CENTERSTONE

September 17, 2014

113th Congress of the United States
House of Representatives
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, D.C. 20515

RE: Energy & Commerce Subcommittee on Oversight and Investigations Hearing: Suicide Prevention and Treatment: Helping Loved Ones in Mental Health Crisis

Dear Honorable Representatives of the Energy and Commerce Committee,

On behalf of the thousand employees of Centerstone of Tennessee working to prevent suicides within Middle Tennessee, we want to applaud the Energy and Commerce Committee, subcommittee chairman Representative Tim Murphy, our congressman Marsha Blackburn, Representative for Tennessee's 7th district, for addressing this very important topic in your hearing on the 17th of September, 2014. Suicide is one of the top ten causes of death in Tennessee, and its results have devastating effects across the families and communities we serve.

While there has been a considerable amount of work accomplished in research regarding what is effective for suicide prevention over the last decade, we believe that there are significant steps remaining to ensure that best practices for suicide prevention are adopted by mental health providers. We endorse Goal 8 of the National Strategy for Suicide Prevention from the United States Surgeon General,[1] and we believe that screening for suicide and promoting suicide prevention should be a core mental health provider service.

As a community mental health provider with over fifty years' experience caring for persons at risk of suicide in the community, we know first-hand the life-saving potential that evidence based suicide prevention practices can have. Through Centerstone Research Institute (CRI), we participated in research & evaluation regarding prevention of suicide, especially with youth. We created the first SAMHSA-approved evidence based practice for prevention of youth suicide within the (residential) juvenile justice system – *The Shield of Care* and participated in research with the Centers for Disease Control that

[1] U.S. Department of Health and Human Services (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention. 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action. Washington, DC: HHS, September 2012. Retrieved on September 17, 2014 from http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/full-report.pdf

showed that increasing connectedness[2] is one of the most powerful interventions to prevent youth suicide. While many providers in mental health care see suicide as an unavoidable byproduct of mental illness, research suggests that it is more effective to treat suicide as an adverse occurrence that is preventable. Thus, we have changed our goal as an agency to move from suicide reduction to a goal of "Zero Suicides."

This commitment has resulted in substantial changes to our clinical processes, our electronic health record, our crisis response protocol, and our quality improvement efforts. Now, all of our clients are screened for suicide risk through an evidence based measure, and at-risk clients receive intensive follow-up and interventions. Out of this commitment, we have seen steady improvement in our suicide prevention results. In the last 12 months, we have reduced the suicide completion rate for our patients by 82%. Currently, our suicide completion rate is 17 out of 100,000 patients, the lowest rate we have had since we started tracking this metric, getting closer to the Tennessee 2012 average of 14.8.

Out of our work, we have been asked to participate in several national and international organizations committed to preventing suicides. As a member of the Advisory Panel for the National Action Alliance Zero Suicides in Healthcare Task Force, the International Institute for Mental Health Leadership, and the International Collaborative for Zero Suicide, we've discovered that there are several national-level needs regarding suicide prevention that, if met, would enable mental health providers to deliver the most effective suicide prevention care.

Most importantly, behavioral health providers have limited access to electronic health records that have evidence-based suicide screening tools embedded within them, alerts to ensure that protocols are followed when an at-risk client misses an appointment, and releases that enable providers to engage with family members and significant loved ones when a client is at risk. These features have been key to our success, but many mental health providers lack these essential tools. Rep. Murphy's legislation to fix the exclusion of behavioral health providers within HITECH funding (S. 1517,S. 1685/H.R. 2957) would go a long way to address this disparity.

Additionally, as our healthcare system moves more towards outcomes-based, accountable care, the "outcome" of suicide completion needs definition. There is currently not a standard "definition" in healthcare for when and how to count a completed suicide. Currently, healthcare organizations can say that they have a "great suicide prevention" practice, but we are measuring apples & oranges nationally. Some organizations only count a client death as a suicide if the word "suicide" is on the death certificate (as opposed to "self-asphyxiation"), and some will document the death as suicide if the clinician "suspects." Who qualifies as a "client" is also loosely defined. Some organizations count someone as a client only if they were seen within the last 7 days, and others may use a 30, 60, or even 90 day threshold. The National Action Alliance Zero Suicide in Healthcare Task Force is working to address this issue, but it has no accountability or oversight within the healthcare system. The National Committee on Quality Assurance (NCQA) might be an appropriate organization to clarify the definition and test whether adding it as a Healthcare Effectiveness Data and Information Set (HEDIS) measure has value for improving care.

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2 "Connectedness is the degree to which an individual or group is socially close, interrelated, or shares resources with other individuals or groups." Centers for Disease Control and Prevention (CDC). Connectedness as a strategic direction for the prevention of suicidal behavior. Retrieved September 27, 2011 from http://www.cdc.gov/violenceprevention/pdf/Suicide_Strategic_Direction_Full_Version-a.pdf

Lastly, many mental health providers "screen" for suicide, but very few use evidence based screening tools. We have found that most providers are not screening in a way that could be effectively captured (using text boxes or paper forms to track suicide risk/suicidality). Centerstone, as part of its Zero Suicide initiative, has adopted the free/open source Columbia Suicide Severity Rating Scale (http://www.cssrs.columbia.edu/), incorporated it within our electronic health record, and all clients in Tennessee are screened using this assessment at intake and at all subsequent service delivery points. We strongly support regulations that require all mental health providers to screen for suicidality.

Thank you so very much for considering these ways to improve suicide prevention across the United States. We appreciate your leadership in this matter, and we look forward to the results coming from this investigation.

Sincerely,

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