TESTIMONY OF
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BEFORE THE
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Chairman Tillis, Ranking Member Gillibrand, and Members of the Committee – thank you for inviting the Substance Abuse and Mental Health Services Administration (SAMHSA) to participate in this extremely important hearing on suicide prevention. I am Richard McKeon, Chief of the Suicide Prevention Branch in the Center for Mental Health Services, SAMHSA. I also serve as Chair of the Federal Working Group on Suicide, and I co-lead the State and Local Line of Effort for the PREVENTS Task Force established under the President's Executive Order to Reduce Veteran Suicide. Previously, I was privileged to be able to serve on the Department of Defense Task Force on the Prevention of Suicide by Members of the Armed Forces.

An American dies by suicide every 11 minutes. In 2018, the Centers for Disease Control and Prevention (CDC) issued a major analysis of deaths by suicide during the time period between 1999 and 2016. The CDC Vital Signs analysis showed that the tragic toll of suicide has been increasing all across the country. Suicide is the 10th leading cause of death in the United States; the second leading cause of death between ages 10 and 34. We lost over 47,000 Americans to suicide in 2017, almost the same number we lost to opioid overdoses. For each of these tragic deaths, there are grief-stricken families and friends, impacted workplaces and schools, and a diminishment of our communities. When one of these deaths involves an American who has served his country in the military, as happens on average17 times each day, we as a nation suffer additionally. SAMHSA's National Survey on Drug Use and Health has also shown that approximately 1.4 million American adults report attempting suicide each year, and over 10 million adults report seriously considering suicide. This leads to huge direct medical costs, and more importantly, tremendous human misery.

As painful as these numbers are, our concern is intensified by the CDC's report that suicide has been increasing in 49 of the 50 states, with 25 of the states experiencing increases of more than 30 percent. These increases have been taking place among both men and women, and across the lifespan. While Federal efforts to prevent suicide have been steadily increasing over time, thus far, they have been insufficient to halt this tragic rise. While we do not know all we need to know about what is driving these increases in suicide, there is much we do know about what puts people at risk for suicide, what protects them from suicide, and about what needs to be done to strengthen our national efforts. We know from CDC's National Violent Death reporting System that mental health issues play a critical role but only about 50 percent of those who die by suicide have had a mental health issue identified and only 25-30 percent are

receiving any mental health treatment. Additionally, problematic substance use is involved with approximately 28 percent of suicide deaths.

We also know that there are many distressing events and circumstances that can precipitate suicidal ideation or attempts, particularly among those with pre-existing vulnerabilities. These vulnerabilities may include homelessness, unemployment, medical illness or interpersonal losses. We know that a suicide attempt is the single strongest predictor of death by suicide, and for those individuals we must provide proactive outreach and coordinated care and treatment. However, we also need to intervene even earlier as the majority of people who die by suicide have never made a suicide attempt, illustrating that we need to intervene earlier, before people act on suicidal thoughts, or ideally, to prevent the onset of suicidal thoughts. We know that our efforts must engage multiple sectors and must include multiple levels. We need a greater scientific foundation for efforts that can prevent individuals from experiencing the onset of suicidal thoughts. We need stronger efforts to apply what we already know to identify people who are thinking about suicide and then to get them the treatment and support they need. In addition, we need to improve both the quality and continuity of care to those who have attempted suicide. We need to make suicide prevention stronger in health care, but also need to engage schools, workplaces, faith communities, and many others. We need to have an infrastructure to support this work in states, tribes and communities, and need to bring what we already know to scale nationally.

While we have not been able yet to halt the tragic rise in suicide, we have seen that concerted, coordinated, and sustained efforts can save lives. We have made a concerted national effort in youth suicide prevention which has produced evidence that lives have been saved. Cross-site evaluation of our Garrett Lee Smith State/tribal youth suicide prevention grants has shown that counties that were implementing grant-supported suicide prevention activities had fewer youth suicides deaths and suicide attempts than matched counties that were not. However, this life-saving impact fades two years after the activities have ended as it has been shown that there is no longer a difference in suicide rates between counties who implemented youth suicide prevention activities and counties that did not. The greatest impact was seen in counties that have had the longest period of sustained funding for their suicide prevention effort. This underscores the need to embed suicide prevention in the infrastructure of states, local government, and tribal communities. While all 50 states have received a Garrett Lee Smith (GLS) state grant at some point in the lifetime of the grant series, too often the suicide prevention activities cannot be sustained when the grant ends.

An example of the successful implementation of a GLS grant is the White Mountain Apache tribe in Arizona, which received three consecutive GLS grants and has shown a reduction of almost 40 percent in youth suicide deaths. In that community, youth who experience suicidal thoughts, wherever they may be on the reservation, will be seen by a trained Apache community worker rapidly after their suicide risk has been identified and the individual will be linked to needed treatment and supports. This example demonstrates the value of timely access to effective suicide prevention and intervention services and the demonstrated success of these grants at the county level

show the potential for a comprehensive, coordinated county based effort to prevent suicide across the lifespan.

In Fiscal Years (FY) 2017 and 2018, Congress provided SAMHSA, $11 million dollars to implement the National Strategy for Suicide Prevention, with a focus on adult suicide prevention, including $9 million appropriated to the Zero Suicide initiative specifically. Zero Suicide is an effort to promote a systematic evidence-based approach to suicide prevention in healthcare systems using the most recent findings from controlled research studies as part of a package of interventions that moves suicide prevention from being a highly variable and inconsistently implemented individual clinical activity to a systematized and prioritized effort across the whole healthcare system. The Zero Suicide initiative uses the most recent evidence-based science on screening, risk assessment, collaborative safety planning, care protocols, treatments and care transitions (providing rapid follow up after discharge from inpatients units and Emergency rooms), as well as ongoing continuous quality improvement. The Zero Suicide initiative was inspired by the success of the Henry Ford Healthcare system in reducing suicide by more than 60 percent among those receiving care, and other early adopters such as Centerstone in Tennessee, one of the Nation's largest community mental health systems, have shown similar results.

More recently, the state of Missouri has shown that it is possible to reduce suicide among those receiving care in the state's community mental health system, achieving a 32 percent decrease in suicide deaths among clients served in community behavioral health centers. As an example of this approach, Centerstone's protocol for treating those identified at high risk requires that an outreach phone call be made promptly if the person at risk misses a scheduled appointment. In one instance, a person on the Centerstone high-risk protocol missed his appointment and when the follow up phone call was made, the person was on a bridge contemplating suicide. Instead, he came to Centerstone and agreed to participate in treatment. SAMHSA has funded 19 states, tribes and health care systems to incorporate Zero Suicide and technical assistance in implementing this approach, has been provided too many more through the Suicide Prevention Resource Center and through SAMHSA's Mental Health Technology Transfer Centers. Improving the training in suicide prevention for all healthcare providers is a key component of the Zero Suicide approach.

SAMHSA has also been working through all of its suicide prevention grant programs to improve post discharge follow up since multiple studies have shown that rapid contact after discharge from Inpatient Psychiatric Units and from Emergency Rooms and prompt link to outpatient services can prevent suicide attempts. While we would all wish that discharge from an Inpatient Unit or from an Emergency Room meant that all risk for suicide had been eliminated, in reality suicide risk persists or re-emerges and there is a demonstrated benefit in maintaining contact with people during this very vulnerable time at least until they can be successfully linked to outpatient care. In a study of over 1 million US veterans treated for depression, the period immediately after inpatient discharge was found to be the time of highest risk. In a study of youth on Medicaid in 33 states who had been admitted to a psychiatric hospital, the odds of

death by suicide was 76 percent lower for youth who had a mental health visit within 30 days of discharge.

The National Institute of Mental Health's Emergency Department Safety Assessment and Follow Up Evaluation, which studied universal screening, safety planning, and follow up phone calls showed that rapid telephonic follow up after discharge reduced the number of suicide attempts. Similarly, the Veterans Administration's Suicide Assessment and Follow Up Engagement Veteran Emergency Treatment (SAFE VET) Study showed that a combination of collaborative safety planning and rapid telephonic follow up reduced suicide attempts and increased linkage to VA care. In a study by the Mental Health Research Network on variations in patterns of health care before suicide, emergency rooms were identified as of particular importance because they combine high utilization with substantial relative risk. The ED-SAFE study showed that universal screening for suicide risk in emergency rooms lead to a doubling of the identification of people experiencing suicidal thoughts and that those identified were at equivalent risk to those being seen in the emergency department because of known suicide risk.

The SAMHSA suicide prevention program that touches the greatest number of people thinking about suicide is the National Suicide Prevention Lifeline (the Lifeline). The Lifeline is a network of over 165 crisis centers across the country that answer calls to the toll-free number 800-273-TALK (8255). The National Suicide Prevention Lifeline includes a special link to the Veterans Crisis Line, which is accessed by pressing "one". The Veterans Crisis Line also serves as the Military Crisis Line. The Lifeline is available 24 hours a day, 7 days a week, and in many communities in America, it is the only immediately available option for a person thinking about suicide to reach out for help. Last year, more than 2.2 million calls were answered through the Lifeline, and that number has been growing at a rate of about 15 percent per year. About 25 percent of Lifeline callers are actively suicidal at the time of the call and some of them need emergency rescue services.

The Lifeline also provides a chat service through the website, and the percentage of those using the crisis chat service who are actively suicidal is even higher. We believe this is reflective of the rising rates of suicide in youth, who may be more likely to use a chat service. Evaluation studies have shown that callers to the Lifeline experience decreased suicidal thoughts and hopelessness by the end of the call. Both the initial calls to the Lifeline as well as follow-up calls from Lifeline centers are frequently experienced as lifesaving. In this way, the calls themselves are actual interventions not simply a triage to another service, although referral for emergency rescue using police or ambulance is utilized when necessary when risk is both acute and imminent. SAMHSA, VA, and the Federal Communications Commission (FCC) have worked together to implement the National Suicide Hotline Improvement Act and this past August the FCC recommended that the number "988" be assigned as a new, national suicide prevention hotline number.

Community crisis centers are responsible for responding to calls and chats. While many of them receive a very small amount of funding from the federal government through SAMSHA, these crisis centers are not directly operated by

SAMHSA. Lifeline community crisis centers largely depend on local, private, or state funding. When local crisis centers are unable to answer Lifeline calls, the calls must be answered by designated regional back up centers. When calls go to regional back up centers, the amount of time it may take to answer the call can increase, highlighting the importance of local crisis center capacity.

SAMHSA and VA have been working together to prevent suicide since 2007, when the Veterans Crisis Line was first established and the "press one option" was introduced into the National Suicide Prevention Lifeline message. More recently, SAMHSA and VA have worked together to fund a series of Mayor's Challenges and Governor's Challenges to prevent suicide among all veterans, service members, and their families, regardless of whether they are receiving care though VA. Supported through an Interagency Agreement with VA, SAMHSA's Service Members, Veterans and their Families Technical Assistance Center, has convened cities and states for policy academies and implementation academies to promote comprehensive suicide prevention for veterans. Multiple public and private partners are engaged in this coordinated effort for which onsite technical assistance is also provided. We believe that this type of strong, continuing, interdepartmental effort that incorporates states and communities as partners is necessary to reduce veteran suicide.

SAMHSA, VA and DOD also work together through the Federal Working Group on Suicide Prevention, which includes Department of Justice, Department of Homeland Security, CDC, National Institute of Mental Health (NIMH), Indian Health Service, Administration for Community Living, and the Health Resources and Services Administration. SAMHSA, VA, DOD, NIMH, CDC and other Federal agencies and Departments also work with other public and private organizations through the National Action Alliance for Suicide Prevention (Action Alliance), which was stood up with SAMHSA funding in 2010 and has engaged over 250 organizations since its inception. The Action Alliance worked with the Office of the Surgeon General, SAMHSA, and others to revise the National Strategy for Suicide Prevention and continues to engage partners from multiple sectors to promote comprehensive suicide prevention efforts.

In summary, SAMHSA, and the entire Federal Government is engaged in an unprecedented number of suicide prevention activities, but we know we all need to do more if we are to halt the tragic rise in loss of life we are experiencing across the country. In particular, we know we need to be engaged in a strong continuing, collaborative effort across the Federal Government along with states, tribes, communities, and private partners across America to implement a comprehensive public health approach that incorporates everything we now know about preventing suicide. We know we must constantly be looking to improve our efforts and to learn from both our successes and our failures. We owe it to those who have served this Nation and to all the people we have lost to suicide, as well as to those that loved them, to continually strive to improve until suicide among veterans, service members, and all Americans is dramatically reduced.