Statement

Of

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On behalf of the American Psychological Association

At a Hearing

"Suicide Prevention and Treatment: Helping Loved Ones in Mental Health Crisis"

U.S. House of Representatives

Committee on Energy and Commerce

Subcommittee on Oversight and Investigations

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Chairman Murphy, Ranking Member DeGette, and members of the committee, I am Dr. Joel Dvoskin, a practicing clinical and forensic psychologist and a clinical faculty member of University of Arizona School of Medicine, Department of Psychiatry. I also serve as Chairman of the Governor's Advisory Council on Behavioral Health and Wellness for the State of Nevada. I thank you for holding this important hearing on the serious problem of suicide and for your stalwart commitment to addressing the unmet behavioral health needs of our nation.

I appear on behalf of the American Psychological Association (APA), which is the largest scientific and professional organization representing psychology in the United States and is the world's largest association of psychologists. Comprised of researchers, educators, clinicians, consultants, and students, APA works to advance psychology as a science, a profession, and as a means of promoting health, education, and human welfare. I recently had the privilege of serving on the APA Presidential Task Force on Gun Violence and helped draft our recommendations on a public health approach to reduce suicide and gun deaths.[i] We look forward to working with Congress and the Administration to make progress in preventing suicide.

APA supports the Committee's focus on ensuring that our nation does all it can to prevent suicide and to provide those in need with the best possible health care. Psychology has been at the forefront of suicide prevention efforts. Psychological research and clinical work provide key tools for assessing risk (e.g., collaborative risk assessment) and treatment (e.g., dialectical behavior therapy and cognitive behavioral therapy). The work of our members on school campuses, in health care settings, jails and prisons, with veterans, and in the military is essential to helping Americans overcome the factors that can lead to suicide.

I have served in a number of roles in the mental health system, and now I work primarily with mental health systems, psychiatric hospitals, and correctional institutions to reduce suicide and violence, and to provide mental health and substance abuse services. Earlier in my career as Acting Commissioner

of Mental Health and Associate Commissioner for Forensic Services for the State of New York, I was responsible for mental health and substance abuse treatment in large psychiatric hospitals, forensic and correctional institutions, and prison mental health programs, as well as the community care of hundreds of thousands of New Yorkers with serious mental illness. In these challenging conditions, our staff worked hard to devise approaches that reduced suicide through crisis intervention, screening and assessment, appropriate clinical services, and follow up. The following key points are drawn from my experience as a clinician, researcher, consultant, and academic.

Suicide is an urgent, complex, and multifaceted problem.

Suicide is of such extraordinary magnitude and importance that it consistently ranks among the 10 leading causes of death in the United States.[ii] Nearly 40,000 Americans commit suicide each year--approximately 105 per day. A recent survey by the Substance Abuse and Mental Health Services Administration (SAMHSA) that tracks self-report of suicide attempts and plans found that, in the past year, 1.3 million Americans over the age of 18 reported a suicide attempt and 2.7 million made plans for suicide.[iii]

Every day in the United States, 53 individuals use a firearm to commit suicide and 40% of youths who commit suicide do so with a gun.[iv] Males complete the vast majority of suicides, and firearms are the most commonly used method of suicide for men--roughly four to six times as many males as females kill themselves with firearms.[v] Among females, poisoning (including prescription drug overdose) is the most common method.

Risk and protective factors

Suicide is a problem across the lifespan. Among youth, suicide ranks high as a cause of death, and is often preceded by childhood trauma, bullying, or other abuse. In 2011, suicide became the second leading cause of death of 15– to 24-year olds, and many prevention efforts are focused on this age group. However, increasing age is also a risk factor, and the fastest growing rates of suicide are found among

middle aged and older adults. A recent study by the Centers for Disease Control and Prevention (CDC) found that over a 10-year period (1999-2009), suicide rates increased among middle-aged adults by almost 30%.[vi] Medicare beneficiaries are also at a greater suicide risk than the general population. Suicide is a major issue in men's health, and males over the age of 45 have rates that far exceed all other major demographic groups.

Alcohol and substance abuse are also risk factors for suicide. Adults aged 18 or older with a recent substance use disorder or abuse were about 400% more likely than those without dependence or abuse to have serious thoughts of suicide in the past year, to make suicide plans, or to attempt suicide.

Suicide can be prevented.

Suicide is a form of violence. Any act of interpersonal violence, including mass violence, is an act of suicide – it ends the person's life as they know it, whether the perpetrator survives or not. APA takes a multidimensional approach to suicide prevention and views suicide prevention as an essential part of violence prevention.

Suicide is often an impulsive act, where an individual is desperate to relieve their suffering and knows no other way. Suicide risk can be reduced through identifying and providing support to address the factors that drive a person to consider suicide. Our suicide prevention work in jails and prisons is one example. By using a public health/prevention approach, experience shows that it is possible to reduce jail suicides by approximately two-thirds - a major accomplishment in one of the nation's most stressful environments.

As the risk of suicide increases over an individual's lifetime, it is important to address risk factors to alter trajectories toward violence. I am proud to serve as a member of the Board of the National Association to Protect Children, an organization that understands that childhood abuse and trauma are risk factors for suicide. Preventing and treating child abuse can interrupt multiple pathways of risk. Federal

programs such as the National Child Traumatic Stress Network are essential to our efforts not only to reduce child abuse, but also to prevent suicide.

Because the risk factors associated with suicide are multifaceted and vary across groups, suicide prevention demands comprehensive, evidence-based efforts across many settings that include early intervention, timely and effective treatment for those in acute crisis, and follow-up and support after a crisis. The Mentally Ill Offender Treatment and Crime Reduction Act (MIOTCRA) provides funding for interagency collaboration and grants aimed at addressing the mental health needs of juvenile and adult offenders. Another example of vital legislation that supports a comprehensive approach is the Garrett Lee Smith Memorial Act, which funds states, tribes, universities, and colleges to provide early intervention, assessment, and treatment services to prevent youth suicide. These important programs should be promptly reauthorized and funded robustly. I am pleased that there is current legislation, such as H.R. 3717, that would reauthorize this important program.

Many of those who complete suicide have not been under the care of a mental health professional. We need to ensure that our health care system reimburses not only for suicide assessment but also for depression and substance abuse screening and treatment. Providers need to be trained in assessing suicide risk, suicide management, and treatment through using therapies especially devised for these problems. Further, we need to ensure that Medicaid eligible adults (ages 21-64) in acute mental health crisis have access to professional mental health treatment in short-term, acute facilities by revising barriers to coverage. Specifically, I believe that the Medicaid Institutions for Mental Disease (IMD) exclusion is long overdue for serious revision.

Too often, people considering suicide are forced to spend hours or days in crowded, noisy, and chaotic emergency rooms that are poorly positioned to cope with emotional, psychiatric, and intoxication-related crises. This form of care is vastly more expensive than more effective settings such as crisis residences, peer-run drop-in centers, and sobering centers. Alternatives to emergency room care can

include innovative community based programs, such as Parachute in New York City, which provides community-based options for those in crisis to help individuals cope within their community. Parachute provides a support line, mobile crisis teams, and safe respite housing for those in acute distress. This cost-effective program is a private-public partnership, but also benefits from Centers for Medicare and Medicaid Innovation grants.

Interagency collaboration and programs are essential for reaching at-risk individuals. Partnerships between mental health professionals, law enforcement, fire and rescue, paramedics, courts, and correctional institutions can help many of those who have mental health, substance abuse and legal problems. MIOTCRA, in particular, provides funding for interagency collaboration and grants that can reduce suicide risk and improve the treatment of mentally ill offenders. I am particularly impressed with the potential of Crisis Intervention Teams, a program that has been developed with law enforcement, but which requires the support of public mental health systems as referral options for people in crisis.

Psychological research indicates that there are also important protective factors against suicide. Family support and connectedness, connection to a caring adult, connection to school are all factors that decrease suicide risk. Programs that support families and provide a supportive and caring school climate are essential, as well as the presence of mental health professionals who can assess and respond to youth experiencing a suicidal crisis.

Recommendations:

We know what works, but not all Americans have access to effective treatment and crisis intervention. Therefore, I offer the following recommendations:

The 2012 National Strategy for Suicide Prevention is an excellent starting place, and we urge Congress to provide the funding to fully implement its many strategic goals.

We specifically urge Congress to take measures to:

1. Increase access to screening for depression, suicide, and other mental health concerns across the lifespan;
2. Ensure insurance coverage for prevention services, including screening for depression across the lifespan;
3. Improve access by increasing the number of trained health care professionals, including psychologists and other mental health professionals, and effective peer services;
4. Increase acute treatment resources by revisiting the Medicaid IMD exclusion to expand coverage for short-term acute inpatient stays;
5. Ensure the continuation of early intervention resources such as the National Suicide Prevention Lifeline. This program received one million calls last year alone, and many of the calls were from those who were actively suicidal. This program has not been formally authorized by Congress and is worthy of continued support;
6. Support reauthorization of essential behavioral health programs such as the Mentally Ill Offender Treatment and Crime Reduction Act (MIOTCRA), National Child Traumatic Stress Network, and Garrett Lee Smith Memorial Act;
7. Increase dissemination of evidenced-based treatments for all populations and ages, which are appropriate to a variety of settings, including schools, prisons, outpatient and inpatient centers; and
8. Support funding streams for innovative community-based programs that work with those at risk, such as Parachute, which provides a support line, peer support, mobile treatment team, and crisis respite centers.
9. Support the various forms of crisis intervention and response: including public mental health systems; first responders such as paramedic, police, and fire and rescue services; and create alternatives to the overcrowded emergency rooms and jails that are so ill-suited to treat people in emotional crisis.

10. Support research into suicide, especially aimed at reducing the prevalence of suicide by firearms, a particularly lethal method of suicide attempts. Suicide is a type of violence and must be part of any violence prevention efforts, particularly gun violence prevention.

Conclusion

I would like to express my deep appreciation for this committee's work and its ongoing attention to the prevention of suicide and the treatment for serious mental illnesses in America. The act of suicide is the result of a belief that there is no other way to end one's psychological pain. Over the many years I have worked in this field, I have seen tremendous progress in identifying approaches to reduce completed suicides, attempts, ideation, and feelings. However, we do not implement these tools effectively and broadly enough. We must reduce the barriers to violence prevention and mental health treatment for all Americans and provide the community supports so that our citizens can build lives of meaning and purpose.

Suicide, like so many tragedies, is the direct result of despair, and there is only one cure for despair – hope. It is my hope that our political parties can join together in a bipartisan effort to give people in the most acute despair some measure of hope for a better life -- by improving the services that are provided to Americans experiencing emotional crisis and the most severe forms of psychological pain. Any one of us has the potential to face unbearable emotions some time in our lives – and we must ensure help is there in those times of crisis.

Thank you for inviting me to testify.

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[i] APA Task Force Report on Gun Violence http://www.apa.org/pubs/info/reports/gun-violence-prevention.aspx and APA Resolution on Gun Violence, http://www.apa.org/about/policy/firearms.aspx

[ii] Murphy, S.L., Xu, J.Q., & Kochanek, K.D. (2013). Deaths: Final data for 2010. National vital statistics reports, 61, *4*. Hyattsville, MD: National Center for Health Statistics.

Substance Abuse and Mental Health Services Administration (2013). Results from the 2012 National Survey on Drug Use and Health: Mental Health Findings. http://www.samhsa.gov/data/NSDUH/2k12MH_FindingsandDetTables/2K12MHF/NSDUHmhfr2012.htm.

[iv] Centers for Disease Control and Prevention (2013, August 23). Injury prevention & control: Data and statistics (WISQUARS). Retrieved from http://www.cdc.gov/injury/wisquars/index.html.

[v] Centers for Disease Control and Prevention (2013, August 23). Injury prevention & control: Data and statistics (WISQUARS). Retrieved from http://www.cdc.gov/injury/wisquars/index.html.

[vi] Centers for Disease Control and Prevention (2013). Suicide Among Adults Aged 35-64 Years—United States, 1999-2010. *Morbidity and Mortality Weekly Report*, (62)17.