



AMERICAN FOUNDATION FOR Suicide Prevention

October 17, 2014

The Honorable Tim Murphy
Chairman, Subcommittee on Oversight and Investigations
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515-6115

Dear Dr. Murphy,

Thank you very much for the opportunity to testify before the Subcommittee on Oversight and Investigations on September 18, 2014 for the hearing entitled "Suicide Prevention and Treatment: Helping Loved Ones in Mental Health Crisis." In response to your letter of October 6, 2014 and questions regarding my testimony, enclosed please find my replies to each of your questions.

Please don't hesitate to let me know if you or any of the Subcommittee Members have any further questions or concerns which I may address.

Sincerely yours,

Christine Moutier, MD
Chief Medical Officer

Dr. Christine Moutier's Replies to Questions by 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?

While there are methodological challenges to studying the impact of stigma reduction on suicide reduction, there is very strong evidence that stigma reduction for both mental illness and help seeking correlates with reducing suicides. The methodological challenges for research in this area include the following: stigma reduction as an isolated factor is very difficult to study in population-based studies because programs that include stigma reduction also tend to include a number of other potentially important prevention tactics; suicide prevention research has the challenge of needing large populations followed over years in order to have the statistical power to detect statistically significant changes in suicide rates. Therefore in order to link suicide reduction to stigma reduction, there are alternate methods to link the two through research, which I will outline here.

Using the transitive property to link stigma reduction to suicide reduction:

There is very strong evidence that improvements in knowledge, beliefs and attitudes toward mental illness and treatment, lead to greater help seeking, increased and improved proactive preventive illness management and crisis prevention (Stafford 2013, Garcia-Soriano 2014). There is also moderately strong evidence that key protective factors in one's suicide risk are access to care and receiving effective mental health treatment, and ongoing communication and support from a healthcare provider (Nock 2013). Therefore with **professional mental healthcare help seeking as the intermediary link**, there is reason to believe that reducing stigma leads to increased help seeking, which in turn lowers suicide rates. Other important by-products of stigma reduction include improved self-care and illness management, and the ability to obtain family and community support when an individual is open, aware and communicating about his/her mental illness.

Stigma reduction as a core tenant of effective suicide prevention strategy:

Prevention programs that have demonstrated impact on suicide rates or proxies such as suicidal behavior include stigma reduction. For example, in the US Air Force suicide prevention program, stigma reduction was a prominent theme in many of its 11 tactics. From 1996 through 2002, a 33% reduction in suicides was accomplished (Knox 2003). By reducing stigma and raising awareness among all levels of the force, this program took an early population-based intervention approach and taught members how to intervene at the first signs of distress or dysfunction, possibly long before the risk of suicide was imminent; while also recognizing more critical acute signs of suicide risk. Stigma was addressed in the leadership, throughout the ranks, and was also given the backing of policy changes that protected the privacy and professional reputation of those who were referred for help. (Knox 2003) In this approach, stigma reduction is a prominent and central tenant around which many educational efforts, policy change, individual and group behavior is shaped in order to become a safety net to recognize suicide risk and prevent suicides. This is very similar to the approach toward suicide prevention in a physician population I co-led at the University of California, San Diego School of Medicine (Moutier 2012), which I'm delighted to say is still going strong.

Studies of stigma and suicide rates in different geographical regions:

Methodologically less rigorous than prospective study design, are the retrospective and cross sectional analyses that look for associations between factors. By using a statistical approach called multiple logistic regression analysis, the odds that particular factors relate to each other can be calculated. In a Dutch study of stigma and help seeking, Reynders et al compared various regions of high and low suicide rates within the Netherlands, and found that in regions with low suicide rates, people have more positive attitudes toward help seeking and experience less self stigma and shame about mental health problems. Conversely, in the region with a higher suicide rate, sense of stigma and shame about mental health problems were much higher, and help seeking lower. They also found that stigma was strongly inversely correlated with help seeking—so the higher the stigmatized beliefs, the lower the likelihood of seeking help. The authors conclude that the promotion of positive attitudes and knowledge about mental health issues has a critical role to play in suicide prevention (Reynders 2014).

- 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?

There are a variety of ways the federal government could take a leadership role in the public conversation to combat stigma surrounding mental illness.

Public education as a way to combat stigma:

In my testimony I referred to the serious problem of mental health illiteracy in our nation, which prevents individuals and families from treating mental health problems in a similar fashion they would for any other kind of health issue. Until the awareness of mental illness is improved, Americans will continue to make decisions under a cloak of ignorance that leads to poor recognition of the roots of one's disability, misunderstanding of mental illness as character weakness, and denial of the existence of mental illness in 1 in 4 Americans. The government can help provide citizens with a basic understanding of mental health along its full continuum, which includes the ability to optimize mental health, prevent crises and some mental health problems, and recognize and seek treatment for serious mental illness. This could be accomplished through public health education strategies such as PSAs, mental health literacy campaigns, and the use of trained peer health educators in order to bridge cultural barriers in particular racial, cultural, occupational, and geographical communities.

Funding of research to reduce stigma:

While many aspects of suicide risk have been established through the research field, the areas that need further clarification include the identification of suicide risk in the near term, the use of screening, protective factors, effective prevention strategies, and we need more suicide reduction-specific interventions for people at risk. If support for research in these areas were increased in the coming decade, the advances that would come from these discoveries would combat stigma. When science elucidated the causes and treatments for other major public health problems such as cancer and HIV Disease, then the facts based in science enlightened lay understanding, addressing fear of the unknown and leading individuals' and families' choices to be based in facts. People can then make healthy choices about everything from diet, exercise, sleep, stress management, substance use, and sexual practices, to treatment, which can all impact the prognosis of disease. But without a solid critical mass of knowledge based in research, public understanding to combat stigma is compromised.

Legislative and policy measures that improve awareness and access to appropriate care:

A number of key changes would lead to improvement in connecting those at risk for suicide with appropriate interventions and support. These include:

- Mandated education, such as Mental Health First Aid, for citizens in key frontline roles- such as teachers, law enforcement, healthcare professionals, and clergy- so that those at risk can be identified, supported, and referred to mental health professional help.
- Increased number of mental healthcare professionals in the workforce
- Improved suicide prevention training of mental healthcare professionals (including psychiatrists, psychologists, social workers, therapists, and psychiatric nurses)
- Improved suicide prevention training of primary care and emergency medicine (ER) professionals (again, including physicians, nurses, nurse practitioners, social workers, and physician assistants)
- Full implementation and enforcement of the intent of the MHPAEA Parity Act for mental health conditions on par with other disorders
- Surveillance of the data for suicide must improve, in terms of timeliness and accuracy, for effective approaches to be identified. Expansion of the NVDRS to all 50 states is imperative. This would combat stigma because the true cause and effect change would highlight the problem as addressable.

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2. 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 the targets arrived at?

The Research Prioritization Task Force of the National Action Alliance for Suicide Prevention worked together over a period of three years to consider the evidence for effective prevention strategies, particularly with the concept of *burden* of the problem in mind. This means that the total number of suicides in the U.S. was broken down into categories of demographic, occupational, means, and situational opportunity in order to determine the most impactful strategies that could drive down the rate of suicide. For example, referencing Figure 1 of the Research Prioritization report, with 17,000 of the 38,000 people who died by suicide in 2010 visiting a healthcare provider within the month before their death, this presents an opportunity for detection and intervention for those at risk if research could shine a light on the way to accomplish that. If a certain percentage of these deaths could be prevented through accurate identification and intervention, then this would represent one portion of the reduction in the overall goal. The Research Prioritization Task Force organized the key questions that research must answer in order to accomplish the goal.

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

At the American Foundation for Suicide Prevention, we have similarly set an overarching goal for reducing the national rate of suicide; ours is a goal of 20% reduction by 2025. So we do believe it can be accomplished. But not by continuing the status quo approach, since suicide rates have indeed been rising steadily over the past decade. It will require a strategic approach in which public and private groups come together to address the critical questions that remain unstudied or unanswered and represent gaps in necessary knowledge (such as the identification of individuals who are at near term suicide risk), and implement programs in key areas of society to produce the critical changes necessary to drive down the rate of suicide.

The key approaches to ensuring the success of the goal of reducing the national rate of suicide include:

1. Increase federal funding of suicide prevention research- As the largest private funder of suicide prevention research, AFSP urges members of congress to prioritize an appropriate amount of funding toward research on suicide, commensurate to its morbidity and mortality toll. If the level of funding toward suicide research increases significantly, we can expect to see a similar reduction in mortality, just as with other major public health problems like heart disease, HIV/AIDS, prostate, breast, and colorectal cancer. When the government invested \$12 billion in HIV research from 2009-2012, HIV-related deaths declined by 42% from 2000-2011. Today our government only spends \$40 million in direct suicide prevention research (see Addendum A, AFSP Research Funding and Mortality Rates).
2. The healthcare field- We need improved access to care, coordination of care, and more and better trained healthcare providers, specifically educated with an eye toward suicide prevention. Thinking of the *burden* concept again, if we change the systems of care in Emergency Departments and Primary Care settings to be effectively equipped for identifying and treating suicidal people, suicides will be prevented. Most people who go on to die by suicide are seen in health care settings in the period of time prior to death (Luoma 2002). Currently our healthcare system is generally not equipped to effectively care for people at risk for suicide. Additionally the U.S. needs more mental health specialists who are trained in suicide prevention. For those at risk individuals who do receive a referral to a mental health professional, we need to improve the quality of specialty care they receive by ensuring that mental health professionals are appropriately trained in suicide prevention.
3. Frontline citizens- By training teachers, first responders, healthcare providers and clergy- any citizens in frontline roles who have contact with the most people in our communities- these citizens can become a safety net, similar to the concept of the widespread knowledge of CPR or infection control measures as safety nets for other health conditions which can lead to death (Kitchener 2002).
4. The media- The media can play a powerful role in suicide prevention by delivering the news and public service education about suicide, framed in a public health and prevention framework, and always including the fact that help is available to change a person's state of desperation (Niederkrötenhaler 2014).
5. Crisis lines- There is a clear role for crisis lines in suicide prevention. When the number of crisis calls goes up, it generally indicates a greater proportion of those who are struggling reaching out and getting connected to help (Draper 2007). One study following the suicide death of Kurt Cobain found that the number of suicide deaths were lower than expected for that region and time of year, and it is hypothesized that the reduced number of suicides was linked to the great increase in crisis calls and community mental health clinic visits that followed Cobain's death and positive messaging for help seeking (Jobes 1996).
6. Legislative changes- By backing these efforts with the appropriate legislative changes, we will ensure that healthcare professionals, frontline citizens and systems are equipped, that people who seek help are not inappropriately or punitively treated in work places or

academic settings, and that healthcare is covered for the health conditions that drive suicidal behavior.

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