



SUICIDE PREVENTION AND INTERVENTION WORKGROUP

Friday, February 10, 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, Mary Edwards, Peggy Handon, David Humes, Sherry Lehman, Nena Lekwauwa, Jeff McKay, Phil Morse, Janice Petersen, Susan Robinson, Jennifer Rothman, Amy Smiley, Mary Smith, Chris Wassmuth, Jessica Wilburn

Steering Committee and NCIOM Staff: Kimberly Alexander-Bratcher, Krutika Amin, Thalia Fuller, Jennifer Hastings, Pam Silberman, Anne Williams, Berkeley Yorkery

Other Interested people: Chad Jordan, Richard McKeon, Jane Miller, Debbie Webster

WELCOME AND INTRODUCTIONS

Flo Stein

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 the Task Force members and asked everyone to introduce themselves.

CHARGE TO THE WORKGROUP, NCIOM OVERVIEW, AND RELATED NCIOM RECOMMENDATIONS

Pam Silberman

President & CEO

North Carolina Institute of Medicine

Dr. Silberman gave the task force an overview of the NCIOM, the task force process, the charge to the workgroup, and related recommendations from past task forces. The Suicide Prevention and Intervention workgroup was convened at the request of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) 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 updated plan will be available by the end of June 2012.

Dr. Silberman's presentation is available here: [Overview of the Task Force Process](#)

Selected Questions and Comments:

- C: The state does have a youth suicide prevention plan, but not a universal plan.

OVERVIEW OF THE PROBLEM AND DMHDDSAS CURRENT SYSTEM

Flo Stein

Ms. Stein emphasized the important and pressing nature of the problem of suicide in North Carolina and summarized the Substance Abuse and Mental Health Services Administration’s (SAMHSA) requirement that each state develop a comprehensive suicide prevention and intervention plan. Ms. Stein gave an overview of the current system including the state’s Medicaid waiver, the consolidation of Local Management Entity-Managed Care Organizations (LME-MCOs), and Critical Access Behavioral Health Agencies (CABHAs). The overarching goal is to successfully provide easily accessible, high quality, cost effective MH/DD/SA services and supports that result in person-centered outcomes for individuals served.

Ms. Stein’s presentation is available here: [Overview of the Problem](#).

Susan Robinson

Mental Health Program Manager/Planner

Prevention and Early Intervention, Community Policy Management

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

Ms. Robinson summarized the problem of suicide in North Carolina as it compares to the nation. She gave the task force an overview of the available demographic information, suicide risk and protective factors, and the current prevention work being done at the state and national level. Current prevention approaches in North Carolina include the NC Suicide Prevention Lifeline and the REALCrisis Center Crisis Line, and mobile crisis teams. North Carolina also has an injury prevention plan, and a violent death reporting system. Ms. Robinson highlighted the related goals from Healthy North Carolina 2020, including reducing the suicide rate, decreasing the average number of poor health days and increasing the number of good health days among adults, and reducing the rate of mental health-related visits to emergency departments.

Ms. Robinson’s presentation is available here: [Overview of the Problem](#).

Selected Questions and Comments:

- Q: Does “North Carolina residents” include the military for the violent death reporting system?
A: If the death certificate is filed in North Carolina, than the reporting system includes the individual as a North Carolina resident.
- C: The workgroup should consider how we can measure undocumented citizens that don’t receive recovery oriented services after hospitalizations.

SURVIVOR STORY

Phil Morse

Founder & Chair

Triangle Consortium for Suicide Prevention

Mr. Morse shared the story of his son’s suicide and his personal experience as someone touched by suicide with the workgroup. He emphasized the unique nature of the trauma associated with suicide because friends and family members are dealing with its violence in addition to their grief. According to Mr. Morse, those touched by suicide primarily need a central support system that includes help communicating with a supportive network of fellow survivors.

Selected Questions and Comments:

- Q: Are there special approaches to take with siblings of youth who die by suicide?
A: High school is a particularly tough time and it's important to offer teens alternatives in addition to talking to peer groups. A lot can be learned from youth self-report surveys regarding the rates of contemplation of suicide.
- C: The focus is on treatment and responding to crisis, but we should strive towards prevention by teaching kids and adults important life skills including communication, stress management, and resilience.

PANEL I – SPECIAL POPULATIONS

Military and Families

Chad Jordan, LMFT

Director, of Psychological Health

National Guard Bureau Psychological Health Program

Mr. Jordan provided a brief overview of the trends and barriers in preventing suicide among the military and their families. Generally, NC has seen improvement in military suicide prevention due to several factors including command involvement in encouraging service members to reach out for help and reducing the associated stigma, less punitive consequences for service members reaching out for help, and early intervention and treatment programs. According to Mr. Jordan, the typical high risk demographic is single males, ages 26-30 with approximately 7-10 years military involvement without deployment, who die by gunshot wound. Factors that increase risk include civilian unemployment, relationship problems, criminal behavior, and substance abuse. The primary barriers to minimizing the risk of suicide are military desensitization to violence, easy access to weapons, military family collusion, and access to care (i.e. long waitlist for appointments at the VA).

Selected Questions and Comments:

- Q: If an individual doesn't follow through with the resources provided after initially reaching out for help, are there people who follow up with him/her?
A: North Carolina does follow up with individuals and check in periodically.
- Q: Are there services available to family members as well?
A: Yes. The North Carolina National Guard (NCNG) will work with family members as well to link them to the appropriate resources.

Children and Adolescents

Jane Anne Miller

Public Health Program Consultant

Chronic Disease and Injury Section

Injury and Violence Prevention Branch

Department of Health and Human Services

Ms. Miller summarized the problem of suicide among children and adolescents. Primary risk factors among youth include mental illness, substance abuse, history of trauma such as child abuse, impulsiveness, and relationship loss. Ms. Miller also noted that youth and young adults are especially susceptible to the messaging surrounding suicide that may glamorize it. North Carolina has a child access protection law that stipulates safe storage of firearms in homes with minors, but according to Ms. Miller, use of firearms is still the leading method of suicide among youth. Youth have a significantly higher attempt to death ratio than other age groups; it is estimated that 20-200 attempts are made for every completed suicide. Ms. Miller highlighted some of the work done by school prevention programs such as SOS (Signs of Suicide), Gatekeeper programs such as ASIST (Applied Suicide Intervention Skills Training) and QPR (Question, Persuade, Refer), and the "it's okay 2 ask" campaign.

Ms. Miller's presentation is available here: [Risk and Protective Factors for Depression and Suicide in Children and Adolescents](#).

Selected Questions and Comments:

- Q: What prevents kids from following through with treatment?
A: Lack of acceptance by the parents that their child has a mental health diagnosis and medication side effects can both cause kids to discontinue treatment.

Elderly

Debbie Webster, MS

Mental Health Program Manager

Best Practice Team

Community Policy Management Section

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

Ms. Webster gave a brief overview of the trends and barriers in preventing suicide among the elderly. A primary barrier Ms. Webster identified is the prevalence of unrecognized or undiagnosed depression among elderly patients: older adults rarely recognize their depression and may associate seeking help with weakness or other stigma; and providers often mistake signs of depression as part of the aging process. Ms. Webster introduced the ongoing work of the mental health and aging coalition, and highlighted a few current prevention programs including PEARLS (Program to Encourage Active and Rewarding Lives for Seniors) and IMPACT (Improving Mood Promoting Access to Collaborative Treatment).

Selected Questions and Comments:

- C: Older adults and others seem to assume that Medicare/their health insurance doesn't cover outpatient mental health services.

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION: SUICIDE PREVENTION STRATEGIES

Richard McKeon, PhD, MPH

Chief

Suicide Prevention Branch

Center for Mental Health Services

Substance Abuse and Mental Health Services Administration

Dr. McKeon summarized SAMHSA's key messages and strategic initiatives for suicide prevention. He argued that the integration of public health and mental health is particularly important in suicide prevention. Dr. McKeon emphasized the need for crisis plans to send people where they will receive the appropriate care. Thus, crisis plans that send people to the emergency department where they receive medical treatment but are unlikely to receive a mental health evaluation are not meaningful. In addition, Dr. McKeon emphasized the importance of post discharge follow up because the period of time after a patient leaves the emergency department is high risk. Dr. McKeon gave an overview of SAMHSA's five major prevention components: the Garret Lee Smith State and Tribal Suicide Prevention Grant Program, the Garret Lee Smith Campus Suicide Prevention Grant Program, the National Suicide Prevention Lifeline, the Suicide Prevention Resource Center, and Native Aspirations.

Dr. McKeon's presentation is available here: [SAMHSA: Suicide Prevention Strategies](#).

Selected Questions and Comments:

- Q: Why would only 50% of patients admitted for suicide attempts receive a mental health evaluation?

A: The study did not get answers to why. It is likely that in rural hospitals, there is little access to mental health expertise.

- C: There is a lot of fatalism surrounding suicide. It will be important for the workgroup to emphasize that you can make a difference.