Statement

Of

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Chairman Murphy, Ranking Member DeGette, and members of the Committee, thank you for inviting the American Foundation for Suicide Prevention (AFSP) to testify today on “Suicide Prevention and Treatment: Helping Loves Ones in Mental Health Crisis.” I am Dr. Christine Moutier and I am AFSP’s Chief Medical Officer.

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 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. My clinical focus was in the areas of mood disorders, cultural issues related to mental health, and educating non-mental health clinicians about mental health issues and suicide risk. As a dean, my emphasis was on medical education through the lens of what needed to change to produce a higher quality healthcare workforce- compassionate, knowledgeable, and capable of the marathon of clinical care. Additionally, after losing too many colleagues and students to suicide, I 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.

Mr. Chairman, last week was National Suicide Prevention Week. AFSP hosted a briefing with Patrick Kennedy and the National Council for Behavioral Health on our new mental health consumer tools. I understand that you also participated in this important briefing to underscore the urgency of suicide as a national public health crisis. Thank you for your long-standing leadership in mental health and suicide prevention.

Sadly, actor and comedian Robin Williams has been gone now for more than a month. Since his suicide, an additional 3400 Americans have died from suicide too. Despite the unfortunate description of Robin's passing as "Genie, you are free," the starry sky from Disney's Aladdin, and the written implication that suicide is somehow a liberating option; it presented suicide in an idealized light. This type of conversation violates well-established public health standards for how we talk about suicide. Our national conversation on suicide must change now!

Nor was Robin's suicide a selfish act, or any suicide a selfish act. Suicide, as we in this room know, has numerous underlying issues that can be addressed successfully through therapy, treatment, and support.

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 39,518 suicides in 2011, and occupational loss and direct healthcare costs estimated to be $34 billion annually. Suicide is one of the leading, yet largely preventable causes

of death in our country. It is currently the 10th leading cause of death, and in adults age 18-64, it is the 4th leading cause of death. We need to do more, particularly for those vulnerable populations who have shown some of the largest rates of increase in suicide risk in recent years, such as our nation's veterans and military personnel. It is estimated that approximately 22% of the 39,518 deaths by suicide in 2011 (latest available data) were completed by veterans; and, according to the 2012 VA Suicide Data Report, an average of 22 veterans die by suicide each day. Additionally, in recent years, military personnel are more likely to die by suicide than be killed in combat. Middle-aged Americans' risk of suicide has also increased significantly over the past decade (in men age 45-64 by nearly 50% from 2000 to 2011.) For every suicide, there are an estimated 25 suicide attempts, each with their own toll on individuals, families, providers, and workplaces. And these figures do not consider the broader spectrum of suicidal behavior, which includes a range of upstream behavioral problems.

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 the area of 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.

But 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, 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.

Warning Signs of Suicide and Protective Actions to Take

If an individual has one or more of the risk factors highlighted above, the key to preventing suicide is recognizing the warning signs of suicide such as:

- Talking or writing about death or a wish to be dead;

- Expressing hopelessness, feeling humiliated, trapped or desperate;
- Losing interest in regular activities or losing the ability to experience pleasure;
- Experiencing insomnia, intense anxiety or panic attacks;
- Being in a state of extreme agitation or intoxication;
- Becoming socially isolated and withdrawing from loved ones; and,
- Looking for a way to hurt or kill oneself such as hoarding medicine, purchasing a new firearm, or searching online for suicide methods.

Whether an individual is in immediate crisis or is just looking for help, immediate protective actions should be taken that include:

- Not leaving the person alone and removing any lethal means for suicide (firearms, sharp objects, prescription drugs, and over-the-counter medicines);
- Encouraging an open conversation about symptoms and problems with a physician or mental health provider;
- Finding and delivering effective clinical care for mental and physical health, and seek treatment for problems with alcohol or drugs; and,
- Providing support through the recovery process, especially during the initial period when medications and treatment plans may need fine-tuning to work.

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.

Research

Research is vitally important to understanding what works to prevent suicide. Suicide research should focus on gaps in the science, which if understood, would have the greatest potential for reducing suicide burden.

The field of suicide research is maturing. The earliest researchers are now mentoring young investigators, to improve methodology and build upon a growing body of findings.

As the leading private funder of suicide research, AFSP has played a defining role in this maturation. We do not just fund research; we also shape its direction. Our scientific advisory includes over 150 suicide researchers across disciplines who provide peer review for AFSP, galvanize interest in research and lay communities, and identify new critical areas for investigation.

But suicide is challenging to study. Timely surveillance is difficult to capture, and large sample sizes are needed to detect changes from a baseline rate (12.3/100,000 in 2011). And this is on top of the usual challenges attendant to cross-disciplinary research that the complex roots of suicidal behavior requires.

Since these challenges require creativity to surmount, AFSP uses a strategic approach to fund the best science with an eye toward impact. Untethered to the restrictions of federal funding, in addition to larger scale projects, AFSP is able to fund many pilot studies that are high risk but potentially high yield. One AFSP-funded study trained primary care physicians in a region of Hungary with one of the highest suicide rates in the world, and found that their training led to a reduction in suicide rates in that region—that is at least until the effect of the training passed two years later. Studies of bridge barriers dispelled the myth that people bent on suicide will find a way, since suicide rates for the whole region diminished following their construction. Studies of community intervention programs, such as educating and partnering with gun shop owners, have shown promising results. And clinical intervention investigation has broadly spanned studies of lithium, clozapine, electroconvulsive therapy, Safety Planning, Cognitive Behavioral Therapy, Dialectical Behavioral Therapy, Attachment Based Family Therapy, as well as focusing on periods of high risk.

While AFSP is the nation's largest private sector funder of scientific research across all disciplines that contribute to understanding suicide and suicide prevention, we cannot do this alone.

Perhaps the biggest problem is that federal funding of research is far from being commensurate with its morbidity and mortality toll.

Before I started in my current position, I was a Co-Investigator of the Sequential Treatment Alternatives to Relieve Depression (STAR*D) study funded by the National Institute of Mental Health. STAR*D is the largest study of treatment for Major Depressive Disorder to date with over 4000 subjects enrolled. It was a unique experience because it utilized a combination of blind randomization and patient preference with no placebo group-therefore a hybrid Randomized Clinical Trial and naturalistic design. It sought to compare the effect of typically used treatment options when an initial SSRI antidepressant was not effective for an individual's depression. The results of the study were sobering to the clinical community because we found that achieving response or remission from depression, even with a combination of treatments and cognitive behavioral therapy, is more difficult and less common than had been previously thought. For example, with the initial antidepressant treatment, about one-third of patients' depression remitted and an additional 15% had a partial response, during 12 weeks of treatment. Those who did not have full remission of symptoms went on to another treatment option or tier of the study (such as switching to a different antidepressant, combining with another medication, or combining with psychotherapy). With each subsequent four tiers of treatment, response rates diminished, meaning more cases of depression are tougher to treat fully and effectively than had been earlier felt to be the case. Clinicians need to monitor symptoms closely and adjust treatment judiciously, just as specialists in other fields would do for other chronic illnesses like hypertension or diabetes.

NIMH showed leadership with this innovative design, using both psychiatry and primary clinics throughout the U.S., to attempt to answer the vexing question of what to do when depression is not improving or not completely resolving. It has been known since the 1990s with earlier NIMH studies like the Collaborative Depression Study (a 10-year prospective study following the course of approximately 400 people with depression from the 1980s-90s) that unless full remission is achieved, the prognosis for relapse and for impaired life functioning is significantly compromised. Therefore the appropriate goal for the treatment of depression, as stated in the American Psychiatric Association's (APA) treatment guidelines, is full and ongoing management of depression with resolution of depressive symptoms, again similar to the goals of treatment for hypertension and diabetes. Other large population based studies of depression have found that among community-dwelling people receiving treatment for depression, only 20% are receiving treatment that is considered on par with these evidence-based recommendations.

AFSP believes that the Federal Government must substantially increase funding of suicide research in the hopes of obtaining similar reductions in mortality that have resulted from strategic investments in other major public health concerns, like HIV/AIDS, heart disease, prostate, breast and colorectal cancer.

For example, we've seen a 42% decline in deaths from HIV/AIDS between 2000-2011 while the government invested more than $12 billion in research between fiscal years 2009-2012. Today, our government only spends around $40 million in direct suicide prevention research.

AFSP urges members of Congress to carefully evaluate the recently released (2/12/14)

recommendations from a three-year study of the Research Prioritization Task Force of the National Action Alliance for Suicide Prevention. This report lays out six prioritized approaches for allocating funds and monitoring future suicide research to ensure that available resources target research with the greatest likelihood of reducing suicide morbidity and mortality. Of the six approaches outlined, the top two include:

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 reduce risk conditions (e.g., insomnia, addiction, agitation, pain, etc.) 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.

Specific detailed information can be found at www.suicide-research-agenda.org.

Suicide Prevention Strategies

Another critical component would be developing and investing in suicide prevention, using education, technology, and advocacy. Prevailing cultural perceptions about suicide and mental health keep 4 out of 5 people suffering from mental health problems like depression and anxiety from seeking help. To change these numbers and encourage more to seek treatment, our strategy

must involve the eradication of stigma and the shattering of real and perceived barriers. And to do this we need to accelerate the translation of research from bench to bedside and permeate societal consciousness.

When reluctance to seek help for mental health problems is this pervasive, tools that circumvent the need for people to self-identify are key. We need mechanisms that streamline help-seeking. To that end, AFSP has developed the Interactive Screening Program, an online tool that connects those at risk with the mental health services they need to get—and stay—healthy. The screening is anonymous, it offers personal interaction with a counselor, and it is already saving lives of veterans, students, physicians, corporate employees, and police personnel. ISP is the only program to offer an anonymous connection to counselor. But we need to make it available to more workplaces.

And there is no lack of incentive for workplaces, because mental health is smart business. The costs associated with mental health problems are staggering—absenteeism and presenteeism due to mental health problems cost the U.S. over $200 billion dollars each year. These billions could be pressed into our service to encourage more businesses to invest in the mental health of their workforce.

Targeted education of frontline citizens and leaders in organizational hierarchies—especially employers, educators, first responders, physicians and other healthcare professionals, and clergy—is essential. Their regular contact with populations affords the opportunity to detect fluctuations in behavior that could signal mental health problems and suicide risk. This is why

Mental Health First Aid is so important to our communities.

Additionally, like the Air Force Suicide Prevention program's strategy, authority figures in these populations are uniquely positioned not only to encourage those struggling to seek help, but to sanction that help-seeking as well. AFSP has a commitment to study the outcomes of all of our prevention programs, addressing a significant gap in suicide prevention science.

Advocacy is a crucial component to an effective prevention strategy. In addition to securing research funding, AFSP and its thousands of field advocates lobby legislators and government officials for laws and policies that can reduce suicides and incentivize best practices. The legislation can be as simple as requiring schools to provide teachers and students suicide prevention education, or as sweeping as the Mental Health Parity and Addiction Equity Act. Finally, we need more and higher quality support in the aftermath of suicide, and we must extend our support to include the emerging population coming out as attempt survivors.

Too often our first responders, from paramedics to funeral home directors to media personnel, do not get the training they need to handle suicide. This lack of preparation can be dangerous, particularly with the media. Research shows that mishandled messaging following a suicide death can precipitate more suicides via contagion. AFSP has developed safe messaging guidelines for media as well as for those who are telling their personal stories as part of grassroots events. And we are using our relationships with media to get safe, effective messaging about suicide adopted into wider use.

But it is more than just controlling the immediate aftermath. The toll a suicide takes on family, friends, and colleagues can have a serious impact on the community, and in some cases trigger more attempts.

Support for those Touched by Suicide

AFSP has a number of programs dedicated to supporting those who are newly bereaved, such as AFSP's Survivor Outreach Program, as well as for those who are farther along in their healing journey. A national summit for seasoned loss survivors will be hosted by AFSP in the fall of 2015. And every year in November for the past 15 years, AFSP hosts more than 250 International Survivors of Suicide Loss Day Programs spanning the globe.

Thanks to grassroots funding, AFSP is now able to engage suicide attempt survivors. There are an estimated 2.5 million suicide attempts each year, with an estimated total of 100 million attempt survivors (lifetime) in the U.S. AFSP recently conducted a series of focus groups to discover more about what kinds of resources and programs would be useful for people with lived experience and their families.

AFSP's 67 chapters across the United States function as supportive networks for their local community and are the delivery mechanism for community-based suicide prevention programs. They host events where AFSP-funded scientists present their research to communities, they provide suicide prevention education for teachers and students, and educate their communities through local awareness campaigns. Chapters also partner with healthcare institutions to provide clinical training programs on suicide prevention. They are a model for community involvement,

and have made a huge impact in changing the conversation regarding mental health.

I believe we can accomplish the goal of reducing the suicide rate in our country 20% by 2025. Science provides clear evidence for strategies to take, and I believe the American people are ready for a greater understanding of the issue. If we push hard with an effective strategy, we can save lives.

One final thought, people have often asked me during my career why suicide has been left out of the conversation around mental health and how can we change this?

During the course of caring for people with mental health problems, clinicians become very busy with the clinical and social issues at hand. Some examples of the activities that need to be done during a clinical session are tracking the person's key symptoms, monitoring treatment's therapeutic and side effects and discussing ways to optimize both with the patient, addressing the functional aspects of the person's life, e.g., the impact of energy and concentration problems on work and home life, helping the person to apply for appropriate aid or health insurance, and communicating with family members when possible. Doing these tasks within a standard 20-minute session is extremely challenging; add the lack of training on the assessment of suicide risk and knowledge about effective ways to approach the suicidal patient; and the scrambling effect of anxiety on even the best of clinicians. As healthcare providers, we work hard and feel gratified when a patient's mental health is improving and we worry about deterioration in the health of our patients; but among our greatest fears is that of losing a patient to suicide. But without thorough training and preparation for working with suicidal patients, clinicians may tend

to avoid it. Like the primary care physician who proclaims, "I don't have any patients with depression," because s/he doesn't ask and doesn't recognize the signs of its presence, mental health clinicians don't always ask about suicidal thoughts even when it would be indicated and the majority do not routinely assess the suicide risk of patients ever, let alone in an ongoing way, which is recommended.

This problem can be readily addressed by 1) continuing to develop and test effective screening and interventions for people at risk for suicide, 2) developing curricula and core competency standards for suicide training for all mental health clinicians, emergency medicine, and primary care clinicians, and 3) disseminating the most effective evidence-based treatment modalities to clinicians.

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 120,000 people to participate in over 325 Out of the Darkness Walks.

We have a strategy that will work—the tactics are backed by sound research, and we've seen similar strategies make headway in reducing other public health related causes of death.

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.

Chairman Murphy and Ranking Member DeGette, the American Foundation for Suicide Prevention thanks you again for the opportunity to provide testimony today and looks 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.

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AFSP is the nation's leading organization in the fight to prevent suicide, bringing together people across communities and backgrounds to understand and prevent suicide, and to help heal the pain it causes. Individuals, families, and communities who have been personally touched by suicide are a powerful force, especially when combined with the science. This combination of grassroots and science is behind everything we do. You can learn more by visiting www.afsp.org.

- We strive for a world that is free of suicide.
- We support research, because understanding the causes of suicide and the effective strategies for prevention and intervention are vital to saving lives.
- We educate community members, particularly those who serve in frontline roles, in order to foster understanding and inspire action.
- We offer a caring community to those who have lost someone they love to suicide, or who are struggling with thoughts of suicide themselves and their families.
- We advocate to ensure that federal, state, and local governments do all they can to prevent suicide, and to support and care for those at risk.