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ONE HUNDRED THIRTEENTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON ENERGY AND COMMERCE

2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6115

Majority (202) 225-2927
Minority (202) 225-3641

MEMORANDUM

September 17, 2014

To: **Subcommittee on Oversight and Investigations Democratic Members and Staff**

Fr: **Committee on Energy and Commerce Democratic Staff**

Re: **Hearing on "Suicide Prevention and Treatment: Helping Loved Ones in Mental Health Crisis"**

On Thursday, September 18, 2014, at 11:30 a.m. in room 2123 of the Rayburn House Office Building, the Subcommittee on Oversight and Investigations will hold a hearing titled "Suicide Prevention and Treatment: Helping Loved Ones in Mental Health Crisis." The majority has indicated that the hearing is a continuation of their investigation into federal programs addressing severe mental illness.

I. BACKGROUND

Suicide takes the lives of nearly 40,000 Americans per year and is the tenth leading cause of death in the United States. [1] The suicide of actor Robin Williams in August 2014 resulted in a new media and public focus on this problem, with calls to the National Suicide Prevention Hotline more than doubling in the days afterward.[2]

Between 2000 and 2011, suicide rates increased by almost 20%, from 10.4 deaths per 100,000 people in 2000 to 12.3 deaths per 100,000 people in 2011. The Director of the National

[1] American Foundation for Suicide Prevention, *Facts and Figures* (online at www.afsp.org/understanding-suicide/facts-and-figures) (accessed Sept. 17, 2014).

[2] *Calls to local crisis hotlines spike after death of Robin Williams*, Orlando Sentinel (Aug. 20, 2014) (online at www.orlandosentinel.com/health/os-mental-health-community-resources-20140820-story.html).

Institute of Mental Health Tom Insel wrote earlier this year that, "suicide has proven stubbornly difficult to understand, to predict, and to prevent."[3]

The strongest risk factors for suicide are major depression, other mood disorders, or substance abuse.[4]

The purchase of a handgun is also strongly associated with the increased risk of suicide.[5] A study conducted of California handgun purchasers found that in the first year after the purchase of a handgun, suicide was the leading cause of death among the purchasers and that a firearm purchaser was more than four times as likely to commit suicide as those who did not purchase a gun.[6] Firearms were used in 19,392 suicides in the United States in 2010, constituting almost 62% of all gun deaths.[7]

Suicide rates are disproportionately high among veterans. A 2012 review by the Department of Veterans Affairs found that veterans compromised approximately 22.2% of all suicides reported.[8] An estimated that 22 veterans committed suicide each day.[9] Though veteran suicides steadily declined until 2003, the rate of suicide has been on the rise since 2007.[10]

II. SUICIDE PREVENTION AND TREATMENT

Ninety percent of people who die by suicide have a mental disorder at the time of their deaths, and according to the American Foundation for Suicide Prevention, "one of the best ways to prevent suicide is by understanding and treating these disorders."[11]

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[3] National Institute of Mental Health, *Director's Blog: A New Research Agenda for Suicide Prevention* (Feb. 5, 2014) (online at www.nimh.nih.gov/about/director/2014/a-new-research-agenda-for-suicide-prevention.shtml).

[4] National Institute of Mental Health, *Suicide in America* (online at www.nimh.nih.gov/health/publications/suicide-in-america/suicide-america-trifold.pdf) (accessed Sept. 17, 2014) and American Foundation for Suicide Prevention, *Key Research Findings* (online at www.afsp.org/understanding-suicide/key-research-findings) (accessed Sept. 17, 2014).

[5] Garen J. Wintemute et al; *Mortality among recent purchasers of handguns*, New England Journal of Medicine (1999) (online at www.ncbi.nlm.nih.gov/pubmed/10564689).

[6] *Id.*

[7] Centers for Disease Control and Prevention, *Web-Based Injury Statistics Query & Reporting System (WISQARS) Injury Mortality Reports, 1999-2010, for National, Regional, and States* (Dec. 2012) (online at webappa.cdc.gov/sasweb/ncipc/dataRestriction_inj.html).

[8] Department of Veterans Affairs, *Suicide Data Report, 2012* (online at www.va.gov/opa/docs/suicide-data-report-2012-final.pdf).

[9] *Id.*

[10] *Id.*

[11] American Foundation for Suicide Prevention, *Treatment* (online at www.afsp.org/preventing-suicide/treatment) (accessed Sept. 15, 2014); National Institute of

The Surgeon General's National Strategy for Suicide Prevention report identifies intervention strategies and encourages targeted communication to certain segments of the population, particularly those at a higher suicide risk.[12] The strategy describes a number of successful approaches: reduced prejudice and responsible media reporting about mental disorders and suicide; effective public awareness campaigns and training of community service providers; training of and screening by primary care providers; and the availability of ongoing care and support for those at risk of suicide.[13]

The Surgeon General also notes that "reducing access to lethal means make it less likely the person will engage in suicidal behaviors."[14] In particular, reducing access to firearms could also reduce suicide rates. A study by the Harvard School of Public Health found that in states where gun ownership was less common, suicide rates were lower. [15] By contrast, states with the high gun ownership rates had some of the highest suicide rates.[16] Keeping guns locked away or storing them outside the home can help prevent suicide.[17]

III. PRIOR COMMITTEE HEARINGS

During the 113th Congress, the Committee has explored mental health issues and treatment on a number of occasions. The Oversight and Investigations Subcommittee held a forum on violence and severe mental illness after the Newtown Tragedy.[18] The Subcommittee has held three other hearings on mental health, examining the effect of the Health Insurance Portability and Accountability Act (HIPAA) on mental health diagnosis and treatment, the role of the Substance Abuse and Mental Health Services Administration (SAMHSA) in aiding those

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Mental Health, *Suicide Prevention* (online at www.nimh.nih.gov/health/topics/suicide-prevention/index.shtml) (accessed Sept. 15, 2014).

[12] U.S. Surgeon General and National Action Alliance for Suicide Prevention, *2012 National Strategy for Suicide Prevention: Goals and Objectives for Action* (Sept. 2012) (online at www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/full_report-rev.pdf).

[13] *Id*., at 12.

[14] *Id.*

[15] Harvard School of Public Health, *Guns and Suicide: A fatal link* (Spring 2008) (online at www.hsph.harvard.edu/news/magazine/guns-and-suicide/).

[16] *To Reduce Suicide Rates, New Focus Turns to Guns*, New York Times (Feb. 13, 2013) (online at www.nytimes.com/2013/02/14/us/to-lower-suicide-rates-new-focus-turns-to-guns.html?pagewanted=all&_r=0).

[17] Harvard School of Public Health, *Guns and Suicide: A fatal link* (Spring 2008) (online at www.hsph.harvard.edu/news/magazine/guns-and-suicide/).

[18] House Committee on Energy and Commerce, *Forum on After Newtown: A National Conversation on Violence and Severe Mental Illness*, 113th Cong. (Mar. 5, 2013).

who are severely mentally ill, and on the psychiatric bed shortage.[19] The Health Subcommittee also held a legislative hearing on H.R. 3717, the Helping Families in Mental Health Crisis Act, sponsored by Chairman Murphy.[20]

IV. FEDERAL GOVERNMENT ROLE IN SUICIDE PREVENTION

Three federal agencies under the umbrella of the Department of Health and Human Services (HHS) play a role in suicide prevention: the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC), and the Substance Abuse and Mental Health Services Administration (SAMHSA). Funding for each of these agencies has steadily declined since 2010.[21]

A. National Institutes of Health

Within NIH, the National Institute of Mental Health (NIMH) has the main responsibility for research on suicide and suicide prevention.[22] In February 2014, the Director of NIMH announced two new initiatives for research: (1) research addressing firearm violence and (2) research addressing the development of screening youth for suicide risk and strategies to guide matching of individuals to the appropriate intervention.[23]

NIH's funding has declined or been stagnant since 2003 (with the exception of stimulus funding in 2009 and 2010).[24] NIH funding on mental health research dropped from $2.25 billion in 2010 to $2.17 billion in 2013, an inflation-adjusted drop of 10%.[25]

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[19] House Committee on Energy and Commerce, *Hearing on Does HIPAA Help or Hinder Patient Care and Public Safety?*, 113th Cong. (Apr. 26, 2013); House Committee on Energy and Commerce, *Hearing on Examining SAMHSA's Role in Delivering Services to the Severely Mentally Ill*, 113th Cong. (May 22, 2013); and House Committee on Energy and Commerce, *Hearing on Where Have All the Patients Gone? Examining the Psychiatric Bed Shortage*, 113th Cong. (Mar. 26, 2014).

[20] House Committee on Energy and Commerce, *Hearing on H.R. 3717, the Helping Families in Mental Health Crisis Act*, 113th Cong. (Apr. 3, 2014).

[21] Congressional Research Service, *Public Health Service Agencies: Overview and Funding* (Nov. 12, 2013) (online at www.crs.gov/pdfloader/R43304) (R43304).

[22] In addition to NIMH, however, other institutes at NIH may fund research on various health and mental health issues relating to suicide.

[23] National Institute of Mental Health, *Director's Blog: A New Research Agenda for Suicide Prevention* (Feb. 5, 2014) (online at www.nimh.nih.gov/about/director/2014/a-new-research-agenda-for-suicide-prevention.shtml).

[24] Congressional Research Service, *A History of NIH Funding* (Mar. 7, 2014) (R43341).

[25] National Institutes of Health, *Estimates of Funding for Various Research, Condition, and Disease Categories (RCDC)* (Mar. 7, 2014) (online at report.nih.gov/categorical_spending.aspx).

B. Centers for Disease Control and Prevention

The Division of Violence Prevention at CDC's National Center for Injury Prevention and Control conducts work on broad areas of violence, including suicide.[26] Its work includes monitoring suicide rates, conducting research on risk factors and effectiveness of prevention strategies, and creating and evaluating the effectiveness of prevention programs on both the state and national levels.

Among the programs at the Division of Violence Prevention is the National Violent Death Reporting System (NVDRS), which is a state-based surveillance system that links data from various sources to assist in designing and implementing tailored prevention and intervention efforts.[27] The data collected is informing suicide prevention efforts at the state level, such as prevention efforts in New Jersey, prevention in older adults in Oregon, and engaging the media in suicide prevention in Utah.[28]

Funding for the National Center for Injury Prevention and Control has declined from $149 million in 2010 to $131 million in 2013.[29]

C. Substance Abuse and Mental Health Services Administration

SAMHSA has made suicide prevention a priority and made it a prominent feature of several of SAMHSA's Strategic Initiatives, including Military Families, Trauma and Justice, and Prevention of Substance Abuse and Mental Illness.[30] SAMHSA also supports the National Suicide Prevention Lifeline, the Suicide Prevention Resource Center, and other suicide prevention efforts.[31]

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[26] Centers for Disease Control and Prevention, Division of Violence Prevention, *Violence Prevention at CDC* (Aug. 26, 2014) (online at www.cdc.gov/violenceprevention/overview/index.html).

[27] Centers for Disease Control and Prevention, *Injury Prevention & Control: Funded Programs, Activities & Research* (Mar. 6, 2014) (online at www.cdc.gov/injury/FundedPrograms/programs.html).

[28] Centers for Disease Control and Prevention, *National Violent Death Reporting System* (Aug. 29, 2014) (online at www.cdc.gov/ViolencePrevention/NVDRS/index.html).

[29] Congressional Research Service, *Public Health Service Agencies: Overview and Funding* (Nov. 12, 2013) (online at www.crs.gov/pdfloader/R43304).

[30] Substance Abuse and Mental Health Services Administration, *Suicide Prevention: Top Priority for SAMHSA and the Nation*, SAMHSA News (Mar./Apr. 2011) (online at www.samhsa.gov/samhsaNewsletter/Volume_19_Number_2/SuicidePrevention.aspx).

[31] *Id.*

Funding for SAMHSA's Center for Mental Health Services declined from just over $1 billion in 2010 to $915 million in 2013.[32]

V. THE AFFORDABLE CARE ACT MARKS "A WATERHSED MOMENT" FOR SUICIDE PREVENTION

The Affordable Care Act (ACA) provides coverage for millions of previously uninsured Americans and requires that all new individual and small group insurance plans cover mental health and substance use disorder services as one of ten Essential Health Benefits. Plans are required to cover these services at parity with medical and surgical benefits, significantly expanding access to these lifesaving services.[33] A February 2014 report by the American Mental Health Counselors Association found 6.6 million uninsured adults with serious mental health and substance use conditions will be eligible for health insurance coverage - including coverage for mental health and substance use conditions - through the new ACA marketplaces or exchanges.[34]

In April 2014, Nadine Kaslow, President of the American Psychological Association, discussed the role of the ACA's coverage in mental health treatment and suicide prevention, writing that:

> Notwithstanding the politics of the Affordable Care Act, the prospect that millions of Americans will have health insurance covering mental health benefits at a level comparable with their physical health care is a watershed moment that could truly destigmatize mental health care and suicide prevention services.[35]

The ACA gives states the ability to expand Medicaid coverage to individuals with incomes below 138% of the federal poverty level. Twenty-seven states plus the District of Columbia have expanded their Medicaid programs, and, as of June 2014, as many as 7.2 million Americans have been determined eligible for Medicaid and CHIP since October 1, 2013.[36]

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[32] Congressional Research Service, *Public Health Service Agencies: Overview and Funding* (Nov. 12, 2013) (online at www.crs.gov/pdfloader/R43304) (R43304).

[33] Healthcare.gov, *Essential Health Benefits* (online at www.healthcare.gov/glossary/essential-health-benefits/) (accessed Sept. 15, 2014); Centers for Medicare and Medicaid Services, *The Mental Health Parity and Addiction Equity Act* (online at cms.hhs.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html) (accessed Sept. 15, 2014).

[34] American Mental Health Counselors Association, *Dashed Hopes; Broken Promises; More Despair: How the Lack of State Participation in the Medicaid Expansion will Punish Americans with Mental Illness* (Feb. 2014).

[35] American Psychological Association, *Our opportunity to reduce suicide* (Apr. 2014) (online at www.apa.org/monitor/2014/04/pc.aspx).

[36] Kaiser Family Foundation, *Status of State Action on the Medicaid Expansion Decision* (Aug. 28, 2014) (online at kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/); Centers for Medicaid & Medicaid Services, *Medicaid & CHIP: June 2014 Monthly Applications, Eligibility Determinations and Enrollment Report*

However, 21 states have not yet moved forward with Medicaid expansion.[37] As a result, nearly four million uninsured adults with mental health and substance use conditions will be unable to obtain health insurance coverage through the ACA's Medicaid expansion. This includes nearly 800,000 individuals with a serious mental illness; over 1.5 million individuals suffering from serious psychological distress, such as panic, anxiety, and mood disorders; and nearly 1.4 million individuals dealing with a substance use disorder.[38]

VI. WITNESSES

The following witnesses have been invited to testify:

Statement by:

The Honorable Lincoln Diaz-Balart
Former Member of Congress.

Panel:

Rear Admiral Boris D. Lushniak, M.D.
U.S. Acting Surgeon General

David A. Brent, M.D.
Endowed Chair in Suicide Studies and Professor of Psychiatry, Pediatrics, Epidemiology, and Clinical and Translational Science
University of Pittsburgh

Christine Moutier, M.D.
Chief Medical Officer
American Foundation for Suicide Prevention

Joel A. Dvoskin, Ph.D.
Assistant Professor of Psychiatry
University of Arizona.

(Aug. 8, 2014) (online at www.medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Downloads/June-2014-Enrollment-Report.pdf). In Pennsylvania, coverage will begin in January 2015.

[37] Kaiser Family Foundation, *Status of State Action on the Medicaid Expansion Decision* (Aug. 28, 2014) (online at kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/).

[38] American Mental Health Counselors Association, *Dashed Hopes; Broken Promises; More Despair: How the Lack of State Participation in the Medicaid Expansion will Punish Americans with Mental Illness* (Feb. 2014).