

**SUICIDE PREVENTION AND INTERVENTION WORKGROUP**

**Monday, February 20, 2012**

**North Carolina Institute of Medicine, Morrisville**

**10:00am – 4:30 pm**

**Meeting Summary**

**ATTENDEES**

*Members:* Debra Farrington (co-chair), Flo Stein (co-chair), Renee Batts, Mark Beson, Willa Casstevens, Alan Dellapenna, Peggy Handon, David Humes, Nena Lekwauwa, Jeff McKay, Phil Morse, Stephanie Nissen, Janice Petersen, Susan Robinson, Jennifer Rothman, Amy Smiley, Mary Smith, Chris Wassmuth, Jessica Wilburn

*Steering Committee and NCIOM Staff:* Kimberly Alexander-Bratcher, Thalia Fuller, Jennifer Hastings, Pam Silberman, Anne Williams

*Other Interested people:* Randy Munn

**WELCOME AND INTRODUCTIONS**

*Flo Stein, MPH*

*Chief*

*Community Policy Management Section*

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

*Co-Chair*

*Debra Farrington, MSW, LCSW*

*Care Management Director*

*OPC Local Management Entity*

*Co-Chair*

Ms. Stein and Ms. Farrington welcomed everyone and asked people to introduce themselves.

**DMH'S CURRENT SUICIDE PREVENTION AND CRISIS RESPONSE SYSTEM:**

*Janice Petersen, PhD*

*Director*

*Office of Prevention*

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

Dr. Petersen gave the workgroup an overview of the current suicide prevention and crisis response services available in North Carolina. The current framework addresses risk and protective factors at the universal, selective, and indicated population levels. Dr. Petersen outlined some of the current funding options as well as the anticipated start dates for the local management entities/managed care organizations (LME/MCOs). The Substance Abuse and Mental Health Services Administration (SAMHSA) set the goal for suicide prevention: Prevent suicides and attempted suicides among populations at high risk, especially military families, LGBTQ youth, and American Indians and Alaska Natives. SAMHSA's recommendations include:

- Educate primary care and behavioral health practitioners, communities, schools, and the public
- Tailor educational materials to address the perspectives of military audiences
- Develop and encourage culturally specific programs that promote strong sense of self and appropriate help seeking among target groups
- Support suicide prevention programming for high risk populations

Dr. Petersen's presentation is available here: [DMH/DD/SAS's Current Suicide Prevention and Crisis Response System](#).

*Selected Questions and Comments:*

- C: We don't understand how all of the protective and risk factors fit together in each case. A suicide can still occur, even when all of the protective factors are present.
- Q: Is prevention a required function of an MCO?  
A: Prevention is required of LMEs not MCOs (as the MCO is a Medicaid managed care organization and Medicaid does not pay for primary prevention community-based programs). However, an entity must qualify as an LME in order to be an MCO. Additionally, future cost savings serve as an incentive for MCOs to focus on prevention.
- C: Part of the challenge is that in this field, it seems there are more promising practices and fewer evidence-based practices.

**PANEL I – PREVENTION**

*Allen Dellapenna*

*Head*

*Injury and Violence Prevention Branch*

*Division of Public Health*

Mr. Dellapenna summarized the work the Division of Public Health (DPH) has been doing on suicide prevention and crisis response. In 2004, the state published its plan to prevent youth suicide, "Saving Tomorrows Today." In addition, DPH investigates every homicide, gunshot death, and suicide for the North Carolina Violent Death Reporting System. DPH is currently using Garrett Lee Smith funding to provide Applied Suicide Intervention Skills Training (ASIST). Mr. Dellapenna noted that the major barriers DPH faced in its initiatives included state bureaucracy and the limited time school staff are available for training.

*Stephanie Nissen, LPC, LMHC, NCC*

*State Behavioral Health Programs Director*

*North Carolina National Guard*

*QSSGS Contractor*

Ms. Nissen gave the workgroup an overview of the North Carolina National Guard (NCNG) Integrated Behavioral Health System (IBHS), and their current work on suicide prevention and crisis response. The NCNG saw a drop in the suicide rate from 2010 to 2011; however the NCNG 2011 suicide rate is significantly higher than the age and gender adjusted rate for the general US population. The NCNG is working towards the goal of having a suicide prevention officer with ASIST training assigned to each unit. Ms. Nissen emphasized the holistic design of the IBHS and the importance of follow up support from case managers for service members who reach out for help, often by calling the helpline. Case managers not only ensure that service members receive the care they are referred to, but also help service and family members with non clinical issues such as civilian employment. In addition to service members and their families, the help line is frequently used by commanders or leaders seeking guidance for how to handle behavioral health problems of service members. Ms. Nissen identified the NCNG schedule as a barrier for their work—best practice calls upon commanders to be informed and engaged in service members lives, but commanders typically see national guard service members only once a month.

Ms. Nissen's presentation is available here: [Review of IBHS for the NCIOM](#).

*Selected Questions and Comments:*

- C: Due to stigma, it is important that people feel assured of helpline confidentiality. The help line cannot call an individual, but they do coach callers on how to get someone to contact the help line.

*Selected Panel Discussion:*

- C: We need to think about how to reach the broader population that aren't youth and aren't national guard because prevention plans/systems are already in place for those groups.
- C: It seems that there are key players that need to be trained, including schools, universities, and Crisis Intervention Teams. Should certain positions types have mandated formal suicide prevention training?
- Q: How does DPH information get disseminated to the broader public, and how can others such as law enforcement use it? A: Reports are available on the website. County level data is available on request.

**PANEL II – CRISIS RESPONSE**

*Chris Wassmuth, LCSW*

*CIT Coordinator*

*Wake County Human Services*

Ms. Wassmuth summarized her work with crisis intervention teams (CITs) and their role in North Carolina suicide prevention efforts. The 40 hour CIT training program was first offered in North Carolina in 2005. The training program was designed to help the Memphis police department handle calls having to do with individuals with mental illness. As a result, fewer Memphis police officers and fewer individuals with mental illness were hurt, and individuals with mental illness were less likely to be incarcerated for a misdemeanor. Every local management entity (LME) has access to a CIT program in their area, and 911 callers always have the option to request a CIT responder.

*Selected Questions and Comments:*

- Q: How much of the 40 hours of training is on suicide prevention? Do you use any of the ASIST or Question, Persuade, and Refer (QPR) curricula? A: The training includes a 3 hour section on suicide prevention. Whether elements of ASIST or QPR are used depends on the trainer.

*Mary Smith*

*Executive Director*

*REAL Crisis Intervention, Inc.*

*NC Suicide Prevention Lifeline for DMHDDAS*

Ms. Smith gave the workgroup an overview of REAL Crisis Intervention, a crisis center that offers a variety of counseling, outreach, and advocacy services. REAL Crisis Intervention runs the North Carolina Suicide Lifeline which covers the whole state as of this past summer and is accredited through the American Association of Suicidology. The center logs an average of 2,200-2,300 calls per month. Ms. Smith emphasized that the center has an active intervention policy, meaning that they work actively to prevent suicide attempts including trying to locate callers and get them the appropriate help. The center also makes follow up calls to medium to high risk callers, and will call to check on individuals based on concerned family and friend reports.

*Jeff McKay, LCSW*

*Crisis Services Director*

*Therapeutic Alternatives, Inc.*

Mr. McKay gave the workgroup an overview of the work and role of mobile crisis management teams. The teams contract with LMEs and Medicaid to provide short term case management at no cost to the patient in order to help reduce hospital stays. Mr. McKay noted that the extent to which LMEs use the mobile crisis management teams varies greatly across the state. Mr. McKay identified a number of challenges facing mobile crisis management teams including: the varied settings in rural and urban counties; staff recruitment and retention due to tough schedules, high burn out rate, and restrictions on team licensure composition; and follow up support which is restricted by the 24 hour window teams have to resolve a crisis.

Mr. McKay's presentation is available here: [Overview of Mobile Crisis Management](#).

*Selected Questions and Comments:*

- Q: Do you have law enforcement accompany you to the homes? A: It depends. The team members go through a lot of safety training, but will usually call law enforcement if something in the phone call triggers concerns or if something at the location is incongruent with the phone call.
- Q: What percentage of cases deal with suicide? A: About 60% (there is significant overlap with substance abuse).
- Q: What kind of training is provided to your staff regarding suicide? A: Mr. McKay did ASIST training but does not use the existing models in team training.

**GROUP DISCUSSION**

Group discussion primarily addressed the question of whether North Carolina has sufficient capacity to provide crisis response services. In considering building capacity in NC for suicide prevention training, the workgroup agreed that it would be helpful to compare different training programs that are available—ASIST and QPR, in particular. For example, how do the training programs differ in content, length, cost, and evidence-based status?

**WRAP-UP AND NEXT STEPS**

The next meeting will be held from 10am – 4pm on Monday March 19<sup>th</sup>, 2012.