



SUICIDE PREVENTION AND INTERVENTION WORKGROUP

Monday, April 16, 2012

North Carolina Institute of Medicine, Morrisville

10:00 am – 4:00 pm

Meeting Summary

Attendees

Members: Debra Farrington (co-chair), Flo Stein (co-chair), Renee Batts, Mark Besen, Willa Casstevens, Mary Edwards, Peggy Handon, David Humes, Jeff McKay, Chris Minard, Phil Morse, Jennifer Rothman, Amy Smiley, Mary Smith, Chris Wassmuth, Jessica Wilburn

Steering Committee and NCIOM Staff: Kimberly Alexander-Bratcher, Janice Petersen, Susan Robinson, Pam Silberman, Anne Williams

Other Interested people: Megan Ragone, Shadé Shakur

WELCOME

Flo Stein, MPH

Chief

Community Policy Management Section

NC Division of Mental Health, Developmental Disability, and Substance Abuse Services

Debra Farrington, MSW, LCSW

Network Manager

OPC Community Operations Center

Piedmont Behavioral Healthcare

DEVELOPING A SUICIDE PREVENTION AND INTERVENTION SYSTEM OF CARE

Pam Silberman, JD, DrPH

President & CEO

North Carolina Institute of Medicine

Dr. Silberman presented the Vision for a Suicide Prevention and Intervention Plan developed based on the task force's previous discussion chart. She walked through the document and invited the task force to review the proposed vision as a starting point for discussion. In the next steps, the document will be expanded into text format.

Dr. Silberman facilitated task force discussion of the vision after reminding the task force that it has been specifically charged with developing a plan for the Division of Mental Health, Developmental Disability and Substance Abuse Services (DMHDDSAS), rather than a statewide plan. Members agreed that successful suicide prevention work will likely need to integrate the

efforts of a number of state agencies. Some members suggested that a strong vision statement in the report encourage efforts to develop a broader, statewide plan.

Summary of Discussion:

- Data
 - The task force briefly discussed the available data sources that can be used for the report:
 - The North Carolina Violent Death Reporting System
 - North Carolina State Center for Health Statistics
 - Local Management Entity (LME) reported data
- Primary Prevention
 - Should the group reference only evidence-based/evidence-informed programs, or are there other types of promising practices that we want to list? Some task force members suggested highlighting a couple of programs and discussing the role of the Practice Improvement Collaborative (PIC) and making it clear that it is not an exhaustive list.
 - In addition to existing proprietary interventions, the state should identify key elements of evidence-based practices, so that local organizations have the flexibility of designing other, non-proprietary prevention strategies that incorporate the key elements.
 - Primary prevention strategies can be employed by the Local Management Entity/Managed Care Organization (LME/MCO), community partners, the provider network, and contracted vendors.
 - Child welfare and foster care should be included for consideration as community partners regarding prevention.
- Early Intervention
 - Early intervention blends together with prevention for at risk populations.
 - Task Force members discussed the issue of screening patients. It was suggested that the populations being screened be better defined. Some members also argued that screenings should be done for all points of entry, whether it is the Screening, Triage, and Referral (STR) phone line, or provider referral lines.. Some members suggested that PIC be included as a collaborator with DMA and DMH in the development of a screening protocol and periodicity schedule.
 - C: The task force should consider what the strategies are for people who do not reach out for help.
 - C: The staff members answering provider phones are often not trained in crisis response.
 - C: When referring to youth and adult populations, make sure that it is clearly inclusive of older adults as well.
- Crisis Services
 - There is a lack of definition, standardization, and regulation of walk-in crisis centers (and other emergency department alternatives) to incorporate them into the system. Walk-in crisis centers differ from residential/facility-based crisis centers in that walk in centers can only serve people for less than 24 hours. If

someone needs 24 hours or more of care, they must be served in a licensed residential facility. In some cases, telemedicine equipment is housed in walk-in crisis centers.

- Facility-based crisis centers are currently only available for adults. Some task force members recommended including more information on crisis/emergency respite for youth. These are not exclusively for suicidal youth; however they are an option available to adolescents in crisis and are a location where youth at higher risk may be found. In addition, members recommended better training around suicide prevention for youth center staff.
- C: The list of current service options should include detox and Alcohol and Drug Abuse Treatment Centers (ADATC).
- C: LME/MCOs need to place a greater emphasis on coordination of the available crisis services when they contract with more than one provider or vendor.
- Treatment
 - Task force members discussed the difficulties of monitoring individual practices and the importance of setting fidelity requirements for treatment services. Some task force members argued that we should be careful not to exclude creativity, or testing new models which may become future evidence-based practices (EBP).
 - Task force members discussed access in rural areas where personnel qualified for the EBP may be lacking.
- Postvention
 - C: Those touched by suicide are at a higher risk of suicide, making postvention an important time to intervene.
 - Terminology
 - C: “Survivors” (meaning those individuals who have survived an attempted suicide) and those touched by suicide should be handled separately.
 - C: In a report glossary, the differentiation of terms such as survivor, those touched by suicide, recovery supports, and postvention should be explained along with the acronyms used.
 - Proposed Vision: Those touched by suicide need to know where to go to be linked into the system. Everyone who works with families or others touched by suicide need to know of available mental health and other resources to help with the aftermath of the suicide.
 - Task force members LME/MCOs should develop stronger partnerships with law enforcement so that the LME/MCO will be informed of all suicides (as well as attempted suicide) in the community. LME/MCO should then actively reach out to the family of the person who died by suicide (or the person who survived the suicide attempt) to link them to services.
 - This role requires LME/MCOs to research what’s available in their catchment area to promote—phone services like REAL crisis lines have extensive resource lists that could be a good starting point for LME/MCOs.

- In addition, groups or programs named in the report should be included in an appendix for LME/MCO staff who want more information.
 - Task force members discussed the need to make resource information more widely available and accessible via websites, and target groups such as law enforcement, and faith communities.
 - C: After care teams could be used to provide the case management that bridges the crisis and follow-up care.
 - C: A suicide in a community should be considered an incident worthy of a response by the critical incident debriefing system. A model for the state for professional response should be developed to connect those touched by suicide to the ongoing natural support network. The state could provide examples of acceptable responses to suicides in the community.
- Coordination of Care
 - Task Force members highlighted the importance of coordination of care and transitions between levels or systems of care. Some members particularly emphasized the transition out of involuntary commitment, or after any experience with mobile crisis, or facility based crisis. Some members summarized the importance of transitions out of all institutions, including the high risk period after release from prison.
 - There are varying definitions and levels of care management and coordination. Task Force members also questioned what triggers or thresholds should be set for coordination services, and at what point is it determined that someone no longer needs care coordination.
 - Task force members emphasized the importance of the follow up window because re-attempts are most likely to happen in the 90 days following treatment. As part of follow up, members highlighted the need for outreach in to reach patients who don't show up for appointments.
 - Some members discussed a clinical protocol that identifies and flags at risk individuals and assigns responsibility where it belongs. LME/MCOs will know about all Medicaid hospitalizations and should also be able to see who's in jail in any given day so they can be flagged.
- Military Personnel:
 - C: Military personnel, as much as possible, should be intercepted and linked to the military behavioral health system
 - C: The discussion of the partnering opportunities with the military system for training, for example, should be strengthened.
 - Accurate data regarding active duty personnel is very difficult to find.

NEXT STEPS

The next meeting will be Wednesday, May 9th from 10:00am-4:00pm.