



Suicide Prevention and Intervention Workgroup

An Overview
of the Current DMHDDSAS System:

Intervention Services
and Recovery Supports



Suicide Prevention and Intervention Workgroup

Today in Perspective

~ What we know &

Where we are.....

~ What we need to know &

Where we are going...



What we know...

Understanding Suicide

- Is complex
 - Combination of risk factors
 - Often not one precipitating event
 - Population groups at higher risk than others
 - Protective factors can balance risks

- Has many perspectives – Those who:
 - have died by suicide
 - have attempted suicide
 - have been touched by suicide
 - are resilient and are able to see/seek help
 - provide services & supports (formal/informal)
 - are in recovery

What we know...

Understanding Suicide

- **Prevention** is possible ~ is population based
- **Intervention** requires many strategies
 - Strengthen protective factors
 - Reduce risks
- **Treatment**
 - Is informed by what works (evidence)
 - Reduces risk factors (depression, substance abuse)
 - Sees risk factors as “alerts” (attempt)
- **Recovery** takes a long time
 - Individual & Peer Support
 - Family & Support Groups

Suicide prevention efforts tend to focus on “at-risk” groups (rates greater than general population)

White Males 65+ 3-4x



Veterans/Military 2-4x



Alaskan Natives/
American Indians (AN/AI) 2-4x



Lesbian, Gay, Bisexual,
Transgender (LGBT) Youth 2-3x



We should focus intervention on those at highest risk



Individuals with Serious Mental Illness (SMI) 6-12x

White Males 65+

The American Association of Suicidology reports the 2006 suicide rate for elderly white males was 31 per 100,000, but 48 per 100,000 for those over 85.

<http://bit.ly/men-s>

Veterans/Military

In 2010, *USA Today* reported the current U.S. Army suicide rate at 22 per 100,000 (<http://usat.ly/army-s>), but the Fort Hood rate was 47 per 100,000. <http://bit.ly/ft-s>

AN/AI

In the Suicide Prevention Resource Center (SPRC) library, Alaskan Native/American Indian males ages 15 to 24 had the highest rate at 28 per 100,000. *USA Today* reported in 2010 a suicide rate for those AN living in Alaska of 42 per 100,000. <http://usat.ly/an-ak>

LGBT Youth

The SPRC library says little can be said with certainty about death rates. However, other research suggests two to three times the national rate.

<http://bit.ly/wik-lgbt>

Individuals with SMI

In 2008, a UK study by Osborn et al. found the hazard ratio for individuals with SMI, including schizophrenia, to be nearly 13 times the general population. In Dec. 2010, King's Health Partners found the risk to be 12 times greater during the first year following diagnosis of a serious mental illness.

<http://bit.ly/SMI-suicide-12x>

Note: The suicide rate in the general population was 11.5 per 100,000 in 2007.

MATRIX OF INTERVENTIONS FOR SUICIDE PREVENTION EXAMPLES

	BIOPSYCHOSOCIAL	ENVIRONMENTAL	SOCIOCULTURAL
<p>UNIVERSAL</p> <p>(The intervention is designed to affect everyone in a defined population)</p>	Incorporate depression screening into all primary care practice	<p>Promote safe storage of firearms and ammunition</p> <p>Package drugs in blister packs</p>	<p>Teach conflict resolution skills to elementary school children</p> <p>Provide programs that improve early parent-child relationships</p>
<p>SELECTIVE</p> <p>(The intervention is designed especially for certain sub-groups at particular risk for suicide)</p>	Improve the screening and treatment for depression of the elderly in primary care practices	Reduce access to the means for self-harm in jails and prisons	Develop programs to reduce despair and provide opportunities (increase protective factors) for high risk populations, such as Native American youth
<p>INDICATED</p> <p>(The intervention is designed for specific individuals who, on examination, have a risk factor or condition that puts them at very</p>	Implement cognitive-behavioral therapy immediately after patients have been evaluated in an emergency department following a suicide attempt	Teach caregivers to remove firearms and old medicines from the home before hospitalized suicidal patients are discharged	Develop and promote honorable pathways for law enforcement officers to receive treatment for mental and substance use disorders and return to full duty without prejudice

Trends to Consider

Suicides:

- Male : female = 4:1
- **Elderly white males** -- highest rate
- **Working aged males** – 60% of all suicides
- **Concern for DMHDDSAS & LME/MCOs :**
 - **People with serious mental illness: rate 6-12x;**
 - **People with health concerns: 50%+ of suicides w/in 30 days of Primary Care Physician visit**

Attempts:

- Female >> male
- Rates peak in adolescence and decline with age

- **Concern:** Latina & Native American youth and LGBT

Source:

National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. (2009).

Web-based Injury Statistics Query and Reporting System (WISQARS). Available from: www.cdc.gov/injury/wisqars/index.html.

In North Carolina....

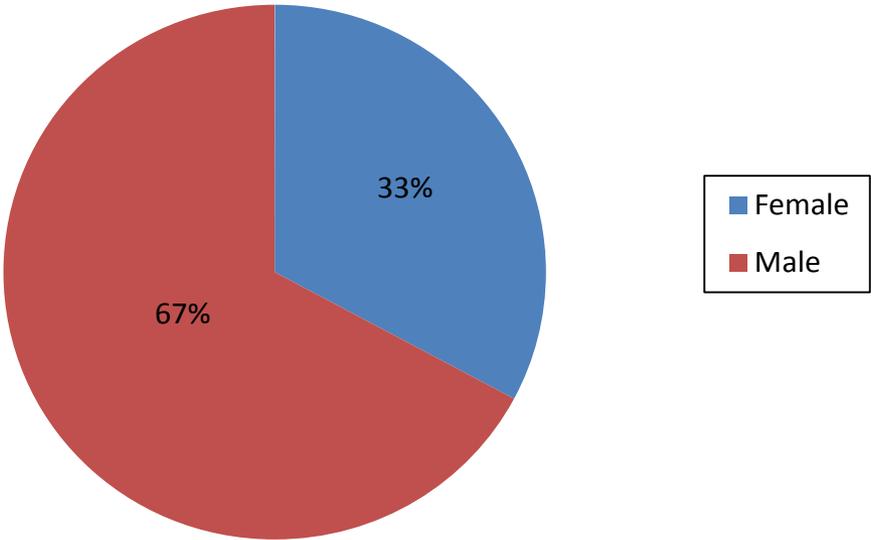
(approx. 92% of those who died by suicide):

- **Current mental health problem – 47%**
- **Current or past mental health treatment – 46%**
 - Depression or dysthymia -82%
 - Bi-polar disorder – 10%
- **Other health:**
 - 27% problem with intimate partner
 - 20% physical health
 - 14% alcohol**
 - 13% other drugs
- **Other known:**
 - 16% prior attempts known
 - 24% disclosed intent to die by suicide
 - 28% left notes
 - 32% alcohol present (male >>female)

****Native American-32%**, whites-25%, blacks– 19%, Asian/Pacific Islanders – 16%

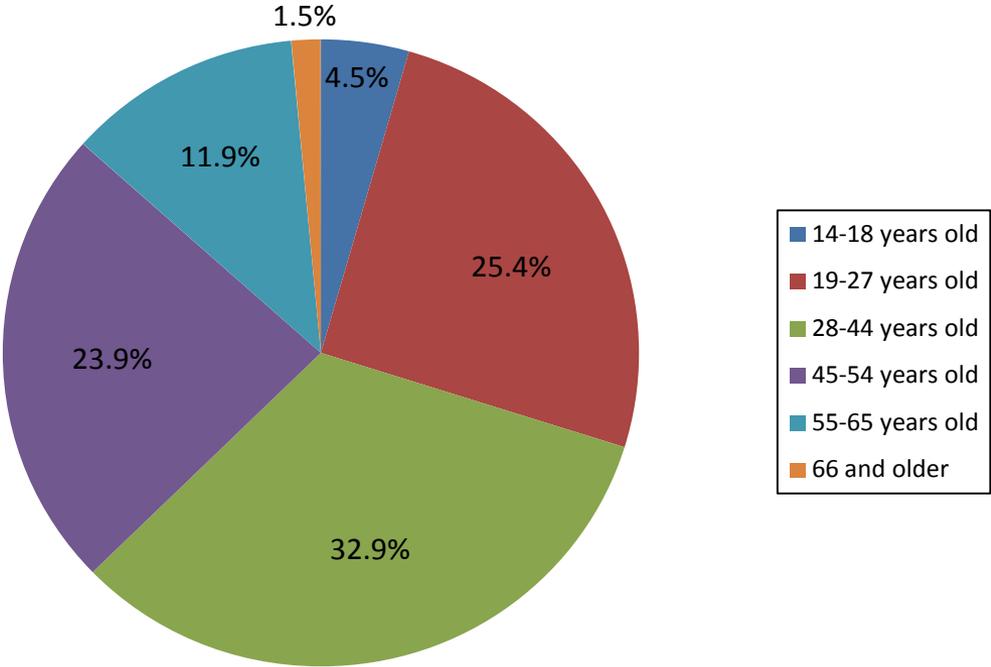
Source: The Burden of Suicide in NC (DHHS/DPH, 2011)

**Suicides Reported in IRIS
SFY 2010-2011, by Gender
(N=67)**



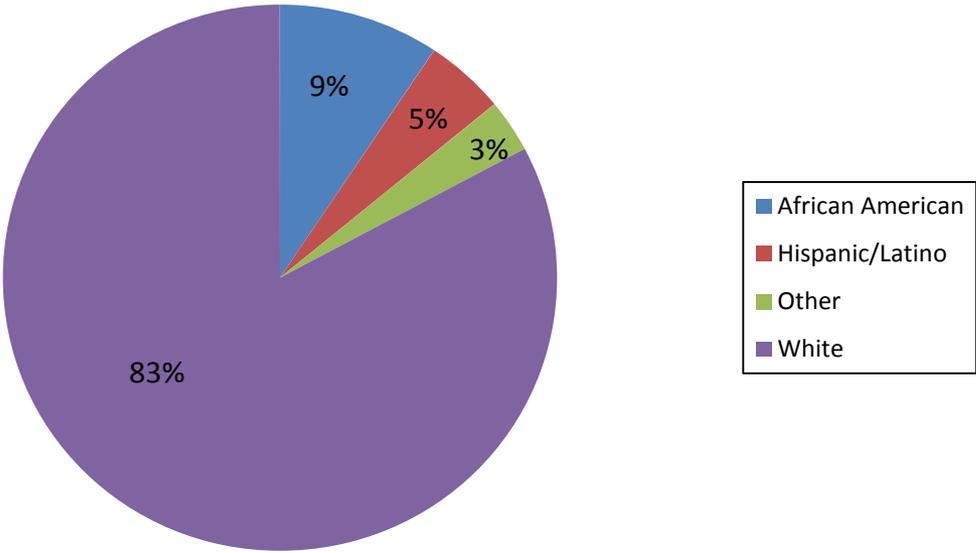
Source: Incident Response Improvement System (IRIS), N=67

Suicides Reported In IRIS (SFY 2010-2011), by Age



Source: Incident Response Improvement System (IRIS), N=67

Suicides Reported in Iris (SFY 2010-2011), by Ethnicity



Source: Incident Response Improvement System (IRIS), N=67 (3 cases had missing values)

LME	Number	Percent
A-C	3	4.5%
CENTERPOINT	3	4.5%
CROSSROADS	2	3.0%
CUMBERLAND	1	1.5%
DURHAM	1	1.5%
ECBH	6	9.0%
EASTPOINTE	1	1.5%
FIVE COUNTY	2	3.0%
GUILFORD	3	4.5%
JOHNSTON	3	4.5%
MECKLENBURG	5	7.5%
ONSLOW-CARTERET	1	1.5%
OPC	5	7.5%
PATHWAYS	2	3.0%
PBH	2	3.0%
SANDHILLS	7	10.5%
SMOKY	7	10.5%
SEC	1	1.5%
SER	1	1.5%
WAKE	8	11.9%
WHL	3	4.5%
Suicides Reported in IRIS (SFY 2010-2011), by LME		
Source: Incident Response Improvement System (IRIS), N=67		

Community MHDDSAS System – LME/MCOs & CABHAs

- Access units & provider networks
 - 1-800 LME 24/7/365 response
 - Walk-in Crisis Centers
 - NC Suicide Prevention Lifeline
1-800-273-8255
- STR - screening, triage & referral
 - Emergent < 2 hours
 - Urgent < 48 hours
 - Routine < 7 days
- Community Re-entry – hospital, justice
 - Aftercare plan
 - Follow-up appointment

Access



Hospital



Schools



DSS & DJJDP



Self Referral

Other

Not in need of DMHDDSAS Services

Screening



LME
Staff
Person

OR



Contract
Provider

DMHDDSAS
Problem

Triage

Urgent

Emergent

Routine

Community Resources

Assessed
for
Potential
Target
Population



Not Eligible
for Target
Population

Target
Population
Identified

Referral for
Basic
Benefits



Client Chooses
Provider

Referral for
Enhanced
Benefits



Client Chooses
Provider

SUICIDAL DESIRE	SUICIDAL CAPABILITY	SUICIDAL INTENT	BUFFERS/CONNECTEDNESS
Suicidal Ideation <ul style="list-style-type: none"> • Killing self and/or others 	History of suicide attempts	Attempt in progress	Immediate supports
	Exposure to someone else's death by suicide		Social supports
	History of/current violence to others		Planning for the future
Psychological pain	Available means of killing self/other	Plan to kill self/other <ul style="list-style-type: none"> • Method known 	Engagement with helper <ul style="list-style-type: none"> • Telephone worker
Hopelessness	Currently intoxicated		Ambivalence for living/dying
Helplessness	Substance abuse	Preparatory behaviors	Core values/beliefs
	Acute symptoms of mental illness, for example: <ul style="list-style-type: none"> • Recent dramatic mood change • Out of touch with reality 		
Perceived burden on others	Extreme agitation/rage, for example: <ul style="list-style-type: none"> • Increased anxiety • Decreased sleep 	Expressed intent to die	
Feeling trapped			
Feeling intolerably alone			

MHDDSA Crisis Services

Coordinated community response plans to crises

- crisis response teams
 - coordinated w/law enforcement response
- traumatic loss intervention & recovery
 - fires, MVCs, hostage, homicide, schools, military, domestic violence, etc.
- disaster response & recovery
 - floods, tornadoes, hurricanes
- postvention
 - plan & implement
- debriefing – trauma, grief & loss
- “first responder” mental health assessment & supportive counseling

MHDDSA Crisis Services

- Crisis Intervention Team Training (CIT) – diversion to treatment
- Mobile Crisis Teams (MH, DD, SA – all ages)
- Facility Based Crisis services (adults, children-pending)
- Detox Facilities
- Alcohol & Drug Addiction Treatment Centers (ADATCs) – acute crisis beds
- START - Systemic/Therapeutic/Assessment/Respite/Treatment team - national model of crisis prevention and intervention supports and services for those with IDD
- Community hospital initiatives – 3-way contracts
- Emergency Department – 23 hour beds
- Inpatient hospital treatment –involuntary/voluntary
- Crisis Plans – person-centered plans



***“People only accept change
in necessity and see
necessity only in crisis.”***

- Jean Monnet

MHDDSA Treatment Services

For all ages & abilities (MHDDDSAS)

- Walk-in Clinics
- Comprehensive Clinical Assessment
- Diagnostic Assessment (interdisciplinary)
- Alcohol and/or Drug Assessment
- Referral for Treatment
- Person-centered plans & Treatment plans – Crisis plans
- Medication Administration & Management
- Individual Counseling & Therapy



MHDDSA Treatment Services

❖ **Psychotherapies & Psychosocial Interventions**

- ❖ Supportive care for depression
- ❖ Psychotherapy
 - ❖ 1st line of treatment
 - ❖ Qualified licensed MH/SA treatment practitioner (scope of practice)
- ❖ Combined psychotherapy and medications

❖ **Pharmacological Treatment**

- ❖ Medications w/ treatment (therapy, psychosocial)

Person Centered Plan – Crisis Plan

WRAP Forms:

Crisis Plan

Post Crisis Plan

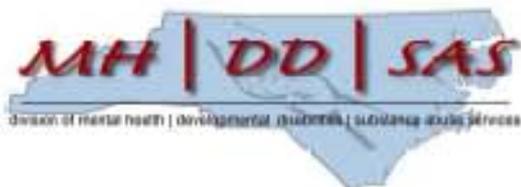
Wellness Tools

Daily Maintenance

Triggers & Response Plan

Early Warning signs & an Action Plan

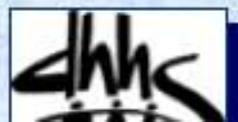
When Things are Breaking Down & Response Plan



From Crisis to Recovery: Strategic Planning for Response, Resilience and Recovery

Emergency Department Length of Stay

Action Plan



November, 2011

SUMMARY OF ACTION PLAN GOALS AND RECOMMENDATIONS

PRE-CRISIS GOAL: To promote early intervention systems and to prevent crisis events through a collaborative effort.

Recommendations:	1. Develop and provide crisis prevention/de-escalation training.
	2. Require enhanced crisis reduction plans for high risk, high volume consumers.
	3. Increase provider accountability for consumer outcomes.
	4. Convene critical care conferences for individuals who have high utilization of crisis services.
	5. Develop funding and planning to provide transportation.

PRE-EMERGENCY DEPARTMENT GOAL: To reduce the number of people entering the Emergency Department with behavioral health issues.

Recommendations:	1. Enhance the effectiveness and efficiency of Mobile Crisis Management Services.
	2. Augment the role of Facility Based Crisis Centers (FBC) and 24 hour Walk-in Clinics.
	3. Work with Law Enforcement.
	4. Enhance accountability in First Responders.
	5. Develop consistent Screening, Triage, and Referral (STR) procedures.
	6. Use non-emergency department resources for medical clearance evaluations.
	7. Work with magistrates.
	8. Provide care coordination.
	9. Diversify and strengthen workforce.

EMERGENCY DEPARTMENT GOAL: To reduce emergency department length of stay for individuals who present with behavioral health crises.

Recommendations:	1. Implement a computerized psychiatry bed registry.
	2. Develop protocols and practice guidelines to standardize /utilize best practices for services the emergency department.
	3. Clarify and support the role of LMEs with regard to emergency department behavioral health crisis admissions.
	4. Reduce legal obstacles.
	5. Enhance disposition options for individuals with behavioral health crises in the emergency department.
	6. Engage individuals with substance use disorders earlier and link to treatment services.

POST-EMERGENCY DEPARTMENT GOAL: To link consumers to housing, services, and supports to prevent future Emergency Department admissions.

Recommendations:	1. Ensure available housing and essential benefits are available in order to help the person remain successfully in the community and out of emergency departments.
	2. Develop a Uniform System of Care Coordination.
	3. Implement Assertive Engagement statewide.
	4. Schedule appointments with-in 48 hours prior to discharge.
	5. Establish local relationships among all stakeholders to facilitate seamless coordination of care.

MHDDSA

Intensive Treatment Services

Adult Mental Health Needs:

- Assertive Community Treatment Team (ACTT)
- Community Support Team (CST)
- Supervised Living

Child & Adolescent Mental Health Needs:

- Intensive In Home Services (IIH)
- Multi-systemic Therapy (MST)
- Child & Adolescent Day Treatment
- Therapeutic Foster Care
- Child Residential Treatment Services

MHDDSA

Intensive Treatment Services

Adult & Child* Substance Abuse Needs:

- Detoxification – Social setting & non-hospital
 - Substance Abuse Treatment for DWI Offenders
 - Substance Abuse Intensive Outpatient Program (SAIOP)*
 - Substance Abuse C Outpatient Program (SACOT)
 - Alcohol and/or Drug Services * – Individual & Group
 - Treatment Alternatives for Safer Communities (TASC)
 - Opioid Treatment
-
- *Appropriate services for children & youth

MHDDSA Rehabilitation Services

Adult & Child Developmental Disability (IDD) Needs:

In addition to Mental Health Treatment Services

- Developmental Therapy
- Personal Care Supports
- Targeted Case Management
- Community Alternative Program (CAP)
- Innovations Waiver (coordinated with 1915 (b)/(c) Waiver)

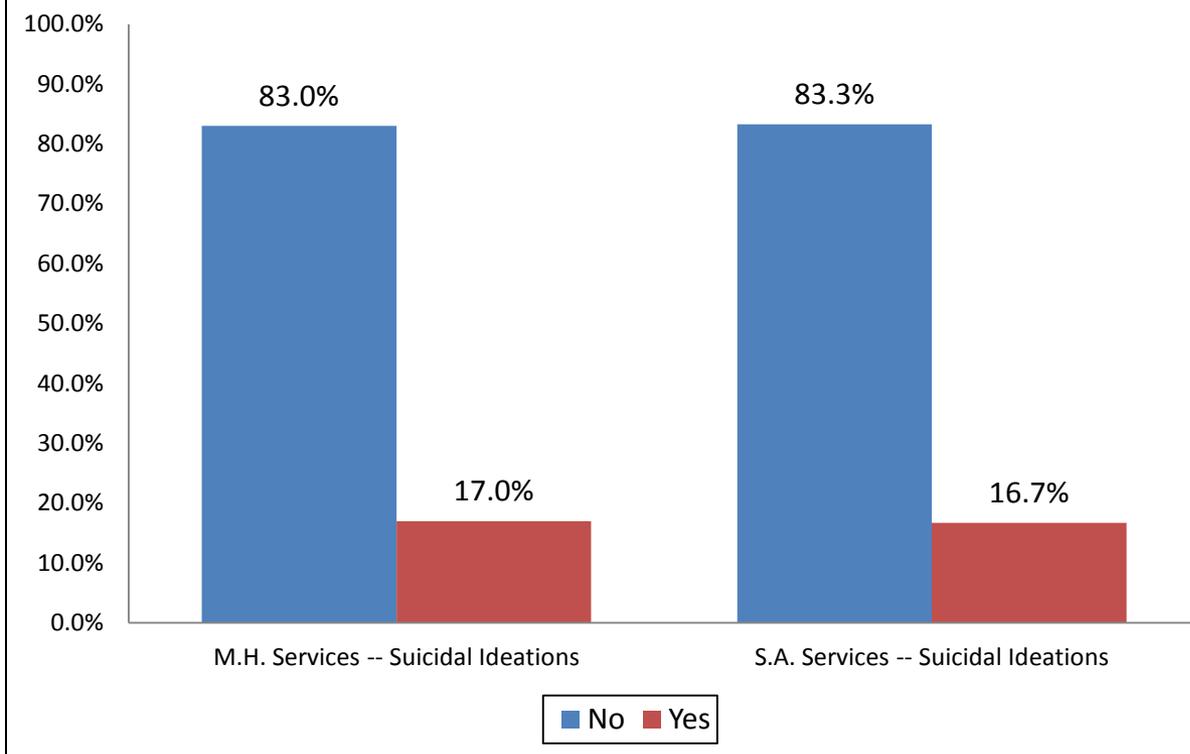
Integrated Care – MHDDSA & Primary Care

- ❖ SAMHSA Primary Care Tool Kit
- ❖ Qualified licensed practitioners
- ❖ Coordinated care
- ❖ Ongoing monitoring & care management
- ❖ Recurrent episodes
- ❖ Ongoing assessment
- ❖ Medication monitoring & management
- ❖ Reduction of symptoms

Community MHDDSAS System – LME/MCOs & CABHAs

- Access – screening, triage & referral (STR)
- Crisis services & coordinated community response
 - “first responder” services –
 - ACTT – Assertive Community Treatment Teams
 - Community Support Team
 - SAIOP
 - SACOT
 - Intensive In-Home
 - Multi-systemic Therapy (MST)
- Outpatient treatment providers –insurance panels, including Medicaid & Medicare
 - Scope of practice & licensing boards require plan for emergency services

Suicides Reported in IRIS (SFY 2010-2011): Suicidal Ideations Reported During Last Visit



Source: Incident Response Improvement System (IRIS), 3 M.H. Service Incidents had missing values and 1 S.A. Service Incident had a missing value for suicidal ideations at last visit

Examples of BEST PRACTICES

PREVENTION	<p>Gatekeeper Training</p> <ul style="list-style-type: none"> ✓ ASIST ✓ QPR <p>Yellow Ribbon ACE (Army) Primary Care – Health Home</p> <ul style="list-style-type: none"> ✓ IMPACT ✓ PEARLS ✓ Healthy Ideas ✓ Primary Care Tool Kit 	<p>Expert Consensus Standard Practice Guidelines Education, Training & Outreach Community at-large Selective at-risk populations</p>
INTERVENTION	<p>Suicide Risk Assessment Columbia Teen Screen* Emergency Department Interventions* Lifelines Postvention* Signs of Suicide* Second Step* Reconnecting Youth*</p>	<p>Consensus Evidence-informed Evidenced-based Practice – NREPP*</p>
TREATMENT	<p>Cognitive Behavioral Therapy (CBT)* Cognitive Behavioral Therapy* & Medication Trauma Focused – CBT* CBT for Suicide*</p>	<p>Evidenced-based Practice – NREPP*</p>
RESILIENCY & RECOVERY	<p>Peer Support Wellness Recovery Action Plan (WRAP)* Futures Planning & Leadership Mentoring Suicide Support Groups</p>	<p>Evidenced-based Practice – NREPP* Evidenced-informed</p>

Thank you...

For more information:

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Insight & Perspective

Recovery Supports

❖ Peer Support & Wellness Recovery Action Planning (WRAP)

~ Marc Jacques

- Peer Support Specialist
- Chair, NC MH Planning & Advisory Council, NAMI Consumer Advisors, Wake County CFAC (Consumer & Family Advisory Council)



Insight & Perspective

Resilience & Recovery Supports

❖ Youth Leadership & FUTURES Planning

~ Damie Jackson-Diop

- Director, NC Youth MOVE & Youth Leadership,
- Youth Mentor and Coach
- NC Families United

Insight & Perspective

~ What we need to know & Where we are going...

Suicide Prevention in the Community

- The system today
- A vision for tomorrow



Strategic Suicide Prevention Planning for MHDDSA

- Strengths & Challenges
 - Focus on most in need of MHDDSA services
- Panels
 - Inform plan components
 - Next Steps

