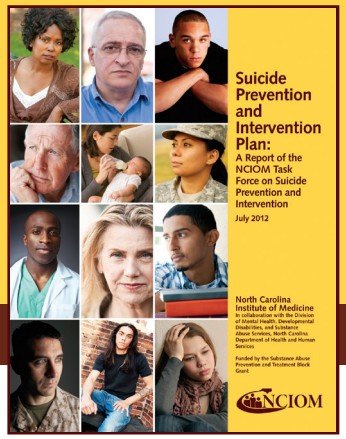

Issue Brief

Suicide Prevention and Intervention Plan

A Report of the NCIOM Task Force on Suicide Prevention and Intervention

July 2012

Suicide is a devastating problem that has major emotional consequences for the family and friends of people who die by suicide, and physical and psychological consequences for those who survive suicide attempts. Death by suicide is one of the top ten leading causes of death for people ages 5-64 in North Carolina. These deaths affect the entire state. Suicide deaths and suicide ideation cross gender, age, race, and other demographic lines. However youth and young adults, older adults, military service members and veterans, and people with mental health and substance use disorders are at increased risk for self-inflicted injury and death by suicide. Each year more than 1,000 North Carolinians die from self-inflicted injuries, more than 6,000 are hospitalized, and more than 8,000 are treated in emergency departments for self-inflicted injuries.[1] Suicide deaths in the state resulted in more years of potential life lost for individuals under age 65 than homicide, congenital abnormalities, cerebrovascular disease, human immunodeficiency virus (HIV), or diabetes mellitus.[2] What distinguishes suicide deaths from most other deaths is that suicide deaths are entirely preventable.

Many people who die by suicide have an underlying mental illness or substance use disorder. National data suggest that 90% of suicides are associated with some form of mental illness.[3] In North Carolina, 37% of the males and 67% of the females who died by suicide from 2004-2008 were in current treatment for a mental illness at the time of their death. Others had indications of mental health problems.[1] However we know that the North Carolina data are likely to underreport the connection between suicide deaths (or suicide attempts) and mental health or substance use disorders. The North Carolina Violent Death Reporting System relies on law enforcement interviews with survivors (those who knew the victim) to try to gather background information about suicide deaths. The people who provide the information may not know, realize the connection to, or feel comfortable revealing the underlying mental health or substance use status of the person who died.

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. Treatment professionals do not always communicate suicide risk or ideation to other professionals and the system does not always ensure appropriate transitional care as people move from one provider to another. Some providers employ evidence-based practices—those services or treatments that have been shown to produce positive health outcomes—while others do not. 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. North Carolina needs a multifaceted suicide prevention and intervention plan that combines broad-based prevention activities, early intervention, crisis services, treatment, and recovery supports for people who have attempted suicide, and postvention for people touched by suicide.

The North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) works with other state and local agencies to provide prevention, crisis intervention, treatment, recovery support, and other services to people who are contemplating suicide or who have attempted suicide, and to their families. DMH/DD/SAS asked the North Carolina Institute of Medicine (NCIOM) to convene a task force to review the state's

current suicide prevention and intervention system and identify strategies to enhance the system to better meet the needs of North Carolinians.

The NCIOM Suicide Prevention and Intervention Task Force included 24 members representing DMH/DD/SAS, the North Carolina National Guard, public health and other health professionals, behavioral health providers, outreach organizations, hospitals, survivors, and advocates. The Task Force met five times over six months to help DMH/DD/SAS develop its Suicide Prevention and Intervention Plan. This report focuses on the role that DMH/DD/SAS and the Division of Medical Assistance (DMA) can play at the state level in reducing suicide deaths and suicide risk. The report also focuses on the role of Local Management Entities/Managed Care Organizations (LME/MCOs) and contracting behavioral health providers in helping to identify people at risk of suicide, and to ensure they get into appropriate evidence-based crisis services or treatment.

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. DMA and DMH/DD/SAS are holding the new LME/MCO entities to higher standards and have enhanced performance requirements to 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.[4] While the plan focuses primarily on the role of LME/MCOs and contracting providers to prevent and reduce suicide risk, it also includes recommendations aimed at primary care medical homes within the Community Care of North Carolina (CCNC) networks. Primary care professionals are uniquely situated to help identify people who are contemplating suicide or otherwise at risk.

Ultimately, we know that effectively reducing the number of suicide attempts and deaths will require new and strengthened partnerships across agencies. **Thus, 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 for people with suicide ideation or who have attempted suicide, and postvention services for those touched by the suicide death of another person.** Comprehensive suicide prevention and intervention models that have been implemented elsewhere have been successful in reducing suicide deaths and suicide risk.[5-8]

This state suicide prevention and implementation plan cannot realistically be implemented immediately. **As a first step, the state and each LME/MCO should identify one or more staff members who will help coordinate the implementation of the state suicide prevention and intervention plan.**

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. **Thus, the state should require all LME/MCOs to use a portion of their federal and state funding for suicide prevention and education in their communities.**

Individuals entering the medical system, including those who enter the mental health or substance abuse service systems, should be screened to determine their level of suicide risk. If identified as high risk, individuals should receive a more thorough suicide risk assessment that obtains information about their risk and protective factors, history of past attempts, current suicidal thoughts, and information about their suicide plans and capabilities. **The state should identify evidence-based screening tools and risk assessment instruments, and develop protocols for when the LME/MCOs and contracted providers should administer these tools.**

Individuals who are actively contemplating or who have attempted suicide need to be linked immediately to effective crisis services. The state and LME/MCOs should ensure that there are trained crisis providers available across the state. These providers should be trained in crisis de-escalation skills, identifying suicide risks and providing treatment to stabilize the immediate suicide risk. Individuals with mental health or substance use disorders who are discharged from institutions, hospitals, or crisis services

should receive care coordination services to connect them with community providers.

Once stabilized, individuals at high risk of suicide should receive high quality, evidence-based treatment for underlying conditions. Treatment, care coordination and information sharing among providers should be designed to target the populations most at risk for suicide, including individuals with major depressive, bipolar, schizophrenia, or borderline personality disorders, as well as those with other mental health or substance use disorders. **The state, LME/MCOs and contracted providers should also ensure that those who have attempted suicide or who have suicidal thoughts have treatment plans to support recovery and manage future crisis.**

In addition, the state and LME/MCOs should implement strategies to link family and friends touched by suicide into postvention services. Toolkits should be available in schools and communities and other approaches should be implemented to help those impacted by a suicide death deal with the tragedy and get appropriate help.

The Task Force recognizes that the state and local LME/MCOs could not implement the statewide suicide prevention and intervention plan all at once. **Therefore, the Task Force recommends that the North Carolina Department of Health and Human Services convene a broader workgroup to develop a timetable to implement the Task Force's statewide suicide prevention and intervention plan.**

Now is the time to act. We have lost the lives of too many North Carolinians by failing to invest in suicide prevention, early intervention, and a coordinated crisis response system, and by failing to provide evidence-based treatments, recovery supports, and postvention services. We have the building blocks for an effective suicide prevention and intervention system; what we have historically lacked is an organized focus on this issue. This plan provides DMH/DD/SAS the blueprint for a more effective suicide prevention and intervention system, targeting people with mental illness or substance use disorders. By implementing this plan, we can go a long way to reduce unnecessary deaths and hospitalizations and improve the well-being of many North Carolinians.

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Task Force members: Debra C. Farrington, MSW, LCSW (co-chair); Flo Stein, MPH (co-chair); Renee Batts, RN, MSN; Mark Besen, PhD; Willa J. Casstevens, PhD, MSW, LCSW; Allen Dellapenna ; Mary Edwards, MA; Jodi Flick, MSW, ACSW, LCSW; Peggy Handon; David Humes, MSW, LCSW; Ureh Lekwauwa, MD, DFAPA; Jeffrey C. McKay, LCSW; Christina K. Minard, MS; Phil Morse; Stephanie Nissen, LPC, LMHC, NCC; Janice Petersen, PhD; Greg Richardson; Susan Robinson, MEd; Jennifer Rothman; Amy Smiley, MSW; Mary L. Smith; Doug Trantham, LCSW; Chris Wassmuth, LCSW; Jessica Wilburn, RN, BSN, MSN.

Steering Committee members: Steering Committee members: Mark Besen, PhD; Debra C. Farrington, MSW, LCSW; Janice Petersen, PhD; Susan Robinson, MEd; Flo Stein, MPH.

A copy of the full report, including the complete recommendations, is available on the North Carolina Institute of Medicine website, http://www.nciom.org.

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