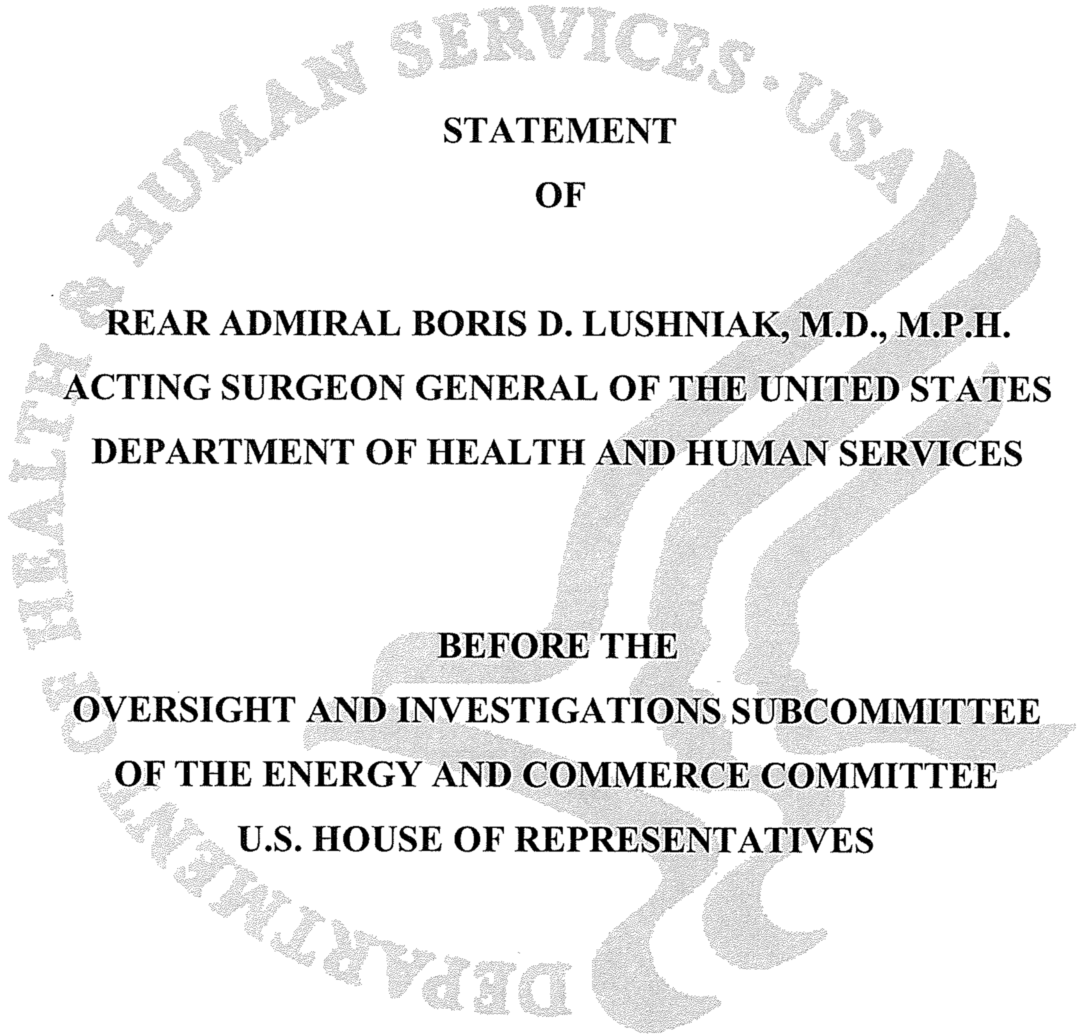

STATEMENT

OF

REAR ADMIRAL BORIS D. LUSHNIAK, M.D., M.P.H.
ACTING SURGEON GENERAL OF THE UNITED STATES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

BEFORE THE
OVERSIGHT AND INVESTIGATIONS SUBCOMMITTEE
OF THE ENERGY AND COMMERCE COMMITTEE
U.S. HOUSE OF REPRESENTATIVES

September 18, 2014

STATEMENT OF
REAR ADMIRAL BORIS D. LUSHNIAK, M.D., M.P.H.
ACTING SURGEON GENERAL OF THE UNITED STATES
DEPARTMENT OF HEALTH AND HUMAN SERVICES
BEFORE THE
OVERSIGHT AND INVESTIGATIONS SUBCOMMITTEE
OF THE ENERGY AND COMMERCE COMMITTEE
U.S. HOUSE OF REPRESENTATIVES
September 18, 2014

Chairman Murphy, Ranking Member DeGette, and Members of the Oversight and Investigations Subcommittee, thank you for the opportunity to testify today about the important public health problem of suicide. My testimony will provide information about what the Department of Health and Human Services (HHS) has learned about this important topic, as well as highlight the current and future directions being pursued on behalf of suicide prevention in the United States.

Background

In 2012, then-Surgeon General Regina Benjamin, in partnership with the National Action Alliance for Suicide Prevention, issued the U.S. *National Strategy for Suicide Prevention* and provided a roadmap for our country's suicide prevention efforts for the next ten years.[1] This report draws on suicide prevention experts from many sectors within and outside government. It includes 13 goals and 60 objectives and focuses on four main strategic directions, which when working together, may most effectively prevent suicides:

1. Create supportive environments that promote healthy and empowered individuals, families and communities;
2. Enhance clinical and community prevention services;
3. Promote the availability of timely treatment and support services; and
4. Improve suicide prevention surveillance collection, research and evaluation.

This approach reinforces that as we learn more, we apply more, and as we apply more, lives can be saved. These strategic directions, developed in collaboration with key stakeholders,[2] provide clear guidance on advancing prevention, treatment and aftercare.

---

[1] The full report is available at: http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/index.html
[2] See Acknowledgements on p. 157 from: http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/index.html

The 2012 report builds on more than a decade of work in the Office of the Surgeon General (OSG) on suicide prevention. In 1999, the very first "call to action" from then-Surgeon General David Satcher was the *Call to Action to Prevent Suicide,* which introduced a blueprint for addressing suicide prevention and set the foundation for developing a national strategy. Two years later in 2001, OSG released the first ever *National Strategy for Suicide Prevention: Goals and Objectives for Action*. That document was a landmark report that created the framework for catalyzing an organized effort to prevent suicide across the Nation.

In 2010, the National Alliance for Suicide Prevention was established by then-HHS-Secretary Kathleen Sebelius, and then-Secretary of Defense, Robert Gates, as the premier public-private partnership to advance suicide prevention.

I am here to build on the strong foundation of my predecessors. As you know, all Surgeon General publications are based on high priority public health needs of the Nation and provide a mechanism for disseminating scientific information that supports the Department's ability to produce improved health outcomes for all Americans. Surgeon Generals' reports address issues of public health importance in in a manner that is understood by all.

Scope of the Problem

We are all here because we know that suicide remains a serious public health problem. Although some people may perceive suicide as the act of a troubled person, it is a complex issue that is influenced by many risk and protective factors. These include the individual characteristics and relationships with family, peers, and others, and influences from the broader social, cultural, economic, and physical environments.

There is no single path that will lead to suicide. Rather, throughout life, a combination of factors, such as a serious mental illness, alcohol abuse, a painful loss, exposure to violence, or social isolation may increase the risk of suicidal thoughts and behaviors.[3]

Suicide results in over 39,000 premature deaths each year,[4] and its incidence has been increasing for more than a decade. In 2011, the most recent year for which statistics are available, suicide was the tenth leading cause of mortality in the United States. Since 2009, suicide has surpassed motor vehicle-related fatalities as a leading cause of death. And when we compare the rates of suicide with that of homicide, most people are surprised to learn that suicide rates remain much higher.[5]

Indeed, suicide is a national problem that affects people of all ages, genders, races and ethnic origins, and geographical locations, but differentially so. It is the second leading cause of death among 15 to 34 year olds. Suicide rates among males are nearly four times higher than among females. The suicide rate among American Indian/Alaska Native (AI/AN) adolescents and young

---

[3] For more information on substance and suicide prevention, see: http://www.samhsa.gov/matrix2/508SuicidePreventionPaperFinal.pdf
[4] See: http://www.cdc.gov/nchs/fastats/leading-causes-of-death.htm
[5] See: http://www.cdc.gov/nchs/fastats/leading-causes-of-death.htm

adults ages 15 to 34 is higher than the national average, and the highest across all races for that age group. And suicide rates are generally higher in the Mountain West and Alaska. Suicide rates are increasing among working age people (35-64 years), and men aged 75 years and older still have the highest rate of suicide of any group.

In addition to the tragic number of deaths attributed to suicide, we must also consider the prevalence of suicidal thoughts, suicide plans, and suicide attempts. In 2013, the National Survey on Drug Use and Health[6] revealed that 3.9 percent or 9.3 million adults over the age of 18 have had serious thoughts of suicide, 1.1 percent or 2.7 million adults made a plan for suicide, and 0.6 percent or 1.3 million adults had attempted suicide.

We also know that those who die by suicide are far from the only ones affected by this tragedy. Suicide exacts a heavy toll on those left behind as well. Loved ones, friends, classmates, neighbors, teachers, faith leaders, and colleagues all feel the effects of these deaths. Sadly, these deaths are just one measure of the challenge we face. For every American who dies by suicide, many others attempt suicide, and many others suffer the despair that leads them to consider taking their own life.

We continue to research the variety of risk factors for suicide, which include factors at the community and societal levels. And, research from the Centers for Disease Control and Prevention (CDC) has indicated that the increases in recent years is, in part, associated with stressors from the recent U.S. economic downturn. While no explanation makes the increase in suicide rates any easier to bear, OSG is committed to improving our ability to understand these trends and to keeping suicide prevention a priority topic for action.

We know that it does not have to be this way. There is much we can do. There are significant opportunities to support many approaches to prevent suicide. Through early intervention and prevention efforts, treatment and aftercare, and by focusing on a public health approach that includes behavioral health strategies, we can help individuals overcome circumstances putting them at risk for taking their own lives.

The National Strategy and HHS Efforts

The National Strategy and its follow-on reports have been a catalyst for much of the work that HHS agencies and other national, state, and local organizations have been doing to address this serious public health problem. Let me now highlight some of the work that HHS agencies are doing and what we have learned.

Suicide Prevention and Response

The Surgeon General's report emphasizes the importance of treatment and support services, as well as clinical and community preventative services. Examples of strategies that support that goal include:

[6] See: http://www.samhsa.gov/data/NSDUH.aspx

- In FY 2014, $2 million in funding for National Strategy for Suicide Prevention grants will focus on implementing the recommendations of the National Strategy with working age adults 25-64 years old. These grants will specifically promote suicide prevention as a core component of health care services and implementation of effective clinical and professional practices for assessing and treating those at risk for suicidal behaviors. In addition, 20 Federally-recognized AI/AN Tribes and Tribal organizations will be funded under the new Tribal Behavioral Health grant program. The initiative's goal is to prevent and reduce suicidal behavior and substance use disorders, and promote mental health among AI/AN young people up to and including age 24.

- Ongoing Federal funding supports the National Suicide Prevention Lifeline (1-800-273-8255), operated by HHS, an immediate resource for those in critical need of support. This resource links 160 crisis centers with well trained staff to callers in need. Last year, this call line handled over one million calls. And in the aftermath of Robin Williams' death, there was a significant spike in usage of this line. Many Federal and private organizations rely on the Lifeline as a resource for those in suicide crisis (and their loved ones seeking help), including the Veterans Crisis Line serving Veterans, military personnel, and their families and friends. Evaluation of the Lifeline has found that compared to the beginning of a hotline call, at the end callers express significantly reduced hopelessness, psychological pain, and intent to die (Gould, et al., 2013).

- The Garrett Lee Smith (GLS) Youth Suicide Prevention grant program is provided to States, Tribes, and colleges to develop, evaluate and improve early intervention and suicide prevention programs for youth. Currently funded at approximately $48 million, it supports 68 state and tribal grantees and 82 colleges, and a resource center. A recent evaluation found that when compared with similar counties that did not implement GLS training, counties implementing GLS trainings showed significantly lower youth suicide rates in the year following the trainings.[7]

- Established in 2002, the Suicide Prevention Resource Center (SPRC) builds capacity and serves as a clearinghouse for science based material and best practices in suicide prevention. SPRC provides training and technical assistance to States, Tribal communities, Territories, schools, and colleges to advance suicide-prevention efforts. The website also includes a Best Practices Registry, which includes evidence-based suicide interventions and also highlights broad principles and processes for creating and implementing prevention efforts that are more likely to be effective.

The Surgeon General's report recommends the development, implementation and monitoring of effective programs that promote wellness and prevent suicide and related behaviors with respect to community prevention and community supports. Examples of strategies to support this approach include:

---

[7] From *Report to Congress on the Garrett Lee Smith Youth Suicide Prevention Program*

- CDC's National Center for Injury Prevention and Control (NCIPC) is funding and evaluating interventions to promote and strengthen individual, family, and community connectedness to prevent suicidal behavior. NCIPC is currently conducting evaluations promoting and strengthening connectedness among two different populations to determine their effectiveness on suicidal behavior. One program focuses on adolescents, while the other addresses an older adult population. In addition, the "Senior Connection" study, funded by CDC, is testing whether improved social connectedness lowers suicide risk among older adults in upstate New York.

- School-based interventions that are showing promise range from those that develop skills to protect against suicidal thoughts and behaviors, to programs that raise awareness, educate children about suicide's risk and protective factors, encourage help-seeking, promote tolerance, decrease stigma, and teach positive life and coping skills. The testing and implementation of a first-grade prevention program, the Good Behavior Game supported by the NIH and SAMHSA, was found to yield benefits not only in reducing aggressive behavior and substance use in youth, but also in reducing suicidal thoughts and attempts in young adulthood (Wilcox, et al., 2008).

- Comprehensive community-based programs offer other promising strategies. The U.S Air Force and Natural Helpers suicide prevention programs, in which CDC participated, are examples of multi-faceted peer-to-peer programs that have been successful. In the Air Force, it is wingmen watching out for each other, and Natural Helpers focuses on youth. The programs emphasize reaching out to peers in distress and notifying others (teachers, commanders, etc.) if one is concerned about a peer. Both used prevention approaches that were adapted to fit the cultural context of the populations who were involved (Goal 5 of the Strategy).

The Surgeon General's report recommends promoting suicide prevention as a core component of health care services. Strategies that improve access to care include:

- The Affordable Care Act includes better coverage for mental and substance use disorders (Goal 5.4 of the Strategy). The Affordable Care Act builds on the Mental Health Parity and Addiction Equity Act and will expand coverage of mental health and substance use disorder benefits and Federal parity protections by including mental health and substance use disorder benefits in essential health benefits and applying Federal parity protections to mental health and substance use disorder benefits in the individual and small group markets. As a result of these new protections, approximately 60 million people will gain expanded mental health and substance use disorder benefits and/or parity protections.[8]

In addition, the Surgeon General's report recommends improving our knowledge base about suicide prevention, intervention and treatment. For example:

---

[8] See: http://aspe.hhs.gov/health/reports/2013/mental/rb_mental.cfm

- We have learned that transitions in care — *e.g.,* discharge from emergency care, inpatient psychiatric care — are high risk periods for vulnerable patients. Studies of health care use, prior to an individual's suicide death, have found that improvements in maintaining 'connections' to individuals transitioning through care reduced the rates of re-attempts. Quality improvement efforts, such as the public-private "ZeroSuicide" activity of the National Action Alliance for Suicide Prevention, directly involve those with experience in health care settings — administrators, providers and service users — to identify practices that are prime candidates for research and evaluation.

- Since the IOM (2002) report on suicide research, we have learned more about the role of child abuse in later suicide risk. Early life stressors can alter gene expression within the brain and later lead to abnormal responses to stressful life events. In a partnership between the National Institutes of Health (NIH) and the Army, the recent Army Study to Assess Risk and Resilience in Service members (Army STARRS) is investigating the possible effects of prior life events and service-related stressors on mental health and suicide risk.

- We need to continue research on the effects of strategies for mandatory training of community and clinical service providers on the prevention of suicide. We are advancing research on interventions focused on the training of "gatekeepers," teachers, clergy, nurses, prison guards, etc., who can spot signs of trouble and recommend courses of action early on (Goal 7 of the 2012 Strategy).

The Strategy emphasizes improving our knowledge of interventions. For example:

- We have identified opportunities to intervene with individuals at risk who are already being served in the healthcare system. New findings revealed that 83 percent of suicide decedents who were members of health maintenance organizations accessed health care in the year before their deaths. Medical specialty and primary care visits without a mental health diagnosis were the most common visit types (Ahmedani, et al., 2014). Research from the Department of Veterans Affairs (VA) has reported that 50 percent of Veterans with substance use disorders had been engaged in care the year before their deaths (Ilgen, et al., 2012). This has led private and Federal health-care-delivery agencies to identify opportunities in care systems to better detect and treat those at risk.

- As the National Institute of Mental Health (NIMH) Recovery After an Initial Schizophrenia Episode (RAISE) study findings are rolled out and coordinated through block grants funded by the Substance Abuse and Mental Health Administration (SAMHSA), we will have the opportunity to see how better quality of care for those experiencing their first episodes of schizophrenia may also reduce risk for suicidal behavior. NIMH Guidance on Coordinated Specialty Care for Mental Illness: The Community Mental Health Services Block Grant (MHBG) Five Percent Set-Aside is a partnership between the Federal Government and States to direct five percent of a State's MHBG allocation administered by SAMHSA to support "evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders." To prepare States to implement the set-aside, NIMH worked collaboratively with SAMHSA to provide States with guidance, and along with NIMH

has held national webinars to inform States of the evidence-based components of coordinated specialty care. Early intervention is critical to preventing negative outcomes.

We have evidence-based treatments that prevent re-attempts among adults, including those with serious mental illness (Goal 8 of the 2012 Strategy). These include psychotherapies such as Dialectical Behavior Therapy (DBT)[9] and other cognitive-based psychotherapies (Cognitive Behavior Therapy for Suicide Prevention (CBT-SP),[10] Collaborative Assessment and Management of Suicidality (CAMS)[11]) that have been tested among individuals with comorbid psychiatric and substance use problems. While research has shown that pharmaceutical interventions, such as clozapine for patients with schizophrenia, have been effective in reducing suicide risk, we need to learn why they are underutilized, in addition to expanding the range of faster acting treatments. Collaborative care for older adult depression, highlighted in the Surgeon General's first call to action to prevent suicide, has been shown to reduce suicidal thoughts, and mortality from all causes over time.

Suicide risk assessment has become a high priority for health care providers. In 2011, the Joint Commission for accreditation of health care organizations made suicide risk assessment a National Patient Safety Goal. A number of HHS agencies are working to identify the best approaches to detection and assessment for important subgroups (*e.g.,* youth, adults, older adults, those in mental health and substance use disorder specialty care). There are also better screening and assessment tools to assess suicide risk with solid data such as the Patient Health Questionnaire 9 (PH-9) and the Columbia Suicide Severity Rating Scale (C-SSRS). Both have been used extensively across various primary care, clinical practice, surveillance, research, and institutional settings.

In addition, we need the public health tools to better monitor trends and prevalence and track the effect of interventions. Strategies to support this goal to increase the timeliness and usefulness of national surveillance systems related to suicide prevention (Goal 11 of the 2012 National Strategy):

- CDC recently awarded grants to expand the National Violent Death Reporting System (NVDRS) from 18 to 32 States, enabling greater collection of critical data on violent deaths. CDC is also linking its NVDRS to Department of Defense (DOD) and VA suicide reporting databases for a more complete data set. The NVDRS provides more useful suicide-related data by combining several datasets (death certificates, medical examiner/coroner reports, law enforcement reports, and toxicology labs). The expanded NVDRS will give States the opportunity to learn more about suicide decedents risk factors, so that prevention efforts can be more targeted and evaluated.[12]

- CDC's National Center for Health Statistics (NCHS) and its partners are funding projects to improve State-based Electronic Death Registration Systems that are helping to

---

[9] See: http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=36
[10] See: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2888910/
[11] See: http://www.ncbi.nlm.nih.gov/pubmed/22971238
[12] For more information, see: : http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2563480/

improve the timeliness and quality of national mortality data. NCHS has also recently transformed the National Vital Statistics System into a system capable of supporting near real-time access to the national mortality data for surveillance and early provisional estimates of a variety of causes of death, including suicides.

The recent World Health Organization report on suicide[13] described several international examples where reduced access to the most lethal suicide methods led to the rapid reduction of suicide deaths. However, there remains limited research on the best ways to field and test these approaches, such as research related to changes in health care practices (*e.g.,* dispensing less lethal doses of medications), testing approaches such as bridge barriers, and learning how community values and norms are linked to behavior that affects access to lethal means (*e.g.,* safer firearm storage) (Goal 6 of the 2012 Strategy).

HHS and its partners are active in the ongoing effort to reduce suicide through direct, on the ground activities.

Partners in Suicide Prevention

Perhaps the greatest success of the National Strategy is a coalescing of many stakeholders around this problem. We know this is not an issue that government can address alone, and we need partnerships across other non-Federal organizations. Mr. Robert Turner, Senior Vice President of Corporate Relations for the Union Pacific Corporation, recently succeeded former Oregon Senator Gordon Smith as a leader of the National Action Alliance for Suicide Prevention's private sector efforts. His focus will be to continue to engage the private sector, ensuring that all sectors with a legitimate role in preventing suicide in our Nation are engaged. The Alliance works to champion suicide prevention as a national priority, catalyze efforts to implement high priority objectives of the NSSP, and cultivate the private resources needed to partner with Federal resources to sustain progress.

Earlier this year, their Research Prioritization Task Force released, *with the support of NIMH, A Prioritized Research Agenda for Suicide Prevention: An Action Plan to Save Lives*[14]. The recommendations are based on the impact of currently known interventions and the potential number of suicide attempts and deaths that could be prevented. Two new NIH initiatives will focus on priorities of the *Research Agenda* including funding opportunities calling for research on violence with particular focus on firearm violence; and supporting research that is developing and testing screening approaches for use in emergency departments to identify children and adolescents at risk for suicide.

Another Action Alliance initiative is the Suicide Attempt Survivors Task Force, which includes suicide attempt survivors' perspectives on the effectiveness of certain interventions and approaches. Their perspectives were used in developing a technical guidance document for

---

[13] See: http://www.who.int/mental_health/suicide-prevention/world_report_2014/en/

[14] See: http://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/Agenda.pdf

governments and organizations; in this way, the voice of those with lived experience has been included in the national efforts.

The Action Alliance is advancing high priority recommendations from the National Strategy that have the potential to substantially lower the burden of suicide in our Nation. Examples of their current initiatives include:

- *Zero Suicide:* The Action Alliance has developed the Zero Suicide framework; this is based on evidence from pioneering health organizations and is grounded in a commitment to suicide prevention in health and behavioral health care systems. Its core proposition is that suicide deaths for people under the care of any health care professional are preventable and that the bold goal of zero suicides among persons receiving care is an aspirational challenge that health systems should accept. The model, which includes a specific set of tools and strategies, is currently being piloted in selected sites across the country; it transforms suicide care through leadership, policies, practices, and outcome measurement. It represents a commitment to patient safety and also to the safety and support of clinical staff.

- *Changing the Conversation:* The Action Alliance is partnering with the media, as well as those who communicate regularly with the media, to change how we report on and speak about suicide and suicide prevention. The Action Alliance is committed to ensuring public messages are safe, accurate, and offer hope and resources to those in distress. Among our many efforts, the Action Alliance has partnered with Poynter Institute, a leading resource for journalists, to begin training both print and broadcast journalists through a Poynter/Action Alliance: Covering Suicide and Mental Health Reporting Institute. This institute will provide journalists with crucial training to effectively communicate to the public about suicide and mental health.

- *Faith Communities*: The Action Alliance launched the Your Life Matters! Campaign which provides guidance and resources to help faith communities devote one worship each year to messages of hope, social connections, reasons for living, and support for community members facing mental health and substance use challenges. As we know, faith communities are often the front line for providing assistance, support and referral for those who struggle with mental health challenges or thoughts of suicide. This initiative is intended to engage a key sector in our suicide prevention efforts.

In addition to the catalyzing efforts mentioned above, the Action Alliance is also developing action plans to address four additional high-priority areas over the next two years: (1) preventing suicide by addressing alcohol and substance use; (2) preventing suicide by improving care transitions for those receiving mental health services; (3) preventing suicide among people in the middle years; and (4) promoting a culture of safety in our health care facilities and in our communities. Recommendations to advance these priorities are being formulated as we speak by teams of both public and private sector participants and will be presented to the Executive Committee of the Action Alliance for decision and action.

Conclusion

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. Our Nation is making steady progress in both understanding the nature of suicide and what can be done to prevent it. While much has been done, much more needs to be done. Our collective efforts are beginning to change systems, engage new partners with a role to play and provide those in need with the services and support they require to assist in their recovery.

Suicide prevention needs to be addressed in the comprehensive, coordinated way outlined in the National Strategy. We know that no one agency or one approach will solve the challenge of suicide in our nation. Reducing the number of suicides requires the engagement and commitment of people in many sectors in and outside government, including public health, mental health, health care, the Armed Forces, business, entertainment, media, and education. No matter where we live or what we do, each of us has a role in preventing suicide.

We will continue to support collaboration across public and private sectors at the Federal, State, Tribal, and local levels, and seek to identify where we can find leaders and organizations willing to test, implement, and sustain effective suicide prevention strategies. From where I sit, at this time in the field of suicide prevention, there is a sense of hope and optimism, there is a sense of urgency, and there is most certainly a need for collaborative and focused action. National suicide prevention efforts are primed to make bold, significant progress that will save lives. I applaud you for bringing attention to this issue and I urge your continued support for suicide prevention.

Thank you Mister Chairman, Ranking Member DeGette, and members of the Subcommittee. I will be happy to answer your questions at this time.

Additional Resources:

National Strategy for Suicide Prevention: Goals and Objectives for Action. 2012
http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/index.html

The Surgeon General's Call to Action to Prevent Suicide. 1999
http://profiles.nlm.nih.gov/ps/retrieve/ResourceMetadata/NNBBBH

National Strategy for Suicide Prevention: Goals and Objectives for Action. 2001
http://www.sprc.org/sites/sprc.org/files/library/nssp.pdf