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ONE HUNDRED THIRTEENTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON ENERGY AND COMMERCE
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October 6, 2014

Rear Admiral Boris Lushniak, M.D.
Acting Surgeon General
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Admiral Lushniak:

Thank you for appearing before the Subcommittee on Oversight and Investigations on Thursday, September 18, 2014, to testify at the hearing entitled "Suicide Prevention and Treatment: Helping Loved Ones in Mental Health Crisis."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

Also attached are Member requests made during the hearing. The format of your responses to these requests should follow the same format as your responses to the additional questions for the record.

To facilitate the printing of the hearing record, please respond to these questions and requests with a transmittal letter by the close of business on Monday, October 20, 2014. Your responses should be mailed to Brittany Havens, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to brittany.havens@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Tim Murphy
Chairman
Subcommittee on Oversight and Investigations

cc: Diana DeGette, Ranking Member, Subcommittee on Oversight and Investigations

Attachments

Attachment 1—Additional Questions for the Record

The Honorable Tim Murphy

1. What do you believe is the proper role for evidence-based psychotherapies in countering the public health crisis of suicide? Do you believe that a gap exists between the state of suicide prevention research and clinical practice?

2. While the efforts of the federal government over the past decade may have increased public awareness about suicide in general, would you agree that it is difficult to evaluate their effectiveness or understand their specific impact?

3. 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?

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

4. The 2012 National Strategy addresses suicide prevention surveillance, research, and evaluation activities as areas where improvement is needed.

    a. As a public health matter, why is the collection and integration of surveillance data so important – how does it help you do your job?

5. A stated goal of the Prioritized Research Agenda is to reduce suicides by 20% in five years and 40% in the next ten years, assuming all recommendations are fully implemented.

    a. How were these targets arrived at?

    b. In your view, how realistic are these targets, particularly in light of our record of performance until this time?

6. Will HHS commit to examining a list of recommendations for service system changes that reduced suicide in the UK, and report back to the Committee on whether the recommendations will be implemented? These recommendations can be found in: While D, Bickley H, Roscoe A, et al. Implementation of mental health service recommendations in England and Wales and suicide rates, 1997-2006: a cross-sectional and before-and-after observational study. *Lancet.* Mar 17 2012;379(9820):1005-1012.

7. In your view, what is the role of primary care clinicians in identifying and responding to suicidal patients? Do they have the training they need to respond effectively in a gatekeeping role and refer patients to a mental healthcare professional? If not, what do propose the Public Health Service do to correct this?

8. Are you concerned that there are not enough mental healthcare professionals to adequately treat the population at large? If so, as Acting Surgeon General, what do you recommend be done?

9. In your testimony you reference the "Good Behavior Game" and cite the Wilcox study which found that "Good Behavior Game" did not have a significant impact on the number of suicide attempts. And, the effects on suicidal ideation could not be replicated. Specifically, the Wilcox study says:

   "A GBG-associated reduced risk for suicide attempt was found, though in some covariate-adjusted models the effect was not statistically robust."

   "The impact of the GBG on suicide ideation and attempts was greatly reduced in the replication trial involving the second cohort."

   "In Cohort 1…those individuals assigned to the GBG intervention were half as likely to have experienced SI, as compared to those in the control classrooms." But, they could not replicate that in the second cohort: "In the Cohort 2 sample… approximately, 9% of those who had received the GBG intervention had experienced SI compared to 12% of those in the control classrooms, but the relative risk estimate did not reach statistical significance."

   In your testimony, however, you claim:

   "The testing and implementation of a first grade prevention program, the "Good Behavior Game" (GBG) supported by NIH and SAMHSA, was found to yield benefits not only in reducing aggressive behavior and substance abuse in youth, but also in reducing suicidal thoughts and attempts in young adults (Wilcox, et al., 2008)"

   Please provide additional information that supports your statement on the effectiveness of the "Good Behavior Game."

The Honorable Gene Green

1. One way to address this very serious issue of suicide in the population that is suffering from serious mental illness is to ensure access to all FDA-approved, proven treatment options.

   And especially treatment options supported by peer-reviewed published evidence that demonstrates efficacy in study populations with severe, chronic depression accompanied by high levels of suicide attempts, numerous unsuccessful treatments, and depression-related hospitalizations.

I'm aware of at least one option, Vagus Nerve Stimulation, that was FDA approved in 2005 for severe, chronic treatment-resistant depression and yet – nine years later - is not generally available because CMS denies coverage.

This lack of coverage continues despite published evidence from studies conducted by experts in the treatment of serious mental illness that show efficacy in patient populations exactly like the ones we are most concerned about.

These studies also show reductions in all-cause mortality and reductions in suicidality for patients treated with this treatment.

Dr. Lushniak, How can we have one branch of our government approving a treatment as "safe and effective" and another refusing access to the most vulnerable people experiencing debilitating, crippling, and even lethal, mental illness?

Attachment 2—Member Requests 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.