House Subcommittee Discusses Suicide Prevention and Treatment

September 22, 2014

On September 18, the House Energy and Commerce Subcommittee on Oversight and Investigations held a hearing, "*Suicide Prevention and Treatment: Helping Loved Ones in Mental Health Crisis*." Subcommittee Chairman Tim Murphy (R-PA), a psychologist, explained that the hearing was an attempt to "take the conversation about suicide out of the dark shadow of stigma and into the bright light of truth and hope. Suicide is the deadly outcome of mental illness. Suicide is when depression kills. Suicide is an epidemic and its impact is staggering."

Murphy noted that in 2013, 9.3 million Americans had serious thoughts of suicide, 2.7 million made suicide plans, 1.3 million attempted suicide, and nearly 40,000 died by suicide; suicide is an American public health crisis that results in more lost lives than motor vehicle crashes, homicide, or drug abuse. It is the third leading cause of death for young people ages 15 to 24, and the second leading cause of death for adults ages 25 to 34. He emphasized that in 90 percent of suicides, an underlying diagnosis of mental illness was a contributing factor. The Chairman emphasized that the research is lagging and evidence-based treatments often fail to reach those who can help. "Suicides and suicidal behavior remain underreported, undertreated, and cloaked in a stigma," said Murphy.

Ranking Member Diana DeGette (D-CO) commended Murphy for holding the hearing and highlighted their efforts to come up with a bipartisan bill to address the issue. She noted that suicide takes about 40,000 lives a year and leaves behind millions of devastated children, parents, spouses, and friends. "It is a very important issue," she said.

The hearing's witnesses included former Congressman Lincoln Diaz-Balart (R-FL), whose son committed suicide in 2013; Rear Admiral Boris Lushniak, U.S. Acting Surgeon General; David Brent, University of Pennsylvania; Christine Moutier, American Foundation for Suicide Prevention; and Joel Dvoskin, University of Arizona on behalf of the American Psychological Association (APA). The video of the hearing and the witnesses' testimony are available on the Committee's website.

Rear Admiral Boris Lushniak provided the Subcommittee testimony on behalf of the Department of Health and Human Services (HHS) and highlighted the current and future directions as they relate to suicide prevention being pursued by the Department. The Acting Surgeon General emphasized that there is no single path that leads to suicide. It is a combination of factors "such as serious mental illness, alcohol abuse, a painful loss, exposure to violence, or social isolation" throughout life that may increase the risk of suicidal thoughts and behaviors.

He highlighted the 2012 *National Strategy for Suicide Prevention* report issued by then-Surgeon General Regina Benjamin in partnership with the National Action Alliance for Suicide Prevention. The report includes 13 goals and 60 objectives and focuses on four main strategic directions, which when working together, may most effectively prevent suicides. It builds on the more than a decade of work in the Office of the Surgeon General on suicide prevention, he noted, pointing to the very first "*Call to Action to Prevent Suicide*" issued by then-Surgeon General David Satcher. That call to action introduced a blueprint for addressing suicide prevention.

The latest research shows that suicide is preventable, suicidal behaviors are treatable, and the support of families, friends, and colleagues is a critical protective factor, said Lushniak. Suicide prevention needs to be addressed in the comprehensive, coordinated way outlined in the National Strategy.

"Suicide is a Form of Violence"

Joel Dvoskin expressed the APA's support for the Subcommittee's focus on suicide prevention, noting that "psychology has been at the forefront of suicide prevention efforts." Dvoskin testified that every day in the U.S., 53 individuals use a firearm to commit suicide and 40 percent of young people who commit suicide do so with a gun. He pointed out that suicide is a problem across the lifespan. In 2011, suicide became the second leading cause of death of 15-24 year olds. Accordingly, many prevention efforts are focused on this age group, said Dvoskin, adding that the fastest growing rates of suicide are found among middle age and older adults. A recent study by Centers for Disease Control and Prevention (CDC), found over a ten-year period (1999-2009), suicide rates increased among middle-aged adults by nearly 30 percent.

Any act of interpersonal violence, including mass violence, is an act of suicide, Dvoskin explained. Consequently, the APA takes a multidimensional approach to suicide prevention and views suicide prevention as essential part of violence prevention. Often an impulsive act, suicide is an individual's desperate attempt to relieve their suffering. Citing the success of suicide prevention work in jails, Dvoskin emphasized that suicide risk can be reduced through identifying and providing support to address the factors that drive a person to consider suicide. Among its recommendations to the Subcommittee, APA urged the Subcommittee's "support of research into suicide, especially aimed at reducing the prevalence of suicide by firearms." Suicide is a type of violence and must be part of any violence prevention efforts, particularly gun violence prevention, Dvoskin reiterated.

David Brent informed the Subcommittee that 90 percent of the people who die by suicide have at least one major psychiatric illness, with the most common illnesses being mood disorders, anxiety disorders, alcohol and substance abuse, disorders of impulsive aggression, and psychotic disorders, especially in combination. Access to good quality mental health treatment can reduce the risk, he explained and noted that psychotherapies have been shown to reduce suicidal ideation or attempts. Brent also testified that research to improve the ability to reduce suicide should include testing treatments for insomnia to reduce suicidal risk and testing large scale applications of the role of safety counseling, collaborative care, dissemination of evidence-based treatments, and prevention programs on suicide.

Although there has been some research in the pharmacological treatment of suicidal risk, Brent explained that the majority of treatment studies have involved psychotherapeutic interventions. Dialectic Behavior Therapy (DBT), an intensive treatment that combines individual and group training in emotion regulation, mindfulness, distress tolerance, and interpersonal effectiveness is among the best treatments. Research that is likely to pay off quickly would include studying the impact of improved detection and treatment on

insomnia on suicidal behavior, effects of safety counseling with regards to firearms storage on firearms injuries and deaths, including suicide, and impact of evidence-based prevention program on premature mortality, including suicide, he told the Subcommittee. He also stressed the need for studies with longer timespans. He concluded by pointing out that that since maltreatment is an important risk factor for suicidal behavior and predicts non-response to treatment, there is a need to understand why treatments don't work for some individuals and what treatments should be offered instead.

Focus On the Gaps in the Science

Christine Moutier shared with the Subcommittee that after losing too many of her colleagues and students to suicide, she launched and led a suicide prevention program for physicians and trainees. "I saw first-hand how knowledge is power and can change even the most stoic, tough-minded workplace culture, especially when education is paired with a way for those to get help without jeopardizing their reputation or career," Moutier stated.

Echoing Brent, Moutier emphasized that "suicide is often the result of unrecognized and untreated mental illness." She noted that in more than 120 studies of completed suicides, at least 90 percent of the individuals involved were suffering from a mental illness at the time of their deaths. She emphasized the need to focus on three key policy areas to prevent suicide: (1) suicide prevention research, (2) suicide prevention programs, and (3) programs and strategies that provide more support to those touched by suicide. Suicide research, said Moutier, is "vitally important to understanding what works to prevent suicide. The research should focus on the gaps in the science and would have the greatest potential for reducing suicide burden."

She highlighted the top two of six prioritized approaches for allocating funds and monitoring future suicide research from the recommendations of the Research Prioritization Task Force of the National Action Alliance for Suicide Prevention: (1) research examining why people become suicidal to discover models that explain contagion as well as resilient, healthy social connections among at-risk groups and to determine if processes that risk conditions also mitigate suicide risk and (2) research looking at which interventions are effective and what prevents individuals from engaging in suicidal behavior. This includes identifying feasible and effective, fast acting interventions and finding interventions for the highest risk groups in care or community settings.