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Dear Ms. Havens,

Thanks for the opportunity to provide backup material to support my testimony. Below please find the p. and line numbers and the citations that go with them. With regard to college interventions (p. 95), there have been programs developed, and good identification of barriers but not large scale test of a prevention program. Please let me know if I can provide any further clarification or be helpful as you and Congressman Murphy go about this very important work.

Best Regards,

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Attachment 1—Additional Questions for the Record

The Honorable Tim Murphy

1. The 2012 National Strategy identifies changing the tone of the current public conversation about suicide and suicide prevention as one of its priority areas for 2012-2014.

a. Is there any correlation between reductions in stigma surrounding mental illness and an actual reduction in suicides?

Stigma, according to Rusch et al. (2014), can take 3 forms: social discrimination, which leads to marginalization and social isolation, structural discrimination, such as difficulty accessing care or employment, and internalized stigma, in which the person with mental illness becomes demoralized and hopeless.¹ There is not a lot of research on the relationship between stigma and suicide.

However, at a population level, regions with lower levels of shame and self-stigma have lower suicide rates.² There is at least one study showing that higher internalized self-stigma is related to higher suicidal risk in schizophrenics.³ Furthermore, Professor Aaron Beck's group adapted cognitive therapy for low-functioning chronic schizophrenics to deal with their hopelessness that presumably was the result of internalized self-stigma, and in a small randomized clinical trial was able to demonstrate improvement in function relative to treatment as usual.^{4,5} In addition, stigma may be related to poorer adherence to treatment, which in turn could put a patient at greater risk for suicide.⁶

Of particular interest to your sub-committee may be the work of Link et al. (2008) that looked at the impact of court ordered outpatient treatment for patients with serious persistent mental illness and found that while court ordered treatment improved function, it also negatively affected at least one component of perceived stigma.⁷

b. In your view, what is the proper role of the federal government in changing the tone or national narratives involved in the public conversation, including combating the stigma surrounding serious mental illness?

Stigma is not unique to mental illness. In the 1950's, people mentioned that someone had cancer in a whisper, and we have seen transformations in people's attitude towards HIV/AIDS.

To deal with structural stigma, there are probably anti-discrimination laws that are already on the books that can be at least evaluated and properly enforced. In addition, provision of parity for coverage of mental illness is critical. Collaborative care, by co-locating mental health treatment embedded in primary care also reduces stigma and improves access. Patients with persistent and serious mental illness have a much greater burden of physical illness, so that the provision of integrated physical and mental health care for these patients is especially indicated.

To deal with social marginalization, education is key and part of the message has to be one of measured hope. Most people with mental illness can lead rewarding and productive lives and the treatments that we have, while imperfect (like the treatments for "physical" illnesses) can lead to significant improvement. The promotion of the understanding of mental disorder as biologically based illnesses

may help to reduce stigma and blaming of patients and families, as long as the view of the importance of social context on recovery is not lost. There is evidence that education about self-identification and identification of depression in others can actually reduce the suicide attempt rate in high schools, so education needs to take place for students, their parents, and professionals. Institutions that care for patients with mental illness need to create environments that are welcoming and professional. There are almost no mental health facilities that offer environments as bright, carefully designed, and welcoming as cancer centers for example. (There are exceptions like the Rachel Upjohn Depression Treatment Center at the University of Michigan). To some extent this is a vicious circle because donations for cancer treatment are easier to solicit than donations for mental health treatment. Research dollars for mental disorders also should have parity with physical disorders in order for progress to occur. The dollar allocation for disability and lives lost due to mental disorder is a small fraction of what has been allocated for cardiac disease or cancer. The new BRAIN initiative is a good step in this direction, as has been the Army STARRS study, which has been likened to the Framingham study for heart disease.

Finally, professionals who take care of patients with mental illness should be aware of the corrosive effects of internalized stigma, should assess for it, and use current therapeutic tools, like Beck's cognitive therapy and other forms of psychotherapy to help patients overcome a sense of helplessness and demoralization that leads to non-adherence, and is the end-product of internalized stigma.^{4,5}

2. In 2011, you published an article in the Journal of the American Academy of Child & Adolescent Psychiatry (JAACAP), "Preventing Youth Suicide: Time to Ask How," describing the bulk of research and program designs related to suicide as emphasizing risk factors and intervention rather than protective factors and prevention.

a. What would be the benefit of a transition by mental health specialists to the kind of outlook you described in the article?

The overall benefit of a protective/preventive focus is that there is overwhelming evidence that programs that enhance protective factors like parenting have long-term benefits on interpersonal, occupational, and educational outcomes. A focus primarily on symptoms is necessary to result in symptom relief, so this is not an either/or proposition. However, since the goal of mental health specialists should be to help their patients attain optimal function, some element of a focus on prevention and protective factors is necessary.

Every intervention has an element of prevention if the clinician takes a developmental and longitudinal view of the patient's outcome. For example, Chorpita and colleagues (2013) have developed a logical algorithm of sequential treatment that takes into account not just child symptoms, but family context as well and the outcomes are better using this system than with simply sequentially applying evidence-based treatments.^{8,9}

The goal is not simply to relieve symptoms but to restore function and allow the person to be able to capitalize on the "protective" elements in his or her environment that may come from friendships, participations in sports or other extracurricular activities, and academic and vocational achievement. There is good evidence for what is known as the "developmental cascade," which is an inter-play between psychopathology and social competence. For example, young children with disruptive

disorders often have difficulties in problem-solving and interpersonal competence.^{10,11} If the disruptive disorder is untreated, the social problems become worse, and eventually the only social group that that young person can belong to is one with strong antisocial tendencies. Therefore, for clinicians dealing with patients with a particular disorder, it is important to assess the social context that will help reinforce the patient's recovery: improvement in the parent-child relationship, including time spent together, warmth, appropriate social monitoring and discipline, facilitating a connection with school, and connecting to a peer group that will reinforce mental health. By tying treatment to academic, social, and vocational goals, rather than just symptom relief, treatment incorporates a preventive focus and will be more likely to promote recovery and prevent recurrences.

b. Do you have any recommendations for advancing programs with protective and preventive emphases?

At a policy level, we allocate too many resources to the downstream effects of illnesses, and not enough to either prevention of illness, or promotion of recovery. This is not only true for mental health, but the overall American health system. With regard to problems of disruptive disorders and substance abuse, there have been careful cost-benefit analyses that recommend allocating more resources to the primary or selective prevention of delinquency and substance abuse and fewer to incarceration, and more to the prevention of child maltreatment rather than to our massive child welfare system that tries to deal with the aftermath of child maltreatment.¹² Some prevention scientists have recommended the need for a central figure or body who would rationally allocate resources across juvenile justice, child welfare, and substance abuse prevention, with ongoing cost-benefit analyses to monitor if the projected cost-offsets actually come to fruition.¹³

We need to be looking at our overall mental health, child welfare, and substance abuse portfolios to make sure that we have a balanced allocation to evidence based treatments.

We need to train clinicians in evidence-based treatments that incorporate protective and preventive elements and provide cost incentives for keeping people well and functioning rather than based on the amount of treatment provided.

Finally, our research portfolio should focus on dissemination and implementation of evidence based preventive programs, and on the integration of preventive/protective elements into current, symptom-focused models of treatment.

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Attachment 2—Member Request for the Record

During the hearing, Members asked you to provide additional information for the record, and you indicated that you would provide that information. For your convenience, descriptions of the requested information are provided below.

The Honorable Tim Murphy

1. Please provide the Committee with any studies, reports, or data that you referenced during the hearing.

Congressional testimony Q&A references

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