



**American
Foundation
for Suicide
Prevention**

**Statement
Of
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submitted to
House Energy and Commerce Subcommittee on
Communications and Technology
regarding H.R 2345
The National Suicide Prevention Hotline
Improvement Act of 2017**

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Chairman Blackburn, Ranking Member Doyle, and members of the Subcommittee, thank you for inviting the American Foundation for Suicide Prevention (AFSP) to testify today on H.R. 2345, “The National Suicide Prevention Hotline Improvement Act of 2017.” I am Dr. Christine Moutier and I am AFSP’s Chief Medical Officer. Many thanks to Representatives Chris Stewart (R-UT) and Eddie Bernice Johnson (D-TX) for their leadership on this important legislation.

I became the Chief Medical Officer for the American Foundation for Suicide Prevention in the fall of 2013. Previously, I was at the University of California, San Diego (UCSD) School of Medicine, where I was a Professor of Psychiatry and served as Assistant Dean for Student Affairs and Medical Education. I maintained an active outpatient and inpatient clinical practice through the UCSD Medical Group, the VA Healthcare System, and UPAC (Union of Pan Asian Communities), a community mental health clinic for the Asian refugee population. I worked with both high functioning people with mood and anxiety disorders, as well as with more severely ill people with chronic mental illness, continuously throughout my academic career.

I am a suicide prevention expert who has experienced the issue in a 360-degree manner with family members who struggle, colleagues who have died by suicide, suicidal patients and medical trainees, and whose research focused on optimizing treatment of depression and anxiety, and addressing burnout and mental health distress of physicians and trainees. I have developed and co-led a suicide prevention program for physicians and other health professionals at the University of California, San Diego School of Medicine. I have been fortunate to help advise national change currently underfoot related to health professionals' burnout, resilience and suicide prevention.

All of this has led me to a holistic way of integrating the body of clinical and suicide research into a framework that approaches mental health and suicide prevention along its fullest continuum. I believe that many effective suicide prevention efforts not only save lives, but reach individuals where they are anywhere along the continuum of human experience, and therefore suicide prevention initiatives may have the added benefit of elevating coping, mental health, and resilience for many more.

The American Foundation for Suicide Prevention (AFSP)

Established in 1987, AFSP is a voluntary health organization that gives those affected by suicide a nationwide community empowered by research, education and advocacy to take action against this leading cause of death.

AFSP is dedicated to saving lives and bringing hope to those affected by suicide. AFSP creates a culture that is smart about mental health by engaging in the following core strategies:

- Funding scientific research,
- Educating the public about mental health and suicide prevention,
- Advocating for public policies in mental health and suicide prevention,
- Supporting survivors of suicide loss and those affected by suicide in our mission.

Scope of the Problem of Suicide

My message today about suicide is hopeful and actionable. It is worth emphasizing the scope of suicide's impact: in recent years suicide has taken more lives than war, murder, and natural disasters combined. The suicide rate in the U.S. continues to climb, with the most recent CDC

data revealing 44,965 deaths in 2016, and occupational loss and direct healthcare costs estimated to be more than \$69 billion annually. Suicide is one of the leading, yet largely preventable causes of death in our country. Here are some facts:

- Suicide is now the 10th leading cause of death in adults age 18-64,
- For every suicide, there are 25 attempts,
- The annual age-adjusted suicide rate is 13.42 per 100,000 individuals,
- After adjusting for differences in age and sex, risk for suicide is 19% higher for male Veterans, than U.S. non-Veteran male adults,
- Risk for suicide is 2.5 times higher among female Veterans, when compared to U.S. non-Veteran women,
- Men die by suicide 3.53 x more than women,
- White males accounted for 7 of 10 deaths in 2016.

The AFSP Public Policy Team has provided each of the members of the Subcommittee with a copy of your particular “Suicide Facts” in your home state. These infographics, based on data from 2016, highlight the suicide situation back home for each of you.

Causes of Suicide

Suicide is often the result of unrecognized and untreated mental illness. In more than 120 studies of series of completed suicides, at least 90% of the individuals involved were suffering from a mental illness at the time of their deaths. When 1 in 4 Americans have a diagnosable mental illness, but only 1 in 5 of them are seeking professional help for that condition, we have a lot of

work to do in mental health literacy, elevating the general lay understanding of how mental health problems are experienced or look like in a loved one or co-worker and toward destigmatizing help-seeking when you detect a change in your own or a loved one's mental health. Just like you would be proactive about any other aspect of your health such as your heart or kidneys.

Mental illness is the necessary, but not sufficient, risk factor for suicide in most cases, since most people with mental illness thankfully do not die by suicide. Mental illnesses such as depression, bipolar disorder and alcohol and drug dependence, Post-Traumatic Stress (PTS) and Traumatic Brain Injury (TBI) may create the underlying risk that when combined with life stressors such as transition from military life, job loss, relationship issues and financial or legal problems and a recipe for increased suicide risk can occur. Other important risk factors include social isolation, biological factors like aggression and impulsivity, childhood abuse, a history of past suicide attempt, serious medical problems, and a family history of suicide.

Suicide risk tends to be highest when multiple risk factors or precipitating events occur in an individual with a mental illness. The most important interventions we can start with are recognizing and effectively treating these disorders. On a population level, we can implement more upstream approaches such as shoring up community, mentorship and peer support, teaching students how to problem solve and process stress, make access to mental health care available and non-stigmatized, train frontline citizens like teachers, first responders, and clinicians, and limit access to lethal means.

The good news is 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 attempt, the fight against suicide is nearing a tipping point. To answer this call to action, AFSP has evolved a three-point strategy that covers Research, Prevention, and Support, and if we push now, we hope to reduce the annual suicide rate 20% by 2025.

Key Policy Areas for Addressing Suicide

I believe we need to focus on three key policy areas to prevent suicide that include:

- Suicide prevention research;
- Suicide prevention programs; and,
- Programs and strategies that provide more support to those touched by suicide.

I am here today to talk about why H.R. 2345 could be a game-changer for our national public safety net.

A vote for H.R. 2345 would allow the FCC and our federal suicide prevention authorities to fully understand how a three-digit code (such as 411 or 611) could enable rapid access to life-saving assistance for persons in emotional and suicidal crisis, while also diverting many individuals in crisis from the unnecessary use of precious 911 emergency services. This legislation will study the effectiveness of the current National Suicide Prevention Lifeline (1-800-273-TALK), and how well it addresses the needs of veterans. We should also look at how the current system in addressing the needs of Alaskan Natives and American Indians, along with our LGBTQ youth.

H.R. 2345 would also provide cost estimates and resource needs for supporting phone hotline, chat and text.

Here are some important facts –

- A national, single point of access—free, anonymous and toll-free for all American residents—is necessary to provide a public health safety net for all persons in the United States experiencing emotional distress and/or suicidal crisis. With approximately 2/3 of persons with diagnosable mental health problems not currently accessing mental health providers, suicide rates and deaths related to substance misuse (including opioids) on the rise, it is essential that we provide immediate access to help for people in crisis when, where and how they need it.
- The experience of the SAMHSA’s National Suicide Prevention Lifeline (800-273-8255) indicates that a national hotline number has been essential for addressing this public health crisis. Lifeline call volume has increased significantly every year since its launch in 2005, serving more than 11 million callers. In 2017, the Lifeline’s national network of 160 local crisis centers answered over 2 million calls. According to independent evaluators of the service, approximately 25% of these callers present with suicidal crises, with the remaining 75% reporting a non-suicidal, mental health or substance related problem (Gould et al, 2012). Because VA also utilizes the Lifeline number as a single point of access to provide a special VA-funded service for U.S. veterans and members of military since 2007, the Lifeline network and the Veterans Crisis Line together have assisted millions of veterans and service members in crisis. Approximately 1 of 3 callers to the Lifeline presses 1 for this special service for veterans and members of military service.

- This national point of access works in reducing emotional distress and suicidality. SAMHSA-funded evaluations of Lifeline crisis center work have consistently demonstrated that the service is reducing emotional distress and suicidality for persons engaging the service.
- In a study of 1085 suicidal callers evaluated at beginning and end of call—and then 3 weeks later—significant reductions in suicidality, psychic pain and hopelessness by end of call and 3 weeks later. Upon follow-up, 12% of suicidal callers spontaneously offered that the call prevented him/her from killing or harming self. (Gould et al, 2007)
- In another study, 1617 non-suicidal crisis callers evaluated at beginning and end of call—and three weeks later. Significant reductions in confusion, anger, anxiety, helplessness and hopelessness by end of the call, and more so 3 weeks later. (Kalafat et al, 2007)
- With more than 12 million persons in the U.S. having suicidal thoughts annually, providing more ready access to this effective, lifesaving service could be beneficial. Service currently serving about half-a-million suicidal callers (25% of 2m callers).
- As more people access the single number for mental health and suicidal crises, the need to enhance infrastructure capacity becomes essential. As the Lifeline call volume has grown 60% in the past year alone, capacity has become strained. While about 85% of callers are being answered in about 30 seconds, more than 1 in 10 callers are averaging waits of over 2 minutes as they roll over to national back-up centers. This is because local centers are under-funded and under-resourced to manage the growing number of calls.
- It is quite possible that a separate 3-digit number for mental health/suicidal crises would significantly reduce burdens on the 911 system, reducing unnecessary use of emergency services nationally. Lifeline standards, trainings and practices of its national network of

local call centers is designed to effectively de-escalate persons in suicidal crises, reduce risk for callers in crisis and ensure that they receive the most appropriate, least invasive care that supports their health, safety and well-being. SAMHSA-funded evaluations indicate that Lifeline member centers are effectively de-escalating persons in suicidal crisis whom might otherwise be diverted to emergency services.

- Of Lifeline’s highest-risk callers (e.g., assessed to be at “imminent risk”), 40% are effectively de-escalated without utilizing emergency services. In 36% of cases, imminent risk callers agree to the use of emergency services (collaborating with counselor to promote their safety), and about 24% of imminent risk callers receive emergency services, because they are unwilling and unable to collaborate with the counselor to prevent their suicide (Gould et al 2016).
- Many 911 centers report a high volume of non-suicidal callers with mental health issues that would more effectively and efficiently be assisted on a mental health hotline.

Suicide touches so many lives, but only recently, as more and more people speak out, has the need for action become so apparent. Ten years ago, we had only a handful of people banding together. Today we have a movement that rallies over 250,000 people to participate in over 400 AFSP Community Out of the Darkness Walks and AFSP 150 College Campus Walks. This coming April 21, AFSP and many other national suicide prevention and mental health organizations are sponsoring a first-ever Rally on the West Front of the US Capitol Building, from 5:30 pm to 6:30 pm. We hope that many of you and your staff can join us for this important call to action.

It's time to answer that grassroots call for action. It's time to wage war on suicide and put a stop to this tragic loss of life. The first line of defense should be robust, 24-7, crisis support services for all Americans, by phone hotline, chat and by text. H.R. 2345, the National Suicide Prevention Hotline Improvement Act of 2017 is another step in the right direction.

Chairman Blackburn and Ranking Member Doyle, and Members of the Subcommittee. On behalf of the American Foundation for Suicide Prevention, I thank you again for the opportunity to provide testimony today and we look forward to working with you, other members of the Congress, the Administration, and all mental health and suicide prevention organizations inside and outside of government to prevent suicide.

I will be happy to answer any questions.

Thank you.

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