**Admiral Lushniak Responses to Energy and Commerce Subcommittee on Oversight and Investigations Questions for the Record pertaining to the hearing entitled, "Suicide Prevention and Treatment: Helping Loved Ones in Mental Health Crisis"**

**Chairman 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?**

**Answer:** Evidence-based psychotherapies have an important role in countering the public health crisis of suicide. Evidence-based psychotherapies are important both to target the underlying behavioral health conditions that are significant risk factors for suicide, such as depression and substance use disorders, as well as to target suicidal behavior directly.

A recent systematic evidence review generated by the Department of Health and Human Services' (HHS) Agency for Healthcare Research and Quality (AHRQ) Evidence Based Practice System (O'Connor et al., 2013) estimated that the effect for all adult psychotherapy trials reporting suicide attempts demonstrated a 32 percent reduction in suicide attempts (relative risk [RR] = 0.68, 95 percent CI, 0.56 to 0.83). Because the studies observed few deaths, the report could not assess whether or not psychotherapeutic interventions reduced the risk of suicide deaths. However, there were some additional benefits of psychotherapy beyond reducing suicide attempts that included a reduction in depression symptoms, and reductions in the use of emergency services and inpatient care.[1]

An example of one of the best-researched approaches is Dialectical Behavior Therapy (DBT) which has been shown in several randomized controlled trials to reduce suicidal behavior. The Substance Abuse and Mental Health Services Administration (SAMHSA) has promoted treatments such as DBT through the National Registry of Evidenced-based Programs and Practices and through webinars and podcasts. In addition, the SAMHSA-funded National Action Alliance for Suicide Prevention has identified the use of evidence-based treatments focused on suicide as one of the core components necessary for health care systems to prioritize suicide prevention.

At the same time, there is still a gap between the state of suicide-prevention research and practice. There are evidence-based approaches to suicide risk-assessment, management, and treatment, but recent data suggest that only slightly more than half (57.2 percent) of mental health programs are utilizing them (SAMHSA, N-MHSS Report, 2014).

[1] See http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0056019/.

**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?**

**Answer:** Over the past decade there have been efforts not only to increase public awareness of suicide, but also to train both the public and healthcare professionals to recognize the warning signs of suicide and actions to take in response. Evaluation of some of these efforts has made clear that they are having a positive impact, but their scope and magnitude have been insufficient to reduce suicide nationally. For example, an evaluation of the Garrett Lee Smith State and Tribal Youth Suicide Prevention grant program has shown that counties that implement grant-sponsored suicide-prevention activities have lower suicide rates than matched counties that do not implement such activities (Report to Congress 2013). However, this reduction in mortality is not maintained past the first year of the activities being implemented highlighting the importance of finding more effective ways of sustaining suicide prevention activities over time in both states and Indian Country. An evaluation of the SAMHSA-funded National Suicide Prevention Lifeline found that compared to the beginning of a hotline call, at the end callers express significantly reduced hopelessness, psychological pain, and intent to die (Gould et al 2013). While there are clearly examples of Federally-supported suicide-prevention efforts that have made a measurable impact, with funding to date, activities have been insufficient in scope and magnitude to reduce the national suicide rate.

**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?**

**Answer:** There are many components to stigma surrounding mental illness, including institutional stigma and self-stigma. Stigma is a prejudice that often results in discrimination. There are studies showing anti-stigma campaigns can be successful in changing attitudes and behavioral intentions toward those with mental illness (Corrigan et al., Psychiatric Services 2012). There is limited research on the effects of reducing self-stigma and whether that leads to lower risk of suicide. However, multilevel approaches using individual-level strategies, such as gatekeeper training, to complement a campaign using media as a tool to distribute information to a smaller, well-defined audience, has been used frequently in recent years, and some evaluations show promising results. A Germany-based awareness campaign focusing on depression has involved: physician training; an information and awareness campaign for the broad public (*e.g.*, movie spots, flyers); educational training for gatekeepers including teachers, priests, or geriatric care staff; as well as support of self-help-activities. There was a significant reduction in suicide attempts and suicide deaths combined following the program (Niederkrotenthaler, Reidenberg, Till, & Gould, 2014).

However, with regard to reduced institutional stigma, where it is operationalized as more equal coverage of mental health care compared to physical health insurance coverage, there are some important findings. Research in 2014 that examined the effect enactment of the Mental Health Parity and Addiction Equity Act found that state mental-health-parity laws were associated with

changes in state suicide rates, at least initially. Dr. Matthew Lang of Xavier University noted that "[t]he results show that mental health parity laws significantly decrease suicide rates when analyzed between 1990 and 2010. Suicide rates decrease significantly the year after the parity law is enacted, but return to pre-enactment levels in the following years. The findings suggest that access to mental health care can play an important role in mental health outcomes such as suicide."[2]

**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?**

**Answer:** On January 16, 2013, President Obama called for "a national conversation to increase understanding about mental health." Since then, private and public partners have conducted these community conversations across the country. Over 151 conversations in more than 30 states have occurred to discuss youth and mental illness.

From Maine to Florida and across to California and Oregon, HHS has engaged parents, peers, teachers, business leaders and policy makers to address and reduce negative attitudes towards mental health disorders, to educate them about recognizing the signs of a potential problem, and to enhance access to treatment for those in need. HHS has been working to ensure that the country engages in frank, open conversations that will bring mental illness out of the shadows and into the light.

The national dialogue on mental health has specifically focused on the social barriers preventing individuals from getting the help they need for mental health issues. These barriers include negative perceptions of individuals with mental illness, shame and fear that may prevent people from reaching out for assistance, and the lack of awareness and understanding that mental illnesses are treatable and that people can and do recover.

This dialogue is a joint effort of groups from many sectors of society – including colleges and universities, high schools, health care providers, the faith community, and civic organizations – all working together to reduce the social barriers that create obstacles to obtaining the treatment necessary to help people gain resilience and recover.

The dialogues have promoted understanding of the importance of mental health in the positive development of children, and prevent, recognize, get treatment for, and cope with mental illness and other behavioral health issues that impact our Nation's youth.

In addition, HHS has supported efforts initiated by the Action Alliance for Suicide Prevention to help change the public conversation around suicide. The Action Alliance is working to leverage the media and national leaders to change the national narratives around suicide and suicide prevention to ones that promote hope, connectedness, social support, resilience, treatment and recovery. This initiative aims to transform attitudes and behaviors relating to suicide and suicide prevention. Messages that promote hope, connectedness, social support, resilience, treatment and recovery have the potential to change the course for those who are struggling with thoughts

[2] Lang, 2014, pp. 131-137, www.suicide-research-agenda.org.

of suicide. This effort promotes stories of those who have struggled, yet were resilient, found help or treatment, and established a stronger will to go on living. It also promotes the cultural norm of providing social support and connectedness for vulnerable individuals struggling with thoughts of suicide.

**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?**

**Answer:** Public health surveillance may be defined as the collection of information that is used for action and is needed at the national, state, and local (community) levels. According to the Institute of Medicine's report, *Reducing the Burden of Injury*, surveillance serves at least four practical uses. First, surveillance describes the magnitude of a health problem relative to other health conditions. Thus surveillance data may direct the priorities for areas in greatest need of attention. Second, surveillance is used to monitor trends in specific areas of injury. Third, surveillance is used to identify new problems. For example, a new at-risk population is identified or a new mechanism being used. Fourth, surveillance is used as one way to evaluate injury prevention or intervention efforts (IOM, 1999). For example, surveillance has shown that the time after discharge from inpatient units and emergency rooms is a time of high risk for suicide (Valenstein et al, 2009), that alcohol is frequently involved in suicide deaths and attempts (Conner et al, 2014), and that American Indian/Alaska Native youth are at heightened risk of suicide.[3] The Action Alliance has emphasized the importance of surveillance within healthcare systems, with findings to be used to improve the quality of care.

**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?**

**Answer:** The Research Prioritization Task Force (RPTF) developed its agenda for research with the stated goal to reduce morbidity (attempts) and mortality (deaths), each by at least 20 percent in five years and by 40 percent or greater in 10 years, if implemented fully and successfully. This approach is consistent with the Action Alliance goal to save 20,000 lives in five years. Asking Action Alliance members, and the RPTF stakeholders in suicide research, to consider these aspirational targets in their efforts has never been tried at a national level before. While such reductions are ambitious, the intent of these targets is to inspire new ways of thinking of how the many suicide prevention efforts can all be a part of the solution. A research document alone cannot reduce suicide deaths or attempts; rather, its intent is to identify the research needed

[3] See http://www.cdc.gov/ncipc/pub-res/American_Indian_Injury_Atlas/11d-Allmaps-suicide.htm.

to guide practice and inform policy decisions across many areas—for example, health care, criminal justice, education, and social media—which will cumulatively contribute to the 20-percent and 40-percent reduction goals.[4] Of course, full and successful implementation requires the necessary private and public resources to undertake the research and bring the science to service sectors.

**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 20 12;379(9820): I 005-1012.**

**Answer:** These recommendations were carefully reviewed by SAMHSA, NIMH, and other public and private partners and many were incorporated into the National Strategy for Suicide Prevention (NSSP, p. 51). The components of systematic integration of suicide prevention into the delivery of mental health services are summarized in Goal 8 (Promote suicide prevention as a core component of healthcare services) and Goal 9 (Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors) of the National Strategy for Suicide Prevention. These goals have now been incorporated as a requirement in SAMHSA's suicide prevention grant portfolio and a learning collaborative has been established to promote implementation in states and healthcare systems. It should also be noted that one of the recommendations in the UK study that had the strongest relationship to reduced suicide deaths is the availability of 24 hour crisis teams. In section 223 of the Protecting Access to Medicare Act, which was enacted earlier this year, 24-hour crisis teams were included as a service of the Certified Community Behavioral Health Clinics to be established by the legislation. HHS is actively engaged in the implementation of this program.

**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?**

**Answer:** Primary care physicians have a vital role to play in suicide prevention. In a major study of health plan members who died by suicide, nearly all received healthcare in the year prior to their death, but half did not have a mental health diagnosis, indicating that underlying risk factors for suicide such as depression, anxiety, or substance use disorders were not recognized and treated (Ahmedani et al, 2013). Unfortunately, many physicians and other healthcare professionals, including behavioral healthcare professionals, have never been trained in screening and assessing for suicide risk.

[4] See *A Prioritized Research Agenda for Suicide Prevention*, 2014, www.suicide-research-agenda.org, at p. 7.

The Department of Veterans Affairs has focused major efforts in training primary care physicians in suicide prevention, as well as integrating screening, suicide-risk evaluation, and collaborative treatment into care.

Tools for use in primary care have been developed and disseminated by the SAMHSA-funded Suicide Prevention Resource Center. In addition, the Center for Integrated Health Solutions (CIHS), on which SAMHSA partners with the Health Resources and Services Administration (HRSA), promotes the development of integrated primary and behavioral health services to better address the needs of individuals with mental health and substance use conditions, whether seen in behavioral health or primary care provider settings.

**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?**

**Answer:** The behavioral health workforce functions in a wide range of prevention, healthcare and social service settings. They include public and private prevention programs, community-based and inpatient treatment programs, primary care health delivery offices, systems and hospitals, emergency rooms, communities, and the housing, criminal justice, research and education fields, including elementary or secondary schools or higher education institutions.

This workforce includes, but is not limited to: psychiatrists and other physicians, counselors, psychologists, social workers, advanced practice psychiatric nurses, marriage and family therapists, certified prevention specialists, addiction and substance use disorder counselors, mental health counselors, psychiatric rehabilitation specialists, psychiatric aides and technicians, paraprofessionals in psychiatric rehabilitation and addiction recovery fields (such as case managers, homeless outreach specialists, parent aides, etc.), and peer support specialists and recovery coaches, as well as school psychologists and school counselors

Recognizing mental health professionals' and paraprofessionals' needs across the United States, in Fiscal Year (FY) 2014, the President proposed and the Congress appropriated approximately $40 million in new funding to SAMHSA to help train additional professionals to work with students and young adults with mental illnesses and other behavioral health problems. SAMHSA is collaborating with HRSA on the Behavioral Health Workforce Education and Training grant program which received $35 million in FY 2014. The purpose of this program is to increase the clinical service capacity of the behavioral health workforce by supporting training for Master's level social workers, psychologists, marriage and family therapists, psychology doctoral interns, as well as behavioral health paraprofessionals. In FY 2014, the grant program provided approximately 111 awards to organizations nationwide and SAMHSA's FY 2015 budget request includes $35 million in continued funding to maintain this effort. This program would help increase the behavioral health workforce by 3,500 individuals trained per year. SAMHSA also was able to expand its Minority Fellowship Program (MFP) in FY 2014 due to an increase of $5 million which allowed for the creation of the MFP-Youth program that expanded the current MFP program to support master's level trained behavioral health providers in the fields of psychology, social work, professional counseling, marriage and family therapy and

nursing. SAMHSA provided grants to five organizations to reduce health disparities and improve behavioral health outcomes for racially and ethnically diverse populations. In addition, with the increased funding SAMHSA provided grants to two organizations to expand the focus of the current MFP program to support Master's level addiction counselors as requested by the Congress.

To support an ongoing focus and discussion on addressing these challenges, SAMHSA is planning the development of regionally-based workforce workgroups to allow states and stakeholders to share strategies for enhancing, developing and financing the behavioral health workforce. These workgroups will allow for the dissemination of information, state-to-state sharing, and linkages to resources between federal, state, tribal and local partners. To address the challenges in recruiting, training, and retaining a diverse behavioral health workforce, SAMHSA has funded a number of programs, initiatives, and technical assistance centers.

The behavioral health workforce is one of the fastest growing workforces in the country. Employment projections for 2020 based on the U.S. Bureau of Labor Statistics show a rise in employment for Substance Abuse and Mental Health Counselors with a 36.3 percent increase from 2010 to 2020—greater than the 11 percent projected average for all occupations.

**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 I ... 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."**

**Answer:** In the research article itself, Figure 4. illustrates the lower probability of attempts among the Cohort 1 youth exposed to the Good Behavior Game (GBG; Wilcox et al., 2008, p. S66). Table 3 shows the odds ratios for the impact of GBG- across various models ranging from 0.3 to 0.6. This translates to a reduction of one third, to two thirds the number of attempts among youth exposed to the GBG, compared to the youth in the control condition.

With regard to the question about the findings for Cohort 2, (p. S69), the difference in prevention effects between cohorts was attributed to Cohort 2 having less consistent training and monitoring for teachers, that, in turn likely reduced the potency of the intervention. In addition, there was more variability in the Cohort 2 control conditions. It is not unusual for interventions, when moved out to the field, to have less precision, and therefore less impact. Researchers in the prevention field are fully aware of this, and there are efforts to build in support for sufficient implementation of proven programs.[5]

[5] For example, see http://www.colorado.edu/cspv/blueprints/.

**The Honorable Gene Green**

**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?**

**Answer:** HHS shares your commitment to ensuring access to services for persons with serious mental illnesses including treatment-resistant depression. We are also committed to providing timely access to new technology that meets the statutory criteria for coverage under Medicare.

Medicare's National Coverage Determination (NCD) on Vagus Nerve Stimulation (VNS) for treatment of resistant depression is currently the subject of a Departmental Appeals Board (DAB) review within HHS. The ongoing litigation precludes us from discussing the VNS coverage policy in detail. However, the policy and its rationale are described in the NCD Decision Memorandum.[6]

[6] Available at: http://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=195&bc=AiAAAAAAAgAAAA%3d%3d&