Vision For a Suicide Prevention and Intervention Plan

Chapter 3

North Carolina needs a multifaceted suicide prevention and intervention plan that combines broad-based prevention activities, early intervention, crisis services, treatment, recovery supports for people who have attempted suicide, and postvention for people touched by suicide (see Figure 3.1). To be effective, the state needs to invest more heavily in prevention—both in reducing risk factors that are known to increase the chance of suicide, and in strengthening the protective factors that can help reduce suicide risk. Effective prevention strategies are multilevel, and include messages or prevention programs targeted to broad based populations ("universal"), higher risk groups ("selective"), and people who have shown early suicide warning signs ("indicated"). Most people, including those who enter the mental health or substance abuse service system, should be screened to determine their level of risk. Once identified as high risk, these individuals should then be assessed more thoroughly for suicidal ideation, past history of suicide attempts, suicide capability (early intervention), as well for as the protective factors that can help reduce the risk of suicide. Individuals who are actively contemplating or who have attempted suicide need to be linked immediately to effective crisis services. Crisis services should be followed with appropriate treatment and recovery supports in order to help the person develop strategies to address future crises. "Postvention" services are needed for the friends, families, and colleagues of

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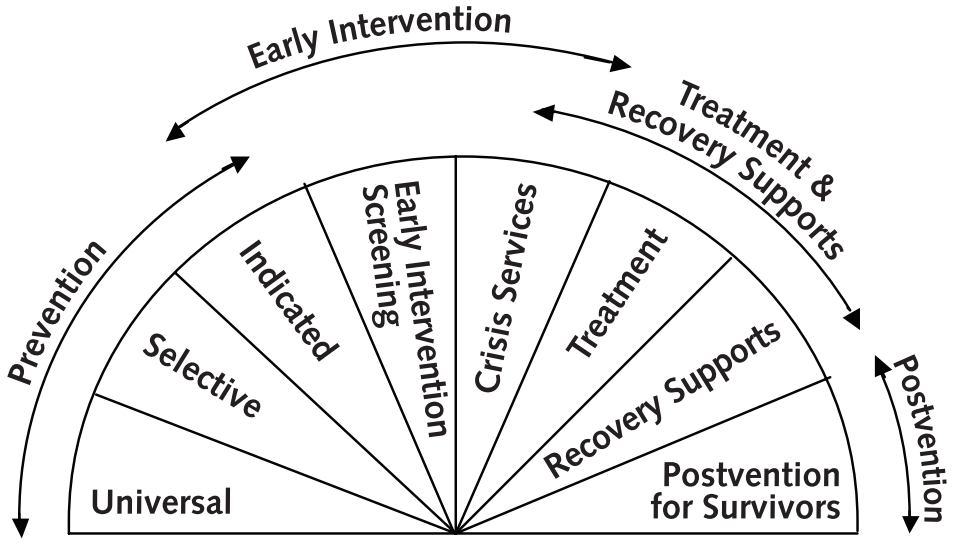
Figure 3.1
Suicide Prevention and Intervention Framework



Adapted from California Strategic Plan on Suicide Prevention. California Department of Mental Health. California Strategic Plan on Suicide Prevention: Every Californian Is Part of the Solution. http://www.dmh.ca.gov/prop_63/MHSA/Prevention_and_Early_Intervention/docs/SuicidePreventionCommittee/FINAL_CalSPSP_V9.pdf. Published June 30, 2008. Accessed April 30, 2012.

the people who die by suicide as they are also at higher risk of suicide following the tragedy.

Comprehensive suicide prevention and intervention models that have been implemented elsewhere have been successful in reducing suicide deaths and suicide risk. Maryland implemented a comprehensive suicide prevention and intervention strategy targeting youth in the 1990s. The Maryland model includes a comprehensive strategy with prevention, intervention and postvention activities including but not limited to a state youth crisis hotline, funds for school-based suicide prevention programs, gatekeeper training and community education, crisis teams, intervention, and postvention services. A study showed that after this model was implemented suicide rates decreased across age groups and decreased by 21.4% among youth ages 15-24 in Maryland while youth suicide rate increased nationally by 11%.[1,2]. Similarly, the US Air Force implemented a comprehensive suicide prevention strategy which included community training to educate the Air Force personnel about suicide risk, screening programs to identify high-risk individuals, crisis services, and efforts to remove the barriers and stigma associated with seeking mental health services. The program also identified appropriate treatment and referral resources, and postvention services to help prevent "copycat" suicides (suicide "contagion"). The United Air Force observed a decrease in suicide rates from 16.4 per 100,000 to 9.4 per 100,000 between 1994 and 1998, and an overall reduction in suicide risk by 33%.[3,4]

Comprehensive suicide prevention and intervention models that have been implemented elsewhere have been successful in reducing suicide deaths and suicide risk.

Ideally, state and local agencies and contracted providers should deliver evidence-based prevention, early intervention, crisis, treatment, and postvention services. With limited public funding, we want to ensure that we use our funding wisely, and invest in programs, interventions and strategies that work. Evidence-based programs and interventions are those that achieve positive health outcomes and have been subject to rigorous evaluation. Evidence-based programs have usually been tested in multiple settings, and often in diverse populations (although some evidence-based programs have been designed to be administered to specific populations). The National Registry of Evidence-based Programs and Practices (NREPP) has reviewed mental health and substance abuse prevention and treatment programs to determine what works, and the level of evidence behind the different strategies.[5] However, achieving positive outcomes requires not only that we identify evidence-based strategies, but also that we implement those strategies as designed. Training, technical assistance, and ongoing monitoring must be provided—either by the state, national program offices, or other intermediary organizations—to ensure that the programs or strategies are implemented with fidelity.

While it is important to invest limited public dollars in programs or strategies with a proven track record, there may be times when such programs do not exist, are cost prohibitive, or do not fit the specific needs of the target population. We

need to ensure that the selected prevention or intervention strategies are age, culture, and gender appropriate, as well as linguistically accessible. Some of the strategies that work well in an urban area may not work as well in a rural community, or those that work for younger populations may not work for older adults. The North Carolina Practice Improvement Collaborative (NC PIC), a project of the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS), was established to identify evidence-based programs that would work well in North Carolina, and to encourage the widespread adoption of those practices.

We recognize, however, that communities need some flexibility to address local populations and local needs. In these instances, it may be appropriate to implement best practices— practices with some evidence of effectiveness or practices that have been modeled after other evidence-based programs—but that have not yet risen to the level of evidence-based.

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The Suicide Prevention Resource Center (SPRC) is the only federally supported national resource center that focuses on suicide prevention. SPRC provides training, technical assistance, and other information for health, social services, and educational professionals, and works with state and local suicide prevention organizations. SPRC has identified three levels of best practices.[6] The first level of evidence (Level I) is NREPP's evidence-based programs, described previously. The second level is Expert/Consensus Statements. To be listed as a best practice under Level II, a group of three expert reviewers must review the protocol to determine if it meets the specified level of importance, likelihood of meeting objectives, accuracy, safety, congruence with prevailing knowledge, and appropriateness in the development process. Level II programs include different suicide screening, assessment, and treatment protocols, and education and training materials. It does not have the same proven track record of efficacy but meets accuracy, safety, and program design standards. The third level is called Adherence to Standards. This includes awareness and outreach materials, educational and training programs, screening tools, and other protocols or policies which are designed to reduce the risk of suicide. To be included in the Level III listings, three experts must have reviewed the materials to examine the accuracy of the content, likelihood of meeting objectives, and the programmatic and messaging guidelines. (All of the programs identified by NREPP as evidence-based or by SPRC as best practices are described in brief and referenced in Appendix C.)

The evidence is always evolving. Thus, the state's plan should charge the North Carolina Practice Improvement Collaborative to regularly monitor existing research evidence to ensure that we know what works, place priority on investing public dollars to implement evidence-based or other best practices, and require ongoing evaluation to ensure that the strategies we are investing in are achieving the desired outcomes.

Today, different governmental and private organizations and agencies in the state offer a patchwork quilt of suicide prevention and intervention services, but this quilt has many holes. Some services are targeted to specific populations, while others are more broadly available. People who are in the midst of a crisis do not always know where to turn to obtain the services that are available. Further, even when services are available, they are not always well coordinated, and treatment professionals do not always communicate suicide risk or ideation to other professionals. Some providers employ evidence-based or other best practices, while others do not. The system does not always ensure appropriate transitional care, as people move from one provider to another. Further, we lack a statewide plan—or vision—for how to effectively use existing state and local resources to ensure that we effectively target this critical public health issue.

This plan focuses on the role that the state Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS), Division of Medical Assistance (DMA), Local Management Entities/Managed Care Organizations (LME/MCOs), and their contracted providers can play to help reduce the number of people who contemplate, attempt, or die by suicide. As noted in Chapter 2, 63% of the females, and 36.7% of the males who died by suicide in North Carolina (2004-2008) were in current treatment for a mental illness at the time of their death.[7] While 42.9% of all North Carolinians who died by suicide were in current treatment during that time period, and 47.5% had indications of current mental health illness (66.8% females, 41.6% males), this is likely to be an underreporting of all the extent of mental health or substance use disorders among people who die by suicide. The National Institute of Mental Health suggests that approximately 90% of suicides are associated with some form of mental illness.[8] Thus, focusing on the state and local mental health system is critical. Yet effectively reducing the number of suicide attempts and deaths will require new and strengthened partnerships across agencies. Ultimately we need to create a statewide plan that includes all the state and community partners involved in suicide prevention, early intervention, crisis services, treatment, recovery supports, and postvention services.

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.

This chapter highlights the key elements of a state Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS), Division of Medical Assistance (DMA), and Local Management Entity/Managed Care Organization (LME/MCO) statewide suicide prevention and intervention plan ("state and local mental health suicide prevention and intervention plan"). It is divided into six sections: prevention, early intervention, crisis services, treatment, recovery supports for people with suicidal ideation or who have survived a suicide attempt, and postvention services for the people touched by the suicide death of another person. Each section describes the vision for programs and services that should be available throughout the state. It also includes examples of nationally recognized evidence-based or other best practices. A more complete description of these strategies is included in Appendix C. In addition, the sections include a description of existing services and gaps, and recommendations for how to improve the state and local mental health suicide prevention and intervention system. Most of these recommendations can be implemented with little additional funding, by focusing on what works and adopting these evidence-based or best practices across the current state and local mental health, developmental disabilities, and substance abuse services systems.

This plan comes at a critical juncture as North Carolina transitions its publicly funded MH/DD/SA system from a loosely organized, fee-for-service system to a more tightly controlled managed care system.

This plan comes at a critical juncture as North Carolina transitions its publicly funded MH/DD/SA system from a loosely organized, fee-for-service system to a more tightly coordinated managed care system. While the transition creates challenges, it also offers new opportunities. LME/MCOs will be responsible for managing dollars from Medicaid, and from state and federal block grants for mental health, substance abuse, and developmental disabilities. LME/MCOs will receive a per member per month (PMPM) payment to manage all the mental health, substance abuse, and developmental disabilities services and supports for the Medicaid recipients in their service area. LME/MCOs also receive an allocation of state and federal block grant funds to help provide services to people who are not eligible for Medicaid, and receive varying levels of local support. This provides LME/MCOs with the flexibility to invest more of their money on prevention, early intervention, and effective outpatient treatment—especially if these services can help reduce more costly interventions or hospitalizations.

The Division of Medical Assistance (DMA) is holding the new LME/MCO entities to higher standards and has built in certain expectations into the MCO contracts. These enhanced performance requirements include community engagement (i.e. engaging community partners), building an adequate network of qualified providers to meet the MH/DD/SA needs of people in their service area, and quality management responsibilities to ensure that high quality services are being delivered. These new standards can also be used to support the development of a more effective suicide prevention and intervention system at the local level.[9]

This suicide prevention and intervention plan cannot be implemented immediately. As a first step, the state and local LME/MCOs must identify one or more staff members who will coordinate suicide prevention and intervention services. These staff must work together at the state and local levels to identify high needs populations, existing resources, and gaps in prevention, early intervention, crisis services, treatment, recovery supports, and postvention services for their respective areas in coordination with the state.

The state and local LME/MCOs should develop suicide risk protocols for use by the state, within LME/MCOs, and with contracted behavioral health providers.

Ultimately, the state and local LME/MCOs should develop suicide risk management protocols for use by the state, within LME/MCOs, and with contracted behavioral health providers. The suicide risk management plan should include, but not be limited to:

- An outreach and education plan to educate the public and gatekeepers about suicide and how to identify people at risk and refer them to appropriate services.
- An evidence-based screening tool to determine level of suicide risk.
- Requirements for when and how often people should be screened for suicide risk and the criteria that would trigger a more comprehensive suicide risk assessment.
- Identification of an evidence-based suicide risk assessment that must be used, or requirements for the information that should be gathered as part of a more comprehensive suicide assessment tool.
- The protocol to ensure people are linked to appropriate crisis services.
- Requirements for what should be included in a person's crisis safety plan.
- Care management protocols to ensure that people successfully transition from one level of care or one behavioral health provider to another.
- Mechanisms to ensure that people at high risk of suicide are linked to professionals who can offer appropriate evidence-based treatment.
- Information about the types of recovery supports (including natural and peer supports) that should be available once the immediate crisis has been successfully resolved.

- Mechanisms to identify people who were touched by suicide death, to offer appropriate postvention services.

The suicide risk management plan should also ensure that clinical and nonclinical staff receive appropriate training to recognize people who are at higher risk of suicide, and that behavioral health professionals receive the training needed to provide evidence-based treatment.

The state and local suicide prevention and intervention coordinators should work together to develop an implementation timeline using this plan as a blueprint, and should monitor progress in implementing the plan on an annual basis.

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.

Examples of Level I (NREPP) evidence-based prevention programs

- **Signs of Suicide (ages 13-17).** Two-day secondary school intervention program targeted at adolescent students (ages 13-17), screens for depression and suicide risk, and teaches appropriate responses.
- **Reconnecting Youth (ages 14-19).** School-based prevention program targeted at students ages 14-19 years with behavioral problems such as suicidal ideation, depression, substance abuse, and aggression, teaches students how to cope with early signs of emotional distress and substance abuse.

Examples of Level III best practices gatekeeper training programs

- **Applied Suicide Intervention Skills Training (ASIST).** Two-day training program for members of all caregiving groups teaches the participants how to help a person at risk for suicide stay safe and seek additional help when needed.
- **Question, Persuade, Refer (QPR).** Training for school personnel, law enforcement, crisis responders, or mental health professionals. This training improves the participants' ability to recognize and respond appropriately to someone exhibiting warning signs or risk factors for suicide.

Prevention

Vision

Prevention is a crucial starting point when devising a system of care or continuum of services to address a particular health issue or set of issues. Prevention activities are a core component of any public health effort to reduce the incidence of preventable diseases and disabilities and to improve overall health and well-being. Although prevention may immediately bring to mind efforts targeting well known chronic diseases (e.g. cancer and heart disease), prevention is not a tool unique to a specific disease or condition. Prevention is preferable to treatment because it provides an opportunity to intervene before an adverse event occurs.[10] Therefore, reducing suicide risk should begin with prevention.

North Carolina state and local partners will engage in a broad-based suicide prevention campaign that includes strategies to reach universal, selective, and indicated populations. *Universal prevention strategies* are targeted at the general public or subsets of the public. Universal prevention strategies help reduce the stigma associated with suicidal ideation and can help people know where they can turn for help. *Selective strategies* focus on those at greater risk, including those with biopsychosocial risk factors (e.g. mental health disorders, alcohol or other substance abuse disorders, history of trauma or abuse, family history of suicide), environmental risk factors (e.g. job loss, recent death in the family, local cluster of suicides), and sociocultural risk factors (e.g. sense of isolation, lack of social supports). Selective strategies include those focused on training individuals who are likely to interact with people at risk (i.e. "gatekeepers") to identify early warning signs and help link people who are at risk into appropriate services. *Indicated strategies* are targeted to those who are at most immediate risk, and who have indicated

suicidal ideation. Some of the early warning signs include people who are talking or writing about death and dying or looking for ways to kill themselves, or those who have been withdrawing from friends and family or society, or expressed feelings of hopelessness. Indicated strategies include screening, early identification, and crisis services to prevent people from attempting suicide.

To ensure maximum effectiveness, the state and LME/MCOs will invest their prevention dollars in strategies that have been shown to be effective (evidence-based), or evidence-informed (best practices).

Existing Resources

The current mental health and substance abuse service system managed by DMH/DD/SAS supports prevention activities that include strategies to address suicide prevention. The strategies implemented are coordinated with other statewide partners. A recent report from the Division of Public Health (DPH) has provided data to identify groups who are experiencing the majority of problems related to suicide, thus providing baseline for universal, selective, and indicated prevention activities. In collaboration, DPH, the Department of Public Instruction, and DMH/DD/SAS have implemented training for professionals, specifically focused on school personnel to identify youth at risk, and other trainings for those in health, mental health, and law enforcement agencies. DPH and DMH/DD/SAS have also created a media campaign called It's Okay to Ask About Suicide with pertinent partners involved in promoting the message.[11]

Gaps

Currently there are no requirements that LMEs invest in suicide prevention. However, with the move to managed care organizations, LME/MCOs must "support community-wide efforts" in education and prevention of suicide as part of their contract with DMA.[9]

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.**

Early Intervention

Vision

One of the best ways to help reduce the risk of suicide is to identify people who are at high risk, and help link them into appropriate services. Engaging in early intervention activities can lead to more favorable outcomes and can help to minimize the need for more intensive treatment. Screenings are often used to detect potential diseases or conditions before obvious signs and symptoms appear. Detecting a disease or condition at an early stage or identifying individuals at high risk is critical to providing high quality care and linking patients to effective interventions.[12]

As described later, there are a number of evidence-based and evidence-informed treatment programs that have been shown to reduce suicidal ideation, feelings of hopelessness, and/or address underlying mental health and substance abuse issues. Screening high-risk individuals—including people who fall into high-risk categories and those who have expressed suicidal ideation or attempted suicide in the past—is an effective strategy to identify people at high risk. People who are identified as high risk should receive a more thorough suicide risk assessment that captures information about their risk and protective factors, history of past attempts, current suicidal thoughts, and information about their suicide plans and capabilities.

One of the best ways to help reduce the risk of suicide is to identify people who are at high risk, and help link them into appropriate services.

Individuals who seek services through the LME/MCO should be screened for suicidal ideation using state-approved screening tools as part of the standard screening, triage, and referral process (STR). Individuals should receive the screening, using approved screening tools (or approved screening questions), whether the person first enters the system through the LME/MCO or through a contracting behavioral health provider. Further, these individuals should be screened on a periodic basis, following a state-approved periodicity schedule. To reduce the administrative burden on LME/MCOs, contracting providers, and primary care professionals, the initial screening tool does not have to be a comprehensive clinical risk assessment. Rather it can be a shorter screening tool to help identify the person's underlying needs and level of risk.

Example of a Level I (NREPP) evidence-based screening tool

- **Columbia University TeenScreen.** Early intervention screening in schools, clinics, doctors' offices, juvenile justice settings, shelters, or any other youth-serving setting for middle school and high school aged students at risk of suicide and mental illness.

Example of a Level II or III best practices screening tool

- **Question, Persuade, Refer, and Treat (QPR-T).** Guided clinical protocol for assessing suicide risk. Integrates a collaborative crisis management, monitoring, and safety plan.

The Task Force was unaware of any studies that specifically examined the impact of talking to at-risk individuals about their suicidal ideation. However, there is research that shows that providing treatment to at-risk individuals leads to reduction in suicidal behavior and ideation.[13] It is important to screen individuals in order to identify risk factors, so that those at high risk can be linked to treatment. If the person indicates major depression, suicidal ideation, or other risk factors for suicide, they should receive a more complete risk assessment to determine the level of suicidal ideation and any immediate plans to attempt suicide. In addition,

the assessment should also capture information about protective factors (or strengths) that can be fostered to help reduce the risk of suicide. This screening and assessment process limits more comprehensive clinical risk assessments for individuals at highest risk.

Each LME/MCO has a standard protocol for how it, and its contracted behavioral health providers, manage suicide risk. The suicide management protocol should have requirements for staff training to ensure that clinical and nonclinical crisis staff understand how to identify people at risk of suicide. The protocol should include information about how often and when individuals should be assessed for suicidal ideation and intent. For example, the standard protocol could require each contracting provider to complete a short screening tool upon intake, with a more comprehensive suicide assessment if the person scores high enough on risk factors (such as feelings of hopelessness, depression, or co-occurring mental illness and substance use disorder). Individuals with a past history of suicidal ideation or suicide attempts should also be assessed at different points of care (for example, after discharge from a hospital, move to a new therapist, or any other time when the person reports suicidal ideation). (A copy of a sample suicide management plan is included in Appendix E).

The suicide management protocol should have requirements for staff training to ensure that clinical and nonclinical crisis staff understand how to identify people at risk of suicide.

Many of the people who have contemplated, attempted, or died by suicide never sought mental health treatment. North Carolina data showed that 18.7% of females over the age of 10, and 20.3% of men had a physical health problem at the time of suicide death (2004-2008).[7] Research shows that approximately 45% of people who died by suicide had contact with a primary care professional within one month of the suicide, and approximately 25-75% had visited their primary care provider within 30-60 days of their death.[14]

In North Carolina, 20% of individuals age 10 or older who died by suicide (2004-2009) had a physical health problem.[7] This is even higher for those age 65 or older who died by suicide (57% who had a physical health problem). The US Preventive Services Task Force recommends that primary care practices routinely screen adolescents (12-18) for major depressive disorders and adults for depression, assuming that there are systems in place to ensure accurate diagnosis, treatment, and follow-up. Primary care providers should routinely screen individuals using a similar brief screening tool, and then follow-up with a more comprehensive suicide assessment tool that captures both the person's suicide risk as well as protective factors.

Existing Resources

All LME/MCOs must provide 24/7 screening, triage, and referral (STR) either in person or by telephone 24 hours a day, 7 days a week. LME/MCOs are required to ask standardized questions about suicidal ideation as part of the STR intake process. Additionally, the incident reporting system set up by DMH/DD/SAS requires LMEs to respond accordingly to the severity level of suicidal ideation or behavior.[15] Contracted providers who are often the first point of entry into the DMH/DD/SAS system are also required to do STR at initial intake.

While the state does require the use of a standardized STR tool as part of the intake process, the state has not identified a more comprehensive, evidence-based assessment instrument that LME/MCOs should use if the person indicates suicidal ideation or feelings of hopelessness, depression, or substance use (high risks for suicide). However, DMA and DMH/DD/SAS requires LME/MCOs to use a standardized level of care instrument as part of its utilization review function to determine the person's needed level of services. LME/MCOs, and contracted providers, must submit information using the Level of Care Utilization System (LOCUS) for adults[16] or the Child and Adolescent Level of Care Utilization System (CALOCUS)[16] to receive authorization for services. The LOCUS tool captures data on six dimensions, including risk of harm; functional status; medical, addictive, and psychiatric co-morbidity; recovery environment; treatment and recovery history; and engagement and recovery status. The questions in the risk of harm section consider the person's present and past suicidal thoughts, history of chronic impulsive suicidal behaviors or threats, whether the person has an immediate plan with the ability to carry out the suicidal behavior, whether the person is under the influence of alcohol or other drugs, and any changes from past behavior. The tool is intended to help clinicians identify needed services, including crisis services, clinical treatment, support services, and environmental interventions. The CALOCUS is similar in that it is intended to help identify level of service needs for children and adolescents. It is also based on six dimensions, including risk of harm; functional status; co-morbidity; recovery environment; resiliency and treatment history; and treatment acceptance and engagement. The CALOCUS also looks at the strengths and weaknesses of the parent/caregiver environment.

Community Care of North Carolina (CCNC), North Carolina's Medicaid patient-centered medical home, encourages all primary care providers to use either the Patient Health Questionnaire 2- or 9-question screening tool (PHQ-2 or PHQ-9) to screen Medicaid recipients in the primary care setting for depression. In addition, CCNC Medicaid care managers are required to administer the PHQ-2 at least once annually. (See Appendix D for a list of PHQ-2 and PHQ-9 questions.) If the person achieves a high enough score on the screening tool, he or she should then be evaluated for major depression. It is at this second step that primary care practitioners should also be asking questions about suicidal ideation. CCNC encourages care managers to use a standardized suicide assessment questionnaire. The CCNC Case Management Information System (CMIS) suicide assessment form asks people if they have ever attempted to harm themselves, whether the person had a plan to harm themselves, and whether the person thinks they may actually attempt to hurt themselves in the near future. (See Appendix D for the Suicide Assessment questionnaires).

In addition, some primary care practices have embedded behavioral health specialists who can provide mental health or substance abuse services directly in the primary care office. Expanding the array of integrated behavioral health

Expanding the array of integrated behavioral health and primary care practices can be an effective strategy to identify and provide early intervention services to people with suicide ideation who seek primary care services, but who might not otherwise seek mental health or substance abuse services.

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Gaps

While LME/MCOs are required to ask standardized questions about suicide as part of the initial intake (STR), LME/MCO staff do not receive training to understand the warning signs for suicide, suicide risk, or protective factors. The state has not identified a standardized evidence-based care assessment instrument that the LME/MCO staff or contracted behavioral health providers should use if the person is determined to either have suicidal ideation or be at high risk for suicide. Further, there is no guidance on how often or when individuals should be screened for suicidal ideation.

There is currently no system of accountability to ensure that LME/MCOs, primary care practitioners, or care managers ask about suicide ideation in the event that depression is identified.

DMA and DMH/DD/SAS are requiring LME/MCOs and contracted providers to use the LOCUS and CALOCUS tools to seek authorization for services. This requirement is new. LME/MCOs and contracting providers need training to ensure that staff and clinicians understand how to use these tools appropriately. In addition, it is possible that these tools may also be able to serve as care assessment instruments. The NC PIC should evaluate the information collected as part of the level of care determination to determine if the LOCUS and CALOCUS includes all the information needed to develop an individualized suicide risk prevention, crisis services, treatment and recovery plan.

While many primary care practices and care managers are beginning to implement the PHQ-2 depression screening tool, this is not a universal practice. Further, there is no guarantee that primary care practitioners or care managers will ask about suicidal ideation even if a person reports hopelessness or signs of major depression. Primary care practitioners and care managers do not always understand the warning signs for suicidal thinking, and may not know what to do if they find out a person is actively thinking about suicide. Further, CCNC does not specifically monitor primary care practices or care managers to determine adherence to the recommended depression screening or follow-up questions about suicidal ideation. In short, there is currently no system of accountability to ensure that the LME/MCOs, primary care practitioners, or care managers ask about suicidal ideation in the event that depression is identified.

While the move to create LME/MCOs offers the potential for improved behavioral health services, with greater emphasis on prevention, early intervention, higher quality, and adherence to evidence-based treatment, the transition and new credentialing standards are causing difficulty for some of the embedded behavioral health providers in primary care practices. Thus, there is some concern that the progress North Carolina has made in developing integrated primary care and behavioral health practices may be lost.

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.**

Crisis Services

Vision

Effective and timely crisis services are critical if the state is serious about reducing suicide attempts or suicide deaths. Crisis services include a well-publicized and adequately staffed suicide hotline, first responders who have been trained in crisis de-escalation skills, and recognizing and addressing suicide risk. A comprehensive array of crisis services would also include mobile crisis teams, walk-in and residential crisis services, and trained emergency departments.

People who are actively planning a suicide or who have attempted suicide need access to well-trained crisis staff throughout the state, and these services must be available 24 hours a day, 7 days a week. These crisis providers must either link individuals in crisis to trained mental health and substance abuse professionals who can offer evidence-based treatment services to help address the underlying problems, or be able to provide these services directly.

The state and local LME/MCOs should include requirements for crisis services in their suicide risk management plans. For example, the suicide risk management plan should identify the elements required in a crisis plan (including when the plan should be developed and updated), and appropriate evidence-based treatment for people who are at risk of suicide. A standard suicide management protocol should include requirements for care transitions, to ensure that the person successfully moves from one behavioral health setting to another (for example, when a person transitions out of an involuntary commitment setting to a community provider), and should have criteria for the information that should be shared among treating professionals (including information about the person's suicidal ideation or past suicide attempts). Suicide management plans should also include protocols for follow-up of high-risk individuals, including procedures to follow when the clinician is concerned about the individual's safety.

The suicide risk management plan should identify the elements required in a crisis plan and appropriate evidence-based treatment for people at risk of suicide.

Existing Resources

There is a broad array of crisis services available in different parts of the state. Some services, such as the suicide hotline, are available throughout the state. Other services are dependent on geographic location. For example:

- ***Suicide and Crisis Hotline:*** REAL Crisis Intervention operates a statewide crisis and suicide hotline that is available to people 24 hours a day, 7 days a week (1.800.273.8255). The REAL crisis hotline is part of a national suicide prevention hotline. Individuals who call the 1.800 national suicide hotline with a North Carolina phone number are routed to the Real Crisis Intervention telephone hotline. The hotline is accredited through the American Association of Suicidology, and all telephone counselors receive more than 60 hours of training before they can answer the phone. The REAL Crisis hotline averages 2,700 calls per month, and has a 99% answer rate (if the phone rings more than three times in one call, it is automatically transferred to another state suicide hotline). The hotline uses the Applied Suicide Intervention Skills Training (ASIST) screening tool. If someone is identified as having thoughts of suicide, the hotline staff help link the person to immediate crisis services, and will call back on an as-needed basis (i.e. it could be hourly or daily) until the crisis is resolved.

- ***Crisis Intervention Teams (CIT):*** CIT is a voluntary training and certification program that is available to law enforcement officers to help improve the capacity of these personnel to address the needs of

people with mental illness. Approximately one in 10 police calls involve a person with a mental illness,[17] and many of these have expressed suicidal thoughts or attempted suicide. CIT training includes 40 hours of training, approximately 3 of which focus on suicide. It is available free of charge to law enforcement personnel, and is provided through a partnership between the LMEs, law enforcement agencies, mental health advocacy organizations, and community colleges. However, there is no requirement that every law enforcement agency has certified staff. As of February 2011, about 18% of the state's law enforcement personnel (more than 4,000 people) were CIT certified.[18] North Carolina does not need to train all first responders to adequately cover the state with CIT certified personnel. Ensuring adequate coverage varies depending on the number of staff in each agency. Ideally, every law enforcement agency would have sufficient numbers of trained and certified personnel to respond 24/7 to mental health crisis calls.

Approximately one in 10 police calls involve a person with a mental illness, and many of these have expressed suicidal thoughts or attempted suicide.

- ***Mobile crisis:*** LME/MCOs currently help fund approximately 50 mobile crisis teams that cover the state.[19] Mobile crisis teams must respond to requests for services within two hours of the request, and services must be available on a 24 hours a day, 7 days a week basis. These teams were created to serve individuals where they need services in the least restrictive setting appropriate to their needs, and to help reduce the need for hospitalization. Mobile crisis teams can be called into a variety of settings to address crises, including homes, adult care homes, schools, and hospital emergency departments. They can also be called to accompany CIT teams as part of a first response system. Mobile crisis teams can continue to provide case management services to the individual for 24 hours post crisis. Mobile crisis teams will work with any individual who has a mental health or substance abuse crisis—not just those with suicidal ideation—but many of the people they serve have expressed suicidal thoughts or attempted suicide. Teams must have a licensed clinical social worker (LCSW), registered nurse, or psychologist that serves as the team leader, at least one trained substance abuse professional, and access to a psychiatrist 24/7. However, the availability of services and staff qualifications vary widely throughout the state. Mobile crisis teams that cover rural areas often have greater distances to cover, and some have difficulty attracting qualified personnel. Further, there is a high turnover among mobile crisis staff because of the low pay, work hours, and safety concerns. While mobile crisis team members all receive training, there is no standardized training across the state. Neither DMH/DD/SAS nor DMA stipulate what screening, assessment, or care planning tools are used. Because of credentialing requirements, some mobile crisis teams have been unable to work out agreements to provide services in hospital emergency departments. Mobile crisis teams have had similar problems developing agreements with some college campuses.

- ***North Carolina Systemic, Therapeutic, Assessment, Respite, and Treatment Program (NC START):*** DMH/DD/SAS has provided support to create three regional NC START programs.[20] Each region operates three crisis teams and one respite home. NC START provides support to other crisis teams (including mobile crisis or first responders), specifically to address the needs of adults with intellectual and developmental disabilities (many of whom have co-occurring mental health problems). NC START also provides assistance to help de-escalate crisis situations.

- ***Walk-in Crisis Centers:*** Currently there are more than 70 walk-in crisis centers across the state.[21] Unlike inpatient or facility-based services, these centers are not licensed. They were created to serve as an alternative to inpatient hospitalization for individuals who could appropriately be served in another setting and who need less than 24 hours of supervised care. These centers vary widely in their capacity to address crises on a 24/7 basis. North Carolina needs sufficient walk-in crisis providers, geographically disbursed through the state, with appropriate staffing to serve as an alternative to hospitalization for those who do not have a medical emergency and do not require hospitalization.

There is a broad array of crisis services available in different parts of the state.

- ***Emergency shelters and respite for youth:*** These services exist in some communities across the state. Most exist when needs have been identified and community partners, through cooperative agreements among county, provider, and nonprofit child-serving entities, provide emergency respite and shelter for youth. These services are not intended to serve youth who are experiencing suicidal ideation, and staff are not likely to be well trained to intervene with suicidal ideation, though they would be trained to access inpatient treatment for youth who present with risk of harm to themselves or others.

- ***Therapeutic Respite Addressing Crisis for Kids (TRACK) respite program for youth with intellectual and developmental disabilities:*** TRACK is a statewide, 5-6 bed program that serves children ages 5-17 with intellectual and developmental disabilities who are in behavioral crisis. The purpose of the program is to divert children from psychiatric hospitalization and avoid extended stays in hospital emergency rooms. The focus of the program is to stabilize a child's behavior so that they may return to their home as quickly as possible. TRACK does not accept involuntary commitments, so every effort must be made in the community to avoid the commitment process when a child is going to TRACK.

- ***Facility-Based Crisis Centers:*** There are currently 23 licensed facility-based crisis centers (FBCCs) for adults located across the state.[22] Facility-based crisis centers offer mental health and detoxification services. There is variability in the capacity of these FBCCs, including business hours when services are provided, involuntary commitment (IVC) process, qualifications of the staff, staff to patient ratios, availability of services

such as medical evaluation and/or medical clearance, and walk-in policies.[23]

- ***Inpatient Substance Abuse Treatment:*** The state currently operates three alcohol and drug abuse treatment centers (ADATC). Julian F. Keith ADATC[24], R.J. Blackley ADATC[25], and Walter B. Jones ADATC[26] are the three centers serving the Western, Central, and Eastern region of North Carolina, respectively. The ADATCs provide inpatient substance abuse treatment for individuals with substance abuse and co-occurring psychiatric diagnoses and admit individuals on involuntary commitment. They provide an array of services including medically monitored inpatient detoxification. Certain populations, including HIV/AIDS patients, communicable disease patients, intravenous drug users, and pregnant women, are given priority status admission to the ADATC.[27] The ADATCs admitted 4,416 individuals in 2011.[a] In addition to the three state run inpatient facilities, private organizations offer detoxification services, as do facility-based crisis services.

Hospital emergency departments often serve as the primary source of crisis services for people who have attempted suicide or have a self-inflicted injury.

- ***Hospital emergency departments:*** Hospital emergency departments often serve as the primary source of crisis services for people who have attempted suicide or have a self-inflicted injury. If the person has injured him or herself, the emergency medical service (EMS) professional or other first responders will transport the person to the emergency department for treatment. Individuals may also be brought to the hospital by a law enforcement officer within 24 hours of a magistrate's determination that there are reasonable grounds to believe the person is a threat to themselves or others. The hospital emergency physician can make this evaluation and may recommend that the patient be committed, involuntarily if necessary, to an inpatient behavioral facility. If the recommendation is for inpatient commitment, the individual will then be transported by the law enforcement officer or other designated person to a twenty-four hour facility such as a hospital, where a second examination will take place. Individuals who are under IVC orders are not discharged from the hospital until a treatment professional—usually the emergency physician and sometimes with consultation from a psychiatrist or other behavioral health professional, dissolves the commitment order. This decision is made through a determination that the person is no longer a threat to themselves or others and has an ongoing source of treatment.[b]

- ***Inpatient psychiatric services:*** The state currently operates three psychiatric hospitals Broughton Hospital (Morgantown), Central Regional Hospital (Butner) and Cherry Hospital (Goldsboro), and one forensic unit,

a Robinson S. Mental Health Program Manager/Planner, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, North Carolina Department of Health and Human Services. Written (email) communication. May 21, 2012.

b Vicario M. North Carolina Hospital Association. Oral communication. June 5, 2012

Dorothea Dix Hospital (Raleigh) in North Carolina that provide services to individuals with severe psychiatric problems. State psychiatric hospitals served 5,754 people in 2011, drastically down from 17,160 people in 2001.[28] In order to expand the number of people who could be served in an inpatient setting, DMH/DD/SAS and some of the state's LMEs entered into three-way contracts with community hospitals to provide community-based psychiatric services. In SFY 2012, there are 21 contracted hospitals across the state, providing 121 psychiatric beds.[23] In addition, 42 medical-surgical hospitals are licensed to provide psychiatric beds.[29]

Gaps

While there are many types of crisis services offered throughout the state, gaps remain. Some providers are equipped to treat some of the underlying problems, but may not have the capacity to address co-occurring conditions (e.g. mental health illness in detoxification facilities, detox in mental health facilities). According to some of the Task Force members, access to the full range of crisis services is more limited in some rural counties than it is in larger urban counties. Some of these access barriers should be addressed in the move to the LME/MCO. As part of the new LME/MCO contract with the state, LME/MCOs are required to have a full service array based on an annual gaps analysis. A range of Medicaid reimburseable crisis services must be available within each LME/MCO catchment area, including inpatient services, facility based crisis services, and mobile crisis management. Services must be available within 30 miles or 30 minutes in urban areas, and 40 miles or 40 minutes in rural areas.[c30]

While there are many types of crisis services offered throughout the state, gaps remain.

Even when crisis services are available in a community, there is not always strong coordination across crisis providers. Hospital emergency departments end up serving as the crisis provider in many communities because of the lack of other appropriate crisis providers, the lack of coordination among existing crisis providers, and because people do not know where else to turn. However hospitals are not appropriate settings for many people, especially those who do not have a medical need but do have a need ongoing behavioral health treatment services. Individuals with behavioral health problems waited, on average, 10 hours in hospital emergency departments in 2010 before being transferred to a more appropriate behavioral health treatment setting.[29] Some are boarded in hospital emergency departments for a week or more. In order to prevent unnecessary hospitalizations, comprehensive and coordinated crisis services should be available throughout the state.

Even when crisis services are available in a community, there is not always strong coordination across crisis providers.

Further, while all crisis professionals must be trained to meet licensure or credentialing standards, there is no oversight over the suicide content in these trainings. There is no requirement that any of the crisis providers receive specific suicide training, let alone that the training be based on an evidence-based curricula. Further, there is not a specified protocol for transitioning people with suicidal ideation from crisis services to other community providers.

c Crosbie K. Behavioral Health Manager, Division of Medical Assistance. Written (email) communication. May 29, 2012.

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.**

Treatment

Vision

People who have contemplated or attempted suicide need access to appropriate treatment services. Research has established that there are specific psychiatric illnesses that have been linked with a greater lifetime prevalence of suicide. Among these are major depressive, bipolar, schizophrenia, alcohol use, and borderline personality disorders. The lifetime risk of suicide for persons with any of these respective disorders ranges from 5-7%.[31,32] The risk of suicide increases if the person has co-occurring alcohol use disorder and psychiatric illness.[33,34] Logic would indicate that if effective services are available and accessible for persons impacted by these disorders, the risk of suicide among persons living with these disorders would be reduced. Further, high-risk individuals with co-occurring mental health and substance use disorders should be treated for both conditions.[30] Each LME/MCO should contract with behavioral health providers who have been trained and skilled in delivering evidence-based treatments that have been shown to reduce suicidal ideation, as well as the underlying mental health, substance abuse, or co-occurring issues that contribute to higher suicide risk. These behavioral health professionals need to be competent to both administer the evidence-based therapies, and also to understand how to apply these therapies to people with immediate suicide risk.

There are specific psychiatric illnesses that have been linked with a greater lifetime prevalence of suicide.

As part of the LME/MCO suicide risk management protocol, the LME/MCO should have a standard system to ensure that individuals who are at high-risk of suicide are linked to trained behavioral health professionals who can provide evidence-based treatment or best practice that is appropriate to the person's underlying behavioral health problem. Clinical staff should obtain more comprehensive training on evidence-based or best practices for suicide assessments and treatment.

Examples of Level I (NREPP) evidence-based programs effective in reducing suicidal ideation

- **Seeking Safety (ages 13-55).** Provides coping skills and psychoeducation for clients with a history of trauma or substance abuse.
- **Trauma Focused Coping (multimodality trauma treatment) (ages 6-17).** Provides intervention through psychoeducation, anxiety management skill building, and cognitive coping to children and adolescents in grades 4-12 who have been exposed to a traumatic stressor.

The suicide risk management protocol should also include provisions to ensure effective transitions between treatment providers or levels of care (e.g. from crisis services to treatment). In order to ensure effective transitions, treatment providers must share information about the individual's strengths, risks, suicidal ideation, medications, and other treatment history. Because people who are at high risk of suicide are already operating in crisis mode, they often need help connecting to appropriate treatment or crisis professionals. Care coordination is needed to help these individuals transition from one level of care to another or from one health provider to another, and to ensure that there is follow-up.

Existing Resources

The NC PIC has identified practices that are effective for many high-risk disorders including cognitive behavioral therapy for major depressive disorder and other affective disorders, illness

management and recovery for bipolar disorder/schizophrenia, integrated dual disorder treatment for co-occurring mental health and substance use disorders, and dialectical behavior therapy, trauma focused therapy, and other cognitive therapy based approaches for borderline personality disorder. There are behavioral health professionals who have been trained in these evidence-based therapy methods. However neither the state nor the local LME/MCOs currently have a data system to know which professionals have been trained in these evidence-based treatment methods. There is no certification system or other mechanism to indicate whether practitioners have been trained in these treatment protocols. Nor is there any mechanism to know whether practitioners who are billing for these services are delivering the treatment protocol with fidelity.

Examples of Level I (NREPP) or other evidence-based programs effective in addressing underlying mental health or substance use disorders

- **Dialectical Behavior Therapy (DBT) for borderline personality disorders.** Cognitive-behavioral treatment that includes behavioral problem-solving and acceptance strategies with an emphasis on multiple disorders.
- **Integrated Dual Disorder Treatment (IDDT) for co-occurring mental health and substance use disorders.** The North Carolina Practice Improvement Collaborative has identified this as an effective intervention to address co-occurring disorders. Treatment involves assertive outreach and stage-wise comprehensive treatment.

Gaps

Although there are evidence-based treatment approaches that have been well established as leading to more effective outcomes for suicidal ideation, as well as for the underlying mental health or substance abuse disorders, these standardized approaches to care are not available consistently in all regions of North Carolina. In addition, the local management entities charged with monitoring the quality of services in their regions do not, as a rule, evaluate the delivery of services in accordance with fidelity standards associated with evidence-based or informed practices.

To decrease the risk of suicide, LME/MCOs should contract for evidence-based or best practices associated with more effective outcomes for people at increased risk of suicide.

In order to decrease the risk of suicide in the community, LME/MCOs should assess their service delivery networks and contract for the availability of specific evidence-based or best practices associated with more effective outcomes for people at increased risk of suicide. They should develop a suicide management plan, as described above, and require contracted providers to follow the plan. In addition, the LME/MCOs should monitor the delivery of services by their contracted providers to assure services are provided in accordance with the suicide management plan and evidence-based practice guidelines. LME/MCOs are required, as part of the 1915(b)/(c) waivers to develop quality management plans and oversee the quality of services provided. Thus, there is an opportunity to require fidelity scales for evidence-based programs as part of the routine monitoring of provider contracts.

Further, more work is needed to ensure effective care transitions. DMH/DD/SAS, DMA, LME/MCOs, working with other health care professionals, must develop standards to ensure that treatment information can be shared across health professionals (within the confines of federal and state privacy laws). Care coordination services need to be provided to ensure that individuals at high risk of suicide effectively transition from one treatment provider to another, and that the high-risk individual receives appropriate follow-up services.

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.**

Recovery Supports for People With a Past History of Suicide Attempts or Suicidal Ideation

Vision

Once stabilized, individuals need to be engaged to develop a personalized recovery support plan or "futures plan" that can help them think about their goals and aspirations, identify people in their lives that can provide support, learn wellness strategies, identify early warning signs of crisis, and identify strategies to successfully manage crisis. In addition, people who have attempted or contemplated suicide, should be linked to natural supports (such as the faith community or civic organizations) or appropriate peer supports (such as support groups with other people who have mental illness or substance use disorders) to help them understand that they are not alone. One of the primary risk factors for suicidal ideation is a feeling of isolation. Helping strengthen or build connections between the individual and other natural or peer supports can help address this feeling of isolation. In addition, peer support groups, led by trained facilitators, can help individuals with problem solving skills and can help individuals with suicidal ideation develop positive goals for the future.

Once stabilized, individuals need to be engaged to develop a personalized recovery support plan.

Existing Resources

There are many sources of natural and peer supports in communities across the state (such as faith-based organizations, civic organizations, or mental health or substance abuse peer support groups). However these resources are not equally available in every community, and what is an appropriate support system for one individual may not work for another. Individuals who are receiving enhanced behavioral health services (such as crisis services, institutional care, or residential care) work with behavioral health professionals to develop a person-centered plan (PCP). As part of this PCP, the behavioral health professional helps the individual develop a crisis action plan which includes linkages to natural or peer supports. It may also include a more formalized "future action plan."

Example of Level I (NREPP) evidence-based recovery supports

- **Wellness Recovery Action Plan (WRAP).** Teaches participants how to implement hope and personal responsibility, education, self-advocacy, and support into their day-to-day lives; organize activities that can help them feel better or prevent mental health difficulties; create an advanced directive with family and friends when they become unable to take appropriate actions for themselves; and develop wellness plans for a return to wellness for when the mental illness subsides.

Gaps

While many of the future recovery support plans are evidence-based for treatment of depression, they have not been specifically identified as an evidence-based or a best practice to help in the recovery process for people who have attempted suicide. However, certain aspects of these recovery plans are evidence-informed—for example, helping individuals identify natural supports that can help people at high risk of suicide feel less isolated, or helping with problem solving skills to help them feel less hopeless. More research is needed to determine the effectiveness of recovery support plans for people with suicidal ideation or past suicide attempts. In the meantime, the plans that are developed should include a specific suicide safety plan to ensure that the person knows where to seek help if he or she has suicidal ideation at some time in the future.

In addition, many people who experience suicidal ideation never get the benefit of a crisis action plan or a futures plan. Individuals whose only connection to the health care system is through a primary care provider or outpatient behavioral health professional, may never get the benefit of a crisis plan. Any individual with suicidal ideation or with an active suicide plan should develop a crisis plan that includes linkages to appropriate natural or peer support systems.

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.

Postvention for People Touched by Suicide

Vision

Suicide deaths can be traumatic for the family, friends, community, and professionals involved in providing treatment or addressing the immediate aftermath of a suicide. People touched by suicide—the family, friends, and colleagues of those who die by suicide—are themselves at higher risk for suicide. These individuals can be overwhelmed with complex emotions, including grief, despair, guilt, and shame.

North Carolina's suicide prevention and intervention plan will include postvention resources for the people touched by suicide. It will include individual grief counseling and peer support, as well as broader interventions for communities to prevent suicide contagion. Efforts to reduce suicide contagion are particularly important among young people when the person who died by suicide was a similar age and demography.[35] Postvention services, such as grief counselors, Survivors of Suicide support groups, and/or resource centers should be available for the family, friends, and colleagues of the person who died by suicide, as well as for the first responders, crisis staff, and others who also interacted with the person who died. Outreach programs should be available to link trained volunteers to people who have recently experienced a suicide loss to help the bereaved learn about local suicide support groups and other resources and to let people know that there are others who can relate to their loss.[36]

Examples of Level II or III best postvention practices

- **Survivor Voices: Sharing the Story of Suicide Loss.** Allows individuals bereaved by suicide to speak safely about their loss.
- **Connect Suicide Postvention Program.** Provides community professionals training to respond to a suicide effectively in order to prevent additional suicides.

Existing Resources

Suicide support groups exist to help individuals who have been touched by suicide. Survivors of Suicide or other support organizations are available in Chapel Hill, Charlotte, Gastonia, Greensboro, Greenville, Hillsborough, Huntersville, King, Mount Airy, Raleigh, Salisbury, Shelby, Spruce Pine, Statesville, Wake Forest, Wilkesboro, Wilmington, and Winston-Salem.[37-39]

Suicide support groups exist to help individuals who have been touched by suicide.

In addition to support groups, communities need access to readily available toolkits to help them respond to individual, or a group of suicides in their community. The American Foundation for Suicide Prevention has created materials for Schools "After a Suicide: A Toolkit for Schools"[40] to help schools address the suicide (or other death) of someone in their school, and to understand what to do (and what not to do) to prevent suicide contagion. Similar toolkits are needed for other community groups.

Gaps

While there is some information about suicide support groups for people touched by suicide, these groups do not exist throughout the state—and people would need to know where to look to find such groups. LME/MCOs should identify the resources that exist in their community to help counsel people who have been touched by suicide, and share that information with other community partners—including schools, law enforcement, and the faith community. Further, there is no toolkit readily available to communities that have been touched by suicide, in order to help reduce the likelihood of copycat suicides.

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.

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