder. So depression is actually the most common mental illness represented in those studies but next comes substance abuse, substance abuse combining with depression and bipolar disorder and then other conditions like personality disorders and psychotic disorders. All to those are represented by the vast majority of that 90 percent is depression, substance abuse and other mood disorders.

Dr. {Gingrey.} Well, your response is why really I am so excited about Dr. Murphy's bill because it addresses a lot of those issues and gets right to the core of the problem.

Dr. Lushniak.

Admiral {Lushniak.} Lushniak, yeah.

Dr. {Gingrey.} Oh, what the heck. Dr. L, our Surgeon General, let me ask you this. Suicide among those who serve in our armed forces and among our veterans is a matter certainly of national concern. The 2012 National Strategy for Suicide Prevention identified the United States Air Force suicide program as a possible model for use in other settings including civilian. Are there particular evidence-based programs in use at either the Department of Veterans Affairs or the Department of Defense like the Air Force that you would recommend expanding to our civilian health care system as well?

Admiral {Lushniak.} Well, certainly there are multiple programs within the VA system, within the DOD, within Health and Human Services. I will provide one example. Although, you know, evaluation is always the difficult thing with any programs, but I will describe the Lifeline, the crisis call-

in line that exists out there. I mean, here is an example where last year in one year alone, a million calls come in to a Lifeline system. This is a call-in system that already-- and there is evidence saying that once people have called in, there are positive repercussions from that call-in.

So the reality is, we have systems built in all through, and the real question that ends up--and I will sort of go back to the Robin Williams tragedy recently, is the fact that there was another peak right after that tragedy of call-ins to that Lifeline, and it really does dovetail into, there are so many aspects to this, so many programs that exist right now, and I think right now, 2 years after the release of this strategy, we still are in the evaluation stage, along with the experts that are here at the table to come up with that final, you know, final set of recommendations, if you will, which is, what are we going to go with nationwide, what are we really going to push, because right now we have multiple pilots going on, and I think that we will be soon ripe for a time period where we can evaluate those programs and decide what really works, and it is going to be multiple answers. It is not going to be one--

Dr. {Gingrey.} General, or I should say Admiral, thank you so much. I realize my time--and thank you for your patience, Mr. Chairman, and I yield back.

Mr. {Murphy.} Thank you. I now recognize Mr. Tonko for 5 minutes.

Mr. {Tonko.} Thank you, Mr. Chair, and thank you to our witnesses. Many of you mentioned the impact that suicide has not only on the victim but the toll it takes on surrounding family, friends and community. I would venture to say that everyone in this room today has been personally affected by suicide at some point in his or her life. The numbers surrounding this epidemic are astounding. While we are in this hearing today, it is estimated that nine people across this country will complete suicide.

Dr. Moutier, just to ensure that everyone in this room and watching this hearing has access to accurate information, what actions should one take if they or someone they know is expressing risk signs for suicide?

Dr. {Moutier.} Sure. I think the first thing to say, which sounds very basic, but if it is somebody that you know and not yourself is to don't write it off, don't write off

that thing that you just observed to the stress of the day because we do a lot of that in our society. So I think just approaching the person in a caring, concerned way and engaging in a caring conversation just like you would normally. Mental health, we need to get all the, you know, mysterious sort of stigma out of it and just start having normal conversations that express caring, that say if you are in that kind of distress, I want to help you get the help that is going to get you back to your normal baseline way of being, that this is something that can happen to anyone of us. It is part of the human condition, so normalizing that.

If it is a matter of safety, then of course you have to act a little more urgently, and in that case, certainly local emergency departments are available. Also, the National Suicide Prevention Lifeline, 1-800-273-TALK is a number to call 24/7 for yourself or for somebody you are concerned about.

Mr. {Tonko.} Thank you. And Dr. Moutier, the Affordable Care Act in conjunction with the Mental Health Parity and Addiction Equity Act, all of those have strengthened insurance coverage for mental health benefits

for an estimated 60 million people, yet according to a recent New York Times story detailing experiences in Kentucky, many people are still having trouble accessing coverage due to an overwhelmed delivery system. Failure to access services in a timely fashion could be devastating for those contemplating suicide as you just indicated. What more do we need to do to ensure that there will be an adequate supply of providers to handle the mental health needs of our community?

Dr. {Moutier.} I think it starts with both improved training of the existing health care workforce as well as down the pipeline, the medical students and other disciplines who are coming up. People may be shocked to know that in only two States in our country is suicide education a small module on suicide even mandated for mental health clinicians who are in training. So we have so much work to do, and in some ways I would say that should give us hope because we can do that kind of thing. You have already heard that to expand the workforce of mental health clinicians is right now we sort of just tied our own hands behind our back. We are not able to do that when we can't even expand our residency training programs and other disciplines as well. So I think

there are a number of things that can be done from a policy standpoint that we should really take a hard look at that are creating the obstruction.

Mr. {Tonko.} Thank you very much.

Admiral Lushniak, in your testimony you refer to the recent World Health report on suicide. Does this report tell us where the United States stands in comparison to other nations in preventing suicides, and if so, are there lessons to be learned from other countries, other cultures that are doing a better job of preventing suicide?

Admiral {Lushniak.} Well, in terms of the lessons, where we stand, I will have to get back with you on that data set in terms of how we stand relative to other nations, but certainly when we look at what is going on in the world, right, we know that national-based programs tend to work, and it really goes back to what I have said earlier. We start off small but things that do work ultimately can be put at the national level. We mentioned examples of the United Kingdom, right, where there are access, for example, a 24-hour crisis line, assertive outreach for people with severe mental illness, written policies on follow-up for those

patients. Taiwan, I talked about a 63 percent reduction. We also have evidence that means reduction, right, the means of that suicide being reduced, and I will describe something that sounds very strange but in Australia, as a result of motor vehicle exhaust suicides, there was a link to changes in their carbon monoxide emission standards. So an engineering improvement, an air pollution improvement in fact led to a change, to a decrease in carbon monoxide poisonings. I think we have to look at the world and learn from those aspects, that in fact we haven't talked much about the means of suicide and we talked a little bit about safety, we talked about the idea, but across the board, if we are able to have some control of the means of that death by suicide, we can actually have impacts, and we see that from the international realm.

Mr. {Tonko.} Thank you. Some very interesting concepts, and with that, Mr. Chair, I yield back.

Mr. {Murphy.} The gentleman yields back. I now recognize Ms. Schakowsky for 5 minutes.

Ms. {Schakowsky.} You know, Dr. Moutier, I was concerned after Robin Williams' suicide that some people were

saying in their tributes to him, he is now finally at peace, that he is in a better place. I am glad to hear that there were more calls to suicide hotlines but were there more suicides?

Dr. {Moutier.} That won't be known for some time because of this problem with surveillance that you have been hearing about, so even when we ask the question, is the program working for preventing suicide, we are operating on the most recent data from the CDC, which is 2011. We are 3 years--

Ms. {Schakowsky.} I just think that--and you were talking about language before. I think when someone does take his or her own life that people should be encouraged to say if you are feeling suicidal, get help, you know, rather than oh, finally, you know, like sometimes we will say someone who has been suffering with cancer where they are finally out of their misery and in a better place. That is not applicable, I don't think, here.

The other thing, Dr. Brent, I know you focus on, or you have dealt with adolescents and young adults. I hope all of you actually will check out--I have a bill called the Mental

Health on Campus Improvement Act. A friend of mine, her son at Harvard committed suicide, just horribly tragic, and it has a public health component, a campus health component but also authorizes a grant program to give campuses more resources to address mental health, and I know the Association for University and College Counseling Centers directors have been very supportive of this legislation.

So Brent, are we doing enough in our educational institutions and on campuses?

Dr. {Brent.} Well, obviously I don't think we can ever we are doing enough, but I think that the Jed Foundation, which is a foundation focused on college suicide that is based in New York, has done a tremendous job with setting certain standards for what campuses ought to have in terms of availability of mental health and actually certifying campuses as having exemplary programs, and I believe there have even been some evaluations of these interventions that are--that have shown some beneficial effects.

Ms. {Schakowsky.} The Jet Foundation?

Dr. {Brent.} Jed, J-e-d. It is named for--Phil and Donna Satow, it is named for their son, who committed suicide

when he was at Arizona State University.

Ms. {Schakowsky.} Dr. Lushniak or Dr. Dvoskin, I wondered if you want to just comment on that.

Admiral {Lushniak.} Let me go back to sort of the first part of your question and the issue--and it is a flabbergasting issue and the issue of sort of how the media can portray can really affect the public perception of this, and we saw this come on as Robin Williams' suicide. We have goals within our national strategy, and two of them are very particular to this. Goal number two is implement research and foreign communication efforts, and goal number four is promote responsible media reporting, and this framework for successful messaging, it is an initiative designed to advance this national strategy of changing the public conversation about suicide and suicide prevention. The Alliance that I had mentioned, this National Action Alliance for Suicide Prevention, the private-public partnership, in fact has an institute that is now set up to provide journalists with crucial training to effectively communicate to the public about suicide and mental health.

I think there are two aspects to this from a public

health perspective, public health communication perspective, one of which is, we can't stigmatize the concepts of severe mental illness, mental health issues nor stigmatize a conversation about suicide. Long gone are the days that these are whispered in hallways--oh, did you hear what happened, this is terrible. We need to bring it front and center as a public health issue with scientific evidence that can solve that public health issue.

At the same time, we have to be able to work with the media, we have to work with public communications aspects of our society that don't portray suicide as an answer to a problem.

Ms. {Schakowsky.} Right.

Admiral {Lushniak.} That somehow it is successful, that somehow it is glorified. We really have to be able to still have that public perception that this is something that has innate and multiple factors associated with it, but it is preventable.

Ms. {Schakowsky.} Thank you.

Admiral {Lushniak.} I will follow up with one last imagery, and that is my daughter last night at dinner, and

she asked me Dad, what are you doing tomorrow. I said I was honored to be brought in front of this subcommittee. What are you talking about, Dad--a 17-year-old senior in high school--and I said I am talking about suicide prevention. Her answer was, it is not preventable, it just happens, and we have to change that. That is the daughter of the Acting Surgeon General. We had a long conversation afterwards.

Ms. {Schakowsky.} Doctor, I know Dr. Dvoskin wants to say something.

Mr. {Dvoskin.} I just wanted to add, in Vienna, Austria, they had a spate of suicides by people jumping in front of subway trains, and they were all on the front page above the fold of the two newspapers in Vienna. They were owned by families, and the two publishers got together and had a meeting that was occasioned by a social science researcher who said to them, you are making this worse because every time you publicize these suicides in this manner, the rate goes way up. They made a gentlepersons' agreement to stop doing it. They stopped putting the suicide reports on the front page, and the phenomenon stopped immediately. There is a study that is published--I will get

it to the chairman--

Ms. {Schakowsky.} I would be interested, because in Chicago area, we have had that problem with people jumping in front of trains. It has been in the--

Mr. {Dvoskin.} We had the same thing with mass homicide. They put the picture of the perpetrator three times the size of the anchor and it makes the perpetrators of mass homicide the most interesting, fascinating people in America, which is exactly what they wanted, and it makes it seem like a way to be cool and to matter and to no longer be, you know, depressed and sad and disconnected and feeling insignificant. All you got to do is kill a bunch of people, and the electronic media is making it worse.

Ms. {Schakowsky.} Get us the Hamburg study. I would like to see it. Thank you.

Mr. {Murphy.} I thank the members. I thank the panelists.

Just clarifying questions, Dr. Moutier and Dr. Brent. You said substance abuse, that increases risk. Any particular substances?

Dr. {Moutier.} It is across the board but certainly

alcohol would be the most common, and just to clarify, there are people with addictions who are at risk for suicide, and then there is the use of substances in the act of dying by suicide, and they are overlapping but sort of separate subsets, and in about half the cases of suicide, a substance was at play.

Mr. {Murphy.} Thank you. I just want to clarify too, in the study referred to as the Good Behavior Game that was referenced, my understanding is that the authors of that study said it did reduce suicide ideation but had no impact on suicide acts, but the idea that you are all bringing up is evidence-based is important.

Now, I want to end this with an important note and ask you each a simple question. Can we prevent suicide with proper intervention? Dr. Lushniak?

Admiral {Lushniak.} Without a doubt, sir.

Mr. {Murphy.} Dr. Brent?

Dr. {Brent.} Yes.

Mr. {Murphy.} Dr. Moutier?

Dr. {Moutier.} Absolutely, yes.

Mr. {Murphy.} Dr. Dvoskin?

Mr. {Dvoskin.} Yes.

Mr. {Murphy.} Does treatment work for people with mental illness? Dr. Lushniak?

Admiral {Lushniak.} Yes.

Mr. {Murphy.} Dr. Brent?

Dr. {Brent.} Some of the time, but it is better than no treatment.

Mr. {Murphy.} Dr. Moutier?

Dr. {Moutier.} Yes, and it needs to be the right treatment.

Mr. {Murphy.} Thank you. And Dr. Dvoskin?

Mr. {Dvoskin.} Yes.

Mr. {Murphy.} And that is important what you said. The proper treatment will work, and that is why we have to get people to access with the right trained professionals.

Now, one more time, Dr. Moutier, what is that phone number people can call?

Dr. {Brent.} 1-800-273-TALK, and that is the National Suicide Prevention Lifeline.

Mr. {Murphy.} And there are lifelines in people's communities as well they can look up.

I want to thank this committee. I know that we will be breaking here for the next weeks and Congress will not be here. This committee is exemplary. I continue to get comments around the Nation as I visit communities to talk about mental health. This is an issue that Congress has not been willing to take up at all, let alone in the depth, so this is exemplary, and my colleagues on both sides of the aisle share the passion for helping people in mental health crisis. I want to thank you all.

I also want to ask unanimous consent. Dr. Burgess asked if we can include articles, one from Health and Science, When Doctors Commit Suicide, It Is Often Hushed Up, and an article from the New York Times, why do doctors commit suicide. I would also like to submit for the record an article from the American Journal of Psychiatry, Modifying Resilience Mechanisms in High-Risk Individuals, a controlled study of mindfulness training in Marines preparing for deployment by Dr. Johnson, Potterat and others. Without objection, I will include those in the record.

[The information follows:]

This is a preliminary, unedited transcript. The statements within may be inaccurate, incomplete, or misattributed to the speaker. A link to the final, official transcript will be posted on the Committee's website as soon as it is available.

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Mr. {Murphy.} Let me also say, I unanimous consent that the members' opening statements be introduced in the record. Without objection, those will be there.

[The information follows:]

********** COMMITTEE INSERT **********

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Mr. {Murphy.} I would like to thank all the witnesses and members that participated in today's hearing. I remind members they have 10 business days to submit questions to the record, and I ask that all the witnesses agree to respond promptly to the questions.

Thank you so much for your dedication and passion, and with that, I adjourn this hearing.

[Whereupon, at 1:16 p.m., the Subcommittee was adjourned.]