Southeast (HHS Region 4)

MHTTC Mental Health Technology Transfer Center Network

Funded by Substance Abuse and Mental Health Services Administration

Mental Health in the Southeast

Volume I, Issue II – July 2019

Southeast Mental Health Technology Transfer Center
1518 Clifton Road, Atlanta, GA 30322
mhttcnetwork.org/southeast

Spotlight on Southeast MHTTC Deputy Director

We would like to take this opportunity to introduce you to the Deputy Director of the Southeast Mental Health Technology Transfer Center, Janet Cummings, PhD. Dr. Cummings is an Associate Professor in the Department of Health Policy and Management at the Rollins School of Public Health at Emory University. She has conducted multiple studies addressing access and quality of care for youth treated in schools and mental health safety-net settings, racial/ethnic disparities in treatment, effects of state policies on mental health treatment, and health care utilization among underserved populations with behavioral health disorders. She has delivered lectures and disseminated information to multiple state and national stakeholders addressing evidence-based approaches to delivering child mental health services

In addition to her role as Deputy Director, Dr. Cummings is the Project Director for the Southeast Regional School Mental Health Learning Community. More than 50 leaders in behavioral health and education in Alabama, Georgia, Kentucky, Mississippi, North Carolina, and South Carolina have joined this initiative to improve school mental health in their states. Dr. Cummings has engaged the expertise of other faculty within the University and members of the National Center for School Mental Health (CSMH) to provide assistance with comprehensive school mental health systems in the region.

In collaboration with the CSMH, several virtual learning sessions have been conducted on topics such as resource mapping, strategies to achieve alignment, and mental health promotion activities (Tier 1 Programs). These learning sessions have featured didactic content as well as opportunities for state leaders to learn from one another. As this effort continues, three more virtual learning sessions will be held presenting information on topics such as financing and sustainability.

Southeast MHTTC and CSMH members will also deliver a one-day in-person training for leaders from each of the six participating states, which is tailored to the teams' stated needs and goals. Team members will select the format of the intensive learning session and provide input into the content that will be presented. The Southeast MHTTC is very excited to partner with state leaders and offer these training opportunities this coming fall.

We look forward to sharing our ongoing progress with regional stakeholders and the MHTTC. Be on the lookout for new distance learning opportunities related to school mental health and updates on our ongoing progress with regional stakeholders.

Spotlight on suicide prevention

Current landscape of suicide

Suicide, the act of intentionally ending one's life, is a major public health problem and the 10th leading cause of death in the United States.[1] In 2017, an estimated 1.4 million individuals attempted suicide, and approximately 47,100 individuals died by suicide.[1] Suicide mortality varies across race/ethnicity, gender, and region.[1] The highest rates are reported among American Indian and Alaskan Native youth; African Americans have the lowest suicide rate.[2,3] Men complete suicide 3.5 times more often than women; however, women are more likely to attempt suicide.[1,2] Significant geographic disparities are also noted as rural areas have consistently higher rates of suicide than urban areas.[4] Within the eight states of Region IV, six states rank among the top 25 in the nation with the highest suicide morality rates.[5]

Individuals with a serious mental illness (SMI) account for about 6-8% of the U.S. population, but make up a large proportion of individuals who complete suicide each year.[6] Death by suicide is 25 times greater for those diagnosed with mood disorders such as depression or bipolar disorder compared to the general population.[7] Similarly, adults with schizophrenia are 20 times more likely to complete suicide compared to the general population.[8]

Preventing suicide

Multiple factors contribute to suicide for those with and without known mental health diagnoses. For providers, preventing suicide includes screening for suicidal ideation or behavior, performing an assessment of the individual's current risk of imminent harm, and creating a treatment plan in cooperation with the client and involved support parties.[9] Contrary to popular belief, having a conversation about suicide does not increase suicide or suicidal thoughts. In fact talking about suicide may reduce suicidal thought.[2] Providers who encounter at-risk individuals and those in need of crisis services have an array of programs, trainings, and resources available to help facilitate open conversations about suicide in the hopes of preventing this tragic outcome.

Spotlight on suicide prevention

Screening, Assessing, and Planning Tools

The purpose of a suicide screening is to determine if there is actionable risk. For example, the Columbia Suicide Severity Rating Scale (C-SSRS) tool can be used to examine a person's suicidal thoughts and behavior, considering intensity, frequency, and changes over time.[9,10] An immense amount of research has been conducted validating the relevance and effectiveness of the questions, and it has been endorsed the Substance Abuse and Mental Health Services Administration (SAMHSA). The C-SSRS is available online for free, is easily administered with minimal training, is appropriate for diverse populations and ages, and has been translated into more than 100 languages.[10]

If an individual is identified as "at risk" after the initial screening, a formal suicide assessment should take place. The goal of the assessment is to gather information about risk factors, protective factors, and the extent of suicidal ideation, intention, or plan. This information will help estimate the risk level (i.e., low, moderate, or high) and guide a treatment plan.[9] Risk factors are characteristics that make an individual more likely to consider, attempt, or complete suicide; while protective factors are those characteristics that make it less likely an individual will consider, attempt, or complete suicide. Below are a few examples of risk and protective factors.[3]

Risk factors	Protective factors
Family history of suicide or child maltreatment	Effective clinical care and positive therapeutic alliance
History of mental disorder, alcohol and/or substance use	Access to clinical intervention and support
Barriers to accessing mental health treatment	Family and community support
Being in prison or jail	Cultural and religious belief, spirituality
Isolation	Life satisfaction
Having guns or firearms in the home	Positive coping skills

Warning signs, which should be distinguished from risk factors, indicate a person is at imminent risk of attempting suicide. Below are a few examples of verbal, behavioral, and situational warning signs.[11]

Screening, Assessing, and Planning Tools (continued)

Verbal	Behavioral	Situational
Talking about unbearable pain or being a burden to others Talking about feeling hopeless or wanting to die	Increasing drug or alcohol use Withdrawing or feeling isolated Extreme mood swings	End of relationship or marriage Death of a loved one Serious financial problems

After screening and assessing, providers should formulate a treatment or stabilization plan in coordination with the individual and identified support systems. Information gathered during the screening and assessing phase will help direct appropriate next steps, including the decision whether or not to hospitalize the individual.[9] Safety plans are effective tools proven to reduce suicide attempts by encouraging individuals to identify warning signs, coping strategies, and supportive people and settings.[5] They should not be confused with "no suicide" contracts which have been shown to be ineffective in reducing suicide or suicidal behavior.[2] The Suicide Prevention Resource Center provides an example template of a safety plan; it can be found at here.[12]

Additional Resources

An array of easily accessible resources are available to assist providers in suicide prevention. Below we highlight a few evidence based programs, national networks, and trainings; besides the ones listed, we encourage providers to learn more about the strategies for preventing suicide.

Zero Suicide is an evidence-based program dedicated to reducing suicide and improving care through a systematic approach made up of 7 key components (lead, train, identify, engage, treat, transition, and improve). Health and behavioral health systems are collaborative partners involved in preventing suicide rather than placing the onus at an individual provider level.[13]

Suicide Prevention Resource Center is a federally funded center that offers a multitude of resources, trainings, and consultations to promote and boost suicide prevention. It is the only center dedicated to promoting the implementation of the National Strategy for Suicide Prevention, which is working to prevent suicide by fostering healthy humans, families, and communities, increasing preventative services and supporting the availability of treatment, and refining suicide surveillance, research, and evaluation.[7,14]

Additional Resources (continued)

National Suicide Prevention Lifeline is a national network of over 150 local crisis centers offering 24 hour free support to individuals in suicidal crisis. Their hotline can be reached at 1-800-273-8255.[15]

National Action Alliance for Suicide Prevention is a national level public-private partnership. It seeks to reduce annual suicide rates by 20% by 2025 through enhancing and bolstering suicide care within the health care system, supporting communities in implementing effective prevention strategies, and changing the way suicide is discussed in the public.[16]

The Southeast MHTTC is currently offering suicide risk assessment trainings throughout the Region IV states. To register for current trainings and stay up to date for future trainings, please visit our website.

Upcoming Southeast MHTTC Suicide Risk Assessment Training

WHERE:

Mississippi State Hospital - The James C. Stubbs Conference Center

WHEN:

Monday, July 29 at 8:30 AM

References

1. American Foundation for Suicide Prevention. (n.d.). Suicide statistics. Retrieved from https://afsp.org/about-suicide/suicide-statistics/
2. National Institute of Mental Health. (n.d.). Suicide in America: Frequently asked Questions. Retrieved from https://www.nimh.nih.gov/health/publications/suicide-faq/index.shtml#pub1
3. Centers for Disease Control and Prevention. (n.d.) Preventing Suicide. Retrieved from https:// www.cdc.gov/violenceprevention/suicide/index.html
4. Ivey-Stephenson, A. Z., Crosby, A. E., Jack, S. P. D., Haileyesus, T., & Kresnow-Sedacca, M-J. (2017). Suicide trends among and within urbanization levels by sex, race/ethnicity, age group, and mechanism of death – United States, 2001–2015. *Morbidity and Mortality Weekly Report,* Surveillance Summaries *66*(18), 1–10.
5. Centers for Disease Control and Prevention. (n.d.) Preventing Suicide. Retrieved from https://www.cdc.gov/nchs/pressroom/sosmap/suicide-mortality/suicide.htm
6. Litts, D. A., Radke, A. Q., Silverman, M. M., Ruter, T. J., & Davis, M. (2008). Suicide prevention efforts for individuals with serious mental illness: Roles for the state mental health authority. Washington, DC: National Association of State Mental Health Program Directors/Suicide Prevention Resource Center
7. U.S. Department of Health and Human Services (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention. (2012). 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action [PDF File]. Retrieved from https://www.hhs.gov/surgeongeneral/reports-and-publications/suicide-prevention/index.html
8. Hor, K., & Taylor, M. (2010). Suicide and schizophrenia: a systematic review of rates and risk factors. *Journal of psychopharmacology (Oxford, England)*, *24*(4 Suppl), 81–90. doi:10.1177/1359786810385490
9. Weber, A. N., Michail, M., Thompson, A., & Fiedorowicz, J. G. (2017). Psychiatric Emergencies: Assessing and Managing Suicidal Ideation. *The Medical clinics of North America*, *101*(3), 553–571. doi:10.1016/j.mcna.2016.12.006
10. Columbia Lighthouse Project. (n.d.) Retrieved from http://cssrs.columbia.edu/the-columbia-scale-c-ssrs/about-the-scale/
11. University of Kentucky. (n.d.). Suicide Risk Warning Signs. Retrieved from https://www.uky.edu/counselingcenter/suicide-risk-warning-signs
12. Suicide Prevention Resource Center. (n.d.) Patient safety plan template. Retrieved from https://www.sprc.org/resources-programs/patient-safety-plan-template
13. Zero Suicide. (n.d.). About Zero Suicide. Retrieved from https://zerosuicide.sprc.org/about
14. Suicide Prevention Resource Cener. (n.d.). Retrieved from https://www.sprc.org/
15. Suicide Prevention Lifeline. (n.d.). Retrieved from https://suicidepreventionlifeline.org/
16. National Action Alliance for Suicide Prevention. (n.d.). Retrieved from https://theactionalliance.org/our-strategy/national-strategy-suicide-prevention