Recommendation 1: Create a Statewide Suicide Prevention and Intervention Plan

The North Carolina Department of Health and Human Services should convene a broader task force to develop a statewide plan for suicide prevention, early intervention, crisis services, treatment, recovery supports, and postvention services. The group should include, but not be limited to, representatives from: the North Carolina Division of Medical Assistance, North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, North Carolina Division of Public Health, North Carolina Division of Social Services, North Carolina Division of Aging and Adult Services, North Carolina Division of Health Service Regulation, North Carolina Department of Public Instruction, North Carolina Community College System, University of North Carolina System, North Carolina Department of Juvenile Justice and Delinquency Prevention, North Carolina Department of Public Safety, Local Management Entities/Managed Care Organizations, law enforcement agencies, jails, crisis intervention teams, mobile crisis teams, survivor support groups, North Carolina National Guard, North Carolina Division of Veterans Affairs, United States Department of Defense, North Carolina Hospital Association, North Carolina Medical Society, North Carolina Academy of Family Physicians, employee assistance programs, and the faith communities.

Recommendation 2: Build Suicide Prevention and Intervention Capacity at the State and Local Mental Health, Developmental Disabilities, and Substance Abuse System

a) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) should identify one or more staff to serve as the state-designated suicide prevention and intervention expert(s), and should require each Local Management Entity/Managed Care Organization (LME/MCO) to have a suicide prevention and intervention coordinator.

b) Each LME/MCO should designate one or more suicide prevention and intervention coordinators. The state and local designated suicide prevention and intervention coordinators should work together to develop a more detailed implementation plan including timelines for when different parts of the plan should be accomplished, using this state suicide prevention and intervention plan as its blueprint. As part of this plan, the state and local suicide prevention and intervention coordinators should identify high needs populations, existing resources and gaps in prevention, early intervention, crisis services, treatment, recovery

supports, and postvention services. The state and local suicide prevention and intervention coordinators should monitor progress in implementing the plan on an annual basis and should include a summary of the progress (or lack thereof) in the DMH/DD/SAS's annual report to the Substance Abuse and Mental Health Services Administration.

C) The local LME/MCO staff should also ensure that the agency examines the need for suicide-related services in its needs assessment, offers gatekeeper training to appropriate community partners (including but not limited to schools and law enforcement), and builds appropriate training and performance measures into provider contracts.

d) Suicide prevention and intervention coordinators at the state and LME/MCOs should work together to identify evidence-based or best practice screening and assessment tools, training for first responders and other crisis service providers, treatment and recovery supports, and bring this information to the North Carolina Practice Improvement Collaborative (NC PIC) for review and recommendations for adoption in North Carolina. Once reviewed, the state and local suicide prevention and intervention coordinators should work within their respective agencies to help implement the recommended evidence-based or best practices within their respective agencies, and by contracted behavioral health providers.

Recommendation 3: Support greater investment in suicide prevention and education at the state and local level

a) State level.

1) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) should require that all Local Management Entities (LMEs) use some of their federal and state funding to support suicide prevention and broad-based education. The state should identify a minimum threshold and identify existing funding sources which can be used to support prevention, such as the Substance Abuse Prevention and Treatment Block Grant and Community Mental Health Services Block Grant funds.

2) DMH/DD/SAS and the Division of Medical Assistance (DMA) should require that LME Managed Care Organizations (LME/MCOs) invest in prevention activities as a means of reducing unnecessary use of emergency departments. As part of the community engagement part of the MCO contract, funding should be used to educate enrollees and gatekeepers, including but not limited to: school personnel, employers

and supervisors, faith-based and community leaders, emergency health care personnel, employment security personnel, and personnel and volunteers in programs serving older adults.

3) DMH/DD/SAS and DMA should work with the DMH/DD/SAS North Carolina Practice Improvement Collaborative (NC PIC) to identify existing prevention programs that are evidence-based or other best practices. DMH/DD/SAS should ensure that training and technical assistance is available to the LME/MCOs and contracting provider organizations at a reasonable cost to ensure that the programs can be implemented with fidelity. In addition to identifying existing evidence-based or evidence-informed training and technical assistance programs, DMH/DD/SAS, DMA, and the NC PIC should identify the key elements/components that are consistent with these evidence-based prevention programs and allow organizations to be certified to provide training and technical assistance using these key components.

b) Local level.

1) As part of their MCO community relations, network, and quality management responsibilities, the LME/MCO should:

i) Select one of the designated evidence-based or evidence-informed prevention strategies, or approved elements and implement it in their local community directly and through contracted providers.

ii) Educate community partners, including but not limited to schools, law enforcement, juvenile justice, social services, and faith based organizations, about suicide and suicide risks, and engage the partners in implementing prevention strategies that are evidence-based or recognized as best practices.

iii) Provide information on their websites about suicide prevention and crisis services in the community.

Recommendation 4: Implement Evidence-Based Screening and Suicide Assessment Instruments to Identify People at High Risk of Suicide

a) State level.

1) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS), Division of Medical Assistance (DMA), Community Care of North Carolina (CCNC),

and the North Carolina Practice Improvement Collaborative (NC PIC) should work together to examine existing screening and risk assessment tools and the research literature to:

i) Select an evidence-based or best practice suicide brief screening tool(s) and follow-up suicide risk assessment tool(s) that can be used by LME/MCOs and contracting providers. As part of this analysis, DMH/DD/SAS, DMA, CCNC and the NC PIC should examine the LOCUS and CALOCUS to determine if these level of care instruments used for utilization review could also serve as a standardized care assessment tool.

ii) Develop a model suicide risk management protocol which includes the frequency and under what conditions the screening and risk assessment tools should be administered. At a minimum, the LME/MCO should administer a screening tool as part of the initial STR intake, and contracted providers should screen as part of the initial intake. Individuals at high risk, including those who have attempted suicide, and those who are leaving state institutions, hospitals, crisis services, jails, or prisons should be screened by a community provider as part of the transition of care protocol.

2) DMH/DD/SAS and DMA should require that the Local Management Entity/Managed Care Organization (LME/MCO) and contracted community providers use one of the approved screening tools at intake, followed by a more comprehensive suicide risk assessment tool (when appropriate), and then follow the recommended periodicity schedule thereafter.

3) DMH/DD/SAS and DMA should require that staff at the LME/MCOs and contracted providers receive training from state approved vendors on how to identify people who are at risk, including an understanding of the evidence-based screening and assessment process, and the appropriate use of the LOCUS and CALOCUS level of care authorization tools.

4) DMH/DD/SAS and DMA should encourage LME/MCOs to support integrated behavioral health and primary care practices.

b) Local level.

1) LME/MCOs must develop a comprehensive suicide risk management protocol that includes guidelines for screening and suicide risk assessment by the LME/MCO and contracted behavioral health

providers. At a minimum, the LME/MCO must use an approved screening tool during the STR intake. If the person is identified as having suicidal ideation or at high risk, then the LME/MCO must administer a state-approved suicide risk assessment to determine suicide risk and protective factors.

2) **LME/MCOs should require community behavioral health providers to use a similar state approved screening and assessment process. The requirement should be built into provider contracts, and monitored as part of the quality management system.**

3) **CCNC primary care practices should routinely screen adolescents and adults for depression using the PHQ-2 or another approved screening tool. If the person tests positive for depression or substance abuse, then the primary care professional and/or care manager should administer a more detailed risk assessment tool that asks specifically about suicidal ideation. Individuals who are identified as high risk for suicide should be immediately linked to the LME/MCO so that the person can get appropriate treatment services.**

4) **LME/MCOs should encourage the development and provide support for integrated primary care and behavioral health practices. The LME/MCOs should ensure that the clinicians in these practices have been trained to recognize suicide risk, administer evidence-based screening and suicide assessment tools, and be able to offer evidence-based treatment or ensure that individuals at high risk of suicide are referred into and receive appropriate evidence-based treatment.**

Recommendation 5: Assure a Comprehensive Array of Crisis Providers Who Are Trained to Identify and Treat People to Reduce Immediate Suicide Risk

a) **State level.**

1) **The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) should use a portion of state and federal funding to help pay for training and technical assistance to Local Management Entities/Managed Care Organizations (LME/MCOs) to help support the development of a coordinated system of crisis providers that have been trained in crisis de-escalation skills, identifying suicide risks, and providing treatment to stabilize the immediate suicide risk. Information about available crisis providers should be distributed widely to community partners, and should be maintained and easily accessible on the DMH/DD/SAS website.**

2) **DMH/DD/SAS and the Division of Medical Assistance (DMA) to provide technical support to LME/MCOs about best practices on crisis response systems that include mobile crisis, walk-in centers, and facility-based services.**

3) **DMH/DD/SAS, DMA, and the North Carolina Practice Improvement Collaborative (NC PIC) should identify evidence-based or evidence-informed suicide crisis training curricula (such as the QPR-T). Once identified, DMH/DD/SAS should certify training providers who can deliver the evidence-based curricula or content that includes the same core elements as the approved evidence-based training curricula, and require that all crisis response workers receive training in one of these approved curricula.**

4) **DMH/DD/SAS and DMA should evaluate these efforts to determine if the availability of well trained, coordinated, and comprehensive crisis providers leads to reduced suicide attempts, reduced suicide deaths, and reduced use of the emergency department.**

5) **DMH/DD/SAS, DMA, the NC PIC should identify evidence-based or best practices to ensure the availability of high quality crisis services. Once identified, DMH/DD/SAS and DMA should include these standards in the model suicide risk management protocol and require that LME/MCOs meet these new standards. These standards should include requirements for a comprehensive array of crisis services, hours of operation (for walk in and facility based), staffing, training, and other requirements.**

6) **DMH/DD/SAS, DMA, and CCNC should expand the definition of people with special health care needs who are eligible for care coordination to include individuals with mental health or substance use disorders who are discharged from institutions, hospitals, or crisis services. Care coordinators should assist these individuals with transitions to community providers. This expanded definition of special health care needs population should be built into the contract with the LME/MCO for care coordination services.**

7) **DMH/DD/SAS should work with DMA, Division of State Operated Facilities, the North Carolina Hospital Association, Division of Health Services Regulation, LME/MCOs, local emergency medical services (EMS), health professional associations, magistrates, and law enforcement to develop new standards for emergency medical services, involuntary commitment (IVC), and interception models. Emergency management should triage individuals to determine if the person expressing suicidal ideation or other emergency mental**

health needs has an immediate medical need. If the person does not have a concurrent medical need, the EMS personnel should transport individuals to appropriate crisis resources, if available in the community and properly staffed to provide crisis and IVC services.

b) Local level.

1) LME/MCOs should determine whether there are sufficient behavioral health crisis providers who are trained to address the needs of people who are actively contemplating, or have attempted suicide; and whether these providers are geographically accessible and available on a 24/7 basis to people throughout the service area.

2) LME/MCOs should contract for a full array of crisis services and require coordination of services across providers. LME/MCOs that contract with more than one crisis service provider should include performance measures to ensure coordination across crisis service providers.

3) LME/MCOs should include requirements to ensure that all crisis team members receive training using an evidence-informed suicide clinical training curriculum, as identified in Recommendation 4.a.3.

4) LME/MCOs should work with law enforcement agencies to develop a protocol to be alerted when someone in their catchment area attempts suicide, so that the LME/MCO can link the person with appropriate treatment and recovery supports.

Recommendation 6: Ensure that People at High Risk of Suicide are Referred Into and Receive Evidence-Based Treatment Appropriate to Their Underlying Mental Health or Substance Use Disorder

a) State level.

1) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) and the Division of Medical Assistance (DMA), working with the North Carolina Practice Improvement Collaborative (NC PIC), should identify evidence-based treatment interventions targeting the populations that are most at risk of suicide (including people with co-occurring mental health and substance use disorders, and individuals with major depressive, bipolar, schizophrenia, or borderline personality disorders). DMH/DD/SAS and DMA should require that the Local Management Entities/

Managed Care Organizations (LME/MCOs) contract with behavioral health professionals that can deliver these evidence-based treatment services and that can ensure effective transitions of care between different service providers. The LME/MCOs should include quality management oversight to ensure that these contracted professionals are implementing the evidence-based clinical protocol with fidelity.

2) DMH/DD/SAS, DMA, and NC PIC should develop clinical practice guidelines for managing suicide risk and communicating risk within provider agencies. These standards should be included in the suicide risk management plans required in contract language with MCOs, and should be included in contract language with community providers. These guidelines should include, but not be limited to: standards for when the provider should conduct a more thorough suicide assessment and when the provider should develop a crisis plan, as well as appropriate evidence-based treatment for high-risk conditions. In addition, the clinical practice guidelines should include information that must be communicated across providers, and procedures to ensure a "warm hand-off" to ensure that individuals at high risk of suicide move seamlessly from one provider to another.

b) Local level.

1) The LME/MCOs should determine, as part of the community needs assessment, whether there are sufficient behavioral health providers with the training and skills needed to provide the state-identified evidence-based or evidence-informed suicide interventions.

2) LME/MCOs should contract with a sufficient number of behavioral health professionals with the training and clinical expertise to deliver these services without delay throughout the LME/MCO service area. The LME/MCO should monitor the performance of these contracted behavioral health professionals to ensure that the contractors meet the standards for managing suicide risk, provide evidence-based treatment services with fidelity, and are achieving positive health outcomes.

3) LME/MCOs should assist, through their care coordination function, in transition planning, linking, and engagement with individuals who are being discharged from hospitals, institutions, or crisis services to other providers.

Recommendation 7: Assure People Who Have Attempted Suicide or With Suicidal Ideation Have Crisis Safety and Recovery Support Plans That Build Upon Their Strengths

a) State level.

1) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) and Division of Medical Assistance (DMA), working with the North Carolina Practice Improvement Collaborative (NC PIC), should develop standards for what information must be included in recovery support plans. The standards should be based on best available evidence about how to build connections to natural supports, help people at high risk of suicide address feelings of isolation and hopelessness, build upon existing strengths, identify early warning signs that can trigger thoughts of suicide, and create a suicide safety plan to prevent future suicide attempts.

2) The Consumer and Family Advisory Committee (CFAC) at the state level should work with local CFAC to identify peer and natural support groups that can help individuals reduce feelings of isolation.

b) Local level.

1) The Local Management Entity/Managed Care Organization (LME/MCO) should require that contracted behavioral health professionals work with the person at high risk of suicide to develop an appropriate recovery action plan, and monitor the performance of the contracted professionals against this requirement.

2) The Consumer and Family Advisory Committee should work with the consumer relations staff in the LME/MCO to identify peer and natural support groups in their community, or work to create linkages to existing organizations for this purpose.

Recommendation 8: Link Family, Friends, and Other People Who Have Been Touched by the Suicide Death of Another into Appropriate Postvention Services

a) State level:

1) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS), in partnership with the

Division of Public Health (DPH) and Department of Public Instruction (DPI), should identify and adapt postvention toolkits for schools and communities in North Carolina. Similar to the "After a Suicide" toolkit for schools, this toolkit should provide information about what to do when a community experiences one suicide or multiple suicides. Toolkits for schools and other community partners should be posted on the web, and should be shared widely with community partners across the state.

2) **DMH/DD/SAS and DMA should ensure that Local Management Entities/Managed Care Organizations (LME/MCOs) include information about postvention resources on their websites, and conduct outreach to community partners to ensure that people touched by suicide will know where to turn for help. As part of the outreach efforts, DMH/DD/SAS and DMA should target schools, law enforcement, and the faith community to ensure that they have information about available resources for others touched by suicide.**

b) **Local level.**

1) **LME/MCOs should work with law enforcement agencies to include trained volunteers or professionals who can accompany first responders to the scene of a suicide (to conduct outreach to the bereaved family members), and/or develop a protocol to have law enforcement alert the LME/MCO to any death by suicide, so that the LME/MCO can reach out to the family, friends, and other community members touched by the suicide and offer them postvention services.**

2) **LME/MCOs should catalog the availability of postvention treatment services and peer delivered support groups, and make this information available and easily accessible on the web. In addition, as part of the community engagement, the LME/MCO should ensure that other community providers (including but not limited to schools, law enforcement, and the faith community) know about the availability of these postvention services.**

3) **LME/MCOs should promote the development of evidence-informed postvention treatment and peer supports if sufficient resources are not available in the community.**