



## **SUICIDE PREVENTION AND INTERVENTION WORKGROUP**

**Monday, March 19, 2012**

**North Carolina Institute of Medicine, Morrisville**

**10:00 am – 3:00 pm**

**Meeting Summary**

### **Attendees**

*Members:* Debra Farrington (co-chair), Flo Stein (co-chair), Renee Batts, Willa Casstevens, Mary Edwards, Peggy Handon, David Humes, Nena Lekwauwa, Jeff McKay, Janice Petersen, Susan Robinson, Mary Smith, Chris Wassmuth, Jessica Wilburn

*Steering Committee and NCIOM Staff:* Pam Silberman, Anne Williams, Berkeley Yorkery

*Other Interested people:* Damie Jackson-Diop, Marc Jacques, Chris manard, Megan Ragone, Shade Shakur

### **WELCOME AND INTRODUCTIONS**

*Flo Stein, MPH*

*Chief*

*Community Policy Management Section*

*North Carolina Division of Mental Health, Developmental Disability and Substance Abuse Services*

*Co-chair*

*Debra Farrington, MSW, LCW*

*Care Management Director*

*OCP Area Program*

*Co-chair*

### **DMH'S CURRENT INTERVENTION AND RECOVERY SUPPORT SYSTEM:**

*Susan Robinson, M.Ed.*

*Mental Health Program Manager/Planner*

*Prevention and Early Intervention*

*Division of Mental Health, Developmental Disabilities, and Substance Abuse Services*

*North Carolina Department of Health and Human Services*

Ms. Robinson gave the task force an overview of the current Division of Mental Health Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) intervention services and recovery supports. She highlighted the service flow of the DMHDDSAS system from access to screening, triage, assessment, and referral. Ms. Robinson gave a brief overview of person centered crisis plans and DMHDDSAS treatment services.

A copy of Ms. Robinson's presentation is available here: [An Overview of the Current DMHDDSAS System](#).

*Selected questions and comments:*

- Dr. Casstevens gave the task force a brief update on the observed relationship between nutrition and dietary factors and depression.

*Nena Lekwauwa, MD, DFAPA*

*Medical Director*

*Division of Mental Health, Developmental Disabilities, and Substance Abuse Services*

*North Carolina Department of Health and Human Services*

Dr. Lekwauwa gave the task force an overview of a comprehensive suicidal ideations assessment and highlighted a few of the post-assessment intervention options. She emphasized the importance of providers using a nonjudgmental demeanor during an assessment and taking the necessary time to be comprehensive. Assessments look at a range of factors including current medications and substance abuse as well as medical, social and family histories. Assessments should ask about homicidal ideation in addition to suicidal ideation and include collateral information from close friends and family in addition to information from the individual. Dr. Lekwauwa summarized some of the intervention options available depending on the immediate risk such as medication, therapy, and involuntary commitment.

A copy of Dr. Lekwauwa's presentation is available here: [Suicide Ideations Assessment and Intervention](#).

**PANEL—RECOVERY SUPPORT**

*Marc Jacques*

*Executive Director*

*Mental Health Advocacy, Inc.*

Mr. Jacques presented WRAP (Wellness Recovery Action Plan) to the task force, and described how WRAPs help individuals create a set of self help tools, learn to recognize their triggers, and respond to changes in their mental health. In addition to building a wellness toolkit that might include favorite stress relievers, for example, WRAP helps individuals seek help long before a crisis develops. In the case that a crisis does develop, the plans also include courses of action for individuals to keep themselves safe. The WRAPs are intended to allow the individual to seek treatment or intervention voluntarily, and determine what incidences activate or inactivate their crisis action plans. After successful intervention, WRAPs incorporate recovery support and continued planning for the future. Mr. Jacques also emphasized the effectiveness of trained peer support and noted that WRAP is a great concept for peers to teach peers.

*Selected questions and comments:*

- C: WRAP has been successful treating patients because you can see where the plan is and is not succeeding and adjust it. As you learn, you develop a resiliency loop.
- Q: How do people get into your peer support networks? A: Usually they have attended an event where it was discussed and expressed interest. It is not a formal process.
- Q: How do individuals get into a WRAP class? A: Peer organizations have grants to operate classes across the state. The best way to find out about signing up for a WRAP class is to contact the NC Mental Health Consumers organization.
- Q: How prevalent are WRAPs? A: Not sure. WRAP has proponents in particular parts of the state or in certain LMEs, but doesn't exist in all parts of the state. It is important for

caregivers across the state to be aware enough to, at the very least, ask their patients whether they have a WRAP and know how to honor it. Providers can also use WRAP as a framework for a planning conversation—Who are your supports? What tools do you have?

- Q: Do you think mass population change can be accomplished using individual based illness, recovery, and resiliency programs—can you teach a population about resilience, or is it an individual process? A: There are aspects of WRAP that can happen systemically—it’s a great concept for peers to teach peers. In addition, the class is a great way to teach people the principles and give them the vocabulary to talk about intervention and recovery planning.

*Damie Jackson-Diop*  
*Youth Transition Program Director*  
*Youth M.O.V.E.*

Ms. Jackson-Diop presented Futures planning to the taskforce. Futures planning is a wellness planning program similar to WRAP but specifically designed to develop resilience in youth and young adults. Ms. Jackson-Diop mentors young adults and facilitates planning sessions in which they answer a set of questions about their goals, history, who they are today, the people they have in their life, their goals, and the next steps. She noted that suicidal ideation is often apparent early in the discussion and crises often emerge when youth are asked to describe who they are today. One of the benefits of Futures planning is the way it allows young adults the opportunity to describe their situation in their own language and context and take a greater role in planning their own wellness. Ms. Jackson-Diop emphasized the importance of enabling youth to tell their stories, and allowing them to drive the process in order to learn and develop. Many of the youth who do Futures planning connect with the leadership program, Youth M.O.V.E. (Youth Motivating Other Through Voices of Experience).

A copy of Ms. Jackson-Diop’s presentation is available here: [Futures Plan](#).

*Selected questions and comments:*

- Q: What does TLP stand for? A: Transitional Living Program; young adults in foster care have the option of signing a contractual agreement for residential services allowing them to stay until age 21. Not all young adults wish to stay in the system, or meet the eligibility requirements such as staying in school.
- Q: What are some of the challenges you encounter doing futures planning? A: Sometimes the adults at the table are not as receptive of the youths’ plans as she would like. Ms. Jackson-Diop often talks to them beforehand to prepare them to be supportive. Another challenge is helping youth find and stay in supportive employment.
- C: Futures planning is a culturally competent program. There are also Spanish speaking partners doing Futures planning.

## VISION FOR A NORTH CAROLINA SUICIDE PREVENTION PLAN

*Debra Farrington*

Ms. Farrington presented her vision for North Carolina public mental health and its role in suicide prevention. She emphasized the need and ability to create system change without additional funds. Ms. Farrington summarized the responsibilities of managed care organizations (MCOs) in the vision, the practical implementation, and critical success factors of the vision.

Ms. Farrington's vision for NC includes a full range of strategies and interventions targeted to all North Carolinians that focuses on:

- Prevention of suicide through health promotion, training, and education
- Engaging families, laypersons and faith community as full partners
- Early identification of those most at risk of suicide
- Provision of evidenced based services to address mental health issues
- Coordination between formal support systems
- Follow up and recovery supports

Ms. Farrington summarized the practical issues that must be addressed to ensure successful implementation of prevention, intervention, linkage, and follow-up systems of care. In particular, she identified care coordination and timely access to proper screening, triage, and referral (STR) as critical factors to system success. Care coordination differs from care management, the latter of which is a population-based intervention. Care coordination links targeted consumers with needed services and supports.

A copy of Ms. Farrington's presentation is available here: [LME MCO Vision](#).

*Selected questions and comments:*

- C: LME/MCOs have the responsibility to make sure public care works for everyone. LME/MCOs and providers are positioned to take some responsibility for suicide prevention as we develop our plan.
- C: We are missing a group of people who don't come to the public system.
- C: Suicide attempts all go through the emergency departments. Could LME/MCOs create liaisons with EDs to share information?
- C: LME websites need to include more information directly related to suicide prevention.

*Mark Besen*

*Director*

*Onslow-Carteret LME*

Mr. Besen summarized his vision for implementing a statewide suicide risk reduction program without new funding. He outlined seven essential elements:

(1) Administrative Will

Designate an individual accountable for long term support of the process, and assign liaisons/consultants to the organizations implementing change.

(2) Consensus about the Model

Whether NC picks one model such as QPR or ASIST or develops its own as the military agencies have done, many of the evidence-informed programs are very similar so the state should be able to agree on the critical components reflected in most models.

Mr. Besen gave a brief overview of QPR and the content of the different types of training.

(3) Consistent Expectations/Written Protocols

In addition to adopting a model with shared understanding, language, and expectations, Mr. Besen emphasized the need for consistent protocols such as risk assessment and communication. Providers are generally good about assessing patients at the first point of contact with the system, but there are high risk points of care that should be identified as required points for reassessment.

(4) Appropriate Network of Services

Mr. Besen highlighted a continuum of community-based alternatives to the emergency department including mobile, facility-based, and residential crisis services. Facilities such as retreats where patients who do not need medical care can receive intensive stabilization support can help divert patients from the emergency department.

(5) Method of Monitoring with Consequences

(6) Methods of Funding

(7) Methods of Measuring Results

For several of the elements of Mr. Besen's vision he pointed to Spokane, Washington as an example. Spokane began its suicide prevention program—a gatekeeper and clinical model—in 1995 and won an insurance company award for risk management.

A copy of Mr. Besen's presentation is available here: [Implementing a Statewide Suicide Risk Reduction Program without New Funding](#).

*Selected questions and comments:*

- Q: How does EMS determine who can be diverted from the hospital and taken to a retreat or other community-based alternative instead? A: EMS has been supportive but want to be sure they are legally allowed to deliver people outside of the emergency department. They are currently working with the county attorney to rewrite EMS delivery protocol.
- Q: What are some of the lessons you have learned in marketing? A: They tried lots of things—fliers, talking to the chamber of commerce, etc.—but had the most success going straight to the police, magistrate, and EMS. This was more effective than marketing directly to the public.

**GROUP DISCUSSION & DISCUSSION OF RECOMMENDATIONS**

*Flo Stein*

*Pam Silberman*

*President & CEO*

*North Carolina Institute of Medicine*

Dr. Silberman facilitated group discussion on the roles and responsibilities of DMHDDSAS/DMA and LME/MCOs in prevention, intervention, and recovery services.

*Selected Discussion:*

- C: Build in peer support (with structure and training) in an ongoing capacity that is available at every point.

- C: Ideally the relationship between the MCOs and the contracting providers will operate as a partnership and conversation rather than simply a contract. Communication is very important at every step in the system. A protocol is needed for everyone in the community to know how to share crucial pieces of information.
- Q: How doe LME/MCOs respond to third party reliable reports? Do they call the individual or send law enforcement to conduct a safety visit? A: When it's a crisis situation the standards for "cold-calling" are different. Get the family member's permission to say they called and call the individual. If the person does not wish to be called, law enforcement can still be sent.

The workgroup will continue discussion of potential recommendations at the next meeting which will be Monday, April 16<sup>th</sup> from 10:00am – 4:00pm.