Suicide Prevention and Intervention Plan:

A Report of the NCIOM Task Force on Suicide Prevention and Intervention

July 2012

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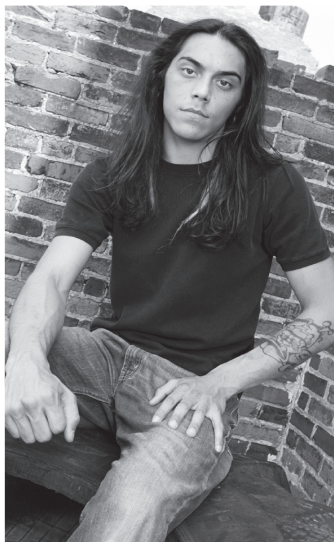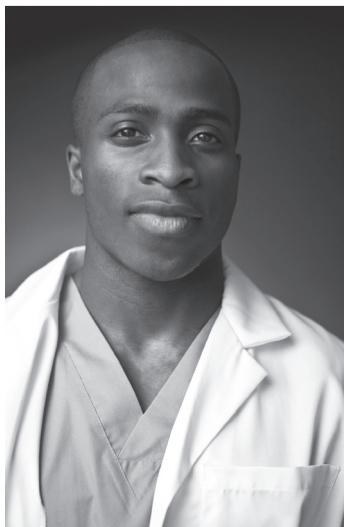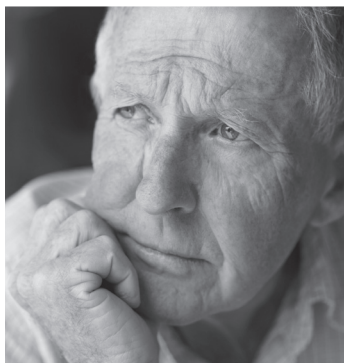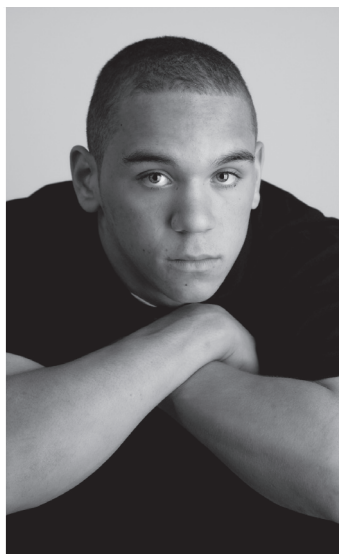Division of Mental Health, Developmental Disabilities,
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S uicide is a public health problem that affects victims, families, and communities. In 2009, suicide was the cause of death for more than 1,157 North Carolinians.[1] Between 2004-2009, more than 1,000 North Carolinians died by suicide each year.[1] These deaths crossed gender, age, race, and other demographic lines to affect the entire state. In addition to deaths by suicide, there are many more people who are at risk for and attempt suicide. During that same time period of 2004-2009, more than 8,000 North Carolinians each year were treated in emergency rooms for self-inflicted injuries.[2] Youth and young adults, older adults, military service members and veterans, and people with mental health and substance use disorders are at increased risk for self-inflicted injury and death by suicide. The issue of suicide affects the whole state and needs significant attention in order to save lives.

The North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) works with other state and local agencies to provide prevention, crisis intervention, treatment, recovery support, and other services to people who are contemplating suicide or who have attempted suicide, and to their families. DMH/DD/SAS asked the North Carolina Institute of Medicine (NCIOM) to convene a task force 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 NCIOM Suicide Prevention and Intervention Task Force included 24 members representing DMH/DD/SAS, the North Carolina National Guard, public health and other health professionals, behavioral health providers, outreach organizations, hospitals, survivors, and advocates. The Task Force met five times over six months to help DMH/DD/SAS develop its Suicide Prevention and Intervention Plan. The Task Force began by examining data on the scope of the problem, as well as recommendations from past task forces or other initiatives to understand what was working and what needed to be changed. In addition, the NCIOM conducted a literature review of evidence-based strategies or promising practices that have been shown to help prevent suicides (see Appendix C).

This report discusses the facts about suicide, including risks and protective factors (Chapter 2). It also includes a description of services and gaps in the current system, and recommendations to create an effective suicide prevention and intervention plan (Chapter 3). The conclusion (Chapter 4) includes a summary of how we, as a state, can work together to reduce suicide risks and suicide deaths. The report also includes five appendices: Appendix A includes the full text of the eight recommendations. Appendix B is a list of acronyms and the glossary. Appendix C includes a brief description of existing suicide prevention and intervention best practices. Appendix D includes an example of a suicide risk screening questionnaire and suicide assessment form, and Appendix E includes an example of a standard guideline for managing suicide risk.

Between 2004-2009, more than 1,000 North Carolinians died by suicide each year.

REFERENCES

1. North Carolina Violent Death Reporting System, Injury & Violence Prevention Branch, Division of Public Health, North Carolina Department of Health and Human Services. Violent Death Reporting System: Annual Report 2009. Raleigh, NC: North Carolina Department of Health and Human Services; 2012.

2. Division of Public Health, North Carolina Department of Health and Human Services. Saving tomorrow's today: North Carolina's plan to prevent youth suicide. http://www.injuryfreenc.ncdhhs.gov/About/YouthSuicidePreventionPlan.pdf. Published October 2004. Accessed August 15, 2011.

What We Know About Suicide: The Facts

Suicide risk is not isolated to any specific population group. It touches all of us, young and old, male and female, as well as those from varying racial and ethnic groups. It is a devastating problem that has tremendous emotional consequences for the family and friends of people who die by suicide, and physical and psychological consequences for those who survive suicide attempts. Suicide death is the 11th leading cause of death for people age 10 and older in the United States.[1] Most Americans have been affected by someone they know who has either attempted or died by suicide. These are our family, our friends, and our neighbors. In 1998, the Surgeon General officially declared suicide a national public health crisis.[2]

Nationally the suicide rate in 2008 was 13.6 per 100,000 population, representing more than 33,000 deaths according to the Centers for Disease Control and Prevention (CDC). However, the death rate is the proverbial tip of the iceberg. It is estimated that for every completed suicide there at least 11 and possibly as many as 25 attempts.[3,4] There is no way to capture an accurate account of everyone who attempts suicide because not everyone who attempts suicide enters the health care system. The most common proxy measure used to measure suicide attempts is the number of people who present in the emergency department with self-inflicted injuries. Between 2005 and 2010, about 392,000 people with self-inflicted injuries went to emergency departments across the country for treatment.[4]

In North Carolina, the state suicide death rate increased slightly between 1999-2007 (from 12.8 per 100,000 people in 1999 to 13.7 in 2007), and has been consistently higher than the national average (see Figure 2.1).[a] In 2009, 1,157 North Carolinians (14.3 per 100,000) died from suicide.[5]

In North Carolina, the state suicide death rate has been consistently higher than the national average.

Figure 2.1
Age-Adjusted Suicide Rate for Ages 10 or Older in North Carolina and the United States (1999-2007) (per 100,000 population)

Year	North Carolina	United States
1999	12.8	12.2
2000	13.9	12.2
2001	14	12.5
2002	13.7	12.7
2003	13.1	12.5
2004	13.9	12.8
2005	13.4	12.7
2006	14.3	12.8
2007	13.7	13.1
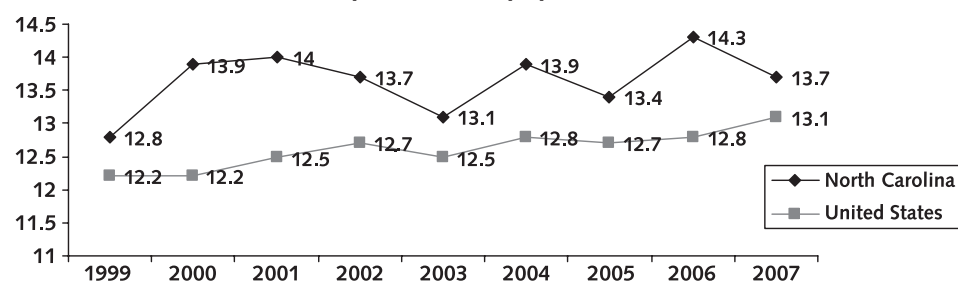
Source: Injury and Violence Prevention Branch, North Carolina Division of Public Health. The Burden of Suicide in North Carolina. Raleigh, NC: North Carolina Department of Health and Human Services; 2011.

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a   North Carolina suicide data are captured in the North Carolina Violent Death Reporting System (NC VDRS). This system is funded through the CDC, which collects information from death certificates, medical examiner reports, and law enforcement reports. NC VDRS is operated by the North Carolina Division of Public Health's Injury and Violence Prevention Branch to provide injury and violence prevention specialists and policymakers detailed information on the victims, suspects, relationships, circumstances, and weapons that are associated with every incident of violence that results in a fatality in North Carolina.

Death by suicide was one of the top ten leading causes of death for people aged 5-64 in 2010.

Death by suicide was one of the top ten leading causes of death for people aged 5-64 in 2010 (see Table 2.1). From 2004 to 2008, the state suicide rate among people age 10 or older averaged 14 per 100,000 population, the rate of hospitalizations for self-inflicted injury was 76.0 per 100,000 population, and the rate of emergency department visits was 106.3 per 100,000 people. Each year more than 1,000 North Carolinians die from self-inflicted injuries, more than 6,000 are hospitalized, and more than 8,000 are treated in emergency departments for self-inflicted injuries.[6] Suicide deaths resulted in 86,690 years of potential life lost in North Carolina between 2004-2007. Years of life lost is the measure of the years of potential life lost because of premature death before 65 years of age. The total years of life lost to suicide deaths under age 65 in the state is more than each of those lost to homicide, congenital abnormalities, cerebrovascular disease, human immunodeficiency virus (HIV), and diabetes mellitus.[7] The most common means of death by suicide in North Carolina in 2009 was firearms, followed by hanging and poisoning.

Table 2.1
Number of Deaths per Year Attributable to Leading Causes of Death by Age Group in North Carolina (2010)

Rank	Age-Group							
	<1	1-4	5-14	15-24	25-44	45-64	65 and Over	All Ages
1	Short gestation 117	Other unintentional injuries 32	Cancer - 28 Motor vehicle injuries - 28	Motor vehicle injuries 282	Other unintentional injuries 576	Cancer 5,348	Diseases of the heart 13,076	Cancer 18,013
2	Congenital anomalies 173	Motor vehicle injuries - 21	*	Other unintentional injuries - 149	Cancer 571	Diseases of the heart 3,515	Cancer 12,020	Diseases of the heart 17,090
3	SIDS 53	Homicide 13	Other unintentional injuries 16	Homicide 133	Motor vehicle injuries 440	Other unintentional injuries 758	Chronic lower respiratory diseases 3,787	Chronic lower respiratory diseases 4,490
4	Maternal complications 51	Congenital anomalies 12	Homicide 10	**Suicide 132**	Diseases of the heart 431	Chronic lower respiratory diseases - 666	Cerebro-vascular disease 3,588	Cerebro-vascular disease 4,281
5	Complications of the placenta - 45	Cancer 9	Congenital anomalies 9	Diseases of the heart - 40	**Suicide 375**	Cerebro-vascular disease - 595	Alzheimer's disease 2,788	Alzheimer's disease 2,813
6	Diseases of the circulatory system 27	Diseases of the heart 5	Diseases of the heart 8	Cancer 36	Homicide 228	Diabetes mellitus 544	Nephritis, nephrotic syndrome, and nephrosis 1,509	Other unintentional injuries 2,762
7	Other unintentional injuries 21	Pneumonia and influenza - 4 Septicemia - 4	Chronic lower respiratory diseases - 5	Congenital anomalies 12	HIV 102	Chronic liver disease and cirrhosis 505	Pneumonia and influenza 1,434	Diabetes mellitus 2,036
8	Bacterial sepsis 18	*	**Suicide 4**	Cerebro-vascular disease 6	Diabetes mellitus 96	**Suicide 475**	Diabetes mellitus 1,392	Nephritis, nephrotic syndrome and nephrosis 1,886
9	Necrotizing enterocolitis 17	Conditions originating in the perinatal period - 3 In-situ/benign neoplasms - 3	In-situ/benign neoplasms - 3 Septicemia - 3	Pneumonia and influenza 5	Cerebro-vascular disease 81	Motor vehicle injuries 350	Other unintentional injuries 1,210	Pneumonia and influenza 1,684
10	Respiratory distress 13	*	*	Anemias - 4 Diabetes mellitus - 4 Nephritis, nephrotic syndrome, and nephroisis - 4 Pneumonitis due to solids and liquids - 4	Chronic liver disease and cirrhosis 78	Nephritis, nephrotic syndorme, and nephrosis 320	Septicemia 971	Motor vehicle injuries 1,368

Source: North Carolina Violent Death Reporting System. Injury and Violence Prevention Branch, Division of Public Health, North Carolina Department of Health and Human Services. Data Request-NCIOM: 2004-2008. Data Analysis Received August 2011.
* Table is blank when two or more conditions had the same number of deaths in the preceding rank.

Demographic Differences in Suicide Attempts and Suicide Deaths

While the risk of suicide is shared among all demographic groups, the burden is not shared equally. Some groups have higher risks. For example, men are more likely to die by suicide (although women are more likely to attempt suicide). The risk of suicide also varies by age and gender.

Gender

In North Carolina, men have an almost four times greater likelihood of dying by suicide than females. Between 1999-2009, the suicide death rate was 18.9 per 100,000 population for men, compared to 5.1 per 100,000 for women (see Figure 2.2).[6] Suicide death was the seventh leading cause of death for males and the 15th leading cause of death for females over the age of 10.[3] The gender difference may be related to the difference between suicide attempts and deaths. North Carolina data showed that women had a 30% greater chance of having an emergency department visit for self-inflicted injury in 2009 (female: 118.9/100,000; male: 90.1/100,000) and an approximately 35% greater likelihood of being admitted for a self-inflicted injury in 2008 (female: 80.0/100,000; male: 59.4/100,000). This suggests that men use more lethal methods to commit suicide. But, some national studies have found that the reason for the higher percentage of male versus female suicide deaths is more complex.[8] Men of all ages are more likely to commit suicide via firearms whereas the method among females varies by age;

In North Carolina, men have almost four times greater chance of dying by suicide than females.

Figure 2.2
North Carolina Suicide Rates Among Males and Females (1999-2009)
(per 100,000 population)
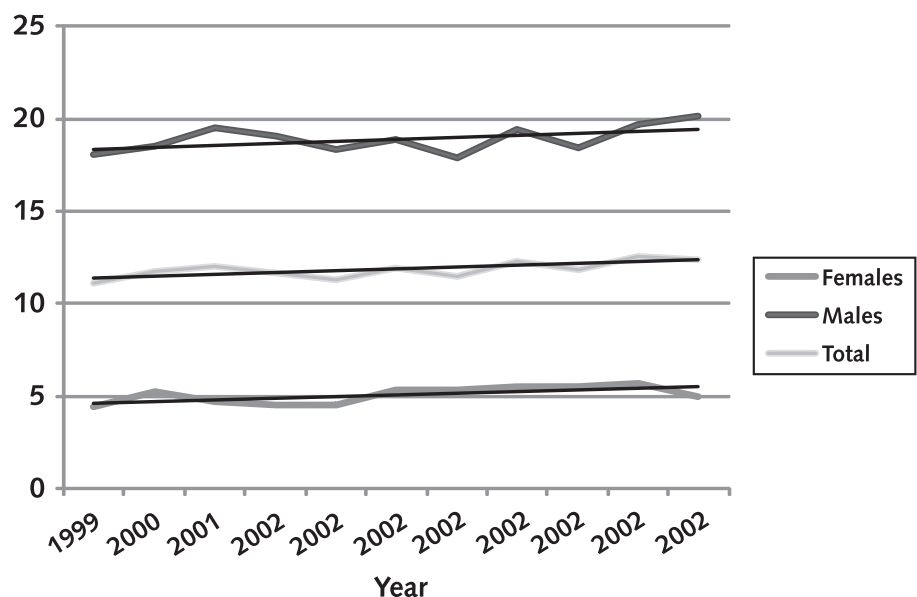
Source: North Carolina Violent Death Reporting System. Injury and Violence Prevention Branch, North Carolina Division of Public Health, North Carolina Department of Health and Human Services. Data Request- NCIOM 2004-2008. Data Analysis Received August 2011.

methods include suffocation (10-24 years), poisoning (25-64 years), and firearms (65+ years).[9] When using firearms, men are more likely to shoot themselves in more lethal areas (e.g. the head) than women.[10] Men who have committed suicide are also more likely than women to have blood alcohol contents (BACs) above 0.08 g/dL, suggesting that alcohol could be a more serious risk factor for suicide among men than among women.[11]

Age

During the 2010-2011 school year in North Carolina, 373 students attempted suicide and 23 died by suicide. There were 25 attempts but no deaths of elementary students, 113 attempts and 3 deaths of middle school students, and 235 attempts and 20 deaths of high school students.[12] Suicide is the fourth leading cause of death among youth and young adults ages 15-24 years in North Carolina.[13] Between 1999 and 2009, 1,439 youth and young adults ages 10 to 24 died. Regardless of age, male youth had higher suicide rates than female youth. More than half (56%) of the youth suicides involved firearms; 30% involved hanging, strangulation, or suffocation; 9% involved poisoning; and 5% involved other methods of suicide.[7]

Risk factors for youth include depression, alcohol or other drug use disorder, physical or sexual abuse, disruptive behavior, association with lethal means, eating disorders, rejection related to lesbian/gay/bisexual/transgender (LGBT) association, stressful life events, and incarceration.[2,3,14,15] Bullying is another risk factor for youth.[16-18] Experiencing a high frequency of bullying as well as experiencing varying types of bullying are both correlated with an increased risk of suicide.[17] Youth are less likely to die from suicide attempts than adults and are more likely to attempt suicide as an act of impulsive desperation.[2,14] Youth are more likely to attempt suicide with firearms (especially among those ages 15-24 years), suffocation (especially among those 10-14 years), and poisoning (including overdose).

The greatest number of deaths by suicide occurs in the 35-44 age group. Between 1999 and 2009, there were 2,432 North Carolinians who died by suicide in this age group, followed by 2,312 in the 45-54 age group. These groups also have the highest rate of dying by suicide (17/100,000 and 17.5/100,000 respectively). However, these total numbers mask very distinct differences by gender. As noted earlier, men have a much higher death rate for suicides than females in every age group. Across all age groups, men are almost four times more likely to die by suicide than women. However this difference is accentuated as the population ages. For example, older men (ages 65-74) have a 6 times greater chance of dying by suicide than women, and men older than age 75 have more than a 12 times greater likelihood of dying by suicide (see Figure 2.3).

National studies suggest that risk factors for older adults include stressful life events, bereavement and family discord, lack of social support, physical illness or perceived poor health, substance use disorders, poor sleep quality, affective illness, depressive symptoms, and bone fracture.[19,20] The co-existence

Suicide is the fourth leading cause of death among youth and young adults ages 15-24 years in North Carolina.

of multiple physical illnesses also increases the risk of suicide, especially those in conjunction with heart failure, chronic lung disease, seizures, and chronic pain.[21] Many older adults who commit suicide see their doctor within one month of death, suggesting that doctor visits could be a good point of intervention.[21] Depression, poor sleep quality, and limited social support are also risk factors for natural death.[20] Because of this, sometimes non-violent suicide in elders can be mistaken for natural causes.[21]

> **Many older adults who commit suicide see their doctor within one month of death, suggesting that doctors visits could be a good point of intervention.**

Figure 2.3
North Carolina Annual Rates of Suicide by Sex and Age (1999-2009)
(per 100,000 population)
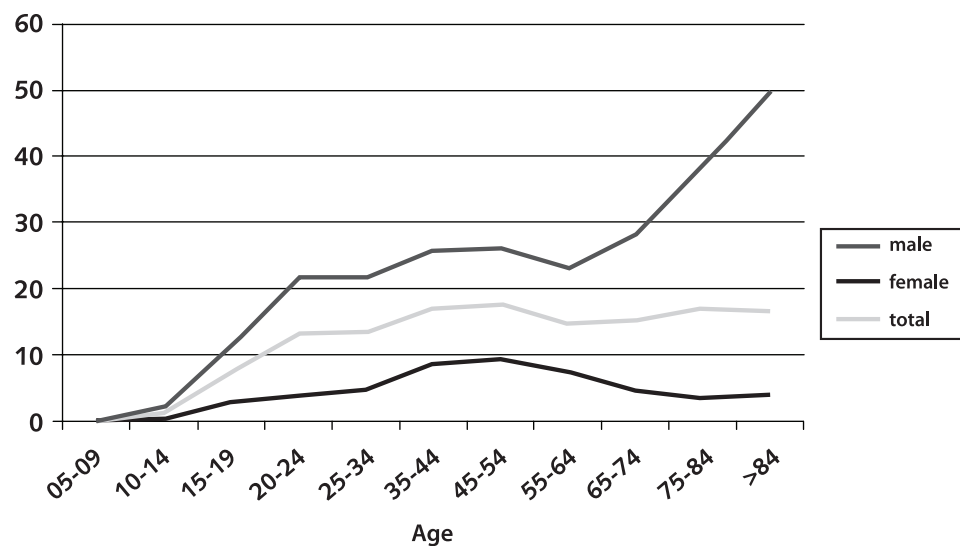
Source: North Carolina Violent Death Reporting System. Injury and Violence Prevention Branch, North Carolina Division of Public Health, North Carolina Department of Health and Human Services. Data Request-NCIOM 2004-2008. Data Analysis Received: August 2011.

Race/Ethnicity

Suicide rates and risk factors also vary by race and ethnicity. In North Carolina, the highest death rate has been consistently among whites (1999-2009), followed by American Indians, Asian and Pacific Islanders, and blacks (see Figure 2.4). National data show that racial discrimination, perceived discrimination (especially among Latinos and US-born whites), familial acculturative stress (especially among blacks, non-US-born whites, and Latinos), and social acculturative stress (especially among Latinos) are all risk factors for suicide associated with race and ethnicity.[15,22] Alcohol is a significant risk factor among the American Indian/Alaskan Native and Latino populations.[11] These two racial/ethnic groups also have the highest blood alcohol content in suicide victims of all racial/ethnic groups.[11]

Figure 2.4
North Carolina Suicide Rates by Race (1999-2009) (per 100,000 population)
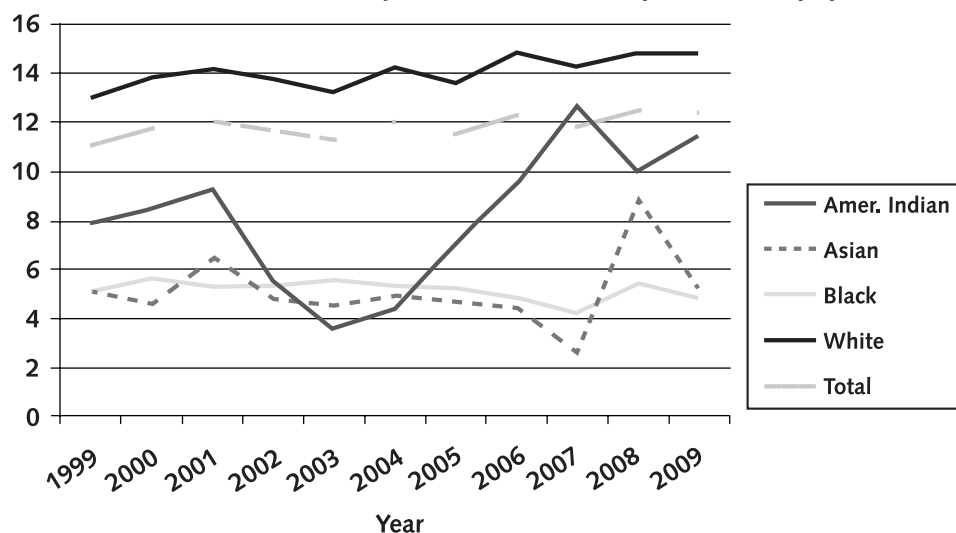
Source: North Carolina Violent Death Reporting System. Injury and Violence Prevention Branch, North Carolina Division of Public Health, North Carolina Department of Health and Human Services. Data Request- NCIOM 2004-2008. Data Analysis Received August 2011.

In North Carolina, the highest suicide death rate has been consistently among whites, followed by American Indians, Asians and Pacific Islanders, and blacks.

Among all ethnicities, non-Hispanic people were more than 2.5 times more likely to die by suicide that people of Hispanic descent (see Figure 2.5).[6]

Figure 2.5
North Carolina Suicide Rates by Hispanic Origin (1999-2009) (per 100,000 population)

Source: North Carolina Violent Death Reporting System. Injury and Violence Prevention Branch, North Carolina Division of Public Health, North Carolina Department of Health and Human Services. Data Request- NCIOM 2004-2008. Data Analysis Received August 2011.

Military Service Status

Nationally, suicide is the second leading cause of death for members of the armed forces.[23] Suicide rates among military members in all branches is on the rise and, as of 2009, was higher than rates among the general population.[23] Male veterans are twice as likely to die by suicide than men in the general population.[23] Currently deployed service members have the highest rates of suicide in the military.[24] Female service members are at higher risk of suicide while deployed.[24] National studies show that risk factors for suicide by service members include combat exposure, frustration secondary to injury, limited insight into personal deficits, challenges related to coping, stressors related to deployment, perceived burdensomeness, thwarted belongingness, cognitive symptoms of traumatic brain injury, and sub-threshold post-traumatic stress disorder (PTSD), and PTSD.[23,25-28] Veterans with co-morbid PTSD and other mental health conditions are at an especially increased risk of suicide ideation and/or attempting suicide.[29,30] This is a current concern since 27% of Operation Iraqi Freedom/Operation Enduring Freedom veterans have at least three co-morbid mental health diagnoses.[30] Military members are most likely to commit suicide by firearms, followed by hanging/suffocation, and poisoning.[31]

> Suicide is the second leading cause of death for members of the armed forces.

In North Carolina between 2004 and 2008, 1,148 veterans died by suicide. The suicide rate among North Carolina veterans was 29.6 per 100,000. That rate was more than twice the overall suicide rate of 14 per 100,000 in the general population.[7] The age adjusted veteran suicide rate for ages 20 or older was slightly higher than the rate for non-veterans of the same age. The small number of veteran suicides compared to those non-veterans ages 20 to 24 may skew the data in favor of a higher veteran rate.[7] The North Carolina National Guard suicide rate for 2010 was 42 per 100,000 and decreased to 33 per 100,000 in 2011.[b]

Rural and Urban

According to the Office of Management and Budget 2010 Standards, there are 40 metropolitan counties leaving 60 that are either micropolitan or neither.[c] In those 40 urban or metropolitan counties, the suicide rate in 2004-2008 was 13.2 per 100,000 population as opposed to 15.9 per 100,000 population in the rural (micropolitan or neither) counties.[d] Similarly, the hospitalization rate for self-inflicted injuries was 74.9 per population in the urban counties and 78.6 per population in the rural counties.

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b   Tyson A. Suicide Prevention and Resilience Program Manager, North Carolina National Guard. Written communication. May 10, 2012

c   A metropolitan county is a county that has at least one urbanized area with a population of at least 50,000, plus adjacent outlying counties that have a high degree of social and economic integration with the metro county. A high degree of social and economic integration means at least 25% of workers living in the county work in the metro (or micro) county, or at least 25% of employment in that county is accounted for by workers who reside in the micro or metro county. A micropolitan county is one that has an urbanized area with 10,000-50,000 or adjacent counties with a high degree of social and economic integration. A county labelled as "Neither" is one that is neither metro or micro. http://www.whitehouse.gov/sites/default/files/omb/assets/fedreg_2010/06282010_metro_standards-Complete.pdf.

d   Data analysis of rural and urban suicide death rates and hospitalization from self-inflicted injury rates prepared by Pam Silberman, JD, DrPH, North Carolina Institute of Medicine.

Risk and Protective Factors

Risk Factors

Suicide is a complex problem with many risk factors. Two of the primary risk factors are mental health problems and/or substance use disorders. The National Institute of Mental Health has reported that over 90% of people who commit suicide have depression and/or substance abuse disorders—often in combination with other mental health disorders.[3] However other studies of people who die by suicide have not shown that high of a correlation between mental illness, substance use, and suicide. One study of suicide victims in the 13 states participating in the National Violent Death Reporting System suggested that between 21-44% of those who have died by suicide had a current mental illness (variations based on race/ethnicity), although only 15-33% of those who died were receiving current treatment for their mental illness at the time of death. This study also showed that between 25-40% had alcohol present in their bodies at the time of death.[32] In general, white non-Hispanics had higher likelihood of mental illness and treatment for mental illness, followed by black non-Hispanics, other non-Hispanics, and then Hispanics. However Hispanics had a higher likelihood of having alcohol present at time of death, followed by white non-Hispanics, other non-Hispanics, and black non-Hispanics.

In North Carolina between 2004-2008, the statistics are somewhat higher than the rest of the country for mental health and substance abuse treatment. More than 60% of females and more than 40% of males who died by suicide in North Carolina had ever been treated for a mental health condition, and a similar percentage were in current treatment when they died (see Table 2.2).[13] Substance abuse was also fairly common among suicide victims with 14% of men and more than 11% of women having an alcohol use disorder and almost 12% of men and almost 15% of women having a disorder with another substance. In 2009, prescription pharmaceuticals were used in 69.2% of all suicide deaths by poisoning (59.2% of male deaths by poisoning and 82.4% of female deaths by poisoning).[13] Another important circumstance of suicide is the connection to previous attempts. Between 2004-2008 in North Carolina, more than 12% of men and almost 30% of women had a previously documented attempt of suicide at the time of their death by suicide. [13]

Two of the primary suicide risk factors are mental health problems and/or substance use disorders.

Table 2.2
Circumstances of Suicide Victims for Ages 10 or Older by Gender in North Carolina (2004-2008)

Circumstance**	Male		Female		TOTAL	
Mental Health	Number	Percent	Number	Percent	Number	Percent
Current depressed mood	1,764	46.6	532	45.3	2,296	46.3
Current mental health problem	1,574	41.6	784	66.8	2,358	47.5
Current treatment for mental illness	1,389	36.7	739	63.0	2,128	42.9
Ever treated for mental illness	1,538	40.6	780	66.4	2,318	46.7
Substance Abuse						
Alcohol problem	562	14.8	135	11.5	697	14.1
Other substance problem	457	12.1	178	15.2	635	12.8
Interpersonal						
Intimate partner problem	1,085	28.6	246	21.0	1,331	26.8
Other relationship problem	276	7.3	86	7.3	362	7.3
Recent suicide of friend/family (past 5 years)	43	1.1	14	1.2	57	1.2
Other death of friend/family	150	4.0	56	4.8	206	4.2
Perpetrator of interpersonal violence in past	303	8.0	17	1.5	320	6.5
Victim of interpersonal violence in past month	10	0.3	20	1.7	30	0.6
Life Stressor						
Crisis within two weeks	1,452	38.3	328	27.9	1,780	35.9
Physical health problem	770	20.3	220	18.7	990	20.0
Job problem	307	8.1	45	3.8	352	7.1
School problem	15	0.4	4	0.3	19	0.4
Financial problem	276	7.3	53	4.5	329	6.6
Recent criminal-related legal problem	353	9.3	32	2.7	385	7.8
Other legal problems	90	2.4	18	1.5	108	2.2
Suicide Event						
Left a suicide note	1,037	27.4	369	31.4	1,406	28.3
Disclosed intent to complete suicide	950	25.1	240	20.4	1,190	24.0
History of suicide attempts	469	12.4	341	29.1	810	16.3

Source: North Carolina Violent Death Reporting System. Injury and Violence Prevention Branch, North Carolina Division of Public Health, North Carolina Department of Health and Human Services. Data Request- NCIOM: 2004-2008. Data Analysis Received August 2011.
**Circumstances were available for 91.9% (3,788/4,120) of male victims, 94.2% (1,174/1,246) of female victims, and 92.5% (4,962/5,366) of all suicide victims. The percentage of circumstances for suicide victims is based on the number of cases reporting circumstances in North Carolina from 2004-2008, not the total number of suicides. Note, too, that each victim may have more than one circumstance. Accordingly, the total number of circumstances may exceed the total number of suicides.

Among those with a current mental health diagnosis at the time of suicide, there were four diagnoses that were the most common (see Table 2.3). Depression or dysthymia was the most common followed by bipolar disorder, schizophrenia, and anxiety disorder in men and women.[13] These four disorders account for more than 90% of mental health diagnoses among both men and women with a current mental health diagnosis at the time of suicide. This probably under reports the number of suicide victims who had an underlying mental illness, as there is still a stigma associated with the receipt of mental health services. Thus, many people who are depressed or have other mental health or substance use disorders do not enter the mental health system.[13]

Table 2.3
Current Mental Health Condition at the Time of Suicide by Gender for Ages 10 or Older in North Carolina (2004-2008)

	Male		Female		TOTAL	
Current Mental Health Problem**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
Depression / Dysthymia	1,276	81.1	649	82.8	1,925	81.6
Bipolar Disorder	140	8.9	91	11.6	231	9.8
Schizophrenia	53	3.4	13	1.7	66	2.8
Anxiety Disorder	37	2.4	13	1.7	50	2.1
Post-Traumatic Stress Disorder	8	0.5	0	0.0	8	0.3
Attention Deficit Disorder (ADD) or Hyper-Reactivity Disorder	7	0.4	0	0.0	7	0.3
Eating Disorder	0	0.0	5	0.6	5	0.2
Obsessive-Compulsive Disorder	0	0.0	1	0.1	1	0.0
Other	31	2.0	4	0.5	35	1.5
Unknown / Missing	58	3.7	23	2.9	81	3.4

Source: North Carolina Violent Death Reporting System. Injury and Violence Prevention Branch, North Carolina Division of Public Health, North Carolina Department of Health and Human Services. Data Request- NCIOM: 2004-2008. Data Analysis Received August 2011.
** Percentages are based on 1,574 males, 784 females, and 2,358 total suicide victims with a current mental health condition.
Note: Each victim may have more than one current condition. Accordingly, the total number of mental health conditions may exceed 100%.

While mental health and substance abuse are the leading risk factors for suicide, there are other biopsychosocial, environmental, and sociocultural risk factors as well (see Table 2.4). The Surgeon General's Call to Action to Prevent Suicide lists the following risk factors:

Many of these risk factors can be reduced through prevention or early intervention at the individual and community level, and by making it easier to access appropriate mental health or substance use services.

Table 2.4
Suicide Risk Factors

Biopsychosocial Risk Factors	Environmental Risk Factors	Sociocultural Risk Factors
• Mental disorders, particularly mood disorders, schizophrenia, anxiety disorders, and certain personality disorders • Alcohol and other substance use disorders • Hopelessness • Impulsive and/or aggressive tendencies • History of trauma or abuse • Major physical illnesses • Previous suicide attempt • Family history of suicide	• Job or financial loss • Relational or social loss • Easy access to lethal means • Local clusters of suicide that have a contagious influence	• Lack of social support and sense of isolation • Stigma associated with help-seeking behavior • Barriers to accessing health care, especially mental health and substance abuse treatment • Certain cultural and religious beliefs (for instance, the belief that suicide is a noble resolution of a personal dilemma) • Exposure to, and influence of, others who have died by suicide, including through the media

Source: National Strategy for Suicide Prevention. Goals and Objective for Action Rockville, MD: Public Health Service. US Department of Health and Human Services, 2001. p.36

While there is debate about the percent of the variation in suicide attempts or suicide deaths attributable to these various risk factors; depression and other serious mental illness, alcohol use, and substance abuse are major risk factors. Many of these risk factors can be reduced through prevention or early intervention at the individual and community level, and by making it easier to access appropriate mental health or substance use services.

Protective Factors
Just as there are risk factors which increase the likelihood of suicide ideation, attempts, or death, there are protective factors which can help protect people from suicide risk as well. The US Surgeon General lists the following protective factors against suicide in the Call to Action to Prevent Suicide report:[33]

■ Effective clinical care for mental, physical, and substance use disorders

■ Easy access to a variety of clinical interventions and support for help-seeking

- Restricted access to highly lethal means of suicide

- Strong connections to family and community support

- Support through ongoing medical and mental health care relationships

- Skills in problem solving, conflict resolution, and nonviolent handling of disputes

- Cultural and religious beliefs that discourage suicide and support self-preservation

Other protective factors have been found in specific populations. For example, friends or relatives to confide in and regular church attendance has been found to be protective against suicide among the older adult population.[20] Social support and spiritual/religious beliefs were also found to be protective among the military population along with a sense of purpose regarding the future, mental health care, employment/volunteerism, and being married.[24,25]

Suicide has devastating effects in North Carolina. Data from the North Carolina Violent Death Reporting System and other sources demonstrate that suicide affects all North Carolinians—both rural and urban, male and female, younger and older, and all races and ethnicities. There are many risk factors that increase the risk for suicide, but there are also protective factors that can reduce risk and prevent suicide. In the next chapter, there will be discussion of current systems and programs and how they may be improved to help keep North Carolinians protected.

There are protective factors which can help protect people from suicide risk.

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North Carolina needs a multifaceted suicide prevention and intervention plan that combines broad-based prevention activities, early intervention, crisis services, treatment, recovery supports for people who have attempted suicide, and postvention for people touched by suicide (see Figure 3.1). To be effective, the state needs to invest more heavily in prevention—both in reducing risk factors that are known to increase the chance of suicide, and in strengthening the protective factors that can help reduce suicide risk. Effective prevention strategies are multilevel, and include messages or prevention programs targeted to broad based populations ("universal"), higher risk groups ("selective"), and people who have shown early suicide warning signs ("indicated"). Most people, including those who enter the mental health or substance abuse service system, should be screened to determine their level of risk. Once identified as high risk, these individuals should then be assessed more thoroughly for suicidal ideation, past history of suicide attempts, suicide capability (early intervention), as well for as the protective factors that can help reduce the risk of suicide. Individuals who are actively contemplating or who have attempted suicide need to be linked immediately to effective crisis services. Crisis services should be followed with appropriate treatment and recovery supports in order to help the person develop strategies to address future crises. "Postvention" services are needed for the friends, families, and colleagues of

North Carolina needs a multifaceted suicide prevention and intervention plan that combines broad-based prevention activities, early intervention, crisis services, treatment, recovery supports for people who have attempted suicide, and postvention services for people touched by suicide.
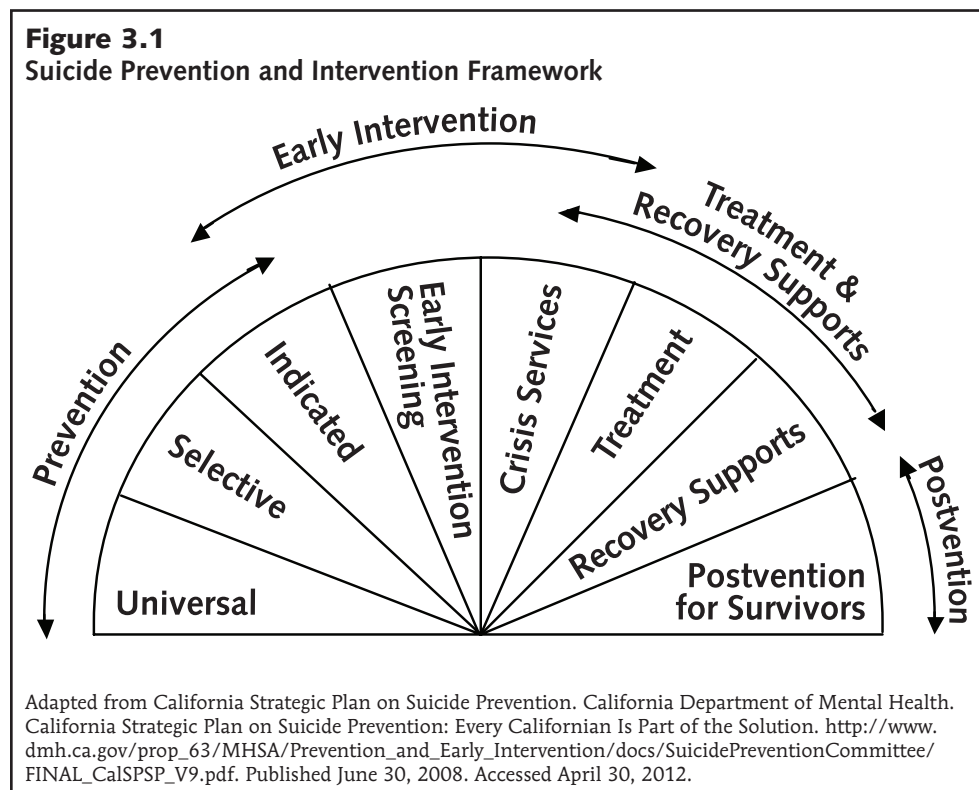
Figure 3.1
Suicide Prevention and Intervention Framework

Adapted from California Strategic Plan on Suicide Prevention. California Department of Mental Health. California Strategic Plan on Suicide Prevention: Every Californian Is Part of the Solution. http://www.dmh.ca.gov/prop_63/MHSA/Prevention_and_Early_Intervention/docs/SuicidePreventionCommittee/FINAL_CalSPSP_V9.pdf. Published June 30, 2008. Accessed April 30, 2012.

the people who die by suicide as they are also at higher risk of suicide following the tragedy.

Comprehensive suicide prevention and intervention models that have been implemented elsewhere have been successful in reducing suicide deaths and suicide risk. Maryland implemented a comprehensive suicide prevention and intervention strategy targeting youth in the 1990s. The Maryland model includes a comprehensive strategy with prevention, intervention and postvention activities including but not limited to a state youth crisis hotline, funds for school-based suicide prevention programs, gatekeeper training and community education, crisis teams, intervention, and postvention services. A study showed that after this model was implemented suicide rates decreased across age groups and decreased by 21.4% among youth ages 15-24 in Maryland while youth suicide rate increased nationally by 11%.[1,2] Similarly, the US Air Force implemented a comprehensive suicide prevention strategy which included community training to educate the Air Force personnel about suicide risk, screening programs to identify high-risk individuals, crisis services, and efforts to remove the barriers and stigma associated with seeking mental health services. The program also identified appropriate treatment and referral resources, and postvention services to help prevent "copycat" suicides (suicide "contagion"). The United Air Force observed a decrease in suicide rates from 16.4 per 100,000 to 9.4 per 100,000 between 1994 and 1998, and an overall reduction in suicide risk by 33%.[3,4]

Ideally, state and local agencies and contracted providers should deliver evidence-based prevention, early intervention, crisis, treatment, and postvention services. With limited public funding, we want to ensure that we use our funding wisely, and invest in programs, interventions and strategies that work. Evidence-based programs and interventions are those that achieve positive health outcomes and have been subject to rigorous evaluation. Evidence-based programs have usually been tested in multiple settings, and often in diverse populations (although some evidence-based programs have been designed to be administered to specific populations). The National Registry of Evidence-based Programs and Practices (NREPP) has reviewed mental health and substance abuse prevention and treatment programs to determine what works, and the level of evidence behind the different strategies.[5] However, achieving positive outcomes requires not only that we identify evidence-based strategies, but also that we implement those strategies as designed. Training, technical assistance, and ongoing monitoring must be provided—either by the state, national program offices, or other intermediary organizations—to ensure that the programs or strategies are implemented with fidelity.

While it is important to invest limited public dollars in programs or strategies with a proven track record, there may be times when such programs do not exist, are cost prohibitive, or do not fit the specific needs of the target population. We

Comprehensive suicide prevention and intervention models that have been implemented elsewhere have been successful in reducing suicide deaths and suicide risk.

need to ensure that the selected prevention or intervention strategies are age, culture, and gender appropriate, as well as linguistically accessible. Some of the strategies that work well in an urban area may not work as well in a rural community, or those that work for younger populations may not work for older adults. The North Carolina Practice Improvement Collaborative (NC PIC), a project of the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS), was established to identify evidence-based programs that would work well in North Carolina, and to encourage the widespread adoption of those practices.

We recognize, however, that communities need some flexibility to address local populations and local needs. In these instances, it may be appropriate to implement best practices— practices with some evidence of effectiveness or practices that have been modeled after other evidence-based programs—but that have not yet risen to the level of evidence-based.

The Suicide Prevention Resource Center (SPRC) is the only federally supported national resource center that focuses on suicide prevention. SPRC provides training, technical assistance, and other information for health, social services, and educational professionals, and works with state and local suicide prevention organizations. SPRC has identified three levels of best practices.[6] The first level of evidence (Level I) is NREPP's evidence-based programs, described previously. The second level is Expert/Consensus Statements. To be listed as a best practice under Level II, a group of three expert reviewers must review the protocol to determine if it meets the specified level of importance, likelihood of meeting objectives, accuracy, safety, congruence with prevailing knowledge, and appropriateness in the development process. Level II programs include different suicide screening, assessment, and treatment protocols, and education and training materials. It does not have the same proven track record of efficacy but meets accuracy, safety, and program design standards. The third level is called Adherence to Standards. This includes awareness and outreach materials, educational and training programs, screening tools, and other protocols or policies which are designed to reduce the risk of suicide. To be included in the Level III listings, three experts must have reviewed the materials to examine the accuracy of the content, likelihood of meeting objectives, and the programmatic and messaging guidelines. (All of the programs identified by NREPP as evidence-based or by SPRC as best practices are described in brief and referenced in Appendix C.)

The evidence is always evolving. Thus, the state's plan should charge the North Carolina Practice Improvement Collaborative to regularly monitor existing research evidence to ensure that we know what works, place priority on investing public dollars to implement evidence-based or other best practices, and require ongoing evaluation to ensure that the strategies we are investing in are achieving the desired outcomes.

With limited public funding, we want to ensure that we use our funding wisely, and invest in programs, interventions and strategies that work.

Today, different governmental and private organizations and agencies in the state offer a patchwork quilt of suicide prevention and intervention services, but this quilt has many holes. Some services are targeted to specific populations, while others are more broadly available. People who are in the midst of a crisis do not always know where to turn to obtain the services that are available. Further, even when services are available, they are not always well coordinated, and treatment professionals do not always communicate suicide risk or ideation to other professionals. Some providers employ evidence-based or other best practices, while others do not. The system does not always ensure appropriate transitional care, as people move from one provider to another. Further, we lack a statewide plan—or vision—for how to effectively use existing state and local resources to ensure that we effectively target this critical public health issue.

This plan focuses on the role that the state Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS), Division of Medical Assistance (DMA), Local Management Entities/Managed Care Organizations (LME/MCOs), and their contracted providers can play to help reduce the number of people who contemplate, attempt, or die by suicide. As noted in Chapter 2, 63% of the females, and 36.7% of the males who died by suicide in North Carolina (2004-2008) were in current treatment for a mental illness at the time of their death.[7] While 42.9% of all North Carolinians who died by suicide were in current treatment during that time period, and 47.5% had indications of current mental health illness (66.8% females, 41.6% males), this is likely to be an underreporting of all the extent of mental health or substance use disorders among people who die by suicide. The National Institute of Mental Health suggests that approximately 90% of suicides are associated with some form of mental illness.[8] Thus, focusing on the state and local mental health system is critical. Yet effectively reducing the number of suicide attempts and deaths will require new and strengthened partnerships across agencies. Ultimately we need to create a statewide plan that includes all the state and community partners involved in suicide prevention, early intervention, crisis services, treatment, recovery supports, and postvention services.

Recommendation 1: Create a Statewide Suicide Prevention and Intervention Plan

The North Carolina Department of Health and Human Services should convene a broader task force to develop a statewide plan for suicide prevention, early intervention, crisis services, treatment, recovery supports, and postvention services. The group should include, but not be limited to, representatives from: the North Carolina Division of Medical Assistance, North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, North Carolina Division of Public Health, North Carolina Division of Social Services, North Carolina Division of Aging and Adult Services, North Carolina Division of Health Service Regulation, North Carolina Department of Public Instruction, North Carolina Community

College System, University of North Carolina System, North Carolina Department of Juvenile Justice and Delinquency Prevention, North Carolina Department of Public Safety, Local Management Entities/Managed Care Organizations, law enforcement agencies, jails, crisis intervention teams, mobile crisis teams, survivor support groups, North Carolina National Guard, North Carolina Division of Veterans Affairs, United States Department of Defense, North Carolina Hospital Association, North Carolina Medical Society, North Carolina Academy of Family Physicians, employee assistance programs, and the faith communities.

This chapter highlights the key elements of a state Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS), Division of Medical Assistance (DMA), and Local Management Entity/Managed Care Organization (LME/MCO) statewide suicide prevention and intervention plan ("state and local mental health suicide prevention and intervention plan"). It is divided into six sections: prevention, early intervention, crisis services, treatment, recovery supports for people with suicidal ideation or who have survived a suicide attempt, and postvention services for the people touched by the suicide death of another person. Each section describes the vision for programs and services that should be available throughout the state. It also includes examples of nationally recognized evidence-based or other best practices. A more complete description of these strategies is included in Appendix C. In addition, the sections include a description of existing services and gaps, and recommendations for how to improve the state and local mental health suicide prevention and intervention system. Most of these recommendations can be implemented with little additional funding, by focusing on what works and adopting these evidence-based or best practices across the current state and local mental health, developmental disabilities, and substance abuse services systems.

This plan comes at a critical juncture as North Carolina transitions its publicly funded MH/DD/SA system from a loosely organized, fee-for-service system to a more tightly coordinated managed care system. While the transition creates challenges, it also offers new opportunities. LME/MCOs will be responsible for managing dollars from Medicaid, and from state and federal block grants for mental health, substance abuse, and developmental disabilities. LME/MCOs will receive a per member per month (PMPM) payment to manage all the mental health, substance abuse, and developmental disabilities services and supports for the Medicaid recipients in their service area. LME/MCOs also receive an allocation of state and federal block grant funds to help provide services to people who are not eligible for Medicaid, and receive varying levels of local support. This provides LME/MCOs with the flexibility to invest more of their money on prevention, early intervention, and effective outpatient treatment—especially if these services can help reduce more costly interventions or hospitalizations.

> **This plan comes at a critical juncture as North Carolina transitions its publicly funded MH/DD/SA system from a loosely organized, fee-for-service system to a more tightly controlled managed care system.**

The Division of Medical Assistance (DMA) is holding the new LME/MCO entities to higher standards and has built in certain expectations into the MCO contracts. These enhanced performance requirements include community engagement (i.e. engaging community partners), building an adequate network of qualified providers to meet the MH/DD/SA needs of people in their service area, and quality management responsibilities to ensure that high quality services are being delivered. These new standards can also be used to support the development of a more effective suicide prevention and intervention system at the local level.[9]

This suicide prevention and intervention plan cannot be implemented immediately. As a first step, the state and local LME/MCOs must identify one or more staff members who will coordinate suicide prevention and intervention services. These staff must work together at the state and local levels to identify high needs populations, existing resources, and gaps in prevention, early intervention, crisis services, treatment, recovery supports, and postvention services for their respective areas in coordination with the state.

Ultimately, the state and local LME/MCOs should develop suicide risk management protocols for use by the state, within LME/MCOs, and with contracted behavioral health providers. The suicide risk management plan should include, but not be limited to:

- An outreach and education plan to educate the public and gatekeepers about suicide and how to identify people at risk and refer them to appropriate services.

- An evidence-based screening tool to determine level of suicide risk.

- Requirements for when and how often people should be screened for suicide risk and the criteria that would trigger a more comprehensive suicide risk assessment.

- Identification of an evidence-based suicide risk assessment that must be used, or requirements for the information that should be gathered as part of a more comprehensive suicide assessment tool.

- The protocol to ensure people are linked to appropriate crisis services.

- Requirements for what should be included in a person's crisis safety plan.

- Care management protocols to ensure that people successfully transition from one level of care or one behavioral health provider to another.

- Mechanisms to ensure that people at high risk of suicide are linked to professionals who can offer appropriate evidence-based treatment.

- Information about the types of recovery supports (including natural and peer supports) that should be available once the immediate crisis has been successfully resolved.

The state and local LME/MCOs should develop suicide risk protocols for use by the state, within LME/MCOs, and with contracted behavioral health providers.

- Mechanisms to identify people who were touched by suicide death, to offer appropriate postvention services.

The suicide risk management plan should also ensure that clinical and nonclinical staff receive appropriate training to recognize people who are at higher risk of suicide, and that behavioral health professionals receive the training needed to provide evidence-based treatment.

The state and local suicide prevention and intervention coordinators should work together to develop an implementation timeline using this plan as a blueprint, and should monitor progress in implementing the plan on an annual basis.

Recommendation 2: Build Suicide Prevention and Intervention Capacity at the State and Local Mental Health, Developmental Disabilities, and Substance Abuse System

a) **The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) should identify one or more staff to serve as the state-designated suicide prevention and intervention expert(s), and should require each Local Management Entity/Managed Care Organization (LME/MCO) to have a suicide prevention and intervention coordinator.**

b) **Each LME/MCO should designate one or more suicide prevention and intervention coordinators. The state and local designated suicide prevention and intervention coordinators should work together to develop a more detailed implementation plan including timelines for when different parts of the plan should be accomplished, using this state suicide prevention and intervention plan as its blueprint. As part of this plan, the state and local suicide prevention and intervention coordinators should identify high needs populations, existing resources and gaps in prevention, early intervention, crisis services, treatment, recovery supports, and postvention services. The state and local suicide prevention and intervention coordinators should monitor progress in implementing the plan on an annual basis and should include a summary of the progress (or lack thereof) in the DMH/DD/SAS's annual report to the Substance Abuse and Mental Health Services Administration.**

c) **The local LME/MCO staff should also ensure that the agency examines the need for suicide-related services in its needs assessment, offers gatekeeper training to appropriate community partners (including but not limited to schools and law enforcement), and builds appropriate training and performance measures into provider contracts.**

d) **Suicide prevention and intervention coordinators at the state and LME/ MCOs should work together to identify evidence-based or best practice screening and assessment tools, training for first responders and other crisis service providers, treatment and recovery supports, and bring this information to the North Carolina Practice Improvement Collaborative (NC PIC) for review and recommendations for adoption in North Carolina. Once reviewed, the state and local suicide prevention and intervention coordinators should work within their respective agencies to help implement the recommended evidence-based or best practices within their respective agencies, and by contracted behavioral health providers.**

Examples of Level I (NREPP) evidence-based prevention programs

- **Signs of Suicide (ages 13-17).** Two-day secondary school intervention program targeted at adolescent students (ages 13-17), screens for depression and suicide risk, and teaches appropriate responses.

- **Reconnecting Youth (ages 14-19).** School-based prevention program targeted at students ages 14-19 years with behavioral problems such as suicidal ideation, depression, substance abuse, and aggression, teaches students how to cope with early signs of emotional distress and substance abuse.

Examples of Level III best practices gatekeeper training programs

- **Applied Suicide Intervention Skills Training (ASIST).** Two-day training program for members of all caregiving groups teaches the participants how to help a person at risk for suicide stay safe and seek additional help when needed.

- **Question, Persuade, Refer (QPR).** Training for school personnel, law enforcement, crisis responders, or mental health professionals. This training improves the participants' ability to recognize and respond appropriately to someone exhibiting warning signs or risk factors for suicide.

Prevention

Vision

Prevention is a crucial starting point when devising a system of care or continuum of services to address a particular health issue or set of issues. Prevention activities are a core component of any public health effort to reduce the incidence of preventable diseases and disabilities and to improve overall health and well-being. Although prevention may immediately bring to mind efforts targeting well known chronic diseases (e.g. cancer and heart disease), prevention is not a tool unique to a specific disease or condition. Prevention is preferable to treatment because it provides an opportunity to intervene before an adverse event occurs.[10] Therefore, reducing suicide risk should begin with prevention.

North Carolina state and local partners will engage in a broad-based suicide prevention campaign that includes strategies to reach universal, selective, and indicated populations. *Universal prevention strategies* are targeted at the general public or subsets of the public. Universal prevention strategies help reduce the stigma associated with suicidal ideation and can help people know where they can turn for help. *Selective strategies* focus on those at greater risk, including those with biopsychosocial risk factors (e.g. mental health disorders, alcohol or other substance abuse disorders, history of trauma or abuse, family history of suicide), environmental risk factors (e.g. job loss, recent death in the family, local cluster of suicides), and sociocultural risk factors (e.g. sense of isolation, lack of social supports). Selective strategies include those focused on training individuals who are likely to interact with people at risk (i.e. "gatekeepers") to identify early warning signs and help link people who are at risk into appropriate services. *Indicated strategies* are targeted to those who are at most immediate risk, and who have indicated

suicidal ideation. Some of the early warning signs include people who are talking or writing about death and dying or looking for ways to kill themselves, or those who have been withdrawing from friends and family or society, or expressed feelings of hopelessness. Indicated strategies include screening, early identification, and crisis services to prevent people from attempting suicide.

To ensure maximum effectiveness, the state and LME/MCOs will invest their prevention dollars in strategies that have been shown to be effective (evidence-based), or evidence-informed (best practices).

Existing Resources

The current mental health and substance abuse service system managed by DMH/DD/SAS supports prevention activities that include strategies to address suicide prevention. The strategies implemented are coordinated with other statewide partners. A recent report from the Division of Public Health (DPH) has provided data to identify groups who are experiencing the majority of problems related to suicide, thus providing baseline for universal, selective, and indicated prevention activities. In collaboration, DPH, the Department of Public Instruction, and DMH/DD/SAS have implemented training for professionals, specifically focused on school personnel to identify youth at risk, and other trainings for those in health, mental health, and law enforcement agencies. DPH and DMH/DD/SAS have also created a media campaign called It's Okay to Ask About Suicide with pertinent partners involved in promoting the message.[11]

Gaps

Currently there are no requirements that LMEs invest in suicide prevention. However, with the move to managed care organizations, LME/MCOs must "support community-wide efforts" in education and prevention of suicide as part of their contract with DMA.[9]

Recommendation 3: Support greater investment in suicide prevention and education at the state and local level

a) State level.

1) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) should require that all Local Management Entities (LMEs) use some of their federal and state funding to support suicide prevention and broad-based education. The state should identify a minimum threshold and identify existing funding sources which can be used to support prevention, such as the Substance Abuse Prevention and Treatment Block Grant and Community Mental Health Services Block Grant funds.

2) **DMH/DD/SAS and the Division of Medical Assistance (DMA) should require that LME Managed Care Organizations (LME/MCOs) invest in prevention activities as a means of reducing unnecessary use of emergency departments. As part of the community engagement part of the MCO contract, funding should be used to educate enrollees and gatekeepers, including but not limited to: school personnel, employers and supervisors, faith-based and community leaders, emergency health care personnel, employment security personnel, and personnel and volunteers in programs serving older adults.**

3) **DMH/DD/SAS and DMA should work with the DMH/DD/SAS North Carolina Practice Improvement Collaborative (NC PIC) to identify existing prevention programs that are evidence-based or other best practices. DMH/DD/SAS should ensure that training and technical assistance is available to the LME/MCOs and contracting provider organizations at a reasonable cost to ensure that the programs can be implemented with fidelity. In addition to identifying existing evidence-based or evidence-informed training and technical assistance programs, DMH/DD/SAS, DMA, and the NC PIC should identify the key elements/components that are consistent with these evidence-based prevention programs and allow organizations to be certified to provide training and technical assistance using these key components.**

b) **Local level.**

1) **As part of their MCO community relations, network, and quality management responsibilities, the LME/MCO should:**

    i) **Select one of the designated evidence-based or evidence-informed prevention strategies, or approved elements and implement it in their local community directly and through contracted providers.**

    ii) **Educate community partners, including but not limited to schools, law enforcement, juvenile justice, social services, and faith based organizations, about suicide and suicide risks, and engage the partners in implementing prevention strategies that are evidence-based or recognized as best practices.**

    iii) **Provide information on their websites about suicide prevention and crisis services in the community.**

Early Intervention

Vision

One of the best ways to help reduce the risk of suicide is to identify people who are at high risk, and help link them into appropriate services. Engaging in early intervention activities can lead to more favorable outcomes and can help to minimize the need for more intensive treatment. Screenings are often used to detect potential diseases or conditions before obvious signs and symptoms appear. Detecting a disease or condition at an early stage or identifying individuals at high risk is critical to providing high quality care and linking patients to effective interventions.[12]

As described later, there are a number of evidence-based and evidence-informed treatment programs that have been shown to reduce suicidal ideation, feelings of hopelessness, and/or address underlying mental health and substance abuse issues. Screening high-risk individuals—including people who fall into high-risk categories and those who have expressed suicidal ideation or attempted suicide in the past—is an effective strategy to identify people at high risk. People who are identified as high risk should receive a more thorough suicide risk assessment that captures information about their risk and protective factors, history of past attempts, current suicidal thoughts, and information about their suicide plans and capabilities.

Individuals who seek services through the LME/MCO should be screened for suicidal ideation using state-approved screening tools as part of the standard screening, triage, and referral process (STR). Individuals should receive the screening, using approved screening tools (or approved screening questions), whether the person first enters the system through the LME/MCO or through a contracting behavioral health provider. Further, these individuals should be screened on a periodic basis, following a state-approved periodicity schedule. To reduce the administrative burden on LME/MCOs, contracting providers, and primary care professionals, the initial screening tool does not have to be a comprehensive clinical risk assessment. Rather it can be a shorter screening tool to help identify the person's underlying needs and level of risk.

The Task Force was unaware of any studies that specifically examined the impact of talking to at-risk individuals about their suicidal ideation. However, there is research that shows that providing treatment to at-risk individuals leads to reduction in suicidal behavior and ideation.[13] It is important to screen individuals in order to identify risk factors, so that those at high risk can be linked to treatment. If the person indicates major depression, suicidal ideation, or other risk factors for suicide, they should receive a more complete risk assessment to determine the level of suicidal ideation and any immediate plans to attempt suicide. In addition,

> **One of the best ways to help reduce the risk of suicide is to identify people who are at high risk, and help link them into appropriate services.**

Example of a Level I (NREPP) evidence-based screening tool

- **Columbia University TeenScreen.** Early intervention screening in schools, clinics, doctors' offices, juvenile justice settings, shelters, or any other youth-serving setting for middle school and high school aged students at risk of suicide and mental illness.

Example of a Level II or III best practices screening tool

- **Question, Persuade, Refer, and Treat (QPR-T).** Guided clinical protocol for assessing suicide risk. Integrates a collaborative crisis management, monitoring, and safety plan.

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the assessment should also capture information about protective factors (or strengths) that can be fostered to help reduce the risk of suicide. This screening and assessment process limits more comprehensive clinical risk assessments for individuals at highest risk.

Each LME/MCO has a standard protocol for how it, and its contracted behavioral health providers, manage suicide risk. The suicide management protocol should have requirements for staff training to ensure that clinical and nonclinical crisis staff understand how to identify people at risk of suicide. The protocol should include information about how often and when individuals should be assessed for suicidal ideation and intent. For example, the standard protocol could require each contracting provider to complete a short screening tool upon intake, with a more comprehensive suicide assessment if the person scores high enough on risk factors (such as feelings of hopelessness, depression, or co-occurring mental illness and substance use disorder). Individuals with a past history of suicidal ideation or suicide attempts should also be assessed at different points of care (for example, after discharge from a hospital, move to a new therapist, or any other time when the person reports suicidal ideation). (A copy of a sample suicide management plan is included in Appendix E).

Many of the people who have contemplated, attempted, or died by suicide never sought mental health treatment. North Carolina data showed that 18.7% of females over the age of 10, and 20.3% of men had a physical health problem at the time of suicide death (2004-2008).[7] Research shows that approximately 45% of people who died by suicide had contact with a primary care professional within one month of the suicide, and approximately 25-75% had visited their primary care provider within 30-60 days of their death.[14]

In North Carolina, 20% of individuals age 10 or older who died by suicide (2004-2009) had a physical health problem.[7] This is even higher for those age 65 or older who died by suicide (57% who had a physical health problem). The US Preventive Services Task Force recommends that primary care practices routinely screen adolescents (12-18) for major depressive disorders and adults for depression, assuming that there are systems in place to ensure accurate diagnosis, treatment, and follow-up. Primary care providers should routinely screen individuals using a similar brief screening tool, and then follow-up with a more comprehensive suicide assessment tool that captures both the person's suicide risk as well as protective factors.

The suicide management protocol should have requirements for staff training to ensure that clinical and nonclinical crisis staff understand how to identify people at risk of suicide.

Existing Resources
All LME/MCOs must provide 24/7 screening, triage, and referral (STR) either in person or by telephone 24 hours a day, 7 days a week. LME/MCOs are required to ask standardized questions about suicidal ideation as part of the STR intake process. Additionally, the incident reporting system set up by DMH/DD/SAS requires LMEs to respond accordingly to the severity level of suicidal ideation or behavior.[15] Contracted providers who are often the first point of entry into the DMH/DD/SAS system are also required to do STR at initial intake.

While the state does require the use of a standardized STR tool as part of the intake process, the state has not identified a more comprehensive, evidence-based assessment instrument that LME/MCOs should use if the person indicates suicidal ideation or feelings of hopelessness, depression, or substance use (high risks for suicide). However, DMA and DMH/DD/SAS requires LME/MCOs to use a standardized level of care instrument as part of its utilization review function to determine the person's needed level of services. LME/MCOs, and contracted providers, must submit information using the Level of Care Utilization System (LOCUS) for adults[16] or the Child and Adolescent Level of Care Utilization System (CALOCUS)[16] to receive authorization for services. The LOCUS tool captures data on six dimensions, including risk of harm; functional status; medical, addictive, and psychiatric co-morbidity; recovery environment; treatment and recovery history; and engagement and recovery status. The questions in the risk of harm section consider the person's present and past suicidal thoughts, history of chronic impulsive suicidal behaviors or threats, whether the person has an immediate plan with the ability to carry out the suicidal behavior, whether the person is under the influence of alcohol or other drugs, and any changes from past behavior. The tool is intended to help clinicians identify needed services, including crisis services, clinical treatment, support services, and environmental interventions. The CALOCUS is similar in that it is intended to help identify level of service needs for children and adolescents. It is also based on six dimensions, including risk of harm; functional status; co-morbidity; recovery environment; resiliency and treatment history; and treatment acceptance and engagement. The CALOCUS also looks at the strengths and weaknesses of the parent/caregiver environment.

Community Care of North Carolina (CCNC), North Carolina's Medicaid patient-centered medical home, encourages all primary care providers to use either the Patient Health Questionnaire 2- or 9-question screening tool (PHQ-2 or PHQ-9) to screen Medicaid recipients in the primary care setting for depression. In addition, CCNC Medicaid care managers are required to administer the PHQ-2 at least once annually. (See Appendix D for a list of PHQ-2 and PHQ-9 questions.) If the person achieves a high enough score on the screening tool, he or she should then be evaluated for major depression. It is at this second step that primary care practitioners should also be asking questions about suicidal ideation. CCNC encourages care managers to use a standardized suicide assessment questionnaire. The CCNC Case Management Information System (CMIS) suicide assessment form asks people if they have ever attempted to harm themselves, whether the person had a plan to harm themselves, and whether the person thinks they may actually attempt to hurt themselves in the near future. (See Appendix D for the Suicide Assessment questionnaires).

In addition, some primary care practices have embedded behavioral health specialists who can provide mental health or substance abuse services directly in the primary care office. Expanding the array of integrated behavioral health

Expanding the array of integrated behavioral health and primary care practices can be an effective strategy to identify and provide early intervention services to people with suicide ideation who seek primary care services, but who might not otherwise seek mental health or substance abuse services.

and primary care practices can be an effective strategy to identify and provide early intervention services to people with suicidal ideation who seek primary care services but who might not otherwise seek mental health or substance abuse services.

Gaps

While LME/MCOs are required to ask standardized questions about suicide as part of the initial intake (STR), LME/MCO staff do not receive training to understand the warning signs for suicide, suicide risk, or protective factors. The state has not identified a standardized evidence-based care assessment instrument that the LME/MCO staff or contracted behavioral health providers should use if the person is determined to either have suicidal ideation or be at high risk for suicide. Further, there is no guidance on how often or when individuals should be screened for suicidal ideation.

DMA and DMH/DD/SAS are requiring LME/MCOs and contracted providers to use the LOCUS and CALOCUS tools to seek authorization for services. This requirement is new. LME/MCOs and contracting providers need training to ensure that staff and clinicians understand how to use these tools appropriately. In addition, it is possible that these tools may also be able to serve as care assessment instruments. The NC PIC should evaluate the information collected as part of the level of care determination to determine if the LOCUS and CALOCUS includes all the information needed to develop an individualized suicide risk prevention, crisis services, treatment and recovery plan.

> **There is currently no system of accountability to ensure that LME/MCOs, primary care practitioners, or care managers ask about suicide ideation in the event that depression is identified.**

While many primary care practices and care managers are beginning to implement the PHQ-2 depression screening tool, this is not a universal practice. Further, there is no guarantee that primary care practitioners or care managers will ask about suicidal ideation even if a person reports hopelessness or signs of major depression. Primary care practitioners and care managers do not always understand the warning signs for suicidal thinking, and may not know what to do if they find out a person is actively thinking about suicide. Further, CCNC does not specifically monitor primary care practices or care managers to determine adherence to the recommended depression screening or follow-up questions about suicidal ideation. In short, there is currently no system of accountability to ensure that the LME/MCOs, primary care practitioners, or care managers ask about suicidal ideation in the event that depression is identified.

While the move to create LME/MCOs offers the potential for improved behavioral health services, with greater emphasis on prevention, early intervention, higher quality, and adherence to evidence-based treatment, the transition and new credentialing standards are causing difficulty for some of the embedded behavioral health providers in primary care practices. Thus, there is some concern that the progress North Carolina has made in developing integrated primary care and behavioral health practices may be lost.

Recommendation 4: Implement Evidence-Based Screening and Suicide Assessment Instruments to Identify People at High Risk of Suicide

a) State level.

1) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS), Division of Medical Assistance (DMA), Community Care of North Carolina (CCNC), and the North Carolina Practice Improvement Collaborative (NC PIC) should work together to examine existing screening and risk assessment tools and the research literature to:

   i) Select an evidence-based or best practice suicide brief screening tool(s) and follow-up suicide risk assessment tool(s) that can be used by LME/MCOs and contracting providers. As part of this analysis, DMH/DD/SAS, DMA, CCNC and the NC PIC should examine the LOCUS and CALOCUS to determine if these level of care instruments used for utilization review could also serve as a standardized care assessment tool.

   ii) Develop a model suicide risk management protocol which includes the frequency and under what conditions the screening and risk assessment tools should be administered. At a minimum, the LME/MCO should administer a screening tool as part of the initial STR intake, and contracted providers should screen as part of the initial intake. Individuals at high risk, including those who have attempted suicide, and those who are leaving state institutions, hospitals, crisis services, jails, or prisons should be screened by a community provider as part of the transition of care protocol.

2) DMH/DD/SAS and DMA should require that the Local Management Entity/Managed Care Organization (LME/MCO) and contracted community providers use one of the approved screening tools at intake, followed by a more comprehensive suicide risk assessment tool (when appropriate), and then follow the recommended periodicity schedule thereafter.

3) DMH/DD/SAS and DMA should require that staff at the LME/MCOs and contracted providers receive training from state approved vendors on how to identify people who are at risk, including an understanding of the evidence-based screening and assessment process, and the appropriate use of the LOCUS and CALOCUS level of care authorization tools.

4) DMH/DD/SAS and DMA should encourage LME/MCOs to support integrated behavioral health and primary care practices.

b) Local level.

1) LME/MCOs must develop a comprehensive suicide risk management protocol that includes guidelines for screening and suicide risk assessment by the LME/MCO and contracted behavioral health providers. At a minimum, the LME/MCO must use an approved screening tool during the STR intake. If the person is identified as having suicidal ideation or at high risk, then the LME/MCO must administer a state-approved suicide risk assessment to determine suicide risk and protective factors.

2) LME/MCOs should require community behavioral health providers to use a similar state approved screening and assessment process. The requirement should be built into provider contracts, and monitored as part of the quality management system.

3) CCNC primary care practices should routinely screen adolescents and adults for depression using the PHQ-2 or another approved screening tool. If the person tests positive for depression or substance abuse, then the primary care professional and/or care manager should administer a more detailed risk assessment tool that asks specifically about suicidal ideation. Individuals who are identified as high risk for suicide should be immediately linked to the LME/MCO so that the person can get appropriate treatment services.

4) LME/MCOs should encourage the development and provide support for integrated primary care and behavioral health practices. The LME/MCOs should ensure that the clinicians in these practices have been trained to recognize suicide risk, administer evidence-based screening and suicide assessment tools, and be able to offer evidence-based treatment or ensure that individuals at high risk of suicide are referred into and receive appropriate evidence-based treatment.

Crisis Services

Vision

Effective and timely crisis services are critical if the state is serious about reducing suicide attempts or suicide deaths. Crisis services include a well-publicized and adequately staffed suicide hotline, first responders who have been trained in crisis de-escalation skills, and recognizing and addressing suicide risk. A comprehensive array of crisis services would also include mobile crisis teams, walk-in and residential crisis services, and trained emergency departments.

People who are actively planning a suicide or who have attempted suicide need access to well-trained crisis staff throughout the state, and these services must be available 24 hours a day, 7 days a week. These crisis providers must either link individuals in crisis to trained mental health and substance abuse professionals who can offer evidence-based treatment services to help address the underlying problems, or be able to provide these services directly.

The state and local LME/MCOs should include requirements for crisis services in their suicide risk management plans. For example, the suicide risk management plan should identify the elements required in a crisis plan (including when the plan should be developed and updated), and appropriate evidence-based treatment for people who are at risk of suicide. A standard suicide management protocol should include requirements for care transitions, to ensure that the person successfully moves from one behavioral health setting to another (for example, when a person transitions out of an involuntary commitment setting to a community provider), and should have criteria for the information that should be shared among treating professionals (including information about the person's suicidal ideation or past suicide attempts). Suicide management plans should also include protocols for follow-up of high-risk individuals, including procedures to follow when the clinician is concerned about the individual's safety.

Existing Resources
There is a broad array of crisis services available in different parts of the state. Some services, such as the suicide hotline, are available throughout the state. Other services are dependent on geographic location. For example:

> *The suicide risk management plan should identify the elements required in a crisis plan and appropriate evidence-based treatment for people at risk of suicide.*

- *Suicide and Crisis Hotline:* REAL Crisis Intervention operates a statewide crisis and suicide hotline that is available to people 24 hours a day, 7 days a week (1.800.273.8255). The REAL crisis hotline is part of a national suicide prevention hotline. Individuals who call the 1.800 national suicide hotline with a North Carolina phone number are routed to the Real Crisis Intervention telephone hotline. The hotline is accredited through the American Association of Suicidology, and all telephone counselors receive more than 60 hours of training before they can answer the phone. The REAL Crisis hotline averages 2,700 calls per month, and has a 99% answer rate (if the phone rings more than three times in one call, it is automatically transferred to another state suicide hotline). The hotline uses the Applied Suicide Intervention Skills Training (ASIST) screening tool. If someone is identified as having thoughts of suicide, the hotline staff help link the person to immediate crisis services, and will call back on an as-needed basis (i.e. it could be hourly or daily) until the crisis is resolved.

- *Crisis Intervention Teams (CIT):* CIT is a voluntary training and certification program that is available to law enforcement officers to help improve the capacity of these personnel to address the needs of

people with mental illness. Approximately one in 10 police calls involve a person with a mental illness,[17] and many of these have expressed suicidal thoughts or attempted suicide. CIT training includes 40 hours of training, approximately 3 of which focus on suicide. It is available free of charge to law enforcement personnel, and is provided through a partnership between the LMEs, law enforcement agencies, mental health advocacy organizations, and community colleges. However, there is no requirement that every law enforcement agency has certified staff. As of February 2011, about 18% of the state's law enforcement personnel (more than 4,000 people) were CIT certified.[18] North Carolina does not need to train all first responders to adequately cover the state with CIT certified personnel. Ensuring adequate coverage varies depending on the number of staff in each agency. Ideally, every law enforcement agency would have sufficient numbers of trained and certified personnel to respond 24/7 to mental health crisis calls.

> **Approximately one in 10 police calls involve a person with a mental illness, and many of these have expressed suicidal thoughts or attempted suicide.**

■ *Mobile crisis:* LME/MCOs currently help fund approximately 50 mobile crisis teams that cover the state.[19] Mobile crisis teams must respond to requests for services within two hours of the request, and services must be available on a 24 hours a day, 7 days a week basis. These teams were created to serve individuals where they need services in the least restrictive setting appropriate to their needs, and to help reduce the need for hospitalization. Mobile crisis teams can be called into a variety of settings to address crises, including homes, adult care homes, schools, and hospital emergency departments. They can also be called to accompany CIT teams as part of a first response system. Mobile crisis teams can continue to provide case management services to the individual for 24 hours post crisis. Mobile crisis teams will work with any individual who has a mental health or substance abuse crisis—not just those with suicidal ideation—but many of the people they serve have expressed suicidal thoughts or attempted suicide. Teams must have a licensed clinical social worker (LCSW), registered nurse, or psychologist that serves as the team leader, at least one trained substance abuse professional, and access to a psychiatrist 24/7. However, the availability of services and staff qualifications vary widely throughout the state. Mobile crisis teams that cover rural areas often have greater distances to cover, and some have difficulty attracting qualified personnel. Further, there is a high turnover among mobile crisis staff because of the low pay, work hours, and safety concerns. While mobile crisis team members all receive training, there is no standardized training across the state. Neither DMH/DD/SAS nor DMA stipulate what screening, assessment, or care planning tools are used. Because of credentialing requirements, some mobile crisis teams have been unable to work out agreements to provide services in hospital emergency departments. Mobile crisis teams have had similar problems developing agreements with some college campuses.

■ *North Carolina Systemic, Therapeutic, Assessment, Respite, and Treatment Program (NC START):* DMH/DD/SAS has provided support to create three regional NC START programs.[20] Each region operates three crisis teams and one respite home. NC START provides support to other crisis teams (including mobile crisis or first responders), specifically to address the needs of adults with intellectual and developmental disabilities (many of whom have co-occurring mental health problems). NC START also provides assistance to help de-escalate crisis situations.

■ *Walk-in Crisis Centers:* Currently there are more than 70 walk-in crisis centers across the state.[21] Unlike inpatient or facility-based services, these centers are not licensed. They were created to serve as an alternative to inpatient hospitalization for individuals who could appropriately be served in another setting and who need less than 24 hours of supervised care. These centers vary widely in their capacity to address crises on a 24/7 basis. North Carolina needs sufficient walk-in crisis providers, geographically disbursed through the state, with appropriate staffing to serve as an alternative to hospitalization for those who do not have a medical emergency and do not require hospitalization.

There is a broad array of crisis services available in different parts of the state.

■ *Emergency shelters and respite for youth:* These services exist in some communities across the state. Most exist when needs have been identified and community partners, through cooperative agreements among county, provider, and nonprofit child-serving entities, provide emergency respite and shelter for youth. These services are not intended to serve youth who are experiencing suicidal ideation, and staff are not likely to be well trained to intervene with suicidal ideation, though they would be trained to access inpatient treatment for youth who present with risk of harm to themselves or others.

■ *Therapeutic Respite Addressing Crisis for Kids (TRACK) respite program for youth with intellectual and developmental disabilities:* TRACK is a statewide, 5-6 bed program that serves children ages 5-17 with intellectual and developmental disabilities who are in behavioral crisis. The purpose of the program is to divert children from psychiatric hospitalization and avoid extended stays in hospital emergency rooms. The focus of the program is to stabilize a child's behavior so that they may return to their home as quickly as possible. TRACK does not accept involuntary commitments, so every effort must be made in the community to avoid the commitment process when a child is going to TRACK.

■ *Facility-Based Crisis Centers:* There are currently 23 licensed facility-based crisis centers (FBCCs) for adults located across the state.[22] Facility-based crisis centers offer mental health and detoxification services. There is variability in the capacity of these FBCCs, including business hours when services are provided, involuntary commitment (IVC) process, qualifications of the staff, staff to patient ratios, availability of services

such as medical evaluation and/or medical clearance, and walk-in policies.[23]

- *Inpatient Substance Abuse Treatment:* The state currently operates three alcohol and drug abuse treatment centers (ADATC). Julian F. Keith ADATC[24], R.J. Blackley ADATC[25], and Walter B. Jones ADATC[26] are the three centers serving the Western, Central, and Eastern region of North Carolina, respectively. The ADATCs provide inpatient substance abuse treatment for individuals with substance abuse and co-occurring psychiatric diagnoses and admit individuals on involuntary commitment. They provide an array of services including medically monitored inpatient detoxification. Certain populations, including HIV/AIDS patients, communicable disease patients, intravenous drug users, and pregnant women, are given priority status admission to the ADATC.[27] The ADATCs admitted 4,416 individuals in 2011.[a] In addition to the three state run inpatient facilities, private organizations offer detoxification services, as do facility-based crisis services.

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Hospital emergency departments often serve as the primary source of crisis services for people who have attempted suicide or have a self-inflicted injury.

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- *Hospital emergency departments:* Hospital emergency departments often serve as the primary source of crisis services for people who have attempted suicide or have a self-inflicted injury. If the person has injured him or herself, the emergency medical service (EMS) professional or other first responders will transport the person to the emergency department for treatment. Individuals may also be brought to the hospital by a law enforcement officer within 24 hours of a magistrate's determination that there are reasonable grounds to believe the person is a threat to themselves or others. The hospital emergency physician can make this evaluation and may recommend that the patient be committed, involuntarily if necessary, to an inpatient behavioral facility. If the recommendation is for inpatient commitment, the individual will then be transported by the law enforcement officer or other designated person to a twenty-four hour facility such as a hospital, where a second examination will take place. Individuals who are under IVC orders are not discharged from the hospital until a treatment professional—usually the emergency physician and sometimes with consultation from a psychiatrist or other behavioral health professional, dissolves the commitment order. This decision is made through a determination that the person is no longer a threat to themselves or others and has an ongoing source of treatment.[b]

- *Inpatient psychiatric services:* The state currently operates three psychiatric hospitals Broughton Hospital (Morgantown), Central Regional Hospital (Butner) and Cherry Hospital (Goldsboro), and one forensic unit,

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a   Robinson S. Mental Health Program Manager/Planner, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, North Carolina Department of Health and Human Services. Written (email) communication. May 21, 2012.
b   Vicario M. North Carolina Hospital Association. Oral communication. June 5, 2012

Dorothea Dix Hospital (Raleigh) in North Carolina that provide services to individuals with severe psychiatric problems. State psychiatric hospitals served 5,754 people in 2011, drastically down from 17,160 people in 2001.[28] In order to expand the number of people who could be served in an inpatient setting, DMH/DD/SAS and some of the state's LMEs entered into three-way contracts with community hospitals to provide community-based psychiatric services. In SFY 2012, there are 21 contracted hospitals across the state, providing 121 psychiatric beds.[23] In addition, 42 medical-surgical hospitals are licensed to provide psychiatric beds.[29]

Gaps

While there are many types of crisis services offered throughout the state, gaps remain. Some providers are equipped to treat some of the underlying problems, but may not have the capacity to address co-occurring conditions (e.g. mental health illness in detoxification facilities, detox in mental health facilities). According to some of the Task Force members, access to the full range of crisis services is more limited in some rural counties than it is in larger urban counties. Some of these access barriers should be addressed in the move to the LME/MCO. As part of the new LME/MCO contract with the state, LME/MCOs are required to have a full service array based on an annual gaps analysis. A range of Medicaid reimburseable crisis services must be available within each LME/MCO catchment area, including inpatient services, facility based crisis services, and mobile crisis management. Services must be available within 30 miles or 30 minutes in urban areas, and 40 miles or 40 minutes in rural areas.[c][30]

Even when crisis services are available in a community, there is not always strong coordination across crisis providers. Hospital emergency departments end up serving as the crisis provider in many communities because of the lack of other appropriate crisis providers, the lack of coordination among existing crisis providers, and because people do not know where else to turn. However hospitals are not appropriate settings for many people, especially those who do not have a medical need but do have a need ongoing behavioral health treatment services. Individuals with behavioral health problems waited, on average, 10 hours in hospital emergency departments in 2010 before being transferred to a more appropriate behavioral health treatment setting.[29] Some are boarded in hospital emergency departments for a week or more. In order to prevent unnecessary hospitalizations, comprehensive and coordinated crisis services should be available throughout the state.

Further, while all crisis professionals must be trained to meet licensure or credentialing standards, there is no oversight over the suicide content in these trainings. There is no requirement that any of the crisis providers receive specific suicide training, let alone that the training be based on an evidence-based curricula. Further, there is not a specified protocol for transitioning people with suicidal ideation from crisis services to other community providers.

> **While there are many types of crisis services offered throughout the state, gaps remain.**

> **Even when crisis services are available in a community, there is not always strong coordination across crisis providers.**

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c   Crosbie K. Behavioral Health Manager, Division of Medical Assistance. Written (email) communication. May 29, 2012.

Recommendation 5: Assure a Comprehensive Array of Crisis Providers Who Are Trained to Identify and Treat People to Reduce Immediate Suicide Risk

a) **State level.**

1) **The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) should use a portion of state and federal funding to help pay for training and technical assistance to Local Management Entities/Managed Care Organizations (LME/MCOs) to help support the development of a coordinated system of crisis providers that have been trained in crisis de-escalation skills, identifying suicide risks, and providing treatment to stabilize the immediate suicide risk. Information about available crisis providers should be distributed widely to community partners, and should be maintained and easily accessible on the DMH/DD/SAS website.**

2) **DMH/DD/SAS and the Division of Medical Assistance (DMA) to provide technical support to LME/MCOs about best practices on crisis response systems that include mobile crisis, walk-in centers, and facility-based services.**

3) **DMH/DD/SAS, DMA, and the North Carolina Practice Improvement Collaborative (NC PIC) should identify evidence-based or evidence-informed suicide crisis training curricula (such as the QPR-T). Once identified, DMH/DD/SAS should certify training providers who can deliver the evidence-based curricula or content that includes the same core elements as the approved evidence-based training curricula, and require that all crisis response workers receive training in one of these approved curricula.**

4) **DMH/DD/SAS and DMA should evaluate these efforts to determine if the availability of well trained, coordinated, and comprehensive crisis providers leads to reduced suicide attempts, reduced suicide deaths, and reduced use of the emergency department.**

5) **DMH/DD/SAS, DMA, the NC PIC should identify evidence-based or best practices to ensure the availability of high quality crisis services. Once identified, DMH/DD/SAS and DMA should include these standards in the model suicide risk management protocol and require that LME/MCOs meet these new standards. These standards should include requirements for a comprehensive array of crisis services, hours of operation (for walk in and facility based), staffing, training, and other requirements.**

6) **DMH/DD/SAS, DMA, and CCNC should expand the definition of people with special health care needs who are eligible for care coordination to include individuals with mental health or substance use disorders who are discharged from institutions, hospitals, or crisis services. Care coordinators should assist these individuals with transitions to community providers. This expanded definition of special health care needs population should be built into the contract with the LME/MCO for care coordination services.**

7) **DMH/DD/SAS should work with DMA, Division of State Operated Facilities, the North Carolina Hospital Association, Division of Health Services Regulation, LME/MCOs, local emergency medical services (EMS), health professional associations, magistrates, and law enforcement to develop new standards for emergency medical services, involuntary commitment (IVC), and interception models. Emergency management should triage individuals to determine if the person expressing suicidal ideation or other emergency mental health needs has an immediate medical need. If the person does not have a concurrent medical need, the EMS personnel should transport individuals to appropriate crisis resources, if available in the community and properly staffed to provide crisis and IVC services.**

b) **Local level.**

1) **LME/MCOs should determine whether there are sufficient behavioral health crisis providers who are trained to address the needs of people who are actively contemplating, or have attempted suicide; and whether these providers are geographically accessible and available on a 24/7 basis to people throughout the service area.**

2) **LME/MCOs should contract for a full array of crisis services and require coordination of services across providers. LME/MCOs that contract with more than one crisis service provider should include performance measures to ensure coordination across crisis service providers.**

3) **LME/MCOs should include requirements to ensure that all crisis team members receive training using an evidence-informed suicide clinical training curriculum, as identified in Recommendation 4.a.3.**

4) **LME/MCOs should work with law enforcement agencies to develop a protocol to be alerted when someone in their catchment area attempts suicide, so that the LME/MCO can link the person with appropriate treatment and recovery supports.**

Treatment

Vision

People who have contemplated or attempted suicide need access to appropriate treatment services. Research has established that there are specific psychiatric illnesses that have been linked with a greater lifetime prevalence of suicide. Among these are major depressive, bipolar, schizophrenia, alcohol use, and borderline personality disorders. The lifetime risk of suicide for persons with any of these respective disorders ranges from 5-7%.[31,32] The risk of suicide increases if the person has co-occurring alcohol use disorder and psychiatric illness.[33,34] Logic would indicate that if effective services are available and accessible for persons impacted by these disorders, the risk of suicide among persons living with these disorders would be reduced. Further, high-risk individuals with co-occurring mental health and substance use disorders should be treated for both conditions.[30] Each LME/MCO should contract with behavioral health providers who have been trained and skilled in delivering evidence-based treatments that have been shown to reduce suicidal ideation, as well as the underlying mental health, substance abuse, or co-occurring issues that contribute to higher suicide risk. These behavioral health professionals need to be competent to both administer the evidence-based therapies, and also to understand how to apply these therapies to people with immediate suicide risk.

As part of the LME/MCO suicide risk management protocol, the LME/MCO should have a standard system to ensure that individuals who are at high-risk of suicide are linked to trained behavioral health professionals who can provide evidence-based treatment or best practice that is appropriate to the person's underlying behavioral health problem. Clinical staff should obtain more comprehensive training on evidence-based or best practices for suicide assessments and treatment.

The suicide risk management protocol should also include provisions to ensure effective transitions between treatment providers or levels of care (e.g. from crisis services to treatment). In order to ensure effective transitions, treatment providers must share information about the individual's strengths, risks, suicidal ideation, medications, and other treatment history. Because people who are at high risk of suicide are already operating in crisis mode, they often need help connecting to appropriate treatment or crisis professionals. Care coordination is needed to help these individuals transition from one level of care to another or from one health provider to another, and to ensure that there is follow-up.

Existing Resources

The NC PIC has identified practices that are effective for many high-risk disorders including cognitive behavioral therapy for major depressive disorder and other affective disorders, illness

> **There are specific psychiatric illnesses that have been linked with a greater lifetime prevalence of suicide.**

Examples of Level I (NREPP) evidence-based programs effective in reducing suicidal ideation

- **Seeking Safety (ages 13-55).** Provides coping skills and psychoeducation for clients with a history of trauma or substance abuse.

- **Trauma Focused Coping (multimodality trauma treatment) (ages 6-17).** Provides intervention through psychoeducation, anxiety management skill building, and cognitive coping to children and adolescents in grades 4-12 who have been exposed to a traumatic stressor.

management and recovery for bipolar disorder/schizophrenia, integrated dual disorder treatment for co-occurring mental health and substance use disorders, and dialectical behavior therapy, trauma focused therapy, and other cognitive therapy based approaches for borderline personality disorder. There are behavioral health professionals who have been trained in these evidence-based therapy methods. However neither the state nor the local LME/MCOs currently have a data system to know which professionals have been trained in these evidence-based treatment methods. There is no certification system or other mechanism to indicate whether practitioners have been trained in these treatment protocols. Nor is there any mechanism to know whether practitioners who are billing for these services are delivering the treatment protocol with fidelity.

> **Examples of Level I (NREPP) or other evidence-based programs effective in addressing underlying mental health or substance use disorders**
>
> ■ **Dialectical Behavior Therapy (DBT) for borderline personality disorders.** Cognitive-behavioral treatment that includes behavioral problem-solving and acceptance strategies with an emphasis on multiple disorders.
>
> ■ **Integrated Dual Disorder Treatment (IDDT) for co-occurring mental health and substance use disorders.** The North Carolina Practice Improvement Collaborative has identified this as an effective intervention to address co-occurring disorders. Treatment involves assertive outreach and stage-wise comprehensive treatment.

Gaps

Although there are evidence-based treatment approaches that have been well established as leading to more effective outcomes for suicidal ideation, as well as for the underlying mental health or substance abuse disorders, these standardized approaches to care are not available consistently in all regions of North Carolina. In addition, the local management entities charged with monitoring the quality of services in their regions do not, as a rule, evaluate the delivery of services in accordance with fidelity standards associated with evidence-based or informed practices.

In order to decrease the risk of suicide in the community, LME/MCOs should assess their service delivery networks and contract for the availability of specific evidence-based or best practices associated with more effective outcomes for people at increased risk of suicide. They should develop a suicide management plan, as described above, and require contracted providers to follow the plan. In addition, the LME/MCOs should monitor the delivery of services by their contracted providers to assure services are provided in accordance with the suicide management plan and evidence-based practice guidelines. LME/MCOs are required, as part of the 1915(b)/(c) waivers to develop quality management plans and oversee the quality of services provided. Thus, there is an opportunity to require fidelity scales for evidence-based programs as part of the routine monitoring of provider contracts.

Further, more work is needed to ensure effective care transitions. DMH/DD/SAS, DMA, LME/MCOs, working with other health care professionals, must develop standards to ensure that treatment information can be shared across health professionals (within the confines of federal and state privacy laws). Care coordination services need to be provided to ensure that individuals at high risk of suicide effectively transition from one treatment provider to another, and that the high-risk individual receives appropriate follow-up services.

To decrease the risk of suicide, LME/MCOs should contract for evidence-based or best practices associated with more effective outcomes for people at increased risk of suicide.

Recommendation 6: Ensure that People at High Risk of Suicide are Referred Into and Receive Evidence-Based Treatment Appropriate to Their Underlying Mental Health or Substance Use Disorder

a) **State level.**

   1) **The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) and the Division of Medical Assistance (DMA), working with the North Carolina Practice Improvement Collaborative (NC PIC), should identify evidence-based treatment interventions targeting the populations that are most at risk of suicide (including people with co-occurring mental health and substance use disorders, and individuals with major depressive, bipolar, schizophrenia, or borderline personality disorders). DMH/DD/SAS and DMA should require that the Local Management Entities/Managed Care Organizations (LME/MCOs) contract with behavioral health professionals that can deliver these evidence-based treatment services and that can ensure effective transitions of care between different service providers. The LME/MCOs should include quality management oversight to ensure that these contracted professionals are implementing the evidence-based clinical protocol with fidelity.**

   2) **DMH/DD/SAS, DMA, and NC PIC should develop clinical practice guidelines for managing suicide risk and communicating risk within provider agencies. These standards should be included in the suicide risk management plans required in contract language with MCOs, and should be included in contract language with community providers. These guidelines should include, but not be limited to: standards for when the provider should conduct a more thorough suicide assessment and when the provider should develop a crisis plan, as well as appropriate evidence-based treatment for high-risk conditions. In addition, the clinical practice guidelines should include information that must be communicated across providers, and procedures to ensure a "warm hand-off" to ensure that individuals at high risk of suicide move seamlessly from one provider to another.**

b) **Local level.**

   1) **The LME/MCOs should determine, as part of the community needs assessment, whether there are sufficient behavioral health providers with the training and skills needed to provide the state-identified evidence-based or evidence-informed suicide interventions.**

2) **LME/MCOs should contract with a sufficient number of behavioral health professionals with the training and clinical expertise to deliver these services without delay throughout the LME/MCO service area. The LME/MCO should monitor the performance of these contracted behavioral health professionals to ensure that the contractors meet the standards for managing suicide risk, provide evidence-based treatment services with fidelity, and are achieving positive health outcomes.**

3) **LME/MCOs should assist, through their care coordination function, in transition planning, linking, and engagement with individuals who are being discharged from hospitals, institutions, or crisis services to other providers.**

Recovery Supports for People With a Past History of Suicide Attempts or Suicidal Ideation

Vision

Once stabilized, individuals need to be engaged to develop a personalized recovery support plan or "futures plan" that can help them think about their goals and aspirations, identify people in their lives that can provide support, learn wellness strategies, identify early warning signs of crisis, and identify strategies to successfully manage crisis. In addition, people who have attempted or contemplated suicide, should be linked to natural supports (such as the faith community or civic organizations) or appropriate peer supports (such as support groups with other people who have mental illness or substance use disorders) to help them understand that they are not alone. One of the primary risk factors for suicidal ideation is a feeling of isolation. Helping strengthen or build connections between the individual and other natural or peer supports can help address this feeling of isolation. In addition, peer support groups, led by trained facilitators, can help individuals with problem solving skills and can help individuals with suicidal ideation develop positive goals for the future.

Existing Resources

There are many sources of natural and peer supports in communities across the state (such as faith-based organizations, civic organizations, or mental health or substance abuse peer support groups). However these resources are not equally available in every community, and what is an appropriate support system for one individual may not work for another. Individuals who are receiving enhanced behavioral health services (such as crisis services, institutional care, or residential care) work with behavioral health professionals to develop a person-centered plan (PCP). As part of this PCP, the behavioral health professional helps the individual develop a crisis action plan which includes linkages to natural or peer supports. It may also include a more formalized "future action plan."

> **Once stabilized, individuals need to be engaged to develop a personalized recovery support plan.**

> **Example of Level I (NREPP) evidence-based recovery supports**
>
> ■ **Wellness Recovery Action Plan (WRAP).** Teaches participants how to implement hope and personal responsibility, education, self-advocacy, and support into their day-to-day lives; organize activities that can help them feel better or prevent mental health difficulties; create an advanced directive with family and friends when they become unable to take appropriate actions for themselves; and develop wellness plans for a return to wellness for when the mental illness subsides.

Gaps

While many of the future recovery support plans are evidence-based for treatment of depression, they have not been specifically identified as an evidence-based or a best practice to help in the recovery process for people who have attempted suicide. However, certain aspects of these recovery plans are evidence-informed—for example, helping individuals identify natural supports that can help people at high risk of suicide feel less isolated, or helping with problem solving skills to help them feel less hopeless. More research is needed to determine the effectiveness of recovery support plans for people with suicidal ideation or past suicide attempts. In the meantime, the plans that are developed should include a specific suicide safety plan to ensure that the person knows where to seek help if he or she has suicidal ideation at some time in the future.

In addition, many people who experience suicidal ideation never get the benefit of a crisis action plan or a futures plan. Individuals whose only connection to the health care system is through a primary care provider or outpatient behavioral health professional, may never get the benefit of a crisis plan. Any individual with suicidal ideation or with an active suicide plan should develop a crisis plan that includes linkages to appropriate natural or peer support systems.

Recommendation 7: Assure People Who Have Attempted Suicide or With Suicidal Ideation Have Crisis Safety and Recovery Support Plans That Build Upon Their Strengths

a) **State level.**

1) **The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) and Division of Medical Assistance (DMA), working with the North Carolina Practice Improvement Collaborative (NC PIC), should develop standards for what information must be included in recovery support plans. The standards should be based on best available evidence about how to build connections to natural supports, help people at high risk of suicide address feelings of isolation and hopelessness, build upon existing strengths, identify early warning signs that can trigger thoughts of suicide, and create a suicide safety plan to prevent future suicide attempts.**

2) **The Consumer and Family Advisory Committee (CFAC) at the state level should work with local CFAC to identify peer and natural support groups that can help individuals reduce feelings of isolation.**

b) **Local level.**

1) **The Local Management Entity/Managed Care Organization (LME/MCO) should require that contracted behavioral health professionals work with the person at high risk of suicide to develop an appropriate recovery action plan, and monitor the performance of the contracted professionals against this requirement.**

2) **The Consumer and Family Advisory Committee should work with the consumer relations staff in the LME/MCO to identify peer and natural support groups in their community, or work to create linkages to existing organizations for this purpose.**

Postvention for People Touched by Suicide

Vision

Suicide deaths can be traumatic for the family, friends, community, and professionals involved in providing treatment or addressing the immediate aftermath of a suicide. People touched by suicide—the family, friends, and colleagues of those who die by suicide—are themselves at higher risk for suicide. These individuals can be overwhelmed with complex emotions, including grief, despair, guilt, and shame.

North Carolina's suicide prevention and intervention plan will include postvention resources for the people touched by suicide. It will include individual grief counseling and peer support, as well as broader interventions for communities to prevent suicide contagion. Efforts to reduce suicide contagion are particularly important among young people when the person who died by suicide was a similar age and demography.[35] Postvention services, such as grief counselors, Survivors of Suicide support groups, and/or resource centers should be available for the family, friends, and colleagues of the person who died by suicide, as well as for the first responders, crisis staff, and others who also interacted with the person who died. Outreach programs should be available to link trained volunteers to people who have recently experienced a suicide loss to help the bereaved learn about local suicide support groups and other resources and to let people know that there are others who can relate to their loss.[36]

Existing Resources

Suicide support groups exist to help individuals who have been touched by suicide. Survivors of Suicide or other support organizations are available in Chapel Hill, Charlotte, Gastonia, Greensboro, Greenville, Hillsborough, Huntersville, King, Mount Airy, Raleigh, Salisbury, Shelby, Spruce Pine, Statesville, Wake Forest, Wilkesboro, Wilmington, and Winston-Salem.[37-39]

Examples of Level II or III best postvention practices

- **Survivor Voices: Sharing the Story of Suicide Loss.** Allows individuals bereaved by suicide to speak safely about their loss.

- **Connect Suicide Postvention Program.** Provides community professionals training to respond to a suicide effectively in order to prevent additional suicides.

Suicide support groups exist to help individuals who have been touched by suicide.

In addition to support groups, communities need access to readily available toolkits to help them respond to individual, or a group of suicides in their community. The American Foundation for Suicide Prevention has created materials for Schools "After a Suicide: A Toolkit for Schools"[40] to help schools address the suicide (or other death) of someone in their school, and to understand what to do (and what not to do) to prevent suicide contagion. Similar toolkits are needed for other community groups.

Gaps

While there is some information about suicide support groups for people touched by suicide, these groups do not exist throughout the state—and people would need to know where to look to find such groups. LME/MCOs should identify the resources that exist in their community to help counsel people who have been touched by suicide, and share that information with other community partners—including schools, law enforcement, and the faith community. Further, there is no toolkit readily available to communities that have been touched by suicide, in order to help reduce the likelihood of copycat suicides.

Recommendation 8: Link Family, Friends, and Other People Who Have Been Touched by the Suicide Death of Another into Appropriate Postvention Services

a) **State level:**

1) **The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS), in partnership with the Division of Public Health (DPH) and Department of Public Instruction (DPI), should identify and adapt postvention toolkits for schools and communities in North Carolina. Similar to the "After a Suicide" toolkit for schools, this toolkit should provide information about what to do when a community experiences one suicide or multiple suicides. Toolkits for schools and other community partners should be posted on the web, and should be shared widely with community partners across the state.**

2) **DMH/DD/SAS and DMA should ensure that Local Management Entities/Managed Care Organizations (LME/MCOs) include information about postvention resources on their websites, and conduct outreach to community partners to ensure that people touched by suicide will know where to turn for help. As part of the outreach efforts, DMH/DD/SAS and DMA should target schools, law enforcement, and the faith community to ensure that they have information about available resources for others touched by suicide.**

b) Local level.

    1) LME/MCOs should work with law enforcement agencies to include trained volunteers or professionals who can accompany first responders to the scene of a suicide (to conduct outreach to the bereaved family members), and/or develop a protocol to have law enforcement alert the LME/MCO to any death by suicide, so that the LME/MCO can reach out to the family, friends, and other community members touched by the suicide and offer them postvention services.

    2) LME/MCOs should catalog the availability of postvention treatment services and peer delivered support groups, and make this information available and easily accessible on the web. In addition, as part of the community engagement, the LME/MCO should ensure that other community providers (including but not limited to schools, law enforcement, and the faith community) know about the availability of these postvention services.

    3) LME/MCOs should promote the development of evidence-informed postvention treatment and peer supports if sufficient resources are not available in the community.

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The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services within the North Carolina Department of Health and Human Services asked the North Carolina Institute of Medicine (NCIOM) to convene a task force 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 Task Force focused on identifying key elements of a statewide suicide prevention and intervention plan. This final report provides a description of existing services and gaps in the current system, and includes eight recommendations to ensure that a statewide suicide prevention and intervention plan is adequate to meet the needs of North Carolinians.

Suicide death is one of the top 10 leading causes of death for people ages 5-64 in North Carolina. Each year more than 1,000 North Carolinians die from suicide, more than 6,000 people are hospitalized due to self-inflicted injuries, and more than 8,000 are treated in emergency departments.[1] Suicide deaths in the state resulted in more years of potential life lost for individuals under age 65 than homicide, congenital abnormalities, cerebrovascular disease, human immunodeficiency virus (HIV), or diabetes mellitus.[2] What distinguishes suicide deaths from most other deaths is that suicide deaths are entirely preventable.

Many people who die by suicide have an underlying mental illness or substance use disorder. National data suggest that 90% of suicides are associated with some form of mental illness.[3] In North Carolina, 37% of the males and 67% of the females who died by suicide from 2004-2008 were in current treatment for a mental illness at the time of their death. Others had indications of mental health problems.[1] However we know that the North Carolina data is likely to be an underreporting of the connection between suicide deaths (or suicide attempts) and mental health or substance use disorders. The North Carolina Violent Death Reporting System relies on law enforcement interviews with survivors (those who knew the victim) to try to gather background information about suicide deaths, and the people who provide the information may not know, or feel comfortable revealing, the underlying mental health or substance use status of the person who died.

This report focuses on the role that the state Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) and the Division of Medical Assistance (DMA) can play at the state level in reducing suicide deaths and suicide risk. The report also focuses on the role of Local Management Entities/Managed Care Organizations (LME/MCOs) and contracting behavioral health providers in helping identify people at risk of suicide, and to ensure they get into appropriate evidence-based crisis services or treatment. This plan comes at a critical juncture as North Carolina transitions its publicly funded MH/DD/SA system from a loosely organized, fee-for-service system to a more tightly coordinated managed care system. DMA and DMH/

This final report provides a description of existing services and gaps in the current system, and includes eight recommendations to ensure that a statewide suicide prevention and intervention plan is adequate to meet the needs of North Carolinians.

DD/SAS are holding the new LME/MCO entities to higher standards and have enhanced performance requirements to include community engagement (i.e. engaging community partners), building an adequate network of qualified providers to meet the MH/DD/SA needs of people in their service area, and quality management responsibilities to ensure that high quality services are being delivered. These new standards can also be used to support the development of a more effective suicide prevention and intervention system at the local level.[4] While the plan focuses primarily on the role of LME/MCOs and contracting providers to prevent and reduce suicide risk, it also includes recommendations aimed at primary care medical homes within the Community Care of North Carolina (CCNC) networks. Primary care professionals are uniquely situated to help identify people who are contemplating suicide or otherwise at risk.

We know that effectively reducing the number of suicide attempts and deaths will require new and strengthened partnerships across agencies.

We know that effectively reducing the number of suicide attempts and deaths will require new and strengthened partnerships across agencies. Thus, we need to create a statewide plan that includes all the state and community partners involved in suicide prevention, early intervention, crisis services, treatment, recovery supports, and postvention services for survivors (Recommendation 1).

This state suicide prevention and implementation plan cannot realistically be implemented immediately. As a first step, the state and the LME/MCOs should identify one or more staff members who will help coordinate the implementation of the state suicide prevention and intervention plan (Recommendation 2).

Ultimately, the state and local LME/MCOs should develop suicide risk management protocols for use by the state, within each LME/MCO, and with contracted behavioral health providers. The suicide risk management plan should include, but not be limited to:

- An outreach and education plan to educate the public and gatekeepers about suicide and how to identify people at risk and refer them to appropriate services.

- An evidence-based screening tool to determine level of suicide risk.

- Requirements for when and how often people should be screened for suicide risk and the criteria that would trigger a more comprehensive suicide risk assessment.

- Identification of an evidence-based suicide risk assessment that must be used, or requirements for the information that should be gathered as part of a more comprehensive suicide assessment tool.

- The protocol to ensure people are linked to appropriate crisis services.

- Requirements for what should be included in a person's crisis safety plan.

- Care management protocol to ensure that people successfully transition from one level of care or one behavioral health provider to another.

- Mechanisms to ensure that people at high risk of suicide are linked to professionals who can offer appropriate evidence-based treatment.

- Information about the types of recovery supports (including natural and peer supports) that should be available once the immediate crisis has been successfully resolved.

- Mechanisms to identify people who were touched by suicide death, to offer appropriate postvention services.

The suicide risk management plan should also ensure that clinical and nonclinical staff receive appropriate training to recognize people who are at higher risk of suicide, and that behavioral health professionals receive the training needed to provide evidence-based treatment. The local suicide risk management plan should also include requirements for postvention services for family, friends, and others who were touched by the suicide death of someone they knew (Recommendations 3-8).

Now is the time to act. We have lost the lives of too many North Carolinians by failing to invest in suicide prevention, early intervention, a coordinated crisis response system, and by failing to provide evidence-based treatments, recovery supports, and postvention services. We have the building blocks for an effective suicide prevention and intervention system; what we have historically lacked is an organized focus on this issue. This plan provides the blueprint for a more effective suicide prevention and intervention system, targeting people with mental illness or substance use disorders. By implementing this plan, we can go a long way to reduce unnecessary deaths and hospitalizations and improve the well-being of many North Carolinians.

By implementing this plan, we can go a long way to reduce unnecessary deaths and hospitalizations and improve the well-being of many North Carolinians.

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Recommendation 1: Create a Statewide Suicide Prevention and Intervention Plan

The North Carolina Department of Health and Human Services should convene a broader task force to develop a statewide plan for suicide prevention, early intervention, crisis services, treatment, recovery supports, and postvention services. The group should include, but not be limited to, representatives from: the North Carolina Division of Medical Assistance, North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, North Carolina Division of Public Health, North Carolina Division of Social Services, North Carolina Division of Aging and Adult Services, North Carolina Division of Health Service Regulation, North Carolina Department of Public Instruction, North Carolina Community College System, University of North Carolina System, North Carolina Department of Juvenile Justice and Delinquency Prevention, North Carolina Department of Public Safety, Local Management Entities/Managed Care Organizations, law enforcement agencies, jails, crisis intervention teams, mobile crisis teams, survivor support groups, North Carolina National Guard, North Carolina Division of Veterans Affairs, United States Department of Defense, North Carolina Hospital Association, North Carolina Medical Society, North Carolina Academy of Family Physicians, employee assistance programs, and the faith communities.

Recommendation 2: Build Suicide Prevention and Intervention Capacity at the State and Local Mental Health, Developmental Disabilities, and Substance Abuse System

a) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) should identify one or more staff to serve as the state-designated suicide prevention and intervention expert(s), and should require each Local Management Entity/Managed Care Organization (LME/MCO) to have a suicide prevention and intervention coordinator.

b) Each LME/MCO should designate one or more suicide prevention and intervention coordinators. The state and local designated suicide prevention and intervention coordinators should work together to develop a more detailed implementation plan including timelines for when different parts of the plan should be accomplished, using this state suicide prevention and intervention plan as its blueprint. As part of this plan, the state and local suicide prevention and intervention coordinators should identify high needs populations, existing resources and gaps in prevention, early intervention, crisis services, treatment, recovery

supports, and postvention services. The state and local suicide prevention and intervention coordinators should monitor progress in implementing the plan on an annual basis and should include a summary of the progress (or lack thereof) in the DMH/DD/SAS's annual report to the Substance Abuse and Mental Health Services Administration.

C) The local LME/MCO staff should also ensure that the agency examines the need for suicide-related services in its needs assessment, offers gatekeeper training to appropriate community partners (including but not limited to schools and law enforcement), and builds appropriate training and performance measures into provider contracts.

d) Suicide prevention and intervention coordinators at the state and LME/MCOs should work together to identify evidence-based or best practice screening and assessment tools, training for first responders and other crisis service providers, treatment and recovery supports, and bring this information to the North Carolina Practice Improvement Collaborative (NC PIC) for review and recommendations for adoption in North Carolina. Once reviewed, the state and local suicide prevention and intervention coordinators should work within their respective agencies to help implement the recommended evidence-based or best practices within their respective agencies, and by contracted behavioral health providers.

Recommendation 3: Support greater investment in suicide prevention and education at the state and local level

a) State level.

1) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) should require that all Local Management Entities (LMEs) use some of their federal and state funding to support suicide prevention and broad-based education. The state should identify a minimum threshold and identify existing funding sources which can be used to support prevention, such as the Substance Abuse Prevention and Treatment Block Grant and Community Mental Health Services Block Grant funds.

2) DMH/DD/SAS and the Division of Medical Assistance (DMA) should require that LME Managed Care Organizations (LME/MCOs) invest in prevention activities as a means of reducing unnecessary use of emergency departments. As part of the community engagement part of the MCO contract, funding should be used to educate enrollees and gatekeepers, including but not limited to: school personnel, employers

and supervisors, faith-based and community leaders, emergency health care personnel, employment security personnel, and personnel and volunteers in programs serving older adults.

3) DMH/DD/SAS and DMA should work with the DMH/DD/SAS North Carolina Practice Improvement Collaborative (NC PIC) to identify existing prevention programs that are evidence-based or other best practices. DMH/DD/SAS should ensure that training and technical assistance is available to the LME/MCOs and contracting provider organizations at a reasonable cost to ensure that the programs can be implemented with fidelity. In addition to identifying existing evidence-based or evidence-informed training and technical assistance programs, DMH/DD/SAS, DMA, and the NC PIC should identify the key elements/components that are consistent with these evidence-based prevention programs and allow organizations to be certified to provide training and technical assistance using these key components.

b) Local level.

1) As part of their MCO community relations, network, and quality management responsibilities, the LME/MCO should:

i) Select one of the designated evidence-based or evidence-informed prevention strategies, or approved elements and implement it in their local community directly and through contracted providers.

ii) Educate community partners, including but not limited to schools, law enforcement, juvenile justice, social services, and faith based organizations, about suicide and suicide risks, and engage the partners in implementing prevention strategies that are evidence-based or recognized as best practices.

iii) Provide information on their websites about suicide prevention and crisis services in the community.

Recommendation 4: Implement Evidence-Based Screening and Suicide Assessment Instruments to Identify People at High Risk of Suicide

a) State level.

1) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS), Division of Medical Assistance (DMA), Community Care of North Carolina (CCNC),

and the North Carolina Practice Improvement Collaborative (NC PIC) should work together to examine existing screening and risk assessment tools and the research literature to:

i) Select an evidence-based or best practice suicide brief screening tool(s) and follow-up suicide risk assessment tool(s) that can be used by LME/MCOs and contracting providers. As part of this analysis, DMH/DD/SAS, DMA, CCNC and the NC PIC should examine the LOCUS and CALOCUS to determine if these level of care instruments used for utilization review could also serve as a standardized care assessment tool.

ii) Develop a model suicide risk management protocol which includes the frequency and under what conditions the screening and risk assessment tools should be administered. At a minimum, the LME/MCO should administer a screening tool as part of the initial STR intake, and contracted providers should screen as part of the initial intake. Individuals at high risk, including those who have attempted suicide, and those who are leaving state institutions, hospitals, crisis services, jails, or prisons should be screened by a community provider as part of the transition of care protocol.

2) DMH/DD/SAS and DMA should require that the Local Management Entity/Managed Care Organization (LME/MCO) and contracted community providers use one of the approved screening tools at intake, followed by a more comprehensive suicide risk assessment tool (when appropriate), and then follow the recommended periodicity schedule thereafter.

3) DMH/DD/SAS and DMA should require that staff at the LME/MCOs and contracted providers receive training from state approved vendors on how to identify people who are at risk, including an understanding of the evidence-based screening and assessment process, and the appropriate use of the LOCUS and CALOCUS level of care authorization tools.

4) DMH/DD/SAS and DMA should encourage LME/MCOs to support integrated behavioral health and primary care practices.

b) Local level.

1) LME/MCOs must develop a comprehensive suicide risk management protocol that includes guidelines for screening and suicide risk assessment by the LME/MCO and contracted behavioral health

providers. At a minimum, the LME/MCO must use an approved screening tool during the STR intake. If the person is identified as having suicidal ideation or at high risk, then the LME/MCO must administer a state-approved suicide risk assessment to determine suicide risk and protective factors.

2) LME/MCOs should require community behavioral health providers to use a similar state approved screening and assessment process. The requirement should be built into provider contracts, and monitored as part of the quality management system.

3) CCNC primary care practices should routinely screen adolescents and adults for depression using the PHQ-2 or another approved screening tool. If the person tests positive for depression or substance abuse, then the primary care professional and/or care manager should administer a more detailed risk assessment tool that asks specifically about suicidal ideation. Individuals who are identified as high risk for suicide should be immediately linked to the LME/MCO so that the person can get appropriate treatment services.

4) LME/MCOs should encourage the development and provide support for integrated primary care and behavioral health practices. The LME/MCOs should ensure that the clinicians in these practices have been trained to recognize suicide risk, administer evidence-based screening and suicide assessment tools, and be able to offer evidence-based treatment or ensure that individuals at high risk of suicide are referred into and receive appropriate evidence-based treatment.

Recommendation 5: Assure a Comprehensive Array of Crisis Providers Who Are Trained to Identify and Treat People to Reduce Immediate Suicide Risk

a) State level.

1) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) should use a portion of state and federal funding to help pay for training and technical assistance to Local Management Entities/Managed Care Organizations (LME/MCOs) to help support the development of a coordinated system of crisis providers that have been trained in crisis de-escalation skills, identifying suicide risks, and providing treatment to stabilize the immediate suicide risk. Information about available crisis providers should be distributed widely to community partners, and should be maintained and easily accessible on the DMH/DD/SAS website.

2) **DMH/DD/SAS and the Division of Medical Assistance (DMA) to provide technical support to LME/MCOs about best practices on crisis response systems that include mobile crisis, walk-in centers, and facility-based services.**

3) **DMH/DD/SAS, DMA, and the North Carolina Practice Improvement Collaborative (NC PIC) should identify evidence-based or evidence-informed suicide crisis training curricula (such as the QPR-T). Once identified, DMH/DD/SAS should certify training providers who can deliver the evidence-based curricula or content that includes the same core elements as the approved evidence-based training curricula, and require that all crisis response workers receive training in one of these approved curricula.**

4) **DMH/DD/SAS and DMA should evaluate these efforts to determine if the availability of well trained, coordinated, and comprehensive crisis providers leads to reduced suicide attempts, reduced suicide deaths, and reduced use of the emergency department.**

5) **DMH/DD/SAS, DMA, the NC PIC should identify evidence-based or best practices to ensure the availability of high quality crisis services. Once identified, DMH/DD/SAS and DMA should include these standards in the model suicide risk management protocol and require that LME/MCOs meet these new standards. These standards should include requirements for a comprehensive array of crisis services, hours of operation (for walk in and facility based), staffing, training, and other requirements.**

6) **DMH/DD/SAS, DMA, and CCNC should expand the definition of people with special health care needs who are eligible for care coordination to include individuals with mental health or substance use disorders who are discharged from institutions, hospitals, or crisis services. Care coordinators should assist these individuals with transitions to community providers. This expanded definition of special health care needs population should be built into the contract with the LME/MCO for care coordination services.**

7) **DMH/DD/SAS should work with DMA, Division of State Operated Facilities, the North Carolina Hospital Association, Division of Health Services Regulation, LME/MCOs, local emergency medical services (EMS), health professional associations, magistrates, and law enforcement to develop new standards for emergency medical services, involuntary commitment (IVC), and interception models. Emergency management should triage individuals to determine if the person expressing suicidal ideation or other emergency mental**

health needs has an immediate medical need. If the person does not have a concurrent medical need, the EMS personnel should transport individuals to appropriate crisis resources, if available in the community and properly staffed to provide crisis and IVC services.

b) Local level.

1) LME/MCOs should determine whether there are sufficient behavioral health crisis providers who are trained to address the needs of people who are actively contemplating, or have attempted suicide; and whether these providers are geographically accessible and available on a 24/7 basis to people throughout the service area.

2) LME/MCOs should contract for a full array of crisis services and require coordination of services across providers. LME/MCOs that contract with more than one crisis service provider should include performance measures to ensure coordination across crisis service providers.

3) LME/MCOs should include requirements to ensure that all crisis team members receive training using an evidence-informed suicide clinical training curriculum, as identified in Recommendation 4.a.3.

4) LME/MCOs should work with law enforcement agencies to develop a protocol to be alerted when someone in their catchment area attempts suicide, so that the LME/MCO can link the person with appropriate treatment and recovery supports.

Recommendation 6: Ensure that People at High Risk of Suicide are Referred Into and Receive Evidence-Based Treatment Appropriate to Their Underlying Mental Health or Substance Use Disorder

a) State level.

1) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) and the Division of Medical Assistance (DMA), working with the North Carolina Practice Improvement Collaborative (NC PIC), should identify evidence-based treatment interventions targeting the populations that are most at risk of suicide (including people with co-occurring mental health and substance use disorders, and individuals with major depressive, bipolar, schizophrenia, or borderline personality disorders). DMH/ DD/SAS and DMA should require that the Local Management Entities/

Managed Care Organizations (LME/MCOs) contract with behavioral health professionals that can deliver these evidence-based treatment services and that can ensure effective transitions of care between different service providers. The LME/MCOs should include quality management oversight to ensure that these contracted professionals are implementing the evidence-based clinical protocol with fidelity.

2) DMH/DD/SAS, DMA, and NC PIC should develop clinical practice guidelines for managing suicide risk and communicating risk within provider agencies. These standards should be included in the suicide risk management plans required in contract language with MCOs, and should be included in contract language with community providers. These guidelines should include, but not be limited to: standards for when the provider should conduct a more thorough suicide assessment and when the provider should develop a crisis plan, as well as appropriate evidence-based treatment for high-risk conditions. In addition, the clinical practice guidelines should include information that must be communicated across providers, and procedures to ensure a "warm hand-off" to ensure that individuals at high risk of suicide move seamlessly from one provider to another.

b) Local level.

1) The LME/MCOs should determine, as part of the community needs assessment, whether there are sufficient behavioral health providers with the training and skills needed to provide the state-identified evidence-based or evidence-informed suicide interventions.

2) LME/MCOs should contract with a sufficient number of behavioral health professionals with the training and clinical expertise to deliver these services without delay throughout the LME/MCO service area. The LME/MCO should monitor the performance of these contracted behavioral health professionals to ensure that the contractors meet the standards for managing suicide risk, provide evidence-based treatment services with fidelity, and are achieving positive health outcomes.

3) LME/MCOs should assist, through their care coordination function, in transition planning, linking, and engagement with individuals who are being discharged from hospitals, institutions, or crisis services to other providers.

Recommendation 7: Assure People Who Have Attempted Suicide or With Suicidal Ideation Have Crisis Safety and Recovery Support Plans That Build Upon Their Strengths

a) State level.

1) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) and Division of Medical Assistance (DMA), working with the North Carolina Practice Improvement Collaborative (NC PIC), should develop standards for what information must be included in recovery support plans. The standards should be based on best available evidence about how to build connections to natural supports, help people at high risk of suicide address feelings of isolation and hopelessness, build upon existing strengths, identify early warning signs that can trigger thoughts of suicide, and create a suicide safety plan to prevent future suicide attempts.

2) The Consumer and Family Advisory Committee (CFAC) at the state level should work with local CFAC to identify peer and natural support groups that can help individuals reduce feelings of isolation.

b) Local level.

1) The Local Management Entity/Managed Care Organization (LME/MCO) should require that contracted behavioral health professionals work with the person at high risk of suicide to develop an appropriate recovery action plan, and monitor the performance of the contracted professionals against this requirement.

2) The Consumer and Family Advisory Committee should work with the consumer relations staff in the LME/MCO to identify peer and natural support groups in their community, or work to create linkages to existing organizations for this purpose.

Recommendation 8: Link Family, Friends, and Other People Who Have Been Touched by the Suicide Death of Another into Appropriate Postvention Services

a) State level:

1) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS), in partnership with the

Division of Public Health (DPH) and Department of Public Instruction (DPI), should identify and adapt postvention toolkits for schools and communities in North Carolina. Similar to the "After a Suicide" toolkit for schools, this toolkit should provide information about what to do when a community experiences one suicide or multiple suicides. Toolkits for schools and other community partners should be posted on the web, and should be shared widely with community partners across the state.

2) DMH/DD/SAS and DMA should ensure that Local Management Entities/Managed Care Organizations (LME/MCOs) include information about postvention resources on their websites, and conduct outreach to community partners to ensure that people touched by suicide will know where to turn for help. As part of the outreach efforts, DMH/DD/SAS and DMA should target schools, law enforcement, and the faith community to ensure that they have information about available resources for others touched by suicide.

b) Local level.

1) LME/MCOs should work with law enforcement agencies to include trained volunteers or professionals who can accompany first responders to the scene of a suicide (to conduct outreach to the bereaved family members), and/or develop a protocol to have law enforcement alert the LME/MCO to any death by suicide, so that the LME/MCO can reach out to the family, friends, and other community members touched by the suicide and offer them postvention services.

2) LME/MCOs should catalog the availability of postvention treatment services and peer delivered support groups, and make this information available and easily accessible on the web. In addition, as part of the community engagement, the LME/MCO should ensure that other community providers (including but not limited to schools, law enforcement, and the faith community) know about the availability of these postvention services.

3) LME/MCOs should promote the development of evidence-informed postvention treatment and peer supports if sufficient resources are not available in the community.

Acronym	Full Name
ADATC	Alcohol and Drug Abuse Treatment Center
ADD	Attention Deficit Disorder
ASIST	Applied Suicide Intervention Skills Training
BAC	Blood Alcohol Content
BH	Behavioral Health
CALOCUS	Child and Adolescent Level of Care Utilization System
CARE	Care, Assess, Respond, Empower
CAST	Coping and Support Training
CBT	Cognitive Behavioral Therapy
CCNC	Community Care of North Carolina
CDC	Centers for Disease Control and Prevention
CFAC	Consumer and Family Advisory Committee
CIT	Crisis Intervention Team
CMIS	Case Management Information System
DBT	Dialectical Behavior Therapy
DJJDP	Department of Juvenile Justice and Delinquency Prevention
DMA	Division of Medical Assistance
DMH/DD/SAS	Division of Mental Health, Developmental Disabilities, and Substance Abuse Services
DPH	Division of Public Health
DPI	Department of Public Instruction
EMS	Emergency Medical Services
FBCC	Facility-Based Crisis Center
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome
IDDT	Integrated Dual Disorder Treatment
IVC	Involuntary Commitment
LCSW	Licensed Clinical Social Worker
LGBT	Lesbian/Gay/Bisexual/Transgender
LME/MCOs	Local Management Entities/Managed Care Organizations
LOCUS	Level of Care Utilization System
NC PIC	North Carolina Practice Improvement Collaborative

NC START	North Carolina Systemic, Therapeutic, Assessment, Respite, and Treatment Program
NC VDRS	North Carolina Violent Death Reporting System
NCIOM	North Carolina Institute of Medicine
NREPP	National Registry of Evidence-Based Programs and Practices
PCP	Patient-Centered Plan
PHQ	Patient Health Questionnaire
PMPM	Per Member Per Month
PTSD	Post-Traumatic Stress Disorder
QPR	Question, Persuade, Refer
QPR-T	Question, Persuade, Refer, and Treat
SPRC	Suicide Prevention Resource Center
STR	Screening, Triage, and Referral
TRACK	Therapeutic Respite Addressing Crisis for Kids
WRAP	Wellness Recovery Action Plan

Glossary

Assessment (for suicide ideation)	Captures information on individuals identified as high risk for risk and protective factors, suicide ideation, past history of suicide attempts, and suicide capability.
Best practices	Methods which have either been shown to provide effective results, or are developed using evidence-based theory, but have not been rigorously evaluated.
Biopsychosocial risk factors	Biological, psychological, and social risk factors that increase risk of suicide such as mental disorders (particularly mood disorders), schizophrenia, anxiety disorders, and certain personality disorders; alcohol and other substance use disorders; hopelessness; impulsive and/or aggressive tendencies; history of trauma or abuse; major physical illnesses; previous suicide attempt; and family history of suicide.
Crisis services	Assess needs and provide temporary intervention to de-escalate crisis on a 24 hours, 7 days a week basis for clients in need of immediate attention.
Early intervention	Includes screening and assessment to identify people at high risk of suicide, in order to link them to crisis services and treatment.
Environmental risk factors	External factors that increase risk of suicide such as job or financial loss, relational or social loss, easy access to lethal means, and local clusters of suicide that have a contagious influence.
Evidence-based programs	Programs that achieve positive health outcomes and have been subject to rigorous evaluations. The levels of evidence range from the highest gold standard of randomized control trials, followed by controlled trials without randomization, cohort or case control studies, time series studies, and descriptive studies.
Gatekeepers	Anyone who is likely to interact with people at risk of suicide. Gatekeepers include but are not limited to school personnel, employers and supervisors, faith-based and community leaders, emergency health care personnel, employment security personnel, and personnel and volunteers in programs serving older adults.
Postvention	Services provided to the friends, families, and colleagues of the people who die by suicide including individual grief counseling, peer support, and community level interventions to prevent suicide contagion.
Prevention	Measures taken to prevent occurrence of disease or injuries. Measures can be broad based (provided universally to all populations), selective (provided to high-risk populations), or indicated (provided to those who have shown early warning signs such as people who have expressed suicide ideation or attempted suicide in the past).

Protective factors	Variables that mitigate or eliminate individuals' risk of an event, such as effective clinical care for mental, physical, and substance use disorders; easy access to a variety of clinical interventions and support for help seeking; restricted access to highly lethal means of suicide; strong connections to family and community support; support through ongoing medical and mental health care relationships; skills in problem solving, conflict resolution, and nonviolent dispute resolution; and cultural and religious beliefs that discourage suicide and support self-preservation.
Risk factors	Variables associated with higher risk of an event occurring, such as substance abuse disorder, depression or dysthmia, bipolar disorder, anxiety disorder, and schizophrenia.
Screening (for suicide ideation)	Short questionnaire used to identify people who may be at higher risk of suicide. People who are identified at higher risk of suicide during a screening should then receive a more thorough assessment to identify risk and protective factors, suicide ideation, past history of suicide attempts, and suicide capability. This is a strategy used in medicine to detect a disease or disorder in a population that is otherwise without signs or symptoms of that disease.
Sociocultural risk factors	Forces within the culture or society that affect individuals' thoughts, feelings, or behavior, such as lack of social support and sense of isolation; stigma associated with help-seeking behavior; barriers to accessing health care, especially mental health and substance abuse treatment; certain cultural and religious beliefs (for instance, the belief that suicide is a noble resolution of a personal dilemma); exposure to and influence of others who have died by suicide, including through the media.
Suicide contagion	Exposure to suicide ideation and/or suicidal behavior by one or more individuals. This exposure may influence others to suicide ideation and/or suicidal behavior.
Suicide ideation	Thoughts about suicide, or having the intent to commit suicide.
Survivor	This term is used in multiple ways. Some people refer to survivors as those who have attempted, but not died from suicide. Others refer to survivors as the friends, family, colleagues, and others touched by someone who died by suicide. Throughout this report, we tried to distinguish between those who survived a suicide attempt, and others who were touched by a suicide death.

Best Practices

The Suicide Prevention Resource Center (SPRC) has identified three levels of best practices:[1] evidence-based practices, expert/consensus statements, and adherence to standards.

Evidence-based practices: The first level of evidence (Level I) is evidence-based programs from the National Registry of Evidence Based Programs and Practices (NREPP). Evidence-based programs and interventions are those that achieve positive health outcomes and have been subject to rigorous evaluation.[2] NREPP selects programs and assigns ratings to each program based on the quality of research and dissemination readiness. The ratings are on a scale of 0.0-4.0, with 4.0 as the highest rating. The quality of research criteria evaluates whether the program has one or more positive behavioral outcomes, uses an experimental or quasi-experimental design, and is published in a peer reviewed journal or other comprehensive evaluation report publication. The programs are also evaluated by NREPP for dissemination readiness, which assesses whether the program has implementation materials, training and support resources, and quality assurance procedures ready for use. NREPP provides a program summary that includes information on program population, outcomes, costs, and replications. NREPP provides information on when each program was reviewed, but does not provide regular updates to the reviews. Thus, more recent information about each program may be obtained from the program's website.[3]

The North Carolina Practice Improvement Collaborative (NC PIC) has identified other evidence-based practices related to mental health, developmental disabilities, and substance abuse. To be selected by the NC PIC as "evidence-based," the intervention must have publicly available evaluation data to show that the intervention achieved positive outcomes, the evaluation results must have been replicated by more than one group of researchers, and the results must have been included in at least three peer reviewed and published articles. In addition, the intervention must include a description of important elements required for program success, and a fidelity scale to ensure that the intervention is being implemented according to the program design. The NC PIC has identified evidence-based practices targeted at the high-risk mental health and substance abuse disorders that increase the risk of suicide. These evidence-based practices, not included in the NREPP review, are included in this appendix.[4]

Expert/consensus statements: The second SPRC best practice-level (Level II) is "expert/consensus statements." Level II programs include suicide screening, assessment and treatment protocols, and education and training materials. To be listed as a best practice under Level II, a group of three expert reviewers must review the protocol to determine if it meets the specified level of importance, likelihood of meeting objectives, accuracy, safety, congruence with prevailing knowledge, and appropriateness in the development process. These programs do not have the same proven track record of efficacy but meet accuracy, safety and program design standards.[5]

Adherence to standards: The third SPRC best practice-level (Level III) is called "adherence to standards", and includes awareness and outreach materials, educational and training programs, screening tools, and other protocols or policies which are designed to reduce the risk of suicide. To be included in the Level III listings, three experts must have reviewed the materials to examine the accuracy of the content, likelihood of meeting objectives, and programmatic and messaging guidelines. Additionally, Level III programs must make program materials available through a website or contact person.[6]

All three levels of programs are described in this appendix with the program contact information (if available). Tables C.1 - C.4 summarizes the target audience, the type of program, and whether the resource contains policy protocol or guidelines. A program is categorized as "prevention" if the program includes universal, selective, or indicated primary prevention efforts (such as educational programs targeted at broad or selective audiences). "Early intervention/screening tools" include programs that help educate gatekeepers or other individuals on how to identify suicide risk, and also include strategies to link people who are at immediate risk into crisis services. An early intervention program that includes a specific screening or assessment tool is denoted with an asterisk (*). "Treatment" programs are those that provide evidence-based treatment or best practices to reduce suicide risk, or to address an underlying mental health or substance abuse disorder that increases suicide risk. Treatment programs may also include recovery supports. "Postvention" strategies include programs targeted at the friends, families, and colleagues of the people who died by suicide. Programs or interventions can be categorized under more than one category (for example, a comprehensive suicide intervention can include components for prevention, early intervention, treatment, and recovery supports).

Level I: NREPP Evidence-Based Programs[2]

Adolescent Coping With Depression (NREPP review July 2007). This is an evidence-based cognitive behavioral health group intervention course targeted at depressed adolescents age 13-17. It has been shown to help reduce symptoms of depression and improve psychosocial level of functioning. The treatment has been tested with adolescents in diverse settings, including urban and rural, schools, juvenile detention, and state correctional facilities. Individuals in this program showed greater improvement on the Hamilton Depression Rating Scale immediately following treatment (Hamilton Depression Rating Scale is a 17-item scale in which a clinical interviewer provides ratings on overall depression, guilt, suicide, insomnia, problems related to work, psychomotor retardation, agitation, anxiety, gastrointestinal and other physical symptoms, hypochondriasis, and weight loss.) In review of the evidence, it received high ratings for outcomes (<3.5/4.0), but lower ratings for dissemination readiness because of a lack of training and support resources. There is no cost to implement this program.
For more information contact: Paul Rohde, PhD, paulr@ori.org, 541.484.2123, http://www.kpchr. org/research/public/acwd/acwd.html.

American Indian Life Skills Development/Zuni Life Skills Development (NREPP review June 2007). This is an evidence-based mental health suicide prevention curriculum targeted at American Indian adolescents ages 14-19. The Zuni Life Skills Development curriculum was first implemented with high school students in the Zuni Pueblo, an American Indian reservation with about 9,000 tribal members located about 150 miles west of Albuquerque, New Mexico. The American Indian Life Skills Development curriculum, an adaptation of the Zuni version, has been implemented with a number of other tribes. Students receiving the Zuni Life Skills Development curriculum had less feelings of hopelessness, and demonstrated a higher level of suicide intervention skills compared to students without an intervention. In the review of evidence, the program received low ratings for outcomes (<2.8/4.0) due to nonrandomized sampling, but received high ratings for dissemination readiness (3.6/4.0) because it is developmentally appropriate, culturally sensitive, and engaging for an adolescent audience. The program costs $30 for each American Indian Life Skills Development Manual,

and $9,000 per site plus travel expenses for three-day, on-site key leader training. The cost also includes six hours of phone consultation.
For more information contact: Teresa D. LaFromboise, PhD, lafrom@stanford.edu, 650.723.1202, http://uwpress.wisc.edu/books/0129.htm.

Care, Assess, Respond, Empower (CARE) (NREPP review February 2007). This is an evidence-based suicide intervention program targeted at adolescents ages 13-17, and young adults ages 18-25. The program includes suicide assessment, counseling, and social support intervention. CARE was piloted and tested with participants ages 14-20 and has since been adapted for young adults (ages 20 to 24). Originally tested with diverse racial and ethnic groups, the program has also been specifically adapted for Native American and Latino students. CARE has been shown to reduce suicide risk factors, specifically suicidal ideation. The program received high ratings for outcomes (>3.3/4.0), but received low ratings for dissemination readiness (2.2/4.0) due to lack of guidance and supervision for program implementation at the organizational level. The implementation point of contact can provide the most up-to-date cost information.
For more information contact: Beth McNamara, MSW, Director beth@reconnectingyouth.com, 425.861.1177, http://www.reconnectingyouth.com.

Coping and Support Training (CAST) (NREPP review February 2007). This is a high school-based treatment program administered through 12 55-minute group sessions for youth ages 14-19, who have been identified as being at risk for suicide. Originally piloted and tested in youth ages 14-19, the CAST program is currently being tested with middle school-aged youth. CAST has been evaluated with racially and ethnically diverse groups of high school youth at risk of dropping out of school. The program has been shown to have outcomes that include a decline in positive attitudes toward suicide, suicide ideation, depression, feelings of hopelessness and anger. The program showed a higher decline in anxiety among females, perceived sense of personal control, and problem-solving/coping skills. In review of the evidence, it received high ratings for outcomes (>3.4/4.0) and high ratings for dissemination readiness ratings (3.5/4.0). The cost of this program is $699 for each CAST curriculum, $26.50 for each student notebook (or $190.80 for a set of eight), $1,000 per person for a four-day, on- or off-site training workshop for CAST leaders and coordinators (minimum of eight trainees per trainer), $400 per person for a one-day, on- or off-site training workshop for administrators, and $800 per person for a two-day, on- or off-site advanced training for CAST coordinators.
For more information contact: Beth McNamara, MSW, beth@reconnectingyouth.com, 425.861.1177, http://www.reconnectingyouth.com.

Columbia University TeenScreen (NREPP review February 2007). This program is targeted at middle school and high school aged students (ages 13-25) at risk for suicide and mental illness. It is aimed at early intervention screening in schools, clinics, doctors' offices, juvenile justice settings, shelters, or any other youth-serving setting. The program has been shown to increase referrals to mental health service providers. In review of the evidence, the program received low outcomes ratings (2.5/4.0) due to potential selection bias, range of informants between schools, lack of systemic data collection, participant attrition, and small sample sizes, but received high dissemination readiness ratings (3.8/4.0). There is no cost to implement this program.
For more information contact: Leslie McGuire, MSW, teenscreen@nyspi.columbia.edu, 866.833.6727, http://www.teenscreen.org.

Cognitive Behavioral Therapy (CBT) for Late-Life Depression (NREPP review December 2006). This is a mental health treatment program targeting adults ages 55 and over. The program teaches older adults to identify, monitor, and challenge negative thoughts about themselves, and develop more positive thoughts. It has been tested with individuals from numerous ethnic-minority groups in their training and research programs using the original protocols with successful outcomes. Adaptations have been developed for use with special populations such as family caregivers, Latinos, Asians, African Americans, and Persians. A male-specific adaptation has also been developed. Translations and back-translations of the manuals and instruments for evaluation have been made available in Spanish and Chinese. Randomized trials have shown the effectiveness of this intervention among Latinos, Chinese, and African Americans. The program has been shown to reduce depression symptoms, improve measures of life satisfaction, reduce psychiatric symptoms other than depression, and improve overall adjustment and coping with treatment. In review of the evidence, it received low outcomes ratings (<3.1/4.0) due to lack of generalizability. The program also received low dissemination readiness ratings (1.8/4.0) due to lack of detailed information for administrators on the organizational requisites for effective implementation; lack of materials, resources, or technical assistance to support training or coaching; lack of information on developing therapeutic relationships; and lack of programmatic quality assurance measures. The cost of this program is $60 for the treatment guide and client workbook, $500 per day per trainer plus travel expenses for a two- to three-day workshop, and variable costs for quality assurance scales.
For more information contact: Larry W. Thompson, PhD, larrywt@stanford.edu, 650.400.8171, or Dolores Gallagher-Thompson, PhD, ABPP, dolorest@stanford.edu, 650.400.8172, http://oafc. stanford.edu.

Dialectical Behavior Therapy (DBT) (NREPP review October 2006). This is a cognitive behavioral- based treatment that includes behavioral problem solving and acceptance strategies with an emphasis on multiple disorders. The program is targeted towards adults 18 years of age and older. Adaptations of DBT have been developed for multiple categories including suicidal adolescents, individuals with substance use disorders, individuals with eating disorders, individuals with comorbid HIV and substance use disorders, developmentally delayed individuals, older adults with depression and one or more personality disorders, individuals with schizophrenia, families of patients, women experiencing domestic violence, violent intimate partners, individuals who stalk, inpatient and partial hospitalization settings for adolescents and adults, and forensic settings for juveniles and adults. One year after DBT for suicidal adolescents during a randomized controlled trial, there were lowered suicide attempts in the DBT group compared to the group in the alternative expert treatment. Multiple evaluations, including randomized controlled trials and independent studies, confirmed that patients completing one year of DBT experienced less non-suicidal self-injury than patients awaiting care or receiving alternative treatment. Seven randomized controlled trials found that one year of DBT improved at least some measures of psychological, social, or global adjustment. In review of evidence, this program received high outcomes ratings (3.2-3.7/4.0) and high dissemination readiness ratings (3.2/4.0). The costs of this program are available by contacting the developer.
For more information contact: Behavioral Tech, LLC, information@behavioraltech.org, 206.675.8588; Kathryn E. Korslund, PhD, ABPP, korslund@uw.edu, 206.616.7324; or Marsha M. Linehan, PhD, ABPP, linehan@uw.edu, 206.543.9886, http://depts.washington.edu/brtc/about/dbt.

Dynamic Deconstructive Psychotherapy (NREPP review October 2011). This is a 12- to 18-month treatment targeting adults ages 18 years and older with borderline personality disorder, alcohol or drug dependence, self-harm, or eating disorders, who have also had recurrent suicide attempts. No population- or culture-specific adaptations of the intervention were identified by the developer. The program has been shown to reduce depression, as measured by the Beck Depression Inventory (BDI), decrease suicide attempts and self-harm, and reduce number of days of heavy drinking. In review of evidence, it received high outcomes ratings (>3.0/4.0) and high dissemination readiness ratings. This program costs individuals $150 per hour, or $100 per hour per person for groups of two or three, with reduced per person cost for groups of four or five. *For more information contact: Georgian T. Mustata, MD, mustatag@upstate.edu, 315.464.3130, or Robert J. Gregory, MD, gregoryr@upstate.edu, 315.464.3105, http://www.upstate.edu/ddp.*

Emergency Department Means Restriction Education (NREPP review March 2010). This is an intervention targeted at adult caregivers of youth (ages 6-19) who are seen in an emergency department (ED) and determined through a mental health assessment to be at risk for committing suicide. This program helps parents and adult caregivers of at-risk youth understand the importance of restricting access to firearms, alcohol, and prescription and over-the-counter drugs. Parents and caregivers who received the intervention were significantly more likely to report limiting access to medications that can be used in an overdose suicide attempt, and limiting access to firearms. In review of the evidence, this program received low outcomes ratings (2.5-2.7/4.0) due to the data collection methods, attrition rates, and lack of positive impact on suicidal ideation. This program also received low readiness for dissemination readiness ratings (2.4/4.0). This program costs $50 per set of implementation materials. *For more information contact: Markus J. Kruesi, MD, 843.792.0135, http://www.militaryfamilies. psu.edu/programs/emergency-department-means-restriction-education.*

Emergency Room Intervention for Adolescent Females (NREPP review October 2007). This program is targeted at teenage girls (ages 12-18) admitted to the emergency department (ED) after attempting suicide. The program involves the teenage girl and one or more family members, and aims to increase outpatient treatment to reduce future suicide attempts. This program is available in English and Spanish, and is being adapted for use by American Indians. The program has been shown to improve adolescents' likelihood to obtain and complete outpatient treatment, lower depression for the teenage girl and the mother, reduce suicidal ideation, and result in more positive maternal attitudes towards treatment. In reviewing the evidence, the program received low outcomes ratings (2.1-3.0/4.0), and low dissemination readiness ratings (1.5/4.0) due to outdated research in implementation materials, difficulty in navigating implementation materials, lack of formal training support material, and lack of quality assurance material. There is no cost to implement this program. *For more information contact: Mary Jane Rotheram-Borus, PhD, rotheram@ucla.edu, 310.794.8278, http://chipts.ucla.edu/interventions/manuals/interer.html.*

Interpersonal Psychotherapy for Depressed Adolescents (NREPP review August 2010). This program is targeted towards adolescents (ages 12-18) with mild to moderate depression. It aims to improve adolescents' communication and social problem-solving skills to reduce depression symptoms. The program is implemented through a therapist in hospital-based, school-based, and community outpatient clinics over 12 weeks through weekly 35- to 50-minute treatment

sessions. The program has been adapted for use with Puerto Rican adolescents with depression. The program monitors the adolescents' depression symptoms and suicide risk. The adolescents receiving program treatment were shown to be less depressed, have better social functioning, and have higher positive problem orientation skills. This program received high ratings for outcomes (>3.9/4.0), and high ratings for dissemination readiness (3.5/4.0). The cost of this program is $33 for each implementation manual, $2,000-$5,000 for on-site implementation training, and various costs for certification.
For more information contact: Laura Mufson, PhD, lhm3@columbia.edu, 212.543.5561, http://www.interpersonalpsychotherapy.org/.

Lifelines Curriculum (NREPP review June 2009). This suicide prevention program is aimed at middle school and high school students (ages 13-17) to increase the likelihood of staff and students identifying at-risk students, providing an appropriate initial response, seeking help, and increasing their inclination to take actions. The program increased knowledge about suicide, improved attitudes towards suicide and suicide intervention, improved attitudes toward seeking adult help, and improved attitudes about not keeping a friend's suicide ideations a secret. In review of the evidence, the program received average range outcomes ratings (2.9/4.0), and high dissemination readiness ratings (3.7/4.0). This program costs $225 for the implementation package.
For more information contact: Richard Solly, rsolly@hazelden.org, 651.213.4484; Cheryl DiCara, cheryl.m.dicara@maine.gov, 207.287.5362; or Mary Madden, PhD, mary.madden@umit.maine.edu, 207.581.3494, http://www.hazelden.org/web/public/lifelines.page.

Multisystemic Therapy With Psychiatric Supports (NREPP review November 2008). This program is targeted at youth (ages 9-17) who are at risk of psychiatric hospitalizations for behavior problems and co-occurring mental health disorders. The goal of the program is to lessen mental health disorders, suicidal behaviors, and family relations through interventions at the family level. The program has been shown to reduce participants' externalizing symptoms, improve family structure and cohesion, improve school attendance, reduce self-reported suicide attempts, prevent hospitalization, and reduce number of days hospitalized. In review of the evidence, this program received high outcomes ratings (3.0-3.5/4.0), and high dissemination readiness rating (4.0/4.0). This program costs $15,000 plus travel expenses for program development start-up fees, $96,500 for annual program support and service fees, $350 per participant plus travel expenses for a two-day supervisor orientation training, about $7,920 for tape coding, and about $3,600 per year for adherence data collection.
For more information contact: Marshall E. Swenson, MSW, MBA, marshall.swenson@mstservices.com, 843.284.2215, or Melisa D. Rowland, MD, rowlandm@musc.edu, 843.876.1800, http://www.mstservices.com/.

Peer Assistance and Leadership (NREPP review November 2010). This program is targeted at youth (ages 6-17) to prevent risk factors for substance use as well as to avoid other problems such as low achievement in school, dropout, absenteeism, violence, teen pregnancy, and suicide through peer-based assistance. Program participation was shown to improve academic performance, classroom attendance, classroom behavior, and relationships with school, family, and peers. In review of the evidence, the program received low outcomes ratings (2.0-2.3/4.0) due to lack of reliability and validity measures, attrition of participants, and lack of control

group. However the program received the highest dissemination readiness ratings (4.0/4.0). This program costs $160 per program packet, $250 for in-state teachers for a two-day off-site teacher training, $500 for out-of-state teachers for a two-day off-site teacher training, and $2,000 per day for an on-site teacher training.
For more information contact: Terrence R. Cowan, MPA, trcowan@wapeap.com, 512.328.8518, or Robert Landry, PhD, rlandryreds@att.net, 281.488.9900, http://www.palusa.org/index.html.

Prevention of Suicide in Primary Care Elderly: Collaborative Trial (NREPP review March 2007). This program is targeted at older primary care patients (ages 55 and older) and aims to reduce suicidal ideation and depression in the primary care setting. The program was shown to decrease depression, have earlier remission of depression, and decrease rates of suicidal ideations. In review of the evidence, the program received high outcomes ratings (3.7/4.0), and high dissemination readiness ratings (3.2/4.0). This program has no cost for implementation.
For more information contact: Patrick J. Raue, PhD, praue@med.cornell.edu, 914.997.8684, http://www.ncbi.nlm.nih.gov/pubmed/22033641.

Reconnecting Youth: A Peer Group Approach to Building Life Skills (NREPP review September 2009). This school-based prevention program is targeted at students ages 14-19 with behavioral problems such as suicidal ideation, depression, substance abuse, and aggression. Students participating in this program showed decrease in progression of drug use, decrease in depression measures, and decrease in suicide risk behaviors. In review of the evidence, this program received high outcomes ratings (3.2-3.3/4.0), and high dissemination readiness ratings (4.0/4.0). The cost of this program is $299.95 for each curriculum, $24.95 for each student workbook (or $211.95 for 10), and $1,000 per person for at least eight participants per trainer for a four-day on- or off-site training workshop for leaders and coordinators.
For more information contact: Beth McNamara, MSW, beth@reconnectingyouth.com, 425.861.1177, http://www.reconnectingyouth.com.

Seeking Safety (NREPP review October 2006). This program is aimed at providing coping skills and psychoeducation for clients with a history of trauma or substance abuse. This program has been tested with women, men, adolescent females, low-income urban women, incarcerated women, and veterans. The program is targeted at men and women (ages 13-55) in a variety of settings, including outpatient, inpatient, and residential. This program has been shown to reduce severity of substance abuse, suicidal thoughts, and risk for future suicide. In review of the evidence, this program received low outcomes ratings (2.1-2.3/4.0) due to small sample sizes and convenience sampling, and high dissemination readiness ratings (4.0/4.0).
For more information contact: Lisa M. Najavits, PhD, lnajavits@hms.harvard.edu, 617.731.1501, http://www.seekingsafety.org.

Signs of Suicide (NREPP review September 2006). This two-day secondary school intervention program is targeted at adolescent students (ages 13-17).The students are screened for depression and suicide risk, and taught appropriate responses to suicide and depression. The Signs of Suicide screening tool is also available in Spanish. This program has been shown to have lowered suicide attempts, increased knowledge about suicide and depression, and increased preventive attitudes towards depression and suicide. In review of the evidence, the program received low outcomes ratings (2.2-2.8/4.0) due to lack of additional documentation on reliability and

validity and lack of pretest measures of outcomes. The program also received low dissemination readiness ratings (2.5/4.0) due to lack of formal training curriculum, supervision and support for the lead implementer, and difficulty in scheduling the program into the existing school schedules. This program costs $375 for each Signs of Suicide high school kit.
For more information contact: Connie DiCocco, MEd, sosinfo@mentalhealthscreening.org, 781.239.0071 ext 105, http://www.mentalhealthscreening.org/highschool.

Sources of Strength (NREPP review September 2011). This universal suicide prevention program is targeted at high school students (ages 13-25) who are at risk of suicide. The program trains peer leaders to conduct messaging activities in order to reduce group problem behaviors such as self-harm, drug use and unhealthy sexual practices, and the acceptability of suicidal activities among youth. During a randomized control trial, the trained peer leaders were more likely to seek help from adults at school, be knowledgeable about adult help options for suicidal students, reject codes of silence, refer distressed students to adults, and reduce maladaptive coping behaviors. In review of the evidence, the program received average outcome ratings (2.8-3.1/4.0) due to lack of documentation of other outcomes, and the highest readiness for dissemination ratings (4.0/4.0). This program costs $7,000 for model I package over 3 years, and $15,500 for model I package plus community and schoolwide presentations, and support in developing local materials, evaluation support and report development.
For more information contact: Mark LoMurray, marklomurray@gmail.com, 701.471.7186, or Peter Wyman, PhD, peter_wyman@urmc.rochester.edu, 585.273.3372, http://www.sourcesofstrength.org.

Trauma-Focused Coping (Multimodality Trauma Treatment) (NREPP review August 2011). This program is targeted at children and adolescents in grades 4-12 who have been exposed to a traumatic stressor. The program provides intervention through psychoeducation, anxiety management skill building, and cognitive coping skill building. Among program participants, it has been shown to reduce frequency and intensity of post-traumatic stress syndrome, decrease depression symptoms, decrease anxiety, decrease anger, shift locus of control from external to internal, and improve general mental health functioning related to trauma and treatment from baseline. In review of the evidence, this program received average outcomes ratings (2.9-3.0/4.0), and high dissemination readiness ratings (3.7/4.0). This program has no implementation cost.
For more information contact: Lisa Amaya-Jackson, MD, MPH, amaya001@mc.duke.edu, 919.403.2784 ext 405, or Ernestine Briggs-King, PhD, brigg014@mc.duke.edu, 919.403.2784 ext 228, http://epic.psychiatry.duke.edu/our-work/projects/trauma-focused-coping.

United States Air Force Suicide Prevention Program (NREPP review July 2006). This program is targeted at reducing suicide among adults in the United States Air Force. The program aims to strengthen social support, promote development of social skills, and encourage effective help-seeking behaviors. It has been shown to reduce the risk of committing suicide, family violence, homicide, and accidental death compared with risk prior to implementation. In review of the evidence, this program received low outcomes ratings (2.8/4.0) due to limited documentation on cause of death and limited control over confounding variables, and received low dissemination readiness ratings (1.7/4.0) due to lack of information on instructor or coach selection, lack of process delineation, and lack of outcome measure data collection methods. There is no cost to implement this program.
For more information contact: Michael Kindt, Lt Col, PhD, michael.kindt@lackland.af.mil, 210.395.9130, afspp.afms.mil/.

Wellness Recovery Action Plan (WRAP) (NREPP review September 2010). This mental health treatment program is targeted at adults ages 26-55 with mental illnesses. This program has also been used for individuals with arthritis and diabetes, military personnel and veterans, and individuals needing help with life issues such as decision making and interpersonal relationships. This program, through lectures, discussion, and exercises teaches participants how to develop and implement hope, personal responsibility, education, self-advocacy, and support in their day-to-day lives; how to organize activities that can help them feel better or prevent experiencing mental health difficulties; how to create an advanced directive with family and friends for when they become unable to take appropriate actions for themselves; and how to develop wellness plans for when the mental illness subsides. The implementation materials for this program have been translated into many languages including Chinese, French, Japanese, Polish, and Spanish. This program has been shown to reduce the occurrence and severity of mental illness, increase hopefulness, produce a higher recovery score, improve self-advocacy, and increase self-reported physical and mental health status. In review of the evidence, the program received high outcomes ratings (3.3-3.9/4.0), and high ratings for dissemination readiness (3.6/4.0). The cost to implement this program is $129 for each facilitator training manual, $10 for each Wellness Recovery Action Plan book, and $2-$60 each for books and videos for facilitators.

For more information contact: Mary Ellen Copeland, PhD, info@copelandcenter.com, 802.254.5335, or Judith A. Cook, PhD, cook@ripco.com, 312.355.3921, http://www.mentalhealthrecovery.com/.

Level I: North Carolina Practice Improvement Collaborative (NC PIC) Evidence-Based Practices[4]

Contingency Management (NC PIC review April 2009). This program is targeted at adults with substance abuse disorders. Contingency Management provides the participants with small rewards for complying with treatment goals such as treatment attendance, prescribed medication adherence, and negative urine samples. This program has been shown to improve treatment retention and reduce drug use.

For more information contact: Maxine Stitzer, mstitzer@jhmi.edu, 410.550.1550; Nancy Petry, petry@psychiatry.uchc.edu, 860.679.2593; or Stephen Higgins, stephen.higgins@uvm.edu, www.bhrm.org/guidelines/petry.pdf.

Integrated Dual Disorder Treatment (IDDT) (NC PIC Review August 2009). This program is targeted at adults with co-occurring mental illness and substance abuse disorders. This program delivers concurrent treatment for substance abuse and mental illness with emphasis on assertive outreach, engagement, persuasion, active treatment and relapse prevention, and treatment goal setting with person-centered interventions. This program has been shown to improve mental health (decrease depression and anxiety, decrease psychiatric symptoms, improve psychological functioning, and improve medication compliance), and substance use outcomes (decrease substance use, increase total and continuous abstinence, and decrease relapse rates). The toolkit to develop an IDDT program is available from the Substance Abuse & Mental Health Services Administration.

For more information contact: Kristine Knoll, Kristine.M.Knoll@Dartmouth.edu, (603) 271-5747; Kim T. Mueser, Kim.t.mueser@dartmouth.edu, 603.271.5747, http://store.samhsa.gov/product/Integrated-Treatment-for-Co-Occurring-Disorders-Evidence-Based-Practices-EBP-KIT/SMA08-4367.

Matrix Intensive Outpatient Treatment (NC PIC review January 2010). This program is targeted at individuals with substance abuse disorders, and specifically at those who abuse stimulants such as methamphetamines. The program combines other evidence-based treatment programs such as motivational interviewing, cognitive behavioral therapy, and contingency management. This program has been shown to increase the number of people who complete treatment for stimulant addiction by 27%-38%, result in higher average drug-free urine screens, and reduce stimulant use during treatment.
For more information contact: Richard Rawson, rrawson@mednet.ucla.edu, 949.631.1510, www.matrixinstitute.org.

Post Deployment Mental Health (NC PIC review June 2011). This program is targeted at active duty National Guard and Reserve service members, as well as veterans. The program provides participants screening, assessment, and, if necessary, evidence-based treatment for post-traumatic stress disorder (PTSD). Treatments include Seeking Safety, Cognitive Processing Therapy (CPT), Prolonged Exposure (PE) therapy for PTSD, and Acceptance and Commitment Therapy (ACT) for depression. This program has been shown to reduce severity of PTSD symptoms and improve social adjustment. Specifically, CPT improved co-occurring symptoms of depression and general anxiety, affect functioning, guilt, distress, and social adjustment.[7]
For more information contact: www.ncoperationrecovery.org/download/93/.

The Seven Challenges (NC PIC review July 2010). This program is targeted at adolescents (ages 13-17) with substance abuse disorders, co-occurring mental illnesses, and/or life skills deficits. The program provides participants with counseling for their illnesses using motivational interviewing, cognitive behavioral therapy, and problem-solving skills training. The program has been shown to increase abstinence, decrease substance use severity and related problems, and improve mental health symptoms.
For more information contact: Sharon Conner, sconner@sevenchallenges.com, 520.405.4559, or Robert Schwebel, PhD, rschwebel@sevenchallenges.com, 520.748.2122, www.sevenchallenges.com.

Trauma-Focused Cognitive Behavioral Therapy (NC PIC review March 2009). This program is targeted at children and adolescents (ages 6-17) who are exposed to trauma. This program treats post-traumatic stress and related emotional and behavioral problems through psychoeducation, parenting skills, relaxation skills, affect expression and regulation skills, cognitive coping skills and processing, trauma narrative, in vivo exposure, conjoint parent-child sessions, and enhancing safety and future development. This program has been shown to improve behavior; decrease symptoms of PTSD, depression, and feelings of shame; and improve emotional reaction of the parent/guardian to the child's experience of trauma. The cost of delivering this program to an individual is estimated at $1,800 for 20 sessions.
For more information contact: NC Child Treatment Program c/o Center for Child and Family Health, ctp@med.unc.edu, 919.419.3474 ext 300, http://ncctp.med.unc.edu/.

Wellness Management and Recovery (NC PIC review December 2009). This program is targeted at adults (ages 18-67) with schizophrenia, bipolar disorder, or major depression. Through psychoeducation, behavioral tailoring for medication adherence, relapse prevention training, coping skills training, and social skills training, the program enables individuals with severe mental illnesses to set and achieve goals towards recovery. Wellness Management and Recovery has been

shown to improve participants' knowledge of mental illnesses, improve medication adherence, reduce relapses and re-hospitalizations, and reduce severity and persistence of symptoms. The toolkit to develop a Wellness Management and Recovery program is available from the Substance Abuse and Mental Health Services Administration.

For more information contact: Ann K. Oshel, aoshel@co.durham.nc.us, 919.560.7541, or Kim T. Mueser, kim.t.mueser@dartmouth.edu, 603.271.5747, http://store.samhsa.gov/product/Illness-Management-and-Recovery-Evidence-Based-Practices-EBP-KIT/SMA09-4463.

Level II: Expert/Consensus Statements[5]

Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment: A Treatment Improvement Protocol TIP 50. This protocol provides guidance for substance abuse counselors regarding substance abuse and suicide, risk factors and warning signs of suicide, and a four-step process for addressing suicidal behavior and thoughts. This protocol also provides information for administrators as well as information on available literature on the topic. The treatment improvement protocol (TIP) recommendations are derived from evidence-based literature and the opinions of expert panels. This protocol guide is available at no cost on the Substance Abuse and Mental Health Services Administration website.

For more information contact: Kenneth R. Conner, PsyD, MPH, 585.273.5136, http://www.kap.samhsa.gov/products/manuals/tips/pdf/TIP50.pdf.

At-Risk in the ED. This is a one-hour online interactive simulation for emergency department (ED) staff. The video teaches staff how to recognize patients with warning signs of suicide and substance abuse, screen patients for these issues, and respond to patients who screen positive. This simulation costs $35- $75 per user.

For more information contact: Ron Goldman, ron@kognito.com, www.kognito.com, 212.675.9234.

Consensus Statement on Youth Suicide by Firearms. This statement provides recommendations on safe firearm storage practices, training of professionals to inquire about the presence of firearms in the homes of youth at risk of suicide, educating parents, and maintaining alcohol and drug-free homes. These recommendations were developed by American Association of Suicidology and are available for no cost.

For more information contact: Alan L. Berman, PhD, berman@suicidology.org, 202.237.2280, http://www.sprc.org/sites/sprc.org/files/bpr/ConsensusStatementYouthSuicideFirearms.pdf.

Framework for Developing Institutional Protocols for the Acutely Distressed or Suicidal College Student. This statement provides colleges and universities with a list of issues to consider when drafting or revising policy related to the management of students in acute distress or at risk for suicide. The guidelines include information on developing a safety protocol, an emergency contact notification protocol, and a leave of absence and re-entry protocol. This protocol was developed by The Jed Foundation and is available at no cost.

For more information contact: Courtney Knowles, cknowles@jedfoundation.org, 212.647.7544, www.jedfoundation.org.

Guidelines for School-Based Suicide Prevention Programs. These guidelines provide schools administrators with recommendations on safe and effective school-based prevention programs. These guidelines were developed by the American Association of Suicidology and are available for a small fee.
For more information contact: Allan L. Berman, PhD, berman@suicidology.org, 202.237.2280, http://www.sprc.org/sites/sprc.org/files/library/aasguide_school.pdf.

National Guidelines for Seniors' Mental Health: The Assessment of Suicide Risk and Prevention of Suicide. These guidelines provide recommendations on assessment of suicide risk and prevention of suicide among seniors. The guidelines were developed by the Canadian Coalition for Seniors' Mental Health (CCSMH) to identify the best practices in Seniors' mental health in Canada and internationally. The guidelines are available at no cost.
For more information contact: Faith Malach, fmalach@baycrest.org, 416.785.2500 ext 6331, http://www.ccsmh.ca/en/natlGuidelines/initiative.cfm.

Recommendations for Reporting on Suicide. These recommendations are aimed at reducing the risk of subsequent suicide deaths among media consumers through reduced language in media that might increase suicide ideation. The recommendations also discuss presentation of suicide causes in the media, avoiding myths and misunderstanding of suicide in media, and guidelines on questions and angles to pursue about suicide. This program is available at no cost.
For more information contact: Wylie G. Tene, wtene@afsp.org, 888.333.AFSP ext 2024, ReportingOnSuicide.org.

Recommendations for Youth Suicide Prevention Training for Early Identification and Referral (Gatekeeper Training). These recommendations are targeted at those interested in developing, training, and implementing gatekeeper programs to prevent suicide. The recommendations provide information on protocols that should be included in gatekeeper training programs to increase effectiveness and safety, tailoring programs to meet local needs, and selecting gatekeepers who would be effective in their roles. The recommendations are available at no cost.
For more information contact: Michael (Chad) Rodi, mrodi@icfi.com, 404.592.2116, http://www.sprc.org/sites/sprc.org/files/library/RecommendationsGatekeeperTraining.pdf.

A Resource Guide for Implementing the Joint Commission 2007 Patient Safety Goals on Suicide. This is a guide developed by Screening for Mental Health, Inc. for health care settings in response to the Joint Commission's requirement to improve identification of those at risk of suicide. This guide provides information on conducting suicide assessment, estimating suicide risk, and developing treatment plans and interventions. This guide follows the American Psychiatric Association practice guidelines. There is no cost associated with this guide.
For more information contact: Screening for Mental Health Inc., smhinfo@mentalhealthscreening. org, www.mentalhealthscreening.org, 781.239.0071, http://www.sprc.org/sites/sprc.org/files/ library/jcsafetygoals.pdf.

Standards for the Assessment of Suicide Risk Among Callers to the National Suicide Prevention Lifeline. These standards provide crisis telephone line workers with evidence-based standards for assessing a person's risk for suicide. The guidelines were developed by the

National Suicide Prevention Lifeline's Standards, Training and Practices Division Subcommittee and are available at no cost.
For more information contact: G. Lee Judy, ljudy@mhaofnyc.org, 618.281.3986, www.atypon-link. com/GPI/toc/suli/37/3.

Student Mental Health and the Law: A Resource for Institutions of Higher Education.
This manual provides clarifications on legal constraints colleges have to abide by and guidelines on addressing campus mental health and students in distress. The guidelines are available at no cost.
For more information contact: Courtney Knowles, cknowles@jedfoundation.org, 212.647.7544, www.jedfoundation.org/legal.

Suicide Prevention Efforts for Individuals with Serious Mental Illness: Roles for the State Mental Health Authority. This report provides guidelines on the roles state mental health authorities can take to increase collaboration, raise awareness of suicide warning signs, and intervene appropriately. These guidelines are available at no cost.
For more information contact: National Association of State Mental Health Program, 703.739.9333, www.nasmhpd.org/publicationsmeddir.cfm.

Talking About Suicide & LGBT Populations. These guidelines provide information on how to talk about suicide in ways that minimize contagion risk; promote need for family support and acceptance for lesbian, gay, bisexual, and transgender (LGBT) individuals; and encourage help seeking among LGBT individuals who may be contemplating suicide. This resource is available at no cost.
For more information contact: Sean Lund, sean@lgbtmap.org, 323.440.2073, www.lgbtmap.org/ talking-about-suicide-and-lgbtpopulations.

Towards Good Practice: Standards and Guidelines for Suicide Bereavement Support Groups. These guidelines were developed for those who develop, facilitate, or participate in suicide bereavement support groups. The guidelines provide benchmarks against which bereavement support groups can be examined, improved or validated. The standards and guidelines are available at no cost.
For more information contact: Susan Beaton, national@lifeline.org.au, 61.02.6215.9442, www. lifeline.org.au.

Video Evaluation Guidelines (for Youth Suicide Prevention). These guidelines were developed for the American Association of Suicidology video review committee to assess youth suicide prevention videos. The guidelines are available at no cost on the AAS website.
For more information contact: Sue Eastgard, MSW, suee@yspp.org, 206.297.5922 ext 1, http:// suicidology.org/web/guest/stats-and-tools/videos.

Warning Signs for Suicide Prevention. These guidelines are targeted at representatives at informational and educational campaigns surrounding suicide and provide information on warning signs for suicide prevention to look for during the campaigns. The warning signs are developed into a hierarchy by degree of risk, and emphasize clear and specific direction about what to do if someone exhibits any of these warning signs.[8]
For more information contact: American Association of Suicidology, info@suicidology.org, 202.237.2280.

Level III: Adherence to Standards[6]

After a Suicide: A Toolkit for Schools. This is an online resource for schools with students bereaved by the suicide of a student or other member of the school community. The materials provide an overview of existing materials and research findings, in addition to references, templates, and additional information links. The materials are designed to be used during a crisis and not as a comprehensive postvention curriculum.

For more information contact: Joanne L. Harpel, JD, MPhil, jharpel@afsp.org, 212.363.3500 ext 32, or Peggy West, PhD, MSW, pwest@edc.org, 206.362.2179, http://www.theconnectprogram.org/.

After an Attempt: A Guide for Medical Providers in the Emergency Department Taking Care of Suicide Attempt Survivors. This guide was developed for medical professionals working in the emergency department in order to provide them with tips on communicating with patients, families, and caregivers, as well tips for discharging the patient. The guide is available at no cost on the Substance Abuse and Mental Health Services Administration website.

For more information contact: Substance Abuse and Mental Health Services Administration Health Information Network, 877.726.4727, http://store.samhsa.gov/product/A-Guide-for-Medical-Providers-in-the-Emergency-Department-Taking-Care-of-Suicide-Attempt-Survivors/SMA08-4359.

After an Attempt: A Guide for Taking Care of Your Family Member After Treatment in the Emergency Department. This guide provides information for family members of those who have attempted suicide. The guide has information regarding suggested assessment, treatment and follow-up to the emergency department visit. The guide is available at no cost.

For more information contact: Substance Abuse and Mental Health Services Administration Health Information Network, 877.726.4727, http://store.samhsa.gov/shin/content//SMA08-4357/SMA08-4357.pdf.

After an Attempt: A Guide for Taking Care of Yourself After Your Treatment in the Emergency Department. This guide is for individuals who have attempted suicide and received treatment in the emergency department. The guide discusses coping with emotional response, steps to take after the emergency department visit, ways to cope with future suicidal ideation, and points the reader to other resources. The guide is available at no cost.

For more information contact: Substance Abuse and Mental Health Services Administration Health Information Network, 877.726.4727, http://store.samhsa.gov/product/A-Guide-for-Taking-Care-of-Yourself-After-Your-Treatment-in-the-Emergency-Department/SMA08-4355.

Applied Suicide Intervention Skills Training (ASIST). This is a two-day training program for members of all caregiving groups. The program teaches participants how to help an at-risk person stay safe and seek additional help when needed. The workshop is targeted at social workers and other caregivers who might be the first point of contact for the individual with suicide ideation. The training-for-trainers costs $2,600. The training cost for caregiving group members varies, and the materials cost $36.

For more information contact: Jerry Swanner, usa@livingworks.net, 910.867.8822, http://www.livingworks.net/.

Army Ask, Care, Escort (ACE) Suicide Intervention Program. This is a three-hour training program for soldiers to provide them with awareness, knowledge, and skills necessary to intervene with those at risk of attempting suicide. The program includes a trainer's manual, PowerPoint slides with embedded videos, suicide prevention tip cards, and wallet cards with simplified information. The program is available at no cost.
For more information contact: James W. Cartwright, PhD, james.cartwright@us.army.mil, 410.436.7945, http://www.armyg1.army.mil/hr/suicide/training_sub.asp?sub_cat=25.

Ask 4 Help Suicide Prevention for Youth. This is one-hour high school-based curriculum that encourages youth to seek help for themselves or for others who may be at risk of suicide. The curriculum provides a wallet card with basic information on how to seek help. The direct training costs vary and are based on the number of participants and the location. The program toolkit costs $299.95.
For more information contact: Dale W. Emme, demme@yellowribbon.org, 303.429.3530, www. yellowribbon.org.

Assessing and Managing Suicide Risk: Core Competencies for Mental Health Professionals. This is a one-day workshop targeted at mental health professionals to help them better assess suicide risk, plan treatment, and manage care. This program was developed through consensus between clinicians and researchers. The training costs $65-$85 per participant.
For more information contact: Xan Young, M PH, xyoung@edc.org, 202.572.3728, http://www. sprc.org/training-institute/amsr.

At-Risk for High School Educators. This program is targeted at high school educators to teach them how to identify students at risk of depression or suicide, approach students to discuss concerns, and make referral to school support services. The program uses simulation to train the educators. The cost of this program is $500-$3,500 per school for the license, depending on the size of the school.
For more information contact: Ron Goldman, ron@kognito.com, 212.675.9234, www.kognito. com/products/highschool.

At-Risk for University and College Faculty: Identifying and Referring Students in Mental Distress. This is a 45-minute online simulation that gives university and college faculty and staff the knowledge necessary to identify and refer students with mental distress including depression, anxiety, and suicide ideation. This program costs $3,250 for annual licensing costs.
For more information contact: Ron Goldman, ron@kognito.com, 212.675.9234, www.kognito. com/products/faculty.

At-Risk for College Students. This is a 30-minute online interactive training program for university and college students. The program teaches students how to identify students at risk of depression or suicide, approach students to discuss concerns, and make referrals to school support services through a simulation. The cost of this program is $2-$20 per user of the licensed program.
For more information contact: Ron Goldman, ron@kognito.com, 212.675.9234, http://www. kognito.com/products/student/.

Be A Link! Suicide Prevention Gatekeeper Training. This program is a two-hour training program that can be implemented in a variety of settings including schools, workplaces, and community groups. The program provides knowledge on how to identify youth at risk for suicide and refer them to appropriate resources. The direct training costs of this program vary and the program toolkit costs $299.95.
For more information contact: Dale W. Emme, demme@yellowribbon.org, 303.429.3530, http://www.yellowribbon.org/.

CALM: Counseling on Access to Lethal Means. This is two-hour workshop targeted at health care providers to enable them to counsel clients at risk of suicide and their families in order to reduce access to lethal means, especially firearms. The program costs $750 for a workshop plus travel costs, and $3,000- $5,000 for a train-the-trainer program.
For more information contact: Elaine Frank, elaine.m.frank@dartmouth.edu, 603.653.1135, http://www.sprc.org/sites/sprc.org/files/bpr/CALM.pdf.

Campus Connect: A Suicide Prevention Training for Gatekeepers. This program is for college and university faculty, and students that is aimed at improving the participants' knowledge, awareness, and skills concerning college student suicide. Through interactive exercises, the program increases the participants' knowledge about suicide statistics, risk and protective factors, warning signs, referral resources, empathic listening skills, communication skills, ability to ask individuals if they are thinking about suicide, and self-reactions when interacting with these individuals. The train-the-trainer workshop for this program costs $4,500.
For more information contact: Cory Wallack, PhD, cwallack@syr.edu, 315.443.4715, or Susan Pasco, LCSW-R, sdpasco@syr.edu, 315.443.4715, http://counselingcenter.syr.edu/campus_connect/connect_overview.html.

Connect Suicide Postvention Program. This is a six-hour or three-day train-the-trainer program targeted at community professionals, including those in law enforcement, education, social services, and mental health/substance abuse, as well as faith leaders. The program provides community professionals with training to respond to a suicide effectively in order to prevent additional suicides. The six-hour training program costs $3,000 for up to 25 participants, plus travel costs, and a three-day train-the-trainer program costs $5,000-$9,000 plus travel expenses.
For more information contact: Anne Rugg, arugg@naminh.org, 207.752.7351, http://www.theconnectprogram.org/training/postvention-training-promoting-healing-and-reducing-risk-after-suicide.

Connect Suicide Prevention Program. This is a six-hour or three-day train-the-trainer program targeted at community professionals, including those in law enforcement, education, social services, and mental health/substance abuse, as well as faith leaders. The program provides community professionals training on how to recognize early warning signs of suicide, connect with individuals at risk, and connect at-risk individuals to help. The six-hour training program costs $3,000 for up to 25 participants plus travel costs, and a three-day train-the-trainer program costs $5,000-$9,000 plus travel expenses.
For more information contact: Anne Rugg, arugg@naminh.org, 207.752.7351, http://www.theconnectprogram.org/training/suicide-preventionintervention.

Depression and Bipolar Wellness Guides for Parents and Teens. These are two guides developed for parents and teens to understand and monitor treatment for depression and bipolar disorder. The guides are available at no cost from the Families for Depression Awareness Website.
For more information contact: Stacey Leibowitz, info@familyaware.org, 781.890.0220, http://www.projectinterface.org/docs/DepressionWellnessParents.pdf, http://www.projectinterface.org/docs/DepressionWellnessTeens.pdf.

Depression Wellness Guide for Adults with Depression and their Family and Friends. This guide is developed for adults with depression and their families and friends to help them better understand and monitor treatment for depression and dysthymia. The guide is available at no cost from the Families for Depression Awareness website.
For more information contact: Stacey Leibowitz, info@familyaware.org, 781.890.0220, http://www.familyaware.org/resources/wellness-guides.html.

The DORA College Program (Depression OutReach Alliance). This is a one-hour peer-based program that teaches successful intervention techniques through a video profile of college students who struggled with depression and suicide ideation. The program kit costs $125.
For more information contact: Jason Marshall, M S, jmarshall@mentalhealthscreening.org, 781.239.0071, http://www.mentalhealthscreening.org/programs/colleges/dora.aspx.

EndingSuicide.com. This website provides online continuing education modules on suicide prevention for professionals in health care and education. The online education modules are available at no cost, but there is a small fee charged if continuing medical education (CME) credit is required.
For more information contact: Mary P. Metcalf, metcalf@clinicaltools.com, 919.967.3023, e: www.EndingSuicide.com.

Family of Heroes. This is a one-hour interactive training program for family members of veterans. The simulation teaches family members how to identify signs of post-employment stress, approach veterans about concerns, and make a referral to a mental health support service. The program costs $2-$25 per user, depending on the number of licenses.
For more information contact: Ron Goldman, ron@kognito.com, 212.675.9234, http://www.kognito.com/products/ptsd/.

Gryphon Place Gatekeeper Suicide Prevention Program: A Middle School Curriculum. This program is targeted at students in grades 7 and 8 to increase the likelihood that students, staff, faculty and parents are able to identify, intervene with, and obtain help for at-risk individuals. The program is delivered in three lessons over three consecutive days with variable costs.
For more information contact: William H. Pell, wpell@gryphon.org, 269.381.1510, or Guy Golomb, ggolomb@gryphon.org, 269.381.1510, www.gryphon.org.

Healthy Education for Life. This is a suicide prevention program targeted at youth ages 14-19 years. The program teaches youth skills to identify the warning signs of depression and suicide, and empowers them to seek help for themselves or others. The program is delivered through a didactic portion and a 12-minute video portion. Healthy Education for Life is currently only available in Oklahoma.
For more information contact: Heartline Oklahoma, 405.840.9396, http://heartlineoklahoma.org/.

Helping Every Living Person Depression and Suicide Prevention Curriculum. This program educates high school students about depression and suicide (specifically stress and depression), risk factors and warning signs of suicide, and suicide intervention skills in four 45-minute lessons. The program integrates interactive learning through practice of intervention. The program materials cost $100 for Washington State schools and $250 for schools outside of Washington State.
For more information contact: Sue Eastgard, MSW, suee@yspp.org, 206.297.5922 ext 1, http://www.yspp.org/curriculum/HELP_curriculum.htm.

High School Gatekeeper Curriculum. This program is targeted at high school students educating them in identifying risk behaviors, asking about risk behaviors of concern, referring at-risk individuals, destigmatizing mental illnesses, breaking the "culture of silence," and encouraging help seeking. The program also includes teacher and parent education components. The cost of this program varies.
For more information contact: William H. Pell, Executive Director, Gryphon Place, wpell@gryphon.org, 269.381.1510, http://www.gryphon.org/, or Guy Golomb, ggolomb@gryphon.org, 269.381.1510.

How Not to Keep a Secret. This is a peer leader training program targeted at teens. The program educates teens about depression and suicide, help-seeking behaviors, and ways to reduce stigma associated with mental illnesses. This is a one-day training program that includes role playing. The manual for this program is available for $50 and the DVD is available for $75.
For more information contact: Barbara J. Green, PhD, bjgreenphd@aol.com, 781.749.9227, ext 3, http://www.adolescentwellness.org/wp-content/uploads/2011/06/How-Not-to-Keep-A-Secret-Table-of-contents.pdf.

In Harm's Way: Law Enforcement Suicide Prevention. This is an eight-hour train-the-trainer program targeted at law enforcement and corrections professionals to reduce the ir risk of suicide. The program is intended for the trained participants to return to their departments and train the administrators, officers, and staff on suicide prevention, reducing stigma associated with help seeking, and development of departmental policies, protocols, and procedures for officers at risk. There is no cost associated with this program.
For more information contact: Todd Kirchgraber, kirchgraber.todd@spcollege.edu, 727.344.8030, http://policesuicide.spcollege.edu.

Interactive Screening Program. This program is targeted at college students. The program, with permission from the college, emails the students a 34-question Stress and Depression Screening Questionnaire. The program provides the students with an assessment and information on help-seeking if necessary. The program costs $5,000 for the first year and $2,500 for the subsequent years.
For more information contact: Ann P. Haas, Ph D, ahaas@afsp.org, 207.236.2475, http://www.afsp.org/index.cfm?page_id=05967029-BC0C-603D-5A32D68043B9D7A8.

"Is Your Patient Suicidal?" Emergency Department Poster and Clinical Guide. This poster and guide were developed to help emergency department personnel recognize and respond to acute suicide risk. They can be purchased through the Emergency Nurses Association (ENA)

for $7 for ENA members and $10 for non-members. The poster and guide are also available in PDF formats through the Suicide Prevention Resource Center.
For more information contact: David Litts, O D, dlitts@edc.org, 202.572.3730, http://www.sprc. org/sites/sprc.org/files/library/ER_SuicideRiskGuide8.pdf, http://www.sprc.org/library_resources /items/your-patient-suicidal.

Late Life Suicide Prevention Toolkit. This program is targeted at preventing suicide among older adults. The toolkit focuses on identifying suicide warning signs, establishing rapport, assessing suicide risk factors, and managing immediate and ongoing risks for suicide. The program is available at no cost.
For more information contact: Kimberley Wilson, kwilson@baycrest.org, 416.785.2500 ext 6331, http://www.ccsmh.ca/en/projects/suicide.cfm.

LEADS for Youth: Linking Education and Awareness of Depression and Suicide. This program is targeted at high school students and designed to be taught in a health class setting. The program educates students as to how to identify symptoms and risk factors of depression and suicide, how to seek help, and where to find resources. The program costs $125 for a curriculum unit including PowerPoint slides, teacher manual, and crisis management protocols.
For more information contact: Dan Reidenberg, PsyD, dreidenberg@save.org, 952.946.7998, http:// www.save.org/.

Let's Talk Gatekeeper Training. This program is targeted at parents and adults who provide care to children. The program provides a two-hour training with lessons and interactive training in identifying risk factors and warning signs of suicide, communicating concern with at-risk youth, restricting means, and responding to a suicide crisis. The program is available at no cost.
For more information contact: Alan Holmlund, alan.holmlund@state.ma.us, 617.624.5476, www. mass.gov/dph/suicideprevention.

Lifelines Intervention: Helping Students at Risk for Suicide. This manual provides school staff with information on the suicide assessment and referral process, and information on how to work with resistant students and parents. The manual is available from the Hazelden Publishing bookstore for $149.
For more information contact: Laura Strapon, lstrapon@hazelden.org, 651.213.4714, http://www. hazelden.org/itemquest/go.view?go=item&item=131105.

Lifelines Postvention: Responding to Suicide and Other Traumatic Death. This manual provides instructions and outlines a template for creating a school-based response to the death of a school community member by suicide or other traumatic event. The manual is available from the Hazelden Publishing bookstore for $99.
For more information contact: Laura Strapon, lstrapon@hazelden.org, 651.213.4714, http://www. hazelden.org/itemquest/go.view?go=item&item=54103.

LifeSavers Training. This program is targeted at high school and college students. The program is a three-day program that teaches students how to listen to their peers to help them make healthier decisions. The program costs $230 per participant with a minimum of 45 participants.
For more information contact: Judy Ashby, MS, LCPC, lifesaversjudy@frontier.com, 618.549.5578, www.thelifesavers.net.

LOOK LISTEN LINK: A Health Curriculum for Middle School. This program, targeted at middle school students, includes four 45-minute lessons on identifying causes of stress, and healthy ways of coping with stress. The program also teaches students how to identify peers who are depressed and how to link them to resources. The program costs $100 within Washington State, and $250 outside of the state.
For more information contact: Sue Eastgard, MSW, suee@yspp.org, 206.297.5922 ext 1, http://www.yspp.org/curriculum/look_listen_link.htm.

Making Educators Partners in Youth Suicide Prevention. This program is targeted at school educators and staff. Through an online interactive training, the program provides the participants with knowledge on identification and referral of potentially suicidal youth. The program is available at no cost on the Society for Prevention of Teen Suicide website.
For more information contact: Maureen M. Underwood, LCSW, maureenunderwood@aol.com, 973.292.0602, http://spts.pldm.com/.

More Than Sad: Suicide Prevention Education for Teachers and Other School Personnel. This program is targeted at school educators and staff to educate them on suicidal behavior in adolescents, as well as causes, treatment, and prevention. The program is available for $99.99 from the American Foundation for Suicide Prevention (AFSP) online store.
For more information contact: Ann P. Haas, PhD, ahaas@afsp.org, 207.236.2475, http://www.morethansad.org/.

More Than Sad: Teen Depression. This is a 26-minute video targeted at teens (ages 13-18). The film provides information on depression through vignettes. The film is available for $49.95 from the American Foundation for Suicide Prevention online store.
For more information contact: Sarah Azrak, sazrak@afsp.org, 212.363.3500, ext 34, http://www.morethansad.org/.

Not My Kid: What Every Parent Should Know About Teen Suicide. This is a web-based video that features culturally diverse parents asking mental health professionals about youth suicide. The video is designed to inform parents on youth suicide. The video is available at no cost at the Society for the Prevention of Teen Suicide Website.
For more information contact: R. Scott Fritz, rsfritz@gmail.com, 973.292.0602, http://www.sptsusa.org/.

Operation S.A.V.E.: VA Suicide Prevention Gatekeeper Training. This is a one- or two-hour training program for veterans and those who care for veterans. The program includes training on identifying warning signs and risk factors of suicide, asking them about the concerns, and encouraging help seeking. The program is available from the VA at no cost.
For more information contact: Janet Kemp, RN, PhD, jan.kemp@va.gov, 585.393.7939.

Parents as Partners: A Suicide Prevention Guide for Parents. This is a nine-page booklet for parents who are concerned that their children might be at risk for suicide. The booklet is available for $3 from the Suicide Awareness Voices of Education (SAVE) website.
For more information contact: Dan Reidenberg, dreidenberg@save.org, 952.946.7998, www.save.org.

Preventing Transgender Suicide: An Introduction for Providers. This is a brochure targeted at health care professionals to inform them of issues related to suicide among the

transgender population. The brochure is available at no cost.
For more information contact: Alison T. Brill, MPH, alison.brill@state.ma.us, 617.624.5299, http://www.masstpc.org/publications/suicideprevention.shtml.

Question, Persuade, Refer (QPR) Gatekeeper Training for Suicide Prevention. This training program is targeted at community members to improve their ability to recognize and respond appropriately to someone exhibiting warning signs or risk factors for suicide. The training is provided in a one to two hour multimedia format. This program costs $495 in fees, $85 for recertification after three years, and $2 per set of materials. The QPR training program cost varies for the in-person version, and costs $29.95 for the online version.
For more information contact: Kathy White, qinstitute@qwest.net, 888.726.7926, www. qprinstitute.com.

Question, Persuade, Refer, and Treat (QPR-T) Suicide Risk Assessment and Management Training. This training program targets mental health providers and includes guided clinical protocol for assessing suicide risk. The program aims to develop standardized suicide risk assessment and integrates a collaborative crisis management, monitoring, and safety plan. The program costs vary depending on the type of training.
For more information contact: Paul Quinnett, PhD, qinstitute@qwest.net, 888.726.7926, www. qprinstitute.com.

Recognizing and Responding to Suicide Risk: Essential Skills for Clinicians. This training program is targeted at mental health clinicians. This two-day interactive training program educates mental health clinicians to better identify, manage, and treat adult patients at risk for suicide. The cost of this training program is $4,600, plus $65 for each participant covering up to 40 participants.
For more information contact: Alan L. Berman, PhD, berman@suicidology.org, 202.237.2280, http://www.suicidology.org/education-and-training/recognizing-responding-suicide-risk.

Recognizing and Responding to Suicide Risk in Primary Care. This training program is targeted at primary care physicians, physician assistants, and other primary care professionals. The one-hour facilitated training educates primary care professionals to better identify, manage, and treat adult patients at risk for suicide. The cost of this training program varies depending on the size of the group and the training location.
For more information contact: Alan L. Berman, PhD, berman@suicidology.org, 202.237, http:// www.suicidology.org/education-and-training/recognizing-responding-suicide-risk-primary-care.

Response: A Comprehensive High School-based Suicide Awareness Program. This high school-based program is targeted at students, staff, and parents. The program is designed to increase awareness, increase identification of warning signs, and increase facilitating referrals. The cost to implement this program is $375 for a school kit that includes implementation manuals, and coordinator and teacher manuals with associated PowerPoint presentations and DVDs. Additional teacher's manuals cost $125, the optional parent workshop costs $150, and an optional overview presentation costs $350.
For more information contact: Jill Hollingsworth, MA, jhollingsworth@columbiacare.org, 541.337.9001, http://www.columbiacare.org.

Riverside Trauma Center Postvention Guidelines. These guidelines are targeted at communities and organizations and provide recommendations on how to respond to suicide deaths in an effort to restore functioning to the community or organization and facilitate the grieving process. This protocol is available at the Riverside Trauma Center website.
For more information contact: Larry Berkowitz, EdD, lberkowitz@riversidecc.org, 781.433.0672, ext 5621, www.riversidetraumacenter.org.

Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version. This is a manual targeted at veterans at risk of suicide. The manual provides instruction on how to develop safety guidelines for at-risk veterans. The manual is available at no cost from the VA.
For more information contact: Janet Kemp, RN, PhD, jan.kemp@va.gov, 585.393.7939, http://www.mentalhealth.va.gov/docs/VA_Safety_planning_manual.pdf.

Saving Our Lives: Transgender Suicide Myths, Reality, and Help. This brochure is targeted at members of the transgender community, their family, and their friends. The brochure provides information regarding warning signs of suicide, myths and realities of suicide, how to listen to those at risk, how to help those at risk, and also contains a list of resources for those at risk. The brochure is available at no cost.
For more information contact: Alison T. Brill, MPH, Alison.Brill@state.ma.us, 617.624.5299, www.masstpc.org/publications/suicideprevention.shtml.

School Suicide Prevention Accreditation Program. This is a self-study course targeted at education professionals or those who work with school-age youth who are interested in learning about school-based suicide prevention issues. The program costs $350 for school-based professionals and $250 for graduate students.
For more information contact: Alan L. Berman, PhD, berman@suicidology.org, 202.237.2280, http://www.suicidology.org/school-accreditation.

Signs of Suicide Middle School Program. This program is targeted at middle school students. The program uses a video to teach students how to identify warning signs and risk factors of depression and suicide, and how to seek help for themselves or others. The program includes an optional screening for depression and suicide ideation. The cost to implement this program is $300.
For more information contact: Diane Santoro, LICSW, dsantoro@mentalhealthscreening.org, 781.591.5230, http://www.mentalhealthscreening.org/.

Sources of Strength. This program is targeted at teens and young adults. The program trains key adult community members to deliver messages of hope, help, and strength through classroom presentations, public service announcements, posters, videos, the Internet, and text messaging. The program costs $5,000 per school plus the trainer travel and accommodation costs.
For more information contact: Mark LoMurray, marklomurray@gmail.com, 701.471.7186, www.sourcesofstrength.info.

Student Support Network. This program is targeted at college students. The program trains peer leaders to identify, support, and refer peers affected by mental health or behavioral health concerns. The training manual for this program is available at no cost from the Worcester Polytechnic Institute Counseling Center. This program also makes available train-the-trainer consultations which cost $1,000-$3,000 plus travel expenses.

For more information contact: Charles Morse, sdcc@wpi.edu, 508.831.5540, www.wpi.edu/Admin/SDCC/index.html.

Suicide Alertness for Everyone. This is a half-day training program that teaches participants to identify individuals who might be having thoughts of suicide, and connect them with appropriate community resources. The program uses 60-90 second scenarios. The train-the-trainer program costs $820 for the instructor and $210 for materials, plus travel expenses. The training costs $300 for the trainer and $6.50-$7.50 for the materials per participant, plus travel expenses.
For more information contact: Jerry Swanner, usa@livingworks.net, 910.867.8822, http://www.livingworks.net/page/safeTALK.

Suicide Assessment Five-Step Evaluation and Triage. This program is targeted at mental health clinicians and healthcare providers. The protocol provides information for conducting a comprehensive suicide assessment, estimating suicide risk, identifying protective factors, and developing treatment plans and interventions responsive to the risk level of patients. The SAFE-T pocket card is available at no cost from the Suicide Prevention Resource Center (SPRC) website.
For more information contact: Screening for Mental Health Inc., smhinfo@mentalhealthscreening.org, 781.239.0071, http://www.sprc.org/sites/sprc.org/files/library/safe_t_pcktcrd_edc.pdf.

Suicide: Coping with the Loss of a Friend or Loved One. This is a 21-page booklet for those who have been bereaved by suicide. The booklet is available for $4 from the Suicide Awareness Voices of Education website.
For more information contact: Dan Reidenberg, dreidenberg@save.org, 952.946.7998, www.save.org.

Suicide Prevention Multicultural Competence Kit. This program presents mental health providers with tools to approach their multicultural clients in an effort to prevent suicide. The kit is available at no cost from the Pace University Counseling Center website.
For more information contact: Richard Shadick, PhD, shadick@pace.edu, 212.346.1526, http://www.pace.edu/counseling-center/sites/pace.edu.counseling-center/files/Multicultural-Competence-Suicide-Prevention-Kit-Manual.pdf.

Suicide Prevention Training for Gatekeepers of Older Adults. This program is targeted at those who have regular contact with older adults. In two four-hour sessions, the training program educates on overview on mental health, aging and suicide, warning signs and risk factors of suicide, working with older adults at risk for suicide, ongoing care and support for older adults at risk for suicide, and self-care. The training program is available to qualifying institutions in Massachusetts at no cost.
For more information contact: Mary Quinn, LICSW, mquinn@familyserviceinc.com, 978.327.6672, www.familyserviceinc.com/samaritans.

Supporting Survivors of Suicide Loss: A Guide for Funeral Directors. This guide is targeted at funeral directors to provide them with an understanding of suicide as it relates to them. The guide is available at no cost at the from the National Mental Health Information Center website.
For more information contact: For more information contact: Substance Abuse and Mental Health Services Administration Health Information Network, 877.726.4727, http://store.samhsa.gov/shin/content//SMA09-4375/SMA09-4375.pdf.

Survivor Voices: Sharing the Story of Suicide Loss. This is a two-day training program for those bereaved by suicide. The training allows individuals to speak safely about their loss. The training program costs $3,600 for two days, eight participants, materials for each participant, and four hours of consultation. This program also provides two- or three-day train-the-trainer program. The train-the-trainer program costs $5,000 for eight participants in a two-day training or $7,500 for a three-day train-the trainer program.
For more information contact: Anne Rugg, arugg@naminh.org, 207.752.7351, http://www. theconnectprogram.org/survivors/survivorvoices-sharing-story-suicide-loss.

Teens for Life. This program is targeted at high school and middle school students and youth served by community-based agencies in Alameda County, California. The one-hour course informs the participants about reducing stigma towards mental health disorders and help seeking, recognizing warning signs of depression and suicide, and seeking help for a friend or for themselves. This program is available at no cost for Alameda County, California, schools and community organizations.
For more information contact: Mercedes Coleman, mcoleman@crisissupport.org, 510.420.2473, http://www.crisissupport.org/teens_for_life.

What is Depression? How to Treat It and What to Do—A Suicide Prevention Guide for Young People. This is an eight-page booklet targeted at young adults. The booklet provides information on depression, its symptoms and causes, effective treatments, warning signs of suicide, recommendations on how to get help, and recommendations of sources of additional information. The booklet is available for $3 from the Suicide Awareness Voices of Education website.
For more information contact: Dan Reidenberg, dreidenberg@save.org, 952.946.7998, www.save.org.

Working Minds: Suicide Prevention in the Workplace. This program is targeted at workplace administrators and employees to help them better understand and prevent suicide. The program is available as a one-hour lunchtime presentation, a 1.5-hour in-service workshop, and a 3.5-hour intensive training. This program costs $99 for the DVD, or $1,000 for full-day training.
For more information contact: Sally Spencer-Thomas, PsyD, sally@carsonjspencer.org, 720.244.6535, http://www.WorkingMinds.org.

Youth Suicide Prevention, Intervention, and Postvention Guidelines: A Resource for School Personnel. This is a guide developed for school personnel informing them on developing protocols for suicide prevention, intervention, and postvention. The manual is available at no cost from the Maine Youth Suicide Prevention Program website.
For more information contact: Linda Williams, lwilliams@mcd.org, 207.622.7566 ext 243, http://www.maine.gov/suicide/docs/Guidelines%2010-2009--w%20discl.pdf.

Youth Suicide Prevention School-based Guide. This is a guide that provides information to school administrators that will enable them to assess their existing or proposed suicide prevention policies, and resources that the administrators could use to improve their existing program. The guide is available at no cost online.
For more information contact: Stephen Roggenbaum MA, roggenba@fmhi.usf.edu, 813.974.6149, http://theguide.fmhi.usf.edu.

Table C.1

LEVEL I: Evidence-Based Programs (NREPP)						
Program	**Target Audience**	Prevention	Early Intervention (*Screening Tool)	Treatment	Postvention	Policy Guidelines/ Protocols
Adolescent Coping With Depression	Adolescents (ages 13-17)			X		
American Indian Life Skills Development/ Zuni Life Skills Development	American Indian adolescents (ages 14 to 19)	X				
Care, Assess, Respond, Empower (CARE)	Adolescents (ages 13-17) and young adults (ages 18-25)		X*			
Coping and Support Training (CAST)	Youth (ages 14 to 19) identified as at risk for suicide			X		
Columbia University TeenScreen	Students at risk for suicide and mental illness (ages 13-25)		X*			
Cognitive Behavioral Therapy (CBT) for Late-Life Depression	Older adults (ages 55 and over)			X		
Dialectical Behavior Therapy (DBT)	Adults (ages 18 and over)			X		
Dynamic Deconstructive Psychotherapy	Adults at risk for or who have attempted suicide (ages 18 and over)			X		
Emergency Department Means Restriction Education	Adult caregivers of youth (ages 6-19) at risk for suicide		X			
Emergency Room Intervention for Adolescent Females	Females who have attempted suicide (ages 12-18)		X	X		
Interpersonal Psychotherapy for Depressed Adolescents	Adolescents with mild to moderate depression (ages 12-18)			X		
Lifelines Curriculum	Adolescents (ages 13-17)	X				
Multisystemic Therapy With Psychiatric Supports	Youth at risk of psychiatric hospitalizations (ages 9-17)			X		
Peer Assistance and Leadership	Children (ages 6-12) and adolescents (ages 13-17)	X				
Prevention of Suicide in Primary Care Elderly: Collaborative Trial	Older adult (ages 55+)	X		X		
Reconnecting Youth: A Peer Group Approach to Building Life Skills	Adolescents (ages 14-19)	X	X			
Seeking Safety	Persons with a history of trauma or substance abuse (ages 13-55)	X	X			
Signs of Suicide	Adolescents (ages 13-17)		X*			
Sources of Strength	High school students (ages 13-25)	X				
Trauma-Focused Coping (Multimodality Trauma Treatment)	Children (ages 6-12) and adolescents (ages 13-17) exposed to traumatic stressors		X			
United States Air Force Suicide Prevention Program	Members of the US Air Force (ages 18-55)	X				
Wellness Recovery Action Plan (WRAP)	Adult (ages 26-55)			X		

Table C.2

Level I: Evidence-Based Programs (NC PIC)						
Program	**Target Audience**	Prevention	Early Intervention (*Screening Tool)	Treatment	Postvention	Policy Guidelines/ Protocols
Contingency Management	Adults with substance abuse disorders	X				
Integrated Dual Disorder Treatment (IDDT)	Adults with co-occurring mental illness and substance abuse disorders	X	X			
Matrix Intensive Outpatient Treatment	Adults with substance abuse disorders (specifically methamphetamine)	X				
Post Deployment Mental Health	Active duty, National Guard and Reserve service members, and veterans	X	X*	X		
The Seven Challenges®	Adolescents (ages 13-17) with substance abuse disorders	X				
Trauma-Focused Cognitive Behavioral Therapy	Children and adolescents (ages 6-17) who were exposed to trauma	X	X			
Wellness Management and Recovery	Adults (ages 18-67) with schizophrenia, bipolar disorder, or major depression	X	X			

Table C.3

Level II: Expert/Consensus Statements (SPRC)						
Program	**Target Audience**	Prevention	Early Intervention (*Screening Tool)	Treatment	Postvention	Policy Guidelines/ Protocols
Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment: A Treatment Improvement Protocol TIP 50	Substance abuse counselors and clinical administrators	X	X	X		X
At-Risk in the ED	Emergency department staff		X			X
Consensus Statement on Youth Suicide by Firearms	Health care professionals					X
Framework for Developing Institutional Protocols for the Acutely Distressed or Suicidal College Student	Higher education institutions					X
Guidelines for School-Based Suicide Prevention Programs	School administrators					X
National Guidelines for Seniors' Mental Health: The Assessment of Suicide Risk and Prevention of Suicide	Healthcare providers and stakeholders		X			X
Recommendations for Reporting on Suicide	Media				X	X
Recommendations for Youth Suicide Prevention Training for Early Identification and Referral (Gatekeeper Training)	Gatekeepers					X
A Resource Guide for Implementing the Joint Commission 2007 Patient Safety Goals on Suicide	Health care professionals		X			X
Standards for the Assessment of Suicide Risk Among Callers to the National Suicide Prevention Lifeline	Crisis telephone line workers					X
Student Mental Health and the Law: A Resource for Institutions of Higher Education	Administrators at higher education institutions					X
Suicide Prevention Efforts for Individuals with Serious Mental Illness: Roles for the State Mental Health Authority	State mental health authorities					X
Talking About Suicide & LGBT Populations	Community members					X
Towards Good Practice: Standards and Guidelines for Suicide Bereavement Support Groups	Leaders of suicide bereavement support groups					X
Video Evaluation Guidelines (for Youth Suicide Prevention)	American Association of Suicidology video review committee					X
Warning Signs for Suicide Prevention	Organizations holding suicide prevention informational campaigns or educational programs	X				X

Table C.4

Level III: Adherence to Standards (SPRC)						
Program	**Target Audience**	Prevention	Early Intervention (*Screening Tool)	Treatment	Postvention	Policy Guidelines/ Protocols
After a Suicide: A Toolkit for Schools	Administrators of schools bereaved by suicide				X	X
After an Attempt: A Guide for Medical Providers in the Emergency Department Taking Care of Suicide Attempt Survivors	Emergency department personnel					X
After an Attempt: A Guide for Taking Care of Your Family Member After Treatment in the Emergency Department	Family members of individuals who attempted suicide					X
After an Attempt: A Guide for Taking Care of Yourself After Your Treatment in the Emergency Department	Individuals who attempted suicide					X
Applied Suicide Intervention Skills Training (ASIST)	Members of caregiving groups	X				
Army Ask, Care, Escort (ACE) Suicide Intervention Program	Members of the Army	X				
Ask 4 Help Suicide Prevention for Youth	High school students		X			
Assessing and Managing Suicide Risk: Core Competencies for Mental Health Professionals	Mental health professionals		X	X		
At-Risk for High School Educators	High school educators	X				
At-Risk for University and College Faculty: Identifying and Referring Students in Mental Distress	University and college faculty and staff	X				
At-Risk for University and College Students	University and college students	X				
Be A Link! Suicide Prevention Gatekeeper Training	Individuals in schools, workplaces, community groups, and other settings	X				
CALM: Counseling on Access to Lethal Means	Health care providers	X				
Campus Connect: A Suicide Prevention Training for Gatekeepers	College and university faculty, students, and staff	X				
Connect Suicide Postvention Program	Community professionals such as those in law enforcement, education, social services, mental health/substance abuse, and the faith community				X	
Connect Suicide Prevention Program	Community professionals such as those in law enforcement, education, social services, mental health/substance abuse, and the faith community	X				
Depression and Bipolar Wellness Guides for Parents and Teens	Teens (ages 13-18) and parents					X
Depression Wellness Guide for Adults with Depression and their Family and Friends	Adults with depression, and their families and friends					X
The DORA College Program (Depression OutReach Alliance)	College students		X			

LEVEL III: Adherence to Standards						
Program	**Target Audience**	Prevention	Early Intervention (*Screening Tool)	Treatment	Postvention	Policy Guidelines/ Protocols
EndingSuicide.com	Professionals in health care and education	X				
Family of Heroes	Family members of veterans	X				
Gryphon Place Gatekeeper Suicide Prevention Program: A Middle School Curriculum	Students in grades 7-8	X				
Healthy Education for Life	Youth (ages 14-19)		X			
Helping Every Living Person: Depression and Suicide Prevention Curriculum	High school students	X				
High School Gatekeeper Curriculum	High school students	X				
How Not to Keep a Secret	Teens (ages 13-18)	X				
In Harm's Way: Law Enforcement Suicide Prevention	Law enforcement and corrections professionals	X				
Interactive Screening Program	College students		X*			
"Is Your Patient Suicidal?" Emergency Department Poster and Clinical Guide	Emergency department personnel		X			
Late Life Suicide Prevention Toolkit	Older adults (ages 55 and over)	X				
LEADS for Youth: Linking Education and Awareness of Depression and Suicide	High school students	X				
Let's Talk Gatekeeper Training	Parents and caregivers of children	X				
Lifelines Intervention:						
Helping Students at Risk for Suicide	School administrators and staff		X			X
Lifelines Postvention: Responding to Suicide and Other Traumatic Death	Schools administrators and staff				X	X
LifeSavers Training	High school students and college students	X				
LOOK LISTEN LINK: A Health Curriculum for Middle School	Middle school students	X				
Making Educators Partners in Youth Suicide Prevention	School educators and staff	X				
More Than Sad: Suicide Prevention Education for Teachers and Other School Personnel	School educators and staff	X				
More Than Sad: Teen Depression	Teens (Ages 13-18)	X				
Not My Kid: What Every Parent Should Know About Teen Suicide	Parents	X				
Operation S.A.V.E.: VA Suicide Prevention Gatekeeper Training	Veterans Caregivers (to veterans)	X				
Parents as Partners: A Suicide Prevention Guide for Parents	Parents	X				
Preventing Transgender Suicide: An Introduction for Providers	Healthcare professionals	X				
Question, Persuade, Refer (QPR) Gatekeeper Training for Suicide Prevention	Community members	X				

LEVEL III: Adherence to Standards						
Program	**Target Audience**	Prevention	Early Intervention (*Screening Tool)	Treatment	Postvention	Policy Guidelines/ Protocols
Question, Persuade, Refer, Treat (QPR-T) Suicide Risk Assessment and Management Training	Mental health care professionals	X	X*	X		
Recognizing and Responding to Suicide Risk: Essential Skills for Clinicians	Mental healthcare professionals		X	X		
Recognizing and Responding to Suicide Risk in Primary Care	Primary care professionals		X	X		
Response: A Comprehensive High School-based Suicide Awareness Program	High school staff, students, and parents	X				
Riverside Trauma Center Postvention Guidelines	Communities and organizations				X	X
Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version	Veterans			X		
Saving Our Lives: Transgender Suicide Myths, Reality and Help	Members of the transgender community, their family, and their friends	X				
School Suicide Prevention Accreditation Program	School administrators					X
Signs of Suicide Middle School Program	Middle school students	X				
Sources of Strength	Teens and young adults	X				
Student Support Network	College students	X				
Suicide Alertness for Everyone	Community members	X				
Suicide Assessment Five-Step Evaluation and Triage	Mental health clinicians and health care professionals		X*	X		
Suicide: Coping with the Loss of a Friend or Loved One	Individuals bereaved by suicide				X	X
Suicide Prevention Multicultural Competence Kit	Mental health professionals					X
Suicide Prevention Training for Gatekeepers of Older Adults	Caregivers of older adults (ages 55 and over)	X				
Supporting Survivors of Suicide Loss: A Guide for Funeral Directors	Funeral directors					X
Survivor Voices: Sharing the Story of Suicide Loss	Individuals bereaved by suicide				X	
Teens for Life	Alameda County, California (high school, middle school youth)	X				
What is Depression? How to Treat It and What to Do—A Suicide Prevention Guide for Young People	Young adults	X				X
Working Minds: Suicide Prevention in the Workplace	Workplace administrators and employees	X				
Youth Suicide Prevention, Intervention, and Postvention Guidelines: A Resource for School Personnel	School personnel	X	X		X	X
Youth Suicide Prevention School-based Guide	School administrators					X

References

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2. National Registry of Evidence-based Programs and Practices. Search criteria: suicide. http://www.nrepp.samhsa.gov/SearchResultsNew.aspx?s=b&q=suicide. Published April 19, 2012. Accessed May 2, 2012.

3. National Registry of Evidence-based Programs and Practices. Reviews & submissions. http://www.nrepp.samhsa.gov/Reviews.aspx. Published April 19, 2012. Accessed May 21, 2012.

4. North Carolina Practice Improvement Collaborative. Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, North Carolina Department of Health and Human Services. Application for an evidence-based practice Rrview. http://www.ncpic.net/?dl_id=30. Accessed May 17, 2012.

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7. North Carolina Practice Improvement Collaborative. Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, North Carolina Department of Health and Human Services. Post deployment mental health. http://www.ncpic.net/download/115/. Published June 2011. Accessed May 18, 2012.

8. Rudd MD, Berman AL, Joiner TE, Jr, et al. Warning signs for suicide: Theory, research, and clinical applications. *Suicide Life Threat Behav.* 2006;36(3):255-262.

Patient Health Questionnaire: PHQ-2 and PHQ-9

The nine item PHQ-9 questionnaire is one of five modules of the Patient Health Questionnaire (PHQ) which covers common type of mental disorders. Each answer is scored 0 to 3, providing a 0 to 27 severity score. The PHQ-2 refers to the first two questions of the PHQ-9, which serve as an ultra-brief depression screener and provides a total score of 0 to 6.

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "✔" to indicate your answer)	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

... Not difficult at all
... Somewhat difficult
... Very difficult
... Extremely difficult

Source: Spitzer RL, Williams JBW, Kroenke K. Patient Health Questionnaire (PHQ) Screeners. Patient Health Questionnaire-9 (PHQ-9). http://www.phqscreeners.com/pdfs/02_PHQ-9/English.pdf.

Case Management Information System (CMIS) Suicide Assessment Form

1. Have you ever attempted to harm yourself
   If Yes, moderate to high risk. Communicate information to PCP immediately.

2. In the past month, have you made any plans or considered a method that you might use to harm yourself?
   If Yes, moderate to high risk. Communicate information to PCP and BH provider immediately.

3. There is a difference between having a thought and acting on a thought. Do you think you may actually make an attempt to hurt yourself in the near future?
   If Yes, moderate to high risk. Communicate information to PCP and BH provider immediately.

4. In the past month, have you told anyone that you were going to commit suicide, or threatened that you might do it?
   If Yes, moderate to high risk. Communicate information to PCP and BH provider immediately.

5. Do you think there is any risk that you might hurt yourself before you see your doctor/ me the next time?
   If Yes, acute risk. Contact PCP and BH provider immediately. If risk appears immediate, stay on phone with patient, call 911 or do your best to make sure the patient goes to the ER immediately. Consider Mobile Crisis Management.

If the response to ALL items, 1-5 is No, the patient is considered at "Low Risk" for suicide. Information should be communicated to the PCP via usual reporting channels in the usual way.

Source: Community Care of North Carolina. Disease Management Model for Depression. https://www. communitycarenc.org/media/related-downloads/depression-toolkit.pdf. Published April 2012. Accessed June 7, 2012.

I. Policy: It is the policy of XXX to set minimum standards of practice across all clinical programs to assure that clients are being assessed at critical points in care for presence of suicidal ideation or intent and to establish consistency of practice when intervening with clients who may be at risk of committing suicide. This policy also establishes guidelines for training staff who are not clinically trained to assist them in identifying clients who may be at risk of suicide and assisting clients in accepting needed services.

II. Purpose: The purpose of this policy is to create a culture at XXX that proactively attempts to reduce risk of suicide in clients receiving services and in the community.

III. Scope: This policy applies to all XXX staff.

IV. Definition: N/A

V. Procedures

Staff Training:
1. All non-clinical staff receives training on XXX method of identifying and assisting clients who are at risk of suicide as part of the XXX orientation process.

2. All clinical staff receives training of XXX method of suicide risk assessment and intervention as part of XXX orientation. Clinical staff to demonstrate competence in use of assessment tool with Supervisor as part of program orientation prior to initiation of clinical practice at XXX. Staff to pass certification on XXX within first three-months of employment.

3. Staff completes annual update training on XXX as part of XXX continued learning.

Suicide Risk Assessment:
1. All clients are assessed at initial point of contact (e.g. telephone triage) using standard suicide risk assessment tool.

2. All clients are assessed at comprehensive intake (if different from initial point of contact).

3. As appropriate, based on assessment client may be referred to screening if present as imminent danger to self or others.

4. All clients presenting with an identified risk of suicide or history of suicidal ideation or attempts are to have suicide risk identified as a need/problem area on the treatment plan.

5. All clients with an identified problem related to substance use are to have substance use identified as a need/problem area on the treatment plan.

6. Clients with active suicidal ideation are not to receive medication only services.

7. Clients with active substance abuse or dependence are not to receive medication only services.

8. The standard assessment of suicide risk is to be completed at all the following points of care:

   ■ First visit after discharge from hospital or screening

   ■ First visit after transfer to a new therapist in same level of care

   ■ First visit after transfer from one level of care to another

   ■ At any point in treatment where client reports suicidal ideation

   ■ As clinically indicated based on client risk factors (losses, life changes, impending loss of freedom, financial crises, humiliating events, etc.)

9. Clients with persistent suicidal ideation or parasuicidal ideation are to have a crisis plan developed in conjunction with their care manager. A client's use of this crisis plan is to be monitored at individual contacts, documented in progress notes and summarized as part of treatment plan review process.

10. Suicide risk is to remain on treatment plan and monitored at all individual sessions and progress summarized on treatment plan reviews until documented as resolved as part of a treatment plan review.

11. If at any point in care a client is assessed to be at risk of suicide, the treatment plan is to be revised by the care manager to add a problem area related to suicide risk. All members of the treatment team are to be informed of changes to plan and signatures of attending prescriber and other team members are obtained on the new plan. The first person who identifies risk of suicide is responsible for alerting care manager immediately.

Additional Intervention/Communication:

1. In the event a clinician is not confident that a client may be safe, the clinician must seek consultation from their supervisor. If no supervisor is available then staff should seek consultation from a masters or more advanced level clinical staff or screener prior to client leaving facility. Staff are to document this consultation in a progress note.

2. When medical staff are treating consumers with overdose histories or histories of suicide attempt, these staff should adjust their prescription practices to address risk of future lethal attempts and upon obtaining appropriate release from consumer communicate with community prescribers to alert them of risk.

3. In the event that a consumer admitted to services at XXX who is assessed to be at-risk of suicide fails to show up for an appointment, the staff member scheduled to see the client will call client to assess for safety and document the attempt to contact client in a progress note. If the outreach attempt is not successful, staff will notify the care manager of the client to provide additional outreach attempts.

4. At the time of referral for all ancillary services, the care manager will indicate risk of suicide on the referral form.

Crisis Plan

Client Name: _____Date:_____

Crisis Behavior: (List behaviors you are concerned about preventing— e.g. attempts to harm self, running away from residential facility, aggression toward others)

1. _____

2. _____

Warning Signs: List and define your personal warning signs of relapse into behaviors of concern (e.g. keeping to myself, thinking of death, short tempered, crying frequently).

1. _____

2. _____

3. _____

Risks/Triggers: List events that may put you at greater risk for crisis behavior (e.g. seeing my biological father, feeling rejected by someone I care about, stop taking my medication).

1. _____

2. _____

3. _____

Coping Techniques: List at least three things that you will do to cope with warning signs when they are present instead of choosing behavior of concern:

1. _____

2. _____

3. _____

Community Supports: List at least three people (other than professional health care staff) you can call or ask for assistance (include phone numbers) if you need support in a crisis situation:

Name   Relationship to you   Phone number

_____

_____

_____

Professional Supports: List at least three professional supports you can use (include phone numbers) if you need help in a crisis situation: (e.g. therapist, psychiatrist, primary physician).

Name   Relationship to you   Phone number

_____

_____

_____

Crisis Screening Center Number: List the number for your local crisis center. If you are not able to manage the crisis on your own after trying above strategies and using above supports it is important for you to call this number and speak with someone instead of choosing crisis behavior.

Screening Center Name   Location/Address   Phone

_____

Expectations for help from Professionals: List what you would like professional staff to do to help you during a crisis situation.

_____

_____

_____

Signatures:

_____
Client Name   Date

_____
Name   Date

_____
Name   Date

_____
Name   Date

Source: Besen, M., Area Director/CEO, Onslow Carteret Behavioral Healthcare Services. Written communication. May 9, 2012.