

FIGHTING AGAINST THE SILENT EPIDEMIC¹: AN IMPERATIVE FOR A FEDERAL SUICIDE PREVENTION ACT NARROWING THE LENS ON MENTAL HEALTH

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ABSTRACT

Suicide is one of the top ten causes of death in the United States. Many who have died by suicide had suffered from some mental disorder, particularly a serious mental illness. Despite its prevalence, suicide has lurked and evaded much of the nation's attempted combats against it. The federal government has nonetheless been aware that preventing suicide is an imperative; it has a legitimate interest in doing so and has been involved in suicide prevention efforts, such as the creation of the *National Strategy for Suicide Prevention*. In light of the correlation between suicide and mental health, this Note examines the *National Strategy for Suicide Prevention* and recent congressional action on mental health, and uses them as a framework in arguing that Congress should place an emphasis on assisting mental health consumers to attack the epidemic of suicide.

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¹ Tony Dokoupil, *Deadly Stigma: Robin Williams' Suicide Exposes Silent Epidemic*, NBC NEWS (Aug. 12, 2014, 6:15 PM), <http://www.nbcnews.com/storyline/robin-williams-death/deadly-stigma-robin-williams-suicide-exposes-silent-epidemic-n179206> ("And yet suicide remains a largely silent epidemic. . .").

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I. INTRODUCTION

Even over two decades after his death, Kurt Cobain, the Nirvana frontman hailed as a rock icon and the voice of Generation X, is still captivating the world.² In 2015, the *Kurt Cobain: Montage of Heck* documentary gave audiences a humanizing perspective into the mythicized musician's life.³ However, the film avoided the topic of his apparent suicide, which has been greatly speculated upon since 1994.⁴ Prior to his suicide, Cobain had been suffering from depression, anxiety, and a heroin

² *Kurt Cobain*, ROLLING STONE, <http://www.rollingstone.com/music/artists/kurt-cobain/biography> (last visited Nov. 9, 2015).

³ Brooks Barnes, *With 'Kurt Cobain: Montage of Heck,' Brett Morgen Demythologizes a Legend*, N.Y. TIMES (Apr. 15, 2015), <http://www.nytimes.com/2015/04/19/movies/with-kurt-cobain-montage-of-heck-brett-morgen-demythologizes-a-legend.html>.

⁴ Paula Mejia, *'Montage of Heck' Takes a Sobering Look at Nirvana Frontman Kurt Cobain*, NEWSWEEK (Apr. 18, 2015, 2:04 PM), <http://www.newsweek.com/2015/05/01/montage-heck-takes-sobering-look-nirvanas-frontman-323146.html>; Zach Schonfeld, *Five Kurt Cobain Myths Dispelled in 'Montage of Heck'*, NEWSWEEK (May 6, 2015, 4:15 PM), <http://www.newsweek.com/five-kurt-cobain-myths-dispelled-montage-heck-328887>.

addiction; he also had a family history of suicide and depression.⁵

Suicide has continued to make its way into headlines. In 2010, fashion designer Alexander McQueen, who was diagnosed with mixed anxiety and depressive disorder, hung himself after overdosing.⁶ In 2013, actor Lee Thompson Young had battled bipolar disorder and depression prior to taking his life.⁷ Beloved comedian actor Robin Williams shocked the world upon news of his suicide in August 2014; he had been fighting Lewy body dementia, which had greatly affected his mental condition, causing him to experience anxiety attacks and depression.⁸

A short drive away from the place of Robin Williams's death stands the magnificent Golden Gate Bridge, where over 1600 suicides have occurred over the years by people plummeting off the bridge to their deaths.⁹ On January 4, 2015 a few miles south of the bridge, Matthew Hoffman, a thirty-two-year-old white male, encountered police officers and inquired as to their weapons, which the officers noted as strange.¹⁰ Later that day while loitering in the restricted parking lot of a police station, he acted erratically toward police officers when asked to leave. Instead of complying with the officers' requests to show hands, he walked and stood in the middle of the driveway, stared at the officers, and lifted his shirt to reveal an apparent gun.¹¹ The police officers interpreted the situation as a threat and shot him multiple times, eventually killing him.¹² Later, it was discovered that the gun was merely a toy air gun, with the toy

⁵ Neil Strauss, *Kurt Cobain's Downward Spiral: The Last Days of Nirvana's Leader*, ROLLING Stone (June 2, 1994), <http://www.rollingstone.com/music/news/kurt-cobains-downward-spiral-the-last-days-of-nirvanas-leader-19940602>; Schonfeld, *supra* note 4.

⁶ *Alexander McQueen Committed Suicide After Taking Drugs*, BBC NEWS, http://news.bbc.co.uk/2/hi/uk_news/8648791.stm (last updated Apr. 28, 2010, 12:52 PM).

⁷ Nancy Dillon, *Lee Thompson Young Suffered from Bipolar Disorder: Coroner's Report*, N.Y. DAILY NEWS (OCT 8, 2013, 9:15 PM), <http://www.nydailynews.com/entertainment/gossip/lee-thompson-young-suffered-bi-polar-disorder-article-1.1480009>.

⁸ Kara Warner, *Robin Williams' Widow Susan Williams Opens up to PEOPLE*, PEOPLE, <http://www.people.com/article/robin-williams-widow-susan-williams-people?> (last updated Nov. 8, 2015, 9:45 PM).

⁹ Gregg Zoroya, *40,000 Suicides Annually, yet America Simply Shrugs*, USA TODAY, <http://www.usatoday.com/story/news/nation/2014/10/09/suicide-mental-health-prevention-research/15276353/> (last visited Mar. 4, 2015).

¹⁰ Amy Hollyfield & Vic Lee, *San Francisco Police Say Shooting Death Was 'Suicide by Cop.'* ABC 7 NEWS (Jan. 5, 2015, 6:38 PM), <http://abc7news.com/news/sf-police-say-shooting-death-was-suicide-by-cop/462940/>.

¹¹ *Report: S.F. Police Fatally Shoot Man after Fake Gun Threat*, CBS NEWS (Jan. 5, 2015, 2:53 PM), <http://www.cbsnews.com/news/report-san-francisco-police-fatally-shoot-man-after-fake-gun-threat/>.

¹² Hollyfield & Lee, *supra* note 10.

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identifier removed.¹³ Hoffman had left behind several suicide notes on his cell phone, including one addressed to the police officers:

You did nothing wrong. You ended the life of a man who was too much of a coward to do it himself. I provoked you. I threatened your life as well as the lives of those around me. You were completely within your legal rights to do what you did. You followed protocols. You did everything right. I just want to find peace within myself. I am so sad and I am so lonely. There is no place for me here. Please, don't blame yourself. I used you. I took advantage of you. I am so lost and I am so hopeless. God made a mistake with me. I shouldn't be here. Please, take solace in knowing that the situation was out of your control. You had no other choice.¹⁴

Suicide is "death caused by self-directed injurious behavior with any intent to die as a result of the behavior."¹⁵ Much of the world has been affected by suicide, whether by an attempted or completed suicide by a loved one or someone in the community, by a notable figure like Cobain or Williams, or even by one's own thoughts or behavior.¹⁶ Despite personal connections to stories of suicide, suicide and suicidal behavior tend to be discussed only in moments of tragedy and fade back into obscurity after news dies down.¹⁷ Sadly, suicide still lurks as a top ten cause of death in the United States, and the nation has been unable to lessen its status.¹⁸ Like any other epidemic, suicide ought to be prevented.

This Note discusses the current stance the United States has on suicide prevention and prescribe an ideal policy for Congress regarding suicide prevention, with a focus on mental health consumers. Part II of this Note discusses the most recent statistics regarding suicides in the United States, as well as the risk factors, warning signs, and protective factors of suicide. Part III discusses the relationship between suicide and the law, particularly under constitutional and tort analyses. Part IV describes the history of government involvement relating to the prevention of suicide and the *National Strategy for Suicide Prevention*. Part V describes current

¹³ *Id.*

¹⁴ *Id.*

¹⁵ *2012 National Strategy for Suicide Prevention: Goals and Objectives for Action*, U.S. DEP'T OF HEALTH & HUMAN SERVS. OFFICE OF THE SURGEON GENERAL & NAT'L ACTION ALLIANCE FOR SUICIDE PREVENTION, 14 (2012), available at http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/full_report-rev.pdf [hereinafter 2012 *National Strategy*].

¹⁶ *Id.* at 3.

¹⁷ *Id.*

¹⁸ *Id.*

bills and actions on the legislative floor regarding suicide prevention. Part VI analyzes and prescribes a suicide prevention proposal of policy for legislature to consider with a lens narrowing on mental health consumers and support of mental health. Part VII concludes.

II. SUICIDE: A NATIONAL EPIDEMIC

In this part, I describe the suicide statistics in the United States to illustrate its prevalence. I also list common factors indicative of risk of suicide, warning signs, and protective factors against suicidal behavior. This serves to provide a basic understanding of suicidal behavior and to emphasize that special attention should be given to factors relating to mental health issues in framing a suicide prevention program.

A. STATISTICS ON SUICIDES IN THE UNITED STATES

According to a data brief compiled by the Centers for Disease Control and Prevention, released in December 2014 based on United States mortality data (data is only available for 2013 at the latest; no such data exists for 2014 yet), suicide is a top ten leading cause of death at 12.6 reported deaths per 100,000 in the United States—a rate unchanged from 2012,¹⁹ but overall has been rising steadily since 2000.²⁰ The number of suicides in 2013, the last year this number was made available, is 41,149.²¹ Because in-depth data on suicide rates are not readily available for 2014, I will proceed with figures from 2013.

In 2013, death by suicide occurred every thirteen minutes, totaling around 113 suicides a day.²² Moreover, another thirty individuals attempt

¹⁹ Kenneth D. Kochanek et al., *Mortality in the United States, 2013*, NCHS DATA BRIEF No. 178, 3 (Dec. 2014), <http://www.cdc.gov/nchs/data/databriefs/db178.pdf>; see Jiaquan Xu et al., *Mortality in the United States, 2012*, NCHS DATA BRIEF No. 168, 3 (Oct. 2014), <http://www.cdc.gov/nchs/data/databriefs/db168.pdf> (showing the same suicide rate as 2013).

²⁰ *Facts and Figures*, AM. FOUND. FOR SUICIDE PREVENTION, <https://www.afsp.org/understanding-suicide/facts-and-figures> (last visited Nov. 7, 2015) [hereinafter *Facts and Figures*]. The American Foundation for Suicide Prevention is a leading, national-scope non-profit organization in the “fight against suicide,” dedicated to funding research, developing educational programming, advocating public policy, and supporting the bereaved by suicide. *About AFSP*, AM. FOUND. FOR SUICIDE PREVENTION, <https://www.afsp.org/about-afsp> (last visited Dec. 1, 2014).

²¹ *Facts and Figures*, *supra* note 20.

²² *Suicide: Facts at a Glance*, CTRS. FOR DISEASE CONTROL & PREVENTION, 1 (2015), <http://www.cdc.gov/violenceprevention/pdf/suicide-datasheet-a.pdf> (citing *WISQARS (Web-based Injury Statistics Query and Reporting System)*, CENTERS FOR DISEASE CONTROL AND PREVENTION, NATIONAL CENTER FOR INJURY PREVENTION AND CONTROL,

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suicide for every death by suicide.²³ In sum, approximately 1,169,291 years of potential life was lost by suicide in 2013.²⁴

1. Suicide Figures by Age

In 2013, suicide was the third leading cause of death among people ages ten to fourteen, the second among people ages fifteen to thirty-four, the fourth among people ages thirty-five to forty-four, the fifth among people ages forty-five to fifty-four, and the eighth among people ages fifty-five to sixty-four.²⁵

The greatest growth in suicide rate between 2000 and 2013 lays in people ages forty-five to sixty-four, having increased from 13.5 suicides per 100,000 people in the United States population in 2000 to 19.1 suicides in 2013.²⁶

One explanation for the comparatively high and increasing suicide rate for the forties to sixties year olds is based on the effect of the social or historical events that occur during the middle-age period.²⁷ Middle-aged individuals have been highly susceptible to economic stress and difficulty affording retirement, particularly among those with less than a college degree.²⁸ Coupled with chronic diseases and costs of health care, the lesser-educated are greatly vulnerable to suicidal thoughts, and they are less likely to have adequate health care insurance.²⁹

Another explanation for the rate of the middle-aged is based on being

<http://www.cdc.gov/injury/wisqars/index.html>).

²³ 2012 *National Strategy*, *supra* note 15, at 10.

²⁴ John L. McIntosh & Christopher W. Drapeau, *U.S.A. Suicide: 2013 Official Final Data*, AMERICAN ASS'N OF SUICIDOLOGY, <http://www.suicidology.org/Portals/14/docs/Resources/FactSheets/2013datapgs3.pdf> (last visited Nov. 7, 2015).

²⁵ *Suicide: Facts at a Glance*, *supra* note 22, at 2 (citing *WISQARS (Web-based Injury Statistics Query and Reporting System)*, CENTERS FOR DISEASE CONTROL AND PREVENTION, NATIONAL CENTER FOR INJURY PREVENTION AND CONTROL, <http://www.cdc.gov/injury/wisqars/index.html>).

²⁶ *Facts and Figures*, *supra* note 20.

²⁷ Julie A. Phillips et al., *Understanding Recent Changes in Suicide Rates Among the Middle-aged: Period or Cohort Effects?*, 125 *PUB. HEALTH REPS.* 680, 681 (2010), <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2925004/pdf/phr125000680.pdf>. Phillips is a social demographer and professor at Rutgers University in the Department of Sociology and the Institute for Health, Health Care Policy and Aging Research. She is funded by the American Foundation for Suicide Prevention to research the differences and patterns of U.S. suicide rates among different demographic, socioeconomic, and behavioral factors, and across life course, time period, and birth cohort.

²⁸ *Id.* at 687.

²⁹ *Id.*

a member of the Baby Boomer cohort; this cohort experienced high rates of depression, substance abuse, and lifetime disadvantages such as greater competition for scarce resources in education and labor.³⁰ Baby boomers without a college degree (and adequate health care) may be most at risk, as they face the “rapid onset and economic burden of chronic illness in middle age” and the competition against younger cohorts for resources.³¹

2. Suicide Figures by Sex

In the past few decades, suicide rate among men has consistently been four times higher than that of women (as of 2013, the rate of suicide among men was 20.2 versus 5.5 with women).³² However, women tend to have more suicidal thoughts than men and account for three-fourths of all non-fatal suicide attempts in the United States.³³ Women are more likely to seek medical help or support than men, and men are more likely to prevail in mortality when attempting suicide.³⁴

B. COMMON RISK FACTORS OF SUICIDE

Studies have compiled characteristics or conditions indicative of suicide risk; however, just because these characteristics correlate with suicide does not mean they are direct causes.³⁵ These factors may be divided into three categories: health, historical, and environmental.³⁶

The health factors include a history of mental disorders, namely bipolar disorder, borderline personality disorder, panic disorder, major depression, post traumatic stress disorder, and schizophrenia (all falling under a narrower category of serious mental illness (“SMI”)); alcohol or

³⁰ *Id.* at 681.

³¹ *Id.* at 687.

³² *Facts and Figures*, *supra* note 20; McIntosh & Drapeau, *supra* note 24.

³³ *Frequently Asked Questions*, AM. FOUND. FOR SUICIDE PREVENTION, <https://www.afsp.org/understanding-suicide/frequently-asked-questions> (last visited Nov. 7, 2015).

³⁴ COMM. ON PATHOPHYSIOLOGY & PREVENTION OF ADOLESCENT & ADULT SUICIDE, REDUCING SUICIDE: A NATIONAL IMPERATIVE 40 (SK Goldsmith et al. eds., 2002) [hereinafter REDUCING SUICIDE]; *Suicide: Facts at a Glance*, *supra* note 22.

³⁵ REDUCING SUICIDE, *supra* note 34, at 2; *see also Suicide: Risk and Protective Factors*, CTNS. FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/violenceprevention/suicide/riskprotectivefactors.html> (last visited Mar. 18, 2015) (listing factors in a concise manner).

³⁶ *Suicide Risk Factors*, AM. FOUND. FOR SUICIDE PREVENTION, <https://www.afsp.org/understanding-suicide/suicide-risk-factors> (last visited Jan. 6, 2015) [hereinafter *Suicide Risk Factors*, AM. FOUND. FOR SUICIDE PREVENTION].

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substance abuse history; and physical illness.³⁷

Suicidal thoughts and suicide rates are highest among those with mental disorders.³⁸ 90 percent of completed suicides in the United States have been correlated to a mental disorder.³⁹ Furthermore, untreated, undertreated, or undiagnosed depression is leading cause of suicide.⁴⁰ The 2012 *National Strategy for Suicide Prevention* wrote:

Having a mental and/or a substance use disorder can greatly increase the risk for suicidal behaviors. Suicide rates are particularly high among individuals with [SMI] such as major depression and bipolar disorders. Suicidal thoughts and/or behaviors are common among patients with bipolar disorders, and suicide rates are estimated to be more than [twenty-five] times higher for these patients than among the general population. Another mental disorder that may increase the risk for suicide is schizophrenia.⁴¹

Suicidal behavior can be lowered if depression and anxiety are treated.⁴² Substance abuse is a close second to mental disorders in being highly correlated to risk of suicide, and a combination of substance abuse and a mental disorder increases the risk of suicide.⁴³

Historical factors include family history of suicide, history of self-harm or attempted suicide, and impulsive or aggressive tendencies.⁴⁴

Environmental factors pertain to external influences, such as cultural and religious beliefs, local or sensationalized suicides, lack of access to mental health treatment, easy access to lethal means like guns and drugs,

³⁷ *Id.*; *About Mental Illness*, NAMI SUMMIT CNTY., <http://namisummit.org/about-mental-illness/> (last visited Nov. 7, 2015).

³⁸ 2012 *National Strategy*, *supra* note 15, at 18.

³⁹ REDUCING SUICIDE, *supra* note 34, at 69.

⁴⁰ See *Facts about Suicide and Mental Illness*, UNIV. OF WASH. SCH. OF SOCIAL WORK, MENTAL HEALTH REPORTING, http://depts.washington.edu/mhreport/facts_suicide.php (last visited Jan. 7, 2015) (“People who die by suicide are frequently experiencing undiagnosed, undertreated, or untreated depression.”); see *Depression Statistics*, DEPRESSION & BIPOLAR SUPPORT ALLIANCE, http://www.dbsalliance.org/site/PageServer?pagename=education_statistics_depression (last visited Jan. 7, 2015) (stating that depression is the cause of over two-thirds of reported suicides yearly in the United States).

⁴¹ 2012 *National Strategy*, *supra* note 15, at 18 (footnotes omitted).

⁴² WORLD HEALTH ORG., WORLD REPORT ON VIOLENCE AND HEALTH 192 (Etienne G. Krug et al. eds., 2002).

⁴³ 2012 *National Strategy*, *supra* note 15, at 19.

⁴⁴ *Suicide Risk Factors*, AM. FOUND. FOR SUICIDE PREVENTION, *supra* note 36; *Suicide: Risk and Protective Factors*, CTRS. FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/violenceprevention/suicide/riskprotectivefactors.html> (last visited Mar. 23, 2015) [hereinafter *Risk and Protective Factors*, CDC].

and an unwillingness to seek assistance because of the stigma associated with suicidal thoughts or mental health.⁴⁵ Environmental factors also include prolonged stress factors, namely feelings of hopelessness—feeling ashamed, guilty, or burdensome, or like a victim—or loneliness, and relational, social, work, or financial loss (e.g. death, divorce, or job loss).⁴⁶

C. WARNING SIGNS OF SUICIDAL BEHAVIOR

Suicidal individuals tend to display one or more warning signs; as an individual displays more warning signs, the risk of suicide increases.⁴⁷ Warning signs include the individual:

- i. Discussing suicide or self-harm, “having no reason to live, being a burden to others, feeling trapped” or “unbearable pain;”⁴⁸
- ii. Exhibiting a new or increased behavior of using alcohol or drugs, giving away property, isolating oneself from interaction with friends and family, looking and arranging ways to die by suicide (e.g. purchasing firearm or a large quantity of pills or searching online for methods), “acting recklessly, withdrawing from activities . . . visiting or calling people to say goodbye,” changing sleeping and eating habits, portraying aggressive or self-destructive behavior;⁴⁹ or
- iii. Facing a drastic mood change like loss of interest in activities formerly enjoyed, humiliation, anxiety, irritability, or depression.⁵⁰

Many of these warning signs are also signs of mental disorders,⁵¹ so it is worth exploring the correlation between mental disorders and suicides to better understand both.

⁴⁵ *Suicide Risk Factors*, AM. FOUND. FOR SUICIDE PREVENTION, *supra* note 36; *Risk and Protective Factors*, CDC, *supra* note 44.

⁴⁶ *Suicide Risk Factors*, AM. FOUND. FOR SUICIDE PREVENTION, *supra* note 36; *Risk and Protective Factors*, CDC, *supra* note 44.

⁴⁷ *Suicide Risk Factors*, AM. FOUND. FOR SUICIDE PREVENTION, *supra* note 36.

⁴⁸ *Suicide Warning Signs*, AM. FOUND. FOR SUICIDE PREVENTION, <https://www.afsp.org/understanding-suicide/suicide-warning-signs> (last visited Feb. 19, 2015).

⁴⁹ *Id.*

⁵⁰ *Id.*

⁵¹ See *Bipolar Disorders in Adults*, NAT’L INST. OF MENTAL HEALTH, <http://www.nimh.nih.gov/health/publications/bipolar-disorder-in-adults/index.shtml> (last visited Feb. 19, 2015); see *Signs and Symptoms of Depression*, NAT’L INST. OF MENTAL HEALTH, <http://www.nimh.nih.gov/health/topics/depression/men-and-depression/signs-and-symptoms-of-depression/index.shtml> (last visited Feb. 19, 2015).

D. PROTECTIVE FACTORS FOR SUICIDE

Protective factors, while far less researched than risk factors, are important to identify and comprehend because they aim to safeguard individuals from suicidal behavior and thoughts.⁵² These factors include “effective clinical care for mental, physical, and substance abuse disorders, easy access to a variety of clinical interventions and support for help seeking, family and community support (connectedness), support from ongoing medical and mental health care relationships, skills in problem solving, conflict resolution, and nonviolent ways of handling disputes, [and] cultural and religious beliefs that discourage suicide and support instincts for self-preservation.”⁵³

III. SUICIDE AND THE LAW

A. A LEGITIMATE STATE INTEREST IN SUICIDE PREVENTION

In *Washington v. Glucksberg* (1997), the Supreme Court unanimously upheld a state law prohibiting physicians from aiding in the suicide of patients, and rejected the plaintiffs’ claim that there was a constitutional right to physician-assisted death.⁵⁴ Under the rational basis test employed in the opinion, the Court asked “whether Washington’s prohibition against ‘causing’ or ‘aiding’ a suicide offends the Fourteenth Amendment.”⁵⁵ The Fourteenth Amendment (and Fifth Amendment) specifically grants substantive Due Process to protect liberty involving fundamental rights that are deeply rooted in our legal tradition.⁵⁶ This protection given to such fundamental rights spawns out of “respect for the teachings of history [and] solid recognition of the basic values that underlie our society.”⁵⁷ The Court found that physician-assisted death was not deeply rooted or implicit in the liberty or order of the nation and that

⁵² *Risk and Protective Factors*, CDC, *supra* note 44.

⁵³ *Id.*

⁵⁴ *Washington v. Glucksberg*, 521 U.S. 702 (1997); *but see Cruzan v. Dir., Mo. Dep’t of Health*, 497 U.S. 261 (ruling that there is a right to refuse treatment; this case is often characterized as a right to die case, but *Gluskberg* narrowly interprets *Cruzan* to grant a constitutional right to refuse lifesaving hydration and nutrition only and not extend to death in general (*Gluskberg*, 521 U.S. at 722)).

⁵⁵ *Glucksberg*, 521 U.S. at 705–06.

⁵⁶ *Id.* at 721.

⁵⁷ *Moore v. E. Cleveland*, 431 U.S. 494, 503 (1977) (quoting *Griswold v. Connecticut*, 381 U.S., 479, 501 (1965) (Harlan, J., concurring)).

there was no history of legal protection of physician-assisted death.⁵⁸ Rather, the Court noted that our nation has a long tradition of rejecting this right.⁵⁹ Thus, the right to assisted suicide is not a fundamental liberty interest and does not warrant the protection of Due Process.⁶⁰

To determine whether there is still a constitutional violation, the Court used the rational basis test afforded to non-fundamental liberty interests, and found that the ban was rationally related to a legitimate government interest in finding that the state had an unqualified interest in

prohibiting intentional killing and preserving human life; preventing the serious public-health problem of suicide, especially among . . . those suffering from untreated pain or from depression or other mental disorders; . . . protecting the poor, the elderly, disabled persons, the terminally ill, and persons in other vulnerable groups from indifference, prejudice, and psychological and financial pressure to end their lives⁶¹

On the same day as the *Glucksberg* decision, the Court unanimously held in *Vacco v. Quill* that a New York state ban on physician-assisted suicide was also constitutional for it was rationally related to the same legitimate state interests as Washington.⁶² *Vacco* exemplifies the Court's recognition of the legitimate state interests of protecting and preserving lives and preventing suicide.

As of now, there is no fundamental liberty to death. I will not argue for or against such liberty, but instead emphasize that there exists a government interest in the preservation of life and prevention of suicide.

B. NO GENERAL DUTY OF CARE TO PREVENT SUICIDE

In general, no duty under tort law exists to prevent another from suicide or self-harm. However, there are special relationships that give rise to affirmative duties—imposed upon actors in a superior position to protect others from harm, such as doctors, therapists, psychologists, schools—based on foreseeability or negligence causing the suicide or self-harm.⁶³ A general affirmative duty-to-rescue rule has not been

⁵⁸ *Glucksberg*, 521 U.S. at 728.

⁵⁹ *Id.*

⁶⁰ *Id.*

⁶¹ *Id.* at 703–04.

⁶² *Vacco v. Quill*, 523 U.S. 793 (1997).

⁶³ RESTATEMENT OF THE LAW THIRD, TORTS: LIABILITY FOR PHYSICAL AND EMOTIONAL HARM, § 40.

implemented due to policy arguments, many of which relate to social behavior.⁶⁴ For example, there exists a high level of voluntary and reasonable rescue efforts that could be offset by the creation of an affirmative duty to rescue.⁶⁵ An increase in rescue efforts would come from coerced rescuers whose lower quality of rescue efforts could replace some higher quality voluntary rescue efforts (thus the person requiring rescue may be worse served by this rule).⁶⁶ Such a rule would increase in potential harm to the rescuer; and the rule may deter delayed aid.⁶⁷

IV. HISTORY OF FEDERAL GOVERNMENT INVOLVEMENT IN SUICIDE PREVENTION

This part describes the efforts the federal government has been involved in regarding the prevention of suicide, with particular emphasis on the creation and revision of the National Strategy for Suicide Prevention (“National Strategy”). I also explain the origins of the National Strategy, federal government action taken in the implementation of the strategy, the evaluation of the strategy, and the Research Prioritization Task Force created to further its goals.

A. *CALL TO ACTION TO PREVENT SUICIDE* (1999)

In 1998, private foundations and private-public partnerships, including agencies in the Department of Health and Human Services, convened at a national conference on suicide prevention.⁶⁸ The following year, the United States Surgeon General issued the *Call to Action to Prevent Suicide* (“*Call to Action*”), an assessment of the status of suicides in the United States and key objectives to fight this epidemic based on the discussion at the conference.⁶⁹ This document presented the “blueprint” for a national strategy for suicide prevention—one built on awareness,

⁶⁴ Romohr, Phillip, *A Right/Duty Perspective on the Legal and Philosophical Foundations of the No-Duty-to-Rescue Rule*, 55 DUKE L.J., 1024 (2006).

⁶⁵ Martin Roger Scordato, *Understanding the Absence of a Duty to Reasonably Rescue in American Tort Law*, 82 TUL. L. REV. 1447, 1479–80 (2008).

⁶⁶ *Id.*

⁶⁷ *Id.*

⁶⁸ *The Surgeon General’s Call to Action to Prevent Suicide*, DEP’T OF HEALTH & HUMAN SERV., U.S. PUB. HEALTH SERVS. 1 (1999), available at <http://profiles.nlm.nih.gov/ps/access/NNBBBH.pdf> [hereinafter *Call to Action*].

⁶⁹ REDUCING SUICIDE, *supra* note 34, at 1.

intervention, and methodology.⁷⁰ "Awareness aimed to increase "public's awareness of suicide and its risk factors;" intervention was designed to "enhance services and programs, both population-based and clinical care;" and methodology focused on "[advancing] the science of suicide prevention."⁷¹ Each key objective fell under of these blueprint categories.⁷²

To further the objective of awareness, the *Call to Action* set the following goals: (1) "promote public awareness that suicide is a public health problem," (2) promote awareness of and enhance mental disorder support and suicide prevention community resources, and (3) "develop and implement strategies to reduce the stigma associated with mental illness, substance abuse, and suicidal behavior and with seeking help for such problems."⁷³

With respect to intervention, the following goals were set: (1) advance cooperation between private and public sectors; (2) improve primary care providers' ability to assess and treat mental illnesses related to suicide risk factors and make better practice of referrals to specialized care; (3) incentivize insurance companies to cover treatment for the those with mental or substance use disorders; (4) train health, mental health, substance abuse, and human services professionals on how to recognize, treat, and manage suicidal risk and interventions; (5) develop training programs for family and community on how to help those at risk of suicide; (6) create supportive school environments for adolescents addressing distress and crisis; (7) have schools and workplaces serve as health services tools and support for those bereaved by suicide; and (8) collaborate with media to ensure balanced and informed representation of suicide and its risk factors.⁷⁴

Regarding methodology, the *Call to Action* aimed to (1) research risk and protective factors, programs, treatment, and interventions; (2) generate more strategies for evaluating suicide prevention interventions and stress importance of evaluations; (3) "establish mechanisms for federal, state and regional interagency public health collaboration," and (4) develop and evaluate new technologies for prevention.⁷⁵

The *Call to Action* recommended that a national strategy target

⁷⁰ *Call to Action*, *supra* note 68, at 2.

⁷¹ *Id.* at 6.

⁷² *Id.*

⁷³ *Id.*

⁷⁴ *Id.* at 6–7.

⁷⁵ *Id.* at 7–8.

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groups at high risk of suicide—youth, physically ill, specific demographic groups like Native Americans and Alaskan Natives, individuals suffering from mental and substance use disorders, and the elderly.⁷⁶

B. 2001 *NATIONAL STRATEGY FOR SUICIDE PREVENTION*

In 2001, a partnership of public and private organizations in conjunction with the Office of the United States Surgeon General expanded on the blueprint laid out in the *Call to Action* and manifested the *National Strategy for Suicide Prevention (2001 National Strategy)*.⁷⁷ The 2001 *National Strategy*'s mission was “to promote and provide direction to efforts to modify the social infrastructure in ways that will affect the most basic attitudes about suicide and its prevention, and that will also change judicial, educational, and health care systems.”⁷⁸ It aimed to prevent deaths by suicide across the age spectrum, lower the rates of other suicidal behaviors, diminish the “harmful after-effects associated with suicidal behaviors and the traumatic impact of suicide on family and friends,” and foster “opportunities and settings to enhance resiliency, resourcefulness, respect, and interconnectedness for individuals, families, and communities.”⁷⁹ The 2001 *National Strategy* presented eleven goals akin to the goals listed in the *Call to Action*,⁸⁰ with sixty-eight objectives described to reach those goals, which were to be implemented by 2005.⁸¹

C. FEDERAL ACTION POST 2001 *NATIONAL STRATEGY*

To further the goals of the 2001 *National Strategy*, the federal government enacted several laws—the most notable laws being the Garrett Lee Smith Memorial Act and the Joshua Omvig Veterans Suicide Prevention Act.⁸² The Garrett Lee Smith Memorial Act, signed into law in

⁷⁶ *Id.* at 4.

⁷⁷ *National Strategy for Suicide Prevention: Goals and Objectives for Action*, U.S. DEP'T OF HEALTH & HUMAN SERVS., U.S. DEP'T OF HEALTH & HUMAN SERVS. 1, (Sept. 2001), available at <http://www.sprc.org/sites/sprc.org/files/library/nssp.pdf> [hereinafter 2001 *National Strategy*].

⁷⁸ *Id.* at 27.

⁷⁹ *Id.* at 28.

⁸⁰ The goals in the 2001 *National Strategy* are nearly identical to the objectives listed in the *Call to Action*, but the *National Strategy* consolidated a few goals from the *Call to Action*; added a goal to reduce access to lethal means, and removed the *Call to Action*'s goals to increase collaboration between private-public sectors and to produce mechanisms for federal, state and regional interagency public health collaboration.

⁸¹ 2001 *National Strategy*, *supra* note 77, at 28.

⁸² Suicide Prevention Resource Center & SPAN USA. *Charting the Future of Suicide*

2004, aimed to reduce suicide prevention among the youth, particularly through early intervention of youth at risk of suicide and suicide prevention programs on college campuses by providing grants to eligible entities to develop these programs.⁸³ By 2009, the grants issued through this act were made to forty-four states, one territory, twenty tribes or tribal consortiums, and eighty-seven universities and colleges, illustrating the reach of this goal on a state and community level.⁸⁴ The Joshua Omvig Veterans Suicide Prevention Act, enacted in 2007, directed the Secretary of Veteran Affairs to construct and implement a comprehensive program to reduce suicide among veterans, particularly veterans suffering from post-traumatic stress disorder and elderly veterans susceptible to depression.⁸⁵ The program included staff education, mental health assessments embedded in overall health assessments, research on the best practices for suicide prevention for veterans, twenty-four hour mental health care availability to veterans, a hotline staffed at all times by trained mental health professionals for veterans, and outreach to for veterans and their families.⁸⁶ This program was effective and improved the nation's position against suicide, and was promising in preventing suicides.⁸⁷

The Mental Health Parity and Addiction Equity Act (“MHPAEA”) was enacted in 2008, which aimed to even out the playing field regarding financial requirements and treatment restrictions between mental health and substance use disorders benefits and medical and surgical benefits.⁸⁸ The act mandated that if a plan offers to cover mental health and substance use disorder benefit, then those benefits must be on par with medical and surgical benefits the plan covers.⁸⁹ This law pertained to health insurance issuers and group health plans covering more than fifty employees. Since approximately ninety percent of individuals who died by suicide had some diagnosable mental and/or substance use disorder, this act was important

Prevention: A 2010 Progress Review of the National Strategy and Recommendations for the Decade Ahead, SUICIDE PREVENTION RESOURCE CENTER 10 (2010), available at www.sprc.org/sites/sprc.org/files/library/ChartingTheFuture_Fullbook.pdf [hereinafter *Charting the Future*].

⁸³ Garrett Lee Smith Memorial Act, Pub. L. 108-355, 118 Stat. 1404 (2004).

⁸⁴ *Charting the Future*, *supra* note 82, at 10.

⁸⁵ Joshua Omvig Veterans Suicide Prevention Act, Pub. L. 110-110, 121 Stat. 1031 (2007).

⁸⁶ *Charting the Future*, *supra* note 82, at 11.

⁸⁷ *See id.*, at 17 (stating that evaluation of the impact of the act's efforts is important to “promote continuous improvement in [Veterans Health Administration]’s suicide prevention efforts,” inferring that some improvement has already been made).

⁸⁸ *Id.* at 18.

⁸⁹ *Id.*

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in providing many at-risk individuals access to get help.⁹⁰

Additional achievements made in suicide prevention since the implementation of the *National Strategy* include the creation of the Suicide Prevention Resource Center (SPRC).⁹¹ The SPRC is a federally supported research organization created to further the *National Strategy*, which provides technical assistance, training, publications and other tools to increase expertise for suicide prevention for professionals, collaboration among organizations with roles in suicide prevention.⁹² The United States Department of Health and Human Service's Substance Abuse and Mental Health Services Administration fund this program.⁹³ Another achievement is the establishment of the National Suicide Prevention Lifeline in 2005 and its partnership with the Veterans Affairs' crisis hotline; research has shown that these suicide prevention lifelines have been effective in significantly decrease a serious at-risk caller's "intent to die, hopeless and psychological pain from the beginning of the call to the end of the call, and that these effects continue for weeks after the call."⁹⁴

Despite the notable efforts toward suicide prevention since the release of the *National Strategy*, data has indicated that the suicide rate in the United States has increased.⁹⁵ It is possible that even with full implementation and participation by the states and communities, the fruits of the strategy, in the form of a momentary stagnation followed by a decline in the rate of suicide, may take many years to manifest. However, this timeline would simply prove the ineffectiveness of the strategy since other countries have experienced a successful decline in their suicide rates within a decade of implementing their national suicide prevention strategies.⁹⁶ Even past the initial deadline of 2005 and into 2011, several

⁹⁰ *Id.* at 18–19 (“many patients who were effectively locked out of the system because they could not afford treatment may have found coverage more affordable.”).

⁹¹ *Id.* at 15–16, 27.

⁹² *About SPRC*, SUICIDE PREVENTION RESOURCE CENTER, www.sprc.org/about_sprc (last visited Mar. 23, 2015).

⁹³ *Id.*

⁹⁴ *Charting the Future*, *supra* note 82, at 28 (citing Madelyn S. Gould et al., *An Evaluation of Crisis Hotline Outcomes: Part 2: Suicidal Callers*, 37 *SUICIDE & LIFE-THREATENING BEHAVIOR* 338).

⁹⁵ Kochanek, *supra* note 19; Xu, *supra* note 19.

⁹⁶ *See Preventing Suicide: A Global Imperative*, WORLD HEALTH ORGANIZATION (2014), available at http://apps.who.int/iris/bitstream/10665/131056/1/9789241564779_eng.pdf (describing case examples from other countries that have implemented suicide prevention strategies and their outcomes thus far). Japan's Basic Act for Suicide Prevention was signed into law in 2006, and a suicide prevention policy was enacted in 2007. The Japanese government gained funding in 2009 for suicide prevention, and that year marked a decline in suicides that

goals have not been met.⁹⁷ For example, the goal to train “health, mental health, substance abuse, and human services professionals” regarding how to recognize, treat, and manage suicidal risk and interventions has not been fulfilled.⁹⁸ This is illustrated by the story of Matthew Milam, a suicide victim whose doctors, despite knowing he was at high risk, failed to treat him by not properly addressing the risk and failed to intervene by withholding information from his parents.⁹⁹ Strides toward the goals still need to be made, especially since news of suicide in the recent years and the public’s reactions to the news have indicated that many are still uninformed and are made uneasy regarding suicide and mental health issues. These reactions are adverse to the goals and illustrate the difficulty the nation was facing in implementing a cohesive strategy.

D. 2010 EVALUATION OF THE 2001 *NATIONAL STRATEGY*

In 2010, the Suicide Prevention Resource Center and Suicide Prevention Action Network USA (a division of the American Foundation for Suicide Prevention) prepared a report of the 2001 *National Strategy: Charting the Future of Suicide Prevention: A 2010 Progress Review of the National Strategy and Recommendations for the Decade Ahead*.¹⁰⁰ The review acknowledged that “the intensity and approach of the [2001 *National Strategy*] has not been a match for the complexities and depth of the suicide problem.”¹⁰¹ It stated that there had been poor communication efforts among the federal, state, community, and tribal groups:

It is also apparent, however, that many individuals working in the field remain unaware of the Federal efforts or feel that insufficient Federal effort trickles down to the community level. Furthermore, they think that

dipped below 30,000 suicides in 2012 for the first time since 1998. Suicides among the youth have increased against the overall trend, so Japan has revised its policy to provide more focus on the youth in 2012. *Id.* at 55. In 2002, Scotland launched a national suicide prevention strategy and, in 2006, had an independent evaluation and assessment of the strategy’s first phase implementation. The evaluation found that Scotland made great progress within those four years but still needed to devote energy on targeting certain areas, such as substance abuse services. Between 2002 and 2012, Scotland’s suicide rate dropped by 18 percent. *Id.* at 62. Both Japan and Scotland serve to exemplify that their strategies led to visible results within the decade following implementation and a need to spend more energy targeting certain objectives. Compare this to the United States, in which the suicide rate overall increased in ten years of implementing the 2001 *National Strategy* instead of seeing a decline.

⁹⁷ Zoroya, *supra* note 9.

⁹⁸ *Id.*

⁹⁹ *Id.*

¹⁰⁰ *Charting the Future*, *supra* note 82.

¹⁰¹ *Id.* at 1.

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there are too many duplicative efforts, e.g., state after state and community after community creating the same or similar public awareness and training materials. Also, states do not appear to be communicating their own successes or best practices with the Federal government or with other states. There is certainly a perceived need for yet more communication and coordination between the Federal government and the state entities responsible for suicide prevention. There also appears to be an unsatisfied desire for more communication among Tribes, where suicide rates are particularly high and more sharing of experiences could be helpful.¹⁰²

The review acknowledged that suicide was easier to discuss within families and with the public, and as a corollary, individuals may have found it easier to utilize mental health services.¹⁰³ However, it stated that many core objectives of the 2001 *National Strategy* were unmet and both stigma and discrimination persisted against individuals with mental disorders, those seeking mental health care, and those considering or attempting suicide.¹⁰⁴ Additionally, the review noted that the increase in the openness of suicide discussion had an inadvertent consequence of “lowering the threshold to suicide” for individuals at risk by disregarding suicide-related health conversations.¹⁰⁵ *Charting the Future* made twenty-six recommendations to implement in a revised national strategy, many focusing on the need to perform far more research and on the need to provide better tools for mental health professionals, health care professionals, and gatekeepers¹⁰⁶ to engage more in suicide prevention.¹⁰⁷

E. 2012 NATIONAL STRATEGY FOR SUICIDE PREVENTION

In 2010, a public-private partnership of more than 200 national leaders, including the Surgeon General, formed the National Action Alliance for Suicide Prevention (“Action Alliance”).¹⁰⁸ After over a decade of the release of the 2001 *National Strategy*, the Action Alliance had a greater comprehension of the relationship between suicide and

¹⁰² *Id.* at 13.

¹⁰³ *Id.*

¹⁰⁴ *See id.* at 39.

¹⁰⁵ *Id.*

¹⁰⁶ “Gatekeeper” is defined as a person “who interact[s] with people in environments of work, play, or natural community settings, [who] are likely to be the first persons to recognize signs of at-risk behavior or warning signs.” *Id.* at 20.

¹⁰⁷ *Id.* at 41–42 (listing all twenty-six recommendations).

¹⁰⁸ 2012 *National Strategy*, *supra* note 15, at 22.

mental health through increased knowledge on at-risk groups; a better understanding of the effectiveness of certain suicide prevention interventions; and an increased recognition of the value of comprehensive and coordinated prevention efforts among private and public organizations, all levels of government, the community, and individuals.¹⁰⁹ To reflect these new developments, the Action Alliance revised, and in 2012, released the *National Strategy* (“2012 *National Strategy*).¹¹⁰ The 2012 *National Strategy*¹¹¹ outlines thirteen goals and sixty objectives; all encapsulated under four strategic directions: (1) “Healthy and Empowered Individuals, Families, and Communities,” (2) “Clinical and Community Preventive Services,” (3) “Treatment and Support Services,” and (4) “Surveillance, Research, and Evaluation.”¹¹²

1. Strategic Direction 1: Healthy and Empowered Individuals, Families, and Communities

The first strategic direction emphasizes the need to “create supportive environments that will promote the general health of the population and reduce the risk for suicidal behaviors and related problems.”¹¹³ Because suicide shares risk factors with mental and substance disorders, this direction focuses on creating positive messages addressing mental and substance use disorders and suicide to reduce the stigma associated with these issues, to increase understanding of these issues’ treatability, and to create a supportive environment where individuals feel safe to seek help or to help others.¹¹⁴ This direction plans to accomplish this with four goals.

The first goal is “[integrating] and [coordinating] suicide prevention activities” across different settings and sectors—like schools, workplaces, health care professionals, law enforcement settings, community organizations, and faith-based organizations—to extend the scope and effect of suicide prevention activities and promoting greater cost-

¹⁰⁹ *Id.* at 11.

¹¹⁰ *Id.* at 23.

¹¹¹ The 2012 *National Strategy* is also in line with the National Prevention Strategy issued by the National Prevention, Health Promotion and Public Health Council and United States Surgeon General, which is a component of the Affordable Care Act to shift a focus on sickness to on wellness and prevention. Issued in 2011, it highlights seven priorities areas, including areas directly related to suicide such as Mental and Emotional Well-Being, Preventing Drug Abuse and Excessive Alcohol Use, and Injury and Violence Free Living. *Id.*

¹¹² *Id.* at 24.

¹¹³ *Id.* at 29.

¹¹⁴ *Id.*

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effectiveness of each group's efforts by deleting duplicative efforts.¹¹⁵ For example, businesses and employers could introduce organizational change to foster employee mental health and ensure that their health plan packages include mental health services.¹¹⁶

The second goal is to research effective channels and messages “designed to prevent suicide by changing knowledge, attitudes, and behaviors” and execute such efforts to communicate to different populations.¹¹⁷ These efforts include determining tailored messages and channels for each target group (e.g., different segments of individuals at risk of suicide or different groups of policymakers), spreading awareness of suicide prevention hotlines, implementing the hotlines into other effective channels, and using social media as a platform for dispersing communication, such as Facebook allowing users to anonymously report a friend's suicidal post so that the friend may receive an email with instructions on how to contact the National Suicide Prevention Lifeline.¹¹⁸

The third goal is to “increase knowledge of the factors that offer protection from suicidal behaviors and that promote wellness and recovery,” especially by promoting effective programs protecting against suicidal risk, reducing stigma associated with mental disorders and suicidal behavior, and “[promoting] the understanding that recovery from a mental or substance use disorder is real and possible.”¹¹⁹

The fourth goal is to “promote responsible media reporting of suicide, accurate portrayals of suicide and mental illnesses in the entertainment industry, and the safety of online content related to suicide.”¹²⁰ Because communications media plays a dominant role in the lives of many Americans, it is imperative to ensure that coverage of suicide and related issues like mental disorders are portrayed accurately and responsibly, and shift the focus of these stories to ones of “hope, resiliency, and recovery” to inspire family, friends, and the community to provide at-risk individuals support and protection and to encourage such individuals to seek help and reclaim a meaningful life.¹²¹

This direction specifically asks the federal government to do the

¹¹⁵ *Id.*

¹¹⁶ *Id.* at 39.

¹¹⁷ *Id.* at 32–33.

¹¹⁸ *Id.* at 33–35.

¹¹⁹ *Id.* at 35–37.

¹²⁰ *Id.* at 37.

¹²¹ *Id.* at 37–38.

following: (1) provide the federal workforce with information on suicide prevention, (2) partake in the National Action Alliance for Suicide Prevention, and (3) ensure that the 2012 *National Strategy* is promoted in the overarching progression of the National Prevention Strategy.¹²²

2. Strategic Direction 2: Clinical and Community Preventive Services

This direction seeks to endorse wellness and to promote at-risk individuals' use of services, resources, and support systems, and to build resilience and overcome suicidal behavior.¹²³ In particular, it aims to create, apply, and monitor suicide prevention and wellness clinical and community-based programs; increase access of mental health services; and train the professionals working in those programs how to use the tools for suicide prevention, among other objectives.¹²⁴ For example, it recommends training mental health providers to recognize, assess, and manage at-risk behavior, and to deliver effective care to at-risk individuals.¹²⁵ It also recommends linking suicide-related curricula to mental disorder topics in accreditation and certification programs. Moreover, it recommends training clinicians and health care mental health screening systems to refer patients to proper treatment or community resources.¹²⁶ This direction specifically asks the federal government to deliver "education, training, and resources on the signs and symptoms of suicide and suicidal behaviors and where to go for help," and "support states, tribes, and communities in the implementation of suicide prevention interventions and policies."¹²⁷

3. Strategic Direction 3: Treatment and Support Services

This direction aims to make suicide prevention an integral element of health care services and endorse and implement effective practices in evaluating and treating recognized individuals at risk for suicidal behavior.¹²⁸ It further acts to strengthen support services to those bereaved by suicide and survivors of attempted suicides to help prevent more

¹²² *Id.* at 39.

¹²³ *Id.* at 40.

¹²⁴ *Id.* at 41–43, 45.

¹²⁵ *Id.*

¹²⁶ *Id.* at 46–47, 49.

¹²⁷ *Id.* at 49.

¹²⁸ *Id.* at 51, 57, 62.

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suicides.¹²⁹ It directs the federal government to increase access to high-quality mental health services and synergize mental health services into federal services, including federally qualified health centers and Veterans Affairs facilities, and to update and revise federally published research and findings discussing appropriate response for those affected by suicide.¹³⁰

4. Strategic Direction 4: Surveillance, Research, and Evaluation

This direction addresses the need to improve surveillance systems and data recording on suicide, research, and evaluate effectiveness of suicide prevention programs.¹³¹ Research on suicide prevention and mental and substance use disorders have grown tremendously, and continuing this trend will navigate us toward the improvement of assessment tools, treatment, and interventions for suicide prevention; and toward “more effective and efficient therapeutic interventions for individuals who engage in suicidal behaviors.”¹³² This direction implores the federal government to advocate the use of the National Violent Death Reporting System;¹³³ support research on suicide and related issues, including research on suicide risk and protective factors among different population groups; and endorse the evaluation of suicide prevention methods and programs, and the synthesis and distribution of research findings.¹³⁴

F. RESEARCH PRIORITIZATION TASK FORCE’S AGENDA FOR 2014

In 2014, the Action Alliance’s Research Prioritization Task Force, which includes the National Institute of Mental Health and the consultation of over sixty national and international research experts, released an agenda in response to the 2012 *National Strategy*’s goal of promoting and supporting suicide prevention research.¹³⁵ The agenda

¹²⁹ *Id.*

¹³⁰ *Id.* at 65.

¹³¹ *Id.* at 66.

¹³² *Id.* at 69.

¹³³ “NVDRS is a surveillance system that links data from law enforcement, coroners and medical examiners, vital statistics, and crime laboratories to assist each participating state in designing and implementing tailored prevention and intervention efforts, including for suicide. NVDRS also pools these data to better depict the scope and nature of violence.” *Id.* at 134.

¹³⁴ *Id.* at 73.

¹³⁵ *A Prioritized Research Agenda for Suicide Prevention: An Action Plan to Save Lives*, NAT’L ACTION ALLIANCE FOR SUICIDE PREVENTION: RESEARCH PRIORITIZATION TASK FORCE (2014), available at <http://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/Agenda.pdf> [hereinafter RESEARCH PRIORITIZATION TASK FORCE].

identifies that research on suicide prevention has been impeded by sparse and delayed data on suicide attempts and death.¹³⁶ The agenda's goal is to "reduce morbidity (attempts) and mortality (deaths), each by at least [20] percent in five years and forty or greater in [ten] years, if implemented fully and successfully,"¹³⁷ by "[identifying] the research needed to guide practice and [informing] policy decisions across many areas"¹³⁸ and that the next steps to take toward suicide prevention involve "disseminating the agenda, encouraging its adoption and implementation by all of those working in this field, updating the agenda's goals as progress is made, and conducting the additional research that will be needed."¹³⁹ It furthermore provided numerous approaches to "allocating funds and monitoring future suicide research to ensure that available resources target research with the greatest likelihood of reducing suicide morbidity and mortality."¹⁴⁰ The agenda aims to research why people become suicidal; how to better or optimally predict and detect suicidal risk; determine which interventions are effective at preventing suicidal behavior; determine which services are most effective for treating the suicidal individual and preventing suicidal behavior; determine which other types of preventive interventions beyond health care systems are effective at lowering the risk of suicide; and identify what research framework can lower suicidal behavior.¹⁴¹

V. CURRENT LEGISLATIVE ACTION ON SUICIDE PREVENTION

In this section, I describe recent Congressional bills and hearings regarding suicide prevention and mental health issues. This includes the Helping Families in Mental Health Crisis Act, the Strengthening Mental Health in Our Communities Act, and the "Suicide Prevention and Treatment: Helping Loved Ones in Mental Health Crisis" Hearing.

A. HELPING FAMILIES IN MENTAL HEALTH CRISIS ACT & STRENGTHENING MENTAL HEALTH IN OUR COMMUNITIES ACT

Representative Tim Murphy (R-PA) introduced the Helping Families in Mental Health Crisis Act in House in 2013 to provide "psychiatric,

¹³⁶ *Id.* at 57.

¹³⁷ *Id.* at 7.

¹³⁸ *Id.*

¹³⁹ *Id.* at 4.

¹⁴⁰ *Id.* at 7.

¹⁴¹ *Id.* at 9.

psychological, and supportive services for individuals diagnosed with mental illness and families in mental health crisis.”¹⁴² This act aims to create an Assistant Secretary for Mental Health and Substance Use Disorders in the Department of Health and Human Services, who will promote mental health reforms through numerous duties;¹⁴³ grant information access under Health Insurance Portability and Accountability Act (a law restricting disclosure of an adult’s medical information to caregivers of individuals with SMI);¹⁴⁴ use grants to improve law enforcement training;¹⁴⁵ increase funding for research for the Brain Research Through Advancing Innovative Neurotechnologies (BRAIN) Initiative at the National Institute Of Mental Health “on the determinants of self—and other directed—violence in mental illness, including studies directed at reducing the risk of self-harm, suicide, and interpersonal violence;”¹⁴⁶ require states receiving a mental health services block grant to require patients with a history of arrests, hospitalizations and violence due to their mental illness, to undergo outpatient treatment;¹⁴⁷ increase Medicaid coverage relating to same-day qualifying mental health services and prohibiting a restriction on access to mental health drugs under Medicaid and Medicare;¹⁴⁸ and reduce the stigma of SMI.¹⁴⁹

Similarly, less than half a year later, Representative Ron Barber (D-AZ) introduced in House the Strengthening Mental Health in Our Communities Act of 2014, which aims to maximize “access of individuals with mental illness to community-based services” and strengthen those services’ impact.¹⁵⁰ This act intends to create an executive office on Mental Health Policy and coordinate efforts with federal departments and agencies providing mental health services;¹⁵¹ reauthorize the Garrett Lee Smith Memorial Act;¹⁵² reduce stigma of mental health;¹⁵³ improve

¹⁴² H.R. 3717, 113th Cong. (1st Sess. 2013).

¹⁴³ *Id.* at § 101.

¹⁴⁴ *Id.* at § 301.

¹⁴⁵ *Id.* at § 401.

¹⁴⁶ *Id.* at § 601.

¹⁴⁷ *Id.* at § 705.

¹⁴⁸ *Id.* at §§ 501–502.

¹⁴⁹ *Id.* at § 801.

¹⁵⁰ H.R. 4574, 113th Cong. (2d Sess. 2014).

¹⁵¹ *Id.* at §§ 101, 104.

¹⁵² *Id.* at § 203.

¹⁵³ *Id.* at § 211.

Medicare and Medicaid services in ways akin to Murphy's bill,¹⁵⁴ and gather more data on mental health and intervention.¹⁵⁵

While both bills aim for substantial mental health reform, both have been attacked as being regressive and neither has garnered enough support to be adopted.¹⁵⁶ For example, critics argue that the "outpatient treatment under Murphy's bill is arguably coercive and denying individuals with mental illness and their families the freedom to choose a measure of care and proposed arrangements for funding will virtually have no impact on progressing mental health issues."¹⁵⁷ Opponents of Barber's bill claim his bill is partisan, disregards individuals with SMI who are unaware of their situation, and only helps individuals who are well enough to seek help.¹⁵⁸ Leaders of the House Energy and Commerce Committee have suggested that the parties combine components of both bills, which may get broader support and may pass a "bipartisan consensus mental health package."¹⁵⁹

B. "SUICIDE PREVENTION AND TREATMENT: HELPING LOVED ONES IN MENTAL HEALTH CRISIS" HEARING

The Subcommittee on Oversight and Investigations has an ongoing examination of mental health programs and resources with the goal that federal funding devoted to mental health are reaching those with SMI and helping them receive the most effective care.¹⁶⁰ The Subcommittee listened to four testimonies on the matter: Rear Admiral Boris Lushniak, then-acting Surgeon General; Dr. David Brent, the Endowed Chair in

¹⁵⁴ *Id.* at §§ 301–302.

¹⁵⁵ *Id.* at §§ 501–503.

¹⁵⁶ *Mental Health Legislative Proposals and Their Impact on Counties*, NAT'L ASSOC. OF CNTYS. 1 (Jul. 2014), <http://www.naco.org/legislation/Documents/NACoMurphyBarberAnalysis.pdf>.

¹⁵⁷ John M. Grohol, *Psych Central Supports the Strengthening Mental Health in Our Communities Act (HR 4574)*, PSYCH CENTRAL (last updated May 19, 2014), <http://psychcentral.com/blog/archives/2014/05/19/psych-central-supports-the-strengthening-mental-health-in-our-communities-act-hr-4574/>.

¹⁵⁸ Pete Earley, *Comparison of Democrat's Alternative Mental Health Bill and Rep. Murphy's Bi-partisan Bill* (May 7, 2014), <http://www.petearley.com/2014/05/07/comparison-of-democrats-alternative-mental-health-bill-and-rep-murphys-bi-partisan-bill/> (quoting Paige W. Cunningham, *Fears of Slowed Progress with New Mental Health Bill*, POLITICO (May 6, 2014, 6:28 PM)).

¹⁵⁹ *Mental Health Legislative Proposals and Their Impact on Counties*, *supra* note 156.

¹⁶⁰ *Hearing on Suicide Prevention and Treatment: Helping Loved Ones in Mental Health Crisis Before the Subcomm. on Oversight & Investigations*, 113th Cong. 2 (2014) [hereinafter *Hearing*] (opening statement of the Hon. Tim Murphy, Chairman, Subcomm. On Oversight & Investigations).

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Suicide Studies at the University of Pittsburgh, and director of the Services for Teens at Risk Center, a suicide prevention program targeting adolescents and young children; Dr. Christine Moutier, Chief Medical Officer of the American Foundation for Suicide Prevention (“AFSP”); and Joel Dvoskin, Assistant Professor at the University of Arizona on behalf of the American Psychological Association.

1. Testimony of Rear Admiral Boris Lushniak, M.D., M.P.H., Former Surgeon General

Acknowledging that suicide persists to be a serious public health problem, Rear Admiral Lushniak iterated the framework of the *National Strategy*.¹⁶¹ He emphasized the importance of treatment, support, clinical, and community services, stating that this was to be accomplished by providing funding toward effective programs such as the National Suicide Prevention Lifeline.¹⁶² He advocated the “development, implementation and monitoring of effective programs that promote wellness and prevent suicide and related behaviors with respect to community prevention and . . . supports,” such as school-based interventions and community-based programs.¹⁶³ He recommended endorsing suicide prevention as a core element of health care services and improving access to suicide prevention care, and he refers to the protections and enhanced coverage for mental disorders under the Affordable Care Act and MHPAEA as ways to accomplish this recommendation.¹⁶⁴ He also proposed increasing knowledge on suicide prevention, intervention, and treatment by continuing research on the effects of services and funding public health tools to track these effects and trends.¹⁶⁵

¹⁶¹ *Id.* at 20–21 (prepared statement of Rear Admiral Boris D. Lushniak, surgeon general of the United States Dep’t of Health & Human Servs.). It should be noted that Rear Admiral Lushniak was acting surgeon general at the time of this hearing, and has retired from the position.

¹⁶² *Id.* at 22–23.

¹⁶³ *Id.* at 23–24.

¹⁶⁴ *Id.* at 24.

¹⁶⁵ *Id.* at 24–26.

2. Testimony of David Brent, M.D., Endowed chair in Suicide Studies and Professor of Psychiatry, Pediatrics, Epidemiology, and Clinical and Translational Science, University of Pittsburgh¹⁶⁶

Dr. Brent summarized his arguments and recommendations below:

1. Suicide is intimately related to psychiatric disorder.
2. Suicide ensues when there is an imbalance between distress and restraint.
3. Given the prominent role of insomnia in suicidal risk, interventions that target insomnia should be tested to see if this is a method for rapidly reducing suicidal risk.
4. Improvement in access and quality of treatment for depression in primary care can reduce the risk for suicide and suicidal behavior.
5. The Black Box Warning¹⁶⁷ may have had negative, unintended consequences on the identification and treatment of depressed adolescents in the community.
6. Evidence-based prevention that has been shown to have robust effects on risk factors for suicide, may be a cost-effective method for lowering the population rate of suicide over time.
7. Safety counseling with regard to firearms storage should be implemented and tested to see if it can help to reduce the suicide rate.
8. Better coordination of care, assertive outreach, availability of 24 hour beds, dual diagnosis programs, and multidisciplinary review of all patient suicides have been shown in England to reduce suicides when these changes were implemented.
9. Research on more rapidly acting agents for depression, biomarkers that can personalize treatment, and identifying ways to treat those with refractory disorders are likely to help reduce the burden of suicide in the long run.¹⁶⁸

¹⁶⁶ In addition to being the endowed chair and director of Services for Teens at Risk, Dr. Brent is a Professor of Psychiatry, Pediatrics, Epidemiology, and Clinical Translational Science and Academic Chief of Child and Adolescent Psychiatry at the University of Pittsburgh. *Id.* at 32 (prepared statement of David Brent).

¹⁶⁷ The Black Box Warning is a FDA-specified boxed warning on certain prescription drugs and is the strongest warning issued by the FDA, as it signifies that the drug carries a clinically significant risk of serious or life-threatening adverse effects. *Guidance for Industry. Warnings and Precautions, Contraindications, and Boxed Warning Sections of Labeling for Human Prescription Drug and Biological Products – Content and Format*, U.S. FOOD & DRUG ADMIN. 11 (Oct. 2011), www.fda.gov/downloads/Drugs/GuidanceComplianceRegulatoryInformation/Guidances/ucm075096.pdf.

¹⁶⁸ *Hearing, supra* note 160, at 38 (prepared statement of David Brent).

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3. Testimony of Christine Moutier, M.D., Chief Medical Officer of the American Foundation for Suicide Prevention

On behalf of the AFSP, Dr. Moutier proposed that a focus for suicide prevention should be on three policy areas: suicide prevention research, suicide prevention programs, and programs providing support to those bereaved by suicide.¹⁶⁹ Under the policy area of research, Moutier recommended that the federal government substantially increase the funding for research on suicide as to reduce mortality rate in a way similar to how the mortality rates were reduced with strategic funding placed in other larger public health concerns, such as HIV/AIDS and heart disease, and breast cancer, and to carefully review the recommendations in the Research Prioritization Task Force agenda.¹⁷⁰ Under Prevention, Moutier proposed using education, technology, and advocacy to develop and implement suicide prevention strategies. To increase effectiveness of such strategies, it is imperative to help individuals seek help by eradicating stigma and “[streamlining] help-seeking.”¹⁷¹ Additionally, Moutier recommended educating and training the frontline members of the community in detecting mental health issues and risk of suicide, and training first responders to handle safe messaging of suicide.¹⁷² Under Support Programs, Moutier listed survivor outreach programs for those bereaved by suicide and community-based suicide prevention programs, and states that programs for suicide attempt survivors are developing.¹⁷³

4. Testimony of Joel A. Dvoskin, Ph.D, for American Psychological Association¹⁷⁴

Dr. Dvoskin, on behalf of the American Psychological Association, presented ten recommendation before the hearing: (1) increase access to screening for mental health concerns, including depression and suicide, for

¹⁶⁹ *Hearing supra* note 160, at 49 (prepared statement of Christine Moutier, chief medical officer of Am. Found. for Suicide Prevention).

¹⁷⁰ *Id.* at 52–53.

¹⁷¹ *Id.* at 53–54.

¹⁷² *Id.* at 54–55.

¹⁷³ *Id.* at 56.

¹⁷⁴ Dr. Dvoskin is a clinical and forensic psychologist and a clinical faculty member of University of Arizona School of Medicine, Department of Psychiatry. He is also the Chairman of the Governor’s Advisory Council on Behavioral Health and Wellness in Nevada. The American Psychological Association is the United States’ largest scientific and professional association for psychology and the world’s largest association of psychologists. *Id.* at 64 (prepared statement of Joel A. Dvoskin).

all ages; (2) ensure insurance coverage for prevention services, including depression screening for all ages; (3) “improve access by increasing the number of trained healthcare professionals, including psychologists and other mental health professionals, and effective peer services;” (4) increase treatment resources for individuals with acute mental illness by increasing coverage for short-term acute inpatient stays through Medicaid; (5) continue support of early intervention resources such as the National Suicide Prevention Lifeline; (6) support reauthorization of “essential behavioral health programs” like the Garrett Lee Smith Memorial Act; (7) spread treatments for all populations and ages to appropriate settings, such as schools, prisons, outpatient and inpatient centers; (8) fund innovative community-based programs working with individuals at risk of suicide; (9) support the various forms of crisis intervention and response, which include public mental health systems and first responders; and create better solutions to the issues of overcrowded emergency rooms and jails that are far from conducive for individuals experiencing a mental health crisis; and (10) support research into suicide, especially aimed at reducing suicide by guns.¹⁷⁵

VI. NARROWING THE LENS ON MENTAL HEALTH—A SUICIDE PREVENTION POLICY FOCUSING ON MENTAL DISORDERS

It is evident that the federal government is concerned about suicide and mental health. However, with few positive outcomes and a consistent suicide rate, we must pay closer attention and boost our offensive against the epidemic of suicide. In this section, I analyze the current testimonies from the hearing and recent bills, and propose a hybrid policy heavily addressing mental disorder, and particularly SMI, that is in line with the *National Strategy*. I also discuss the normative justifications of the policy.

A. A NEED FOR A SUICIDE PREVENTION BILL FOCUSING ON INDIVIDUALS WITH MENTAL DISORDERS

Congress is clearly not a stranger to suicide prevention bills.¹⁷⁶ As mentioned earlier, Congress has passed the Joshua Omvig Veterans Suicide Prevention Act and the Garrett Lee Smith Memorial Act, both targeting specific groups—veterans and youth and college campuses,

¹⁷⁵ *Id.* at 68–69.

¹⁷⁶ *Supra* Part IV.C.

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respectively—in intervention and suicide prevention.¹⁷⁷ So far, these acts that are tailored to a specific population have been able to see positive results—according to Rear Admiral Lushniak’s testimony at the hearing, a recent study found that counties implementing a Garrett Lee Smith Youth Suicide Grant program showed significantly lower suicide rates among the youth in the year following the program’s training than the rates in similar counties that did not implement such training.¹⁷⁸ Currently on the Senate floor is the Clay Hunt Suicide Prevention for American Veterans Act (H.R. 5059), a House bill that was passed unanimously in House and the Senate Committee on Veteran Affairs.¹⁷⁹ The Bill aims to have additional benefits to better the positions of veterans, such as having yearly independent third-party evaluations of current mental health and suicide prevention programs within the Department of Veterans Affairs.¹⁸⁰ The Bill also directs the Department to make its website a comprehensive, centralized resource for veterans on mental health care services, providing loan repayment incentives to recruit psychiatrists for the Veterans Health Administration, and implementing new support programs for veterans transitioning from active duty.¹⁸¹ Based on history and current actions, and suicide’s status as a top ten cause of death in the United States, Congress is indeed aware that suicide prevention is urgent and more action must be taken.¹⁸² In her testimony at the hearing, Moutier spelled out this urgency:

Suicide is often the result of unrecognized and untreated mental illness. In more than 120 studies of series of completed suicides, at least [ninety percent] of the individuals involved were suffering from a mental illness at the time of their deaths. When [one in four] Americans have a diagnosable mental illness, but only [one in five] 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

¹⁷⁷ *Id.*

¹⁷⁸ *Hearing, supra* note 160, at 23 (prepared statement of Rear Admiral Boris D. Lushniak).

¹⁷⁹ H.R. 5059, 113th Cong. (2d Sess. 2014); Jacqueline Klimas, *Veteran Suicide Bill Passes House Second Time, Goes to Senate*, THE WASH. TIMES (Jan. 12, 2015) <http://www.washingtontimes.com/news/2015/jan/12/veteran-suicide-bill-passes-house-second-time-goes/>.

¹⁸⁰ Klimas, *supra* note 179.

¹⁸¹ *Id.*

¹⁸² *Supra* Part II.A.

kidneys.¹⁸³

Because of the high prevalence of mental disorders, particularly SMI, among individuals who die by suicide, I propose that a suicide prevention policy bill that targets the general population suffering from mental disorders, especially those individuals with SMI, to generate progression toward suicide prevention and, concurrently, the mental health field. Furthermore, this proposal will serve to support state and local prevention resources and catalyze progress toward goals of National Strategy.

B. A HYBRID PROPOSAL BASED ON RECENT LEGISLATIVE ACTIONS

1. Heavy Emphasis on Research

All the foregoing bills and testimony stress the need for increased funding in research on suicide prevention.¹⁸⁴ I wholeheartedly agree, and believe that this must be a cornerstone of any suicide prevention policy. The suicide prevention policy bill that I am proposing asks for a substantial increase in funding to support organizations performing research on suicide prevention and related mental health issues. These organizations would include the National Institute of Mental Health, the American Foundation for Suicide Prevention, the Brain & Behavior Research Foundation, and other organizations that would like to seek a grant to conduct research on suicide prevention and mental disorders. The research would be in line with the Research Prioritization Task Force's Agenda, which would make it ultimately in line with the National Strategy (particularly toward the fourth strategic direction of Surveillance, Research, and Evaluation). Thus, the type of research this proposal's funding is looking for will have a wide scope of areas to cover.

Key items to research would include determining the effectiveness of current treatments, interventions, and support programs delivered to individuals with mental disorders in reducing suicide risk (which will require statistics of suicide decedents who have not been in treatment and those who have to gauge effectiveness of certain treatment). Other items include determining what improvements can be made and how any improvements could increase effectiveness in reducing suicide risk,¹⁸⁵ and developing further comprehension of protective factors to implement into

¹⁸³ *Hearing, supra* note 160, at 46 (prepared statement of Christine Moutier).

¹⁸⁴ *See* H.R. 3717, 113th Cong. (1st Sess. 2013); H.R. 4574, 113th Cong. (2d Sess. 2014); *supra* Part V.B.

¹⁸⁵ RESEARCH PRIORITIZATION TASK FORCE, *supra* note 135, at 33.

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treatment and intervention programs. Another key item would be to include measures of suicidal behavior outcomes into studies targeting depression and other known mental disorders contributing to risk factors, to better understand the role of these risk factors in suicide.¹⁸⁶ There has been evidence that particular psychotherapies, such as dialectical behavioral therapy and cognitive behavioral therapy, are effective in preventing suicide attempt survivors from attempting again.¹⁸⁷ These psychotherapies are areas for additional research, to study and improve to make them effective in preventing suicide the first time around.

It is also worthwhile, as Brent recommended, to research causes for depression and biomarkers that can personalize treatment, and how to treat it accordingly, which in turn should help reduce suicide.¹⁸⁸ This kind of research should also extend to other SMI linked to suicide (like insomnia, as recommended by Brent); not only does it have the potential to reduce suicide but also great potential to aid non-suicidal mental health consumers. We also need statistics of suicide decedents who have not been in treatment and those who have to gauge effectiveness of certain treatment.

2. Support Services

I propose funding for organizations built on developing support services. For example, the Dave Nee Foundation offers support and tools to law school students, as lawyers have a higher rate of depression than any other occupation and rank highly in incidence of suicide by occupation.¹⁸⁹ I also propose that funding be provided for support services designed for attempted suicide survivors, as this is a fairly nascent concept.¹⁹⁰ This group undoubtedly also includes a large number of individuals suffering from SMI.¹⁹¹ I propose provide funding for

¹⁸⁶ *Id.* at 11.

¹⁸⁷ *Charting the Future*, *supra* note 82, at 16. (“One study provided ten weeks of CBT for attempt survivors, who were identified after presenting themselves in an inner city emergency room. After eighteen months, the results showed a fifty percent reduction in repeat attempts”).

¹⁸⁸ *Supra* Part V.B.2; *Hearing*, *supra* note 160, at 33, 38 (prepared statement of David Brent).

¹⁸⁹ *Lawyers and Depression*, DAVE NEE FOUNDATION, <http://www.daveneefoundation.org/scholarship/lawyers-and-depression/> (last visited Jan. 20, 2015).

¹⁹⁰ *See Hearing*, *supra* note 160, at 56 (statement of Christine Moutier) (stating that “AFSP recently conducted a series of focus groups to discover more about what kinds of resources and programs would be useful for [attempt survivors] with lived experience and their families”).

¹⁹¹ *See id.* at 47; *supra* Part II.B (emphasizing the connection between suicide and mental disorders such as depression, an SMI, and inferring that this connection exists among individuals attempting suicide).

communities to design programs for individuals with mental disorders, given that the programs are in line with the *National Strategy* and are communicating their effectiveness or issues to other communities, the state, and federal government to foster a healthy communication on suicide prevention. Funding is necessary to provide these communities and individuals with resources and knowledge to aid individuals with mental disorders. I am not asking to impose an affirmative duty on them to participate in preventive or support programming to aid those at-risk, but am aiming to provide the altruistic individuals with the proper tools to carry out this mission.

3. Preventive Services & Health Care Services

As indicated by the Helping Families in Mental Health Crisis Act, and Lushniak, Moutier and Dvoskin's testimonies, there must also be funding to support forms of crisis intervention and response.¹⁹² Without such funding, intervention will not reach those in need of aid. Furthermore, we need intervention and first responder personnel to have the proper tools and knowledge to understand why an individual is suffering and how to assess, diagnose the individual and situation, and appropriately react to prevent that individual's suicide; it is even more important when aiding an individual with SMI due to the heightened risk of suicide. I propose that there be a specific provision for additional support training provided to law enforcement. Suicide by cop, as illustrated by Matthew Hoffman's story, is an actual form of suicide. Law enforcement agencies, as first responders, must be able to form strategies for recognition and handling of suicide by cop as to reduce its occurrence; this would also require research.

Similarly, mental health care and clinical personnel must be given the proper tools to be better suited at serving these individuals with mental disorders. Approximately 17,100 out of 38,000 identified suicide decedents accessed health care within thirty days of death, a little under half the identified decedents.¹⁹³ This indicates that a relevant percentage of individuals who sought health care were unable to get the help they needed to stay alive, which highlights a problem with health care. I propose that such professionals be given incentives to go through any training research may deem to be beneficial to individuals suffering with mental disorder and at risk of suicide. Doctors still have an affirmative

¹⁹² *Supra* Parts V.A, B.

¹⁹³ RESEARCH PRIORITIZATION TASK FORCE, *supra* note 135, at 8 (Figure 1).

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duty to help their patients,¹⁹⁴ so an alternative route is to first get schools of medicine to implement the new standards for treatment based on such research and require these doctors to follow them or risk medical malpractice, but this route may take longer to implement.

I also propose that they be able to grant information access under HIPAA to caregivers of individuals with SMI, as implored in H.R. 3717, Helping Families in Mental Health Crisis Act.¹⁹⁵ The importance for this access grant is illustrated by the story of twenty-four-year-old Matthew Milam. On October 21, 2011, Milam's parents were waiting to take him to therapy as an ongoing treatment for his bipolar disorder and paranoid schizophrenia when Milam killed himself with a homemade explosive in his closet.¹⁹⁶ Milam had been struggling with his mental state since adolescence.¹⁹⁷ He once dug his own grave in the backyard, begged God to strike him as he stood outside during a lightning storm, and another time, he cut his throat with a steak knife.¹⁹⁸ He was institutionalized several times in 2011, and although each time he showed improvement and promised to keep his medication regimen, he broke his promise every time he was discharged.¹⁹⁹ The psychiatric staff at the facility institutionalizing Milam did not convey concerns of "escalating homicidal and suicidal ideation" or "high risk of suicide or other bad outcomes" to his parents because of HIPAA, and as such, Milam's parents were kept in the dark and "felt helpless to prevent their worst fears from coming true."²⁰⁰

While there is the concern that allowing caregivers access to private patient information infringes on the privacy interests of the individuals, there is a strong argument that a compelling interest exists in protecting the lives of these individuals suffering from SMI who are likely posing a danger to themselves and potentially others. This will serve the *National Strategy's* second and third strategic directions, Clinical and Community Preventive Services and Treatment and Support Services.

As stressed by Lushniak and the *National Strategy*, suicide

¹⁹⁴ RESTATEMENT OF THE LAW THIRD, TORTS § 40, *supra* note 63.

¹⁹⁵ H.R. 3717, 113th Cong. § 301 (1st Sess. 2013).

¹⁹⁶ Zoroya, *supra* note 9.

¹⁹⁷ Gary Fields, *Families of Violent Patients: 'We're Locked Out' of Care*, WALL ST. J. (June 7, 2013, 10:46 PM), <http://www.wsj.com/articles/SB1000142412788732346370457849515421729> 1958.

¹⁹⁸ Zoroya, *supra* note 9.

¹⁹⁹ *Id.*

²⁰⁰ *Id.*

prevention ought to be a core element of health care.²⁰¹ Lushniak states that this can be done through enhanced coverage under the Affordable Care Act and the MHPAEA.²⁰² H.R. 3717 and H.R. 4574 both implore increasing Medicaid coverage and removing restrictions on drug access to mental health drugs. I agree with these; mental health is a public health concern and must be treated with the same high regard as physical health issues, and the proposed actions aid in doing this. As indicated in the aforementioned statistic regarding less than half of identified suicide decedents seeking health care within thirty days prior to death, over half of the study did not seek health care for undetermined reasons (but it is plausible that it is due to lack of access to health care).²⁰³ In regards to the MHPAEA, there was a limit that it applied to health insurance issuers and group health plans covering over fifty employees: to exclude all the individuals inflicted with mental disorder without adequate health insurance who could potentially be at an equal or higher level of risk of suicide.²⁰⁴

My proposal seeks to broaden the coverage of ACA by carving out a section for mental health coverage to assist these individuals with mental disorders, which in turn will broaden the application of MHPAEA to the individuals not meeting its current standards. Furthermore, as suggested by Dvoskin and recommended in the Research Prioritization Task Force agenda, I propose that there be an increase in access to screening for depression and other SMI as part of overall health assessment, and funding for anonymous screening for streamlined help-seeking.²⁰⁵ Moutier described a program created by the American Foundation for Suicide Prevention that connects those at risk anonymously with mental health services through an anonymous screening process.²⁰⁶ Because this program has claimed to already saved the lives of veterans, students, physicians, corporate employees, and police personnel,²⁰⁷ I propose that funding be given to researching this program and developing it, and

²⁰¹ *Hearing, supra* note 160, at 24 (prepared statement of Rear Admiral Boris D. Lushniak); 2012 *National Strategy, supra* note 15, at 3.

²⁰² *Hearing, supra* note 160, at 24 (prepared statement of Rear Admiral Boris D. Lushniak).

²⁰³ RESEARCH PRIORITIZATION TASK FORCE, *supra* note 135, at 8 (Figure 1); *See Charting the Future, supra* note 82, at 18–19 (“many patients . . . were effectively locked out of the system because they could not afford treatment.”).

²⁰⁴ *Supra* Part III.C.

²⁰⁵ *Hearing, supra* note 160, at 68 (prepared statement of Joel A. Dvoskin); RESEARCH PRIORITIZATION TASK FORCE, *supra* note 135, at 25.

²⁰⁶ *Hearing, supra* note 160, at 54 (prepared statement of Christine Moutier).

²⁰⁷ *Id.*

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implementing it in the workplace and campuses as to increase accessibility as it shows promise in providing screening to those under the detrimental effects of stigma and who wish to remain anonymous.

4. Reduction of Stigma

Suicide is highest among middle-aged men.²⁰⁸ As discussed in Part II, this is due to the rate of depression and other SMI among this group, the stigma associated with suicide and mental disorders, and an unwillingness to get help.²⁰⁹ We must expand dialogue on mental health and suicide to create hopeful messages that will encourage these individuals and the people around them to be proactive in getting them the right help, which in turn can lead to treatment and support of their mental disorders and lower the risk of suicide.²¹⁰ We must build familiarity with mental health issues through constant exposure and actually seeing support for mental health via the community, workplace, school, home, media, health care, etc. I propose that the federal government spend effort on improving communications with states, tribes, and communities to properly create these safe messages targeted for different audiences and reduce duplication efforts. In conjunction with improved communications between government levels, the federal government should also incentivize the media to properly portray suicide and mental disorders in a light that welcomes discussion and foster awareness and support.

C. THE CONSTITUTIONALITY OF THE HYBRID PROPOSAL

In creating acts for (non-suspect) specific groups, the federal government must be wary of over-inclusiveness and under-inclusiveness as it tailors the classification to a legitimate government interest of preventing suicide as to not violate the Equal Protection Clause under the Fifth Amendment.²¹¹ I am proposing a policy bill for individuals with mental disorders with emphasis on SMI. Based on the high correlation between suicide prevention and SMI,²¹² it is highly likely that there is a fit between the legitimate interest of suicide prevention and the class. It is

²⁰⁸ Phillips, *supra* note 27; McIntosh & Drapeau, *supra* note 24.

²⁰⁹ Phillips, *supra* note 27; REDUCING SUICIDE, *supra* note 34.

²¹⁰ 2012 *National Strategy*, *supra* note 15, at 38 (suggesting that “increas[ing] help-seeking and referrals for at-risk individuals by decreasing stigma” would be effective for treating the at-risk individuals and preventing suicidal behavior).

²¹¹ *N.Y.C. Transit Auth. v. Beazer*, 440 U.S. 568, 607–11 (1979).

²¹² *Hearing*, *supra* note 160, at 46 (prepared statement of Christine Moutier).

perhaps under-inclusive because it does not include individuals with substance use disorders or individuals with non-serious mental disorders and does not provide the same amount of attention to non-serious mental disorders, but it is not necessary for the fit to be perfect.

In the seminal case of *Railway Express Agency v. New York*, the Supreme Court found that a New York traffic regulation prohibiting operation of “advertising vehicles” to reduce traffic hazards by eliminating distractions to protect drivers and pedestrians was under-inclusive because it targeted too few factors contributing to the problem, but further said that regulations need not to eradicate all the problem at once and thus does not violate equal protection.²¹³ Likewise, I am proposing to address the issue of suicide through focusing on the greatest risk factor and allowing room for the future addressing of substance abuse and other factors. Seeing how substance abuse is a close second to mental disorders as having a strong correlation to suicide and often is accompanied by mental disorders,²¹⁴ it is likely that these individuals with substance use disorders may also benefit from this proposal; this can pave the way for a suicide prevention bill primarily concerned with substance abuse or a bill that targets individuals with mental disorders and substance use disorders as well. However, because funding has been relatively lukewarm compared to funding for other public health concerns²¹⁵ and bills demanding high costs and great reform tend to move slowly through Congress, this proposal aims to start out a bit more narrow and ask for a significant, but slightly smaller, amount of funding as to not intimidate Congress.

D. NORMATIVE JUSTIFICATIONS

First and foremost, this proposal will lead to a reduction of negative economic impact. The direct cost of suicide attempts in the United States is approximately \$2 billion a year in medical care; indirect costs, such as lost wages and productivity, accrue to approximately \$4.3 billion a year.²¹⁶ The cost of completed suicides in the United States was calculated at \$34.6 billion annually in 2005—price adjustment for inflation raises it to

²¹³ *Railway Express Agency v. New York*, 336 U.S. 106, 110 (1949).

²¹⁴ *2012 National Strategy*, *supra* note 15, at 19.

²¹⁵ *Hearing*, *supra* note 160, at 52 (prepared statement of Christine Moutier) (“we’ve seen a 42 [percent] 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.”).

²¹⁶ *Facts and Figures*, *supra* note 20.

\$42.2 billion—and the rate of suicide has increased since 2005.²¹⁷ This number has risen to \$51 billion in 2013.²¹⁸ Implementation of the suicide prevention policy bill proposal in the long run would significantly reduce these costs and lead to economic improvements.²¹⁹ Productivity will increase as individuals with SMI (with the right treatment, support, and access to health care) ought to be fit to work, and there will be fewer lives for suicide to take and so those lives can potentially remain in or rejoin the work force.²²⁰ Furthermore, there will be increased connectedness in the household and community through fostering proper tools to engage in safe and responsible dialogue on mental illness and suicide.²²¹ This, in turn, will reduce stigma for the future and pave a better road for mental health consumption and suicide prevention.

VII. CONCLUSION

Suicide is an urgent yet silent epidemic lurking in our nation. While it has been established that the Government has a legitimate interest in preventing suicide and preserving life, the Government has largely been unsuccessful in doing so as suicide rates have climbed in the last decade. That is not to say it is due to lack of trying; the Government has been involved in suicide prevention efforts and had a hand in the creation of the *National Strategy for Suicide Prevention*. To carry out the mission of the *National Strategy*, the Government has enacted laws aimed to help groups at risk of suicide, such as the youth and the veterans. Because of the high correlation of suicide and mental disorders, and particularly with serious mental illnesses, I propose a hybrid suicide prevention policy that mirrors components of mental health crisis bills and aims to further the goals of the *National Strategy*. This proposal focuses on the need to foster more research on the relationship between mental disorders and suicide,

²¹⁷ *Id.*

²¹⁸ *Suicide: Facts at a Glance*, *supra* note 22.

²¹⁹ *Cf. id.* (inferring that reduction in completed and attempted suicides, which is the goal of the bill, will reduce the associated direct and indirect costs, and that a reduction in these costs will allow the savings to be spent in proactive manner that benefits the economy).

²²⁰ *Cf. id.* (inferring that the bill will result in a reduction in completed and attempted suicides, which would reduce the associated costs of lost wages and productivity); *see* 2012 *National Strategy*, *supra* note 15, 137 (stating that providing access to mental health care, which is a goal of my proposal, may improve financial and social outcomes, including wages).

²²¹ *Strategic Direction for the Prevention of Suicidal Behavior: Promoting Individual, Family, and Community Connectedness to Prevent Suicidal Behavior*, CTRS. FOR DISEASE CONTROL & PREVENTION, 3–5 (2012), http://www.cdc.gov/violenceprevention/pdf/Suicide_Strategic_Direction_Full_Version-a.pdf.

effective treatment and intervention programs, and protective factors of suicide; advance support systems by providing communities with proper resources and tools; increase the burden on health care, mental health personnel, and first responders to properly assess and treat individuals with SMI and at risk of suicide; make mental health care accessible and a part of overall health care; and reduce stigma through efforts on the parts of all parties on every level. Doing so would shine a light on this lurking epidemic, suppress it, make room for future suicide prevention action, and overall create a healthier nation.