# SB

# 60

SFIN

FILE

REPORTED OUT
FEB 14 2005
SENATE FINANCE COMMITTEE

# SENATE FINANCE COMMITTEE REPORT

DATE: 2/4/05

FURTHER:

DATE TURNED IN TO OFFICE: 02/14/05

Finance Committee considered SENATE BILL NO. 60

SB 60 EXTEND SUICIDE PREVENTION COUNCIL

"An Act extending the termination date of the Statewide Suicide Prevention Council; and providing for an effective date."

and recommends:

[ ] be **replaced** with _____ CS _____ (_____)

[ ] adopt **previous** _____ CS _____ (_____)

[ ] attached amendment(s)

[ ] adopt Letter of Intent by _____ Committee

[ ] further referral to _____ Committee

**Senate Bill:**
[ ] Same Title
[ ] New Title

**House Bill:**
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #_____

**NEW FISCAL NOTE(S):**

| Department | Date | Fiscal | Ind. | Zero | FN# |
|---|---|---|---|---|---|
| H&SS | 2/11/05 | | | ✓ | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**PREVIOUS FISCAL NOTE(S):**

| Department | Date | Fiscal | Ind. | Zero | FN# |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

[ ] **APPROPRIATION - no fiscal note**

| SIGNATURES AND RECOMMENDATIONS: | DO PASS | DO NOT PASS | NO REC | AMEND |
|---|---|---|---|---|
| | ✓ | | | |
| | ✓ | | | |
| | ✓ | | | |
| | | | | |
| | | | | |
| COCHAIR: | | | | |
| COCHAIR: | ✓ | | | |

# SENATE BILL NO. 60

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FOURTH LEGISLATURE - FIRST SESSION

BY SENATORS BEN STEVENS, Therriault

Introduced: 1/14/05
Referred: Health, Education and Social Services, Finance

## A BILL

## FOR AN ACT ENTITLED

"An Act extending the termination date of the Statewide Suicide Prevention Council; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* Section 1. AS 44.66.010(8) is amended to read:

(8) Statewide Suicide Prevention Council (AS 44.29.300) - June 30, 2009 [2005];

* Sec. 2. This Act takes effect immediately under AS 01.10.070(c).

# FISCAL NOTE

STATE OF ALASKA
2005 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB060-DHSS-FMS-02-11-05
( ) Publish Date:

Revision Date/Time (Note if correction): 2/11/05 6:45 a
Dept. Affected: Health & Social Services

Title: EXTENDING THE TERMINATION DATE OF THE STATEWIDE SUICIDE PREVENTION COUNCIL
RDU: Boards and Commissions
Component: Suicide Prevention Council

Sponsor: STEVENS, BEN
Requester: SENATE (HES)
Component No.: 2651

REPORTED OUT
SENATE FINANCE COMMITTEE

**Expenditures/Revenues** (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

| OPERATING EXPENDITURES | FY 2006 | FY 2007 | FY 2008 | FY 2009 | FY 2010 | FY 2011 |
|---|---|---|---|---|---|---|
| Personal Services | | 38.2 | 38.2 | 38.2 | 38.2 | 38.2 |
| Travel | | 41.5 | 41.5 | 41.5 | 41.5 | 41.5 |
| Contractual | | 38.3 | 38.3 | 38.3 | 38.3 | 38.3 |
| Supplies | | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 |
| Equipment | | | | | | |
| Land & Structures | | | | | | |
| Grants & Claims | | | | | | |
| Miscellaneous | | | | | | |
| **TOTAL OPERATING** | **0.0** | **119.0** | **119.0** | **119.0** | **119.0** | **119.0** |
| **CAPITAL EXPENDITURES** | | | | | | |
| **CHANGE IN REVENUES (0)** | | | | | | |

**FUND SOURCE** (Thousands of Dollars)

| | | | | | | |
|---|---|---|---|---|---|---|
| 1002 Federal Receipts | | | | | | |
| 1003 GF Match | | | | | | |
| 1004 GF | | | | | | |
| 1037 GF/Mental Health | | 119.0 | 119.0 | 119.0 | 119.0 | 119.0 |
| Other(Specify Type-do not abbreviate) | | | | | | |
| Other(Specify Type-do not abbreviate) | | | | | | |
| **TOTAL** | **0.0** | **119.0** | **119.0** | **119.0** | **119.0** | **119.0** |

**Estimate of any current year (FY2005) cost:**
**Mark this box (X) if funding for this bill is included in the Governor's FY 2006 budget proposal:** X

**POSITIONS**

| | | | | | | |
|---|---|---|---|---|---|---|
| Full-time | | | | | | |
| Part-time | | 1 | 1 | 1 | 1 | 1 |
| Temporary | | | | | | |

**ANALYSIS:** *(Attach a separate page if necessary)*

The Suicide Prevention Council (SPC) is due to sunset on June 30, 2005. The SPC is the state planning and coordinating agency for issue surrounding suicide and suicide prevention. The powers, duties and responsibilities of the Council are to act in the advisory capacity to the Governor and legislature with respect to what actions can and should be taken to:

(continued on page 2)

Prepared by: Janet Clarke, Assistant Commissioner — Phone 465-1632
Division: Finance and Management Services — Date/Time 02/11/2005
Approved by: Joel S. Gilbertson, Commissioner — Date 02/11/2005
Agency: Department of Health and Social Services

STATE OF ALASKA
2005 LEGISLATIVE SESSION

BILL NO. SB060-DHSS-FMS-02-11-05

ANALYSIS CONTINUATION

- Improve health and wellness throughout the state by reducing suicide and its effect on individuals, families, and communities;
- Broaden the public's awareness of suicide and the risk factor related to suicide;
- Enhance suicide prevention services and programs throughout the state;
- Develop healthy communities through comprehensive, collaborative, community-based approaches;
- Develop and implement a statewide suicide prevention plan; and
- Strengthen existing and build new partnerships between public and private entities that will advance suicide prevention efforts in the state.

Extension of the Council does not have any fiscal impact since the funding is budgeted in the Governor's budget.

# Alaska State Legislature

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## SPONSOR STATEMENT
## SENATE BILL 60

"An Act extending the termination date of the Statewide Suicide Prevention Council; and providing for an effective date."

Suicide is an Alaskan tragedy. On average suicide takes 130 Alaskans every year, nearly twice the national average. With Alaska's large geography, multiple cultures, and many communities, addressing suicide is a complicated matter.

In 2001, the 22nd Alaska State Legislature enacted legislation that created the Statewide Suicide Prevention Council (SSPC) and tasked it with the mission to reduce suicide through coordination with public and private entities as well as its own initiatives, and broaden suicide awareness. Under Alaska Statute 44.29.350, the Council is charged with advising the legislature and the governor on "*...actions that can and should be taken to improve health and wellness throughout the state by reducing suicide and its effect on individuals, families and communities.*"

The council is made up of 15 members. In addition to legislative and executive branch members there are nine public members. The public appointments represent a broad spectrum of individuals from rural and urban communities, clergy, youth, and behavioral health community. There is one part-time staff person to coordinate council activities

Among the council's accomplishments is a recently completed statewide suicide prevention plan. The plan sets up goals and strategies for suicide prevention. Currently, the Council is also in the process of implementing a Follow Back Study and a public awareness campaign. This study consists of voluntary interviews of family and friends; information from the Medical Examiner's Office; law enforcement agencies; and other records as permitted. The media campaign fulfils the council's mission to educate Alaskans on suicide and its devastating effects.

The findings from a recently conducted sunset audit recommend the SSPC to continue in its work of research, broadening public awareness, collaborating prevention and intervention efforts around the state and in making recommendations to the Governor and Legislature.

Senate Bill 60 will extend the termination date of the council to 2009 allowing the Statewide Suicide Prevention Council to continue in their mission.

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# Alaska State Legislature

## Senate Majority Web: www.akrepublicans.org

**Sponsor:** Senator Ben Stevens
**Current Version:** SB 60
**Contact:** Shannon Straube, 465-4993

**Fact Sheet for: Senate Bill 60**

**Short Title:** EXTEND SUICIDE PREVENTION COUNCIL

**Summary:**

- Extends the termination date of the Statewide Suicide Prevention Council from June 2005 to June 2009.

**Benefits:**

- Implements a recommendation by the Legislative Budget & Audit Committee to continue the Statewide Suicide Prevention Council.
- Provides a centralized statewide effort to educate individuals and communities on suicide prevention.
- Gives the council the opportunity to enact its new statewide suicide prevention plan.
- Allows the council to create a network with public and private groups across Alaska that are working towards similar goals.
- Reduces the stigma that comes with suicides through outreach work with families and friends of suicide victims.
- Assures groups and individuals working towards similar goals that Alaska's elected officials are also committed to preventing suicides.

**Background:**

- Alaska has nearly twice the average national number of suicides. In 2001, the Alaska Legislature created the Statewide Suicide Prevention Council to establish strategies and goals to reduce the number of suicides. The council is currently working with the Alaska Injury Prevention Center on a study that examines suicides over a 12 month period. Voluntary interviews with friends and families of victims will be combined with medical records and law enforcement reports. The council will also conduct a media campaign to educate Alaskans about suicide and its devastating effects. The council also serves in an advisory capacity to the governor and the legislature on suicide issues.

# ALASKA STATE LEGISLATURE

LEGISLATIVE BUDGET AND AUDIT COMMITTEE
Division of Legislative Audit

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November 16, 2004

Members of the Legislative Budget
and Audit Committee:

In accordance with the provisions of Title 24 and Title 44 of the Alaska Statutes (sunset legislation), the attached report is submitted for your review.

DEPARTMENT OF HEALTH AND SOCIAL SERVICES
STATEWIDE SUICIDE PREVENTION COUNCIL
SUNSET REVIEW

November 15, 2004

Audit Control Number

06-20037-05

This audit was conducted as required by AS 44.66.050 and under the authority of AS 24.20.271(1). Alaska Statute 44.66.050(c) lists criteria to be used to assess the demonstrated public need for a given board, commission, agency, or program subject to the sunset review process. Currently under AS 44.66.010(a)(20), the Statewide Suicide Prevention Council is scheduled to terminate June 30, 2005. If the legislature takes no action to extend this date, the council would have one year to conclude operations.

In our opinion, the termination date for the Statewide Suicide Prevention Council should be extended. The council serves a public need and is operating in the public's interest. We recommend the legislature extend the council's termination date to June 30, 2009.

The audit was conducted in accordance with generally accepted government audit standards. Fieldwork procedures utilized in the course of developing the findings and discussion presented in this report are discussed in the Objectives, Scope, and Methodology.

Pat Davidson

Pat Davidson, CPA
Legislative Auditor

# TABLE OF CONTENTS

# OBJECTIVES, SCOPE, AND METHODOLOGY

In accordance with Titles 24 and 44 of the Alaska Statutes, we have reviewed the activities of the Statewide Suicide Prevention Council (SSPC) to determine if there is a demonstrated public need for its continued existence and if it has been operating in an efficient and effective manner.

As required by AS 44.66.050(a), the legislative committee of reference shall consider this report as part of the oversight process in determining if the council should be reestablished. State law currently specifies SSPC will terminate on June 30, 2005. If no action is taken by the legislature, the council will have one year from that date to conclude its administrative operations.

## Objectives

The two central, interrelated objectives of our report are:

1. To determine if the termination date of the council should be extended.

2. To determine if the council is operating in the public interest.

Our assessment of the operations and performance of the council was based on criteria set out in AS 44.66.050(c). Criteria set out in this statute relate to the determination of a demonstrated public need for the council.

## Scope and Methodology

Our audit reviewed the operations and activities of the Statewide Suicide Prevention Council from FY 02 through the first quarter of FY 05.

During the course of our examination, we reviewed and evaluated the following:

- Applicable statutes and regulations.

- Budget documents, session laws, and other legislative information related to the council's operations.

- Council meeting minutes, bi-laws and website.

- Annual reports to the legislature and governor.

- Financial reports from the State Accounting System.

- The *Statewide Suicide Prevention Plan.*
- Alaska Injury Prevention Center's follow-back study reports to the council.
- The Surgeon General's *Call to Action to Prevent Suicide.*
- Other documents related to the council's operations and mission, as necessary.

In addition, we interviewed:

- Various SSPC members, SSPC coordinators and staff under the Department of Health and Social Services.
- Executive directors of the Alaska Mental Health Trust Authority, Alaska Mental Health Board and Governor's Advisory Board on Alcoholism and Drug Abuse.
- Directors of suicide prevention programs in Washington, Oregon, Montana, and Wyoming.

We also attended the June and September 2004 SSPC meetings, the September suicide survivor community gathering and the World Suicide Prevention Day commemoration. At these meetings and gatherings, we observed the proceedings and the interaction of the board with the public.

# ORGANIZATION AND FUNCTION

In 2001, Alaska Statute 44.29.300 established the Statewide Suicide Prevention Council in the Department of Health and Social Services (DHSS). Under AS 44.29.350, the council is charged with advising the legislature and the governor on "*...actions that can and should be taken to improve health and wellness throughout the state by reducing suicide and its effect on individuals, families, and communities.*"

In addition to this advisory role, the council's scope of activities include developing Alaska's statewide suicide prevention plan, educating the public about suicide, providing suicide prevention training to teachers, students and others, coordinating suicide prevention efforts statewide and providing technical assistance to communities as they develop their own plans.

The council consists of 15 members. There are two members of the Alaska State Senate, two members of the House of Representatives, two executive branch employees and nine public members. The Alaska State Senate seats and the House of Representative seats are appointed by the president of the senate and the speaker of the House, respectively. The executive branch and public seats are appointed by the governor.

Statutes require that public appointments ensure broad representation from various communities statewide. Public members are selected from rural and urban communities as well as from the educational, youth, faith-based and behavioral health communities.[1] As such, each public member appointed to the council brings unique experiences and perspective to a shared vision and mission. Except for the representatives who serve two years, council members serve staggered four-year terms.

Council Members
As of September 30, 2004

Jeanine Sparks, Public, Chair
Judith Lethin, Public
William Martin, Public
Bill Hogan, DHSS
Tracy Barbee, Public
Noelle Hardt, Public
Kelsi Ivanoff, Public
Charles Jones, Public
Representative Mary Kapsner
Representative Pete Kott
Senator Georgianna Lincoln
Karen Perdue, Public
Susan Soule, DHSS
Senator Ben Stevens
Stan Tucker, Public

The council is staffed by a coordinator, who, by statute, is employed by the council and directly responsible to the council. Currently the council employs the coordinator on a part-time basis. The council receives administrative assistance from DHSS.

[1] AS 44.29.300 specifies the public seats be filled by *"one member of the Advisory Board on Alcoholism and Drug Abuse; one member of the Alaska Mental Health Board; one person recommended by the Alaska Federation of Natives, Inc.; one person who is a counselor in a secondary school; one adult who is active in a statewide youth organization; one person who has experienced the death by suicide of a member of the person's family; one person who resides in a rural community in the state that is not connected by road or the Alaska marine highway to the main road system of the state; one person who is a member of the clergy; and one person who is under the age of 18."*

# REPORT CONCLUSIONS

We reviewed operations of the Statewide Suicide Prevention Council (SSPC) from FY 02 through the first quarter of FY 05. Our primary conclusion is the termination date of the council should be extended. We also have concluded that the Department of Health and Social Services (DHSS) hindered the efforts of the council by providing inadequate financial information to the council and by spending almost 20 percent of SSPC's FY 04 funding for unrelated expenditures. More extensive discussion of these conclusions follows.

The termination date of the Statewide Suicide Prevention Council should be extended

Under AS 44.29, SSPC is charged with advising the legislature and governor on suicide and suicide prevention in Alaska. Suicide has historically been, and continues to be, a major state public health problem. According to the council's suicide prevention plan, an average of 126 Alaskan lives is lost each year to suicide. The state's 2002 rate of 20.9 deaths for every 100,000 residents, almost twice the national average of 10.6, ranked Alaska sixth among the states in rate of suicide.

Recently the council completed a statewide suicide prevention plan, one of SSPC's duties under state law. The plan establishes goals and strategies for suicide prevention. The plan also identifies various measures to be used to evaluate progress in reducing Alaska's suicide rate. In addition to developing the suicide prevention plan, council duties include educating the public about suicide, providing suicide prevention training, coordinating suicide prevention efforts statewide and providing technical assistance to communities as they develop their own plans. Through these various roles, the council operates in the public interest in a manner consistent with its statutory responsibility.

Currently, AS 44.66.010(a)(20) requires that the council be terminated on June 30, 2005. If not extended by legislature, the council will have one year to administratively conclude its operations. In our opinion, SSPC is operating in the public interest. Now that the suicide prevention plan is complete, we encourage the council to continue with implementation of suicide prevention strategies (see Recommendation No. 1 for an example of such implementation). We recommend the legislature extend the termination date for the council to June 30, 2009.

Misspent funds and miscommunications limited SSPC spending to 20% of FY 04 funding

In FY 04, the council was appropriated more than $200,000 by the legislature for council operations and suicide prevention activities. A line-item veto by the Governor reduced the appropriation to $179,800, which was subsequently further reduced to $171,400 as part of an add/delete supplemental[2] requested by DHSS.

[2] See Section 20 Chapter 159 SLA 2004.

Five months into FY 04, SSPC's acting coordinator, who was also a DHSS employee and a member of the council, believed she was being told that access to the operating funding was restricted. The acting coordinator told us she was instructed by the Director of the Division of Administrative Services (DAS)[3] that the council was not to spend any further money on its operations. The director denies she ever gave such instruction or advice.

In any event, in light of direction the individual believed she received, the council did not convene its third quarterly meeting originally scheduled to be held in January 2004. This action delayed work on the council's drafting of the statewide suicide prevention plan by several months.

Toward the end of the fiscal year, DAS restructured the council's funding, increasing the allocation for supplies by $32,200. This was done to enable DHSS to commit almost $32,000, or 19 percent of the council's FY 04 budget, to purchase office furnishings for another DHSS agency with no direct operational relationship to suicide prevention.[4]

The council did not authorize, nor was the council aware of, the expenditure which did not contribute directly to SSPC operations or suicide prevention efforts (see Recommendation No. 2).

Exhibit 1

**Statewide Suicide Prevention Council**
**Summary of FY 04 Expenditures**
**(Unaudited)**

| | Expenditures | As Percentage of Authorization |
|---|---|---|
| Council-related Costs | $ 34,700 | 20.2% |
| Office Furnishings | 31,700 | 18.5% |
| Lapse | 10,100 | 5.9% |
| Working Reserve Sweep: | | |
| Terminal Leave | 91,500 | 53.4% |
| Insurance Catastrophe | 3,400 | 2.0% |
| | $171,400 | 100.0% |

As summarized in Exhibit 1, at the end of FY 04, $94,900 of SSPC's remaining balance was transferred into the state's terminal leave and insurance catastrophe working reserve accounts. While such transfers are permissible under state law,[5] the funding was largely available because council funds were either intentionally or unintentionally restricted from council use. As a result, funding appropriated for suicide prevention was spent on items that

[3] Now Finance and Management Services under the most recent DHSS reorganization.
[4] As of October 15, 2004, $27,524 of the commitment was spent.
[5] AS 37.05.510(b) mandates the Department of Administration accumulate funding to various working reserve accounts, such as the one set up for terminal leave for state employees, by *"charging the unencumbered balance of any appropriation enacted to finance the payment of employee salaries and benefits that is determined to be available for lapse at the end of the fiscal year."*

did not benefit the council's central mission. In the end, only $34,647, or 20 percent, of the council's FY 04 budget was actually spent on council activities.

# FINDINGS AND RECOMMENDATIONS

Recommendation No. 1

The Division of Behavioral Health (DBH) Community-based Suicide Prevention Program coordinator should ensure prevention programs conform to the Statewide Suicide Prevention Plan.

The Community-based Suicide Prevention Program (CBSPP) was established in 1989 to provide financial support and assistance primarily to small, rural communities to carry out activities that would contribute to preventing suicide. The program is administered by DBH. In FY 04, 52 communities received more than $763,000 in funding to implement suicide prevention programs in their community. As part of the grant application process, applicants must submit community suicide prevention plans to the DBH program coordinator.

Historically, community plans have included activities directly focused on suicide prevention as well as cultural, social and recreational activities aimed at strengthening relationships and dialogue within the communities. With some communities, the emphasis is on social and recreational events more than activities with a direct relationship to suicide prevention. However, the community coordinator, typically a part-time employee funded by the grant, has received some suicide prevention training. Grantees submit monthly activity reports to the DBH program coordinator.

Although their missions are directly related, SSPC has no involvement with the community-based suicide prevention program grant award process. While the primary role of the council is to serve in advisory capacity to the legislature and the governor, under AS 44.29.350(3)-(6) such advice is regarding actions necessary to:

> *(3) enhance suicide prevention services and programs throughout the state;*
>
> *(4) develop **healthy communities** through comprehensive, collaborative, community-based and faith-based approaches;*
>
> *(5) develop and **implement** a statewide suicide prevention plan;*
>
> *(6) **strengthen existing and build new partnerships** between public and private entities that will advance suicide prevention efforts in the state.* [emphases added]

Now that SSPC has a statewide suicide prevention plan in place, we believe as a first step, the various community-based suicide prevention plans, at a minimum, should be consistent with the statewide plan. Developing procedures that require grant applicants to certify and explain how their grant activities and community plans are consistent with the state plan will

provide more assurance that this particular state funding is being implemented in a manner consistent with the centrally-developed state plan.

Accordingly, we recommend DBH modify the grant application process as necessary, requiring communities to read the statewide prevention plan and certify their local plan is consistent with the state plan. Further, we recommend that DBH report to SSPC regarding these grant applications and talk about how the various community-based efforts are consistent with the council's plan.

Recommendation No. 2

The Administrative Manager for DHSS Boards and Commissions and the Statewide Suicide Prevention Council coordinator should develop a more formalized, informative system of reporting financial information to the council.

As discussed in the conclusions section of this report, 80 percent of the FY 04 operating budget for the council was either lapsed or spent for items that were not directly related to suicide prevention activities. While it is unclear whether DHSS management actively prohibited the council from spending much of their funding, it is clear that in FY 04 SSPC did not receive consistent and informative financial reports from the department. Turnover in the coordinator's position and extensive use of "borrowed" personnel to fill in as part-time acting coordinator made clear communication of financial and budgetary information even more critical. Additionally, such reporting is an important function for a state agency to carry out when charged with providing administrative support to a council consisting largely of members from the general citizenry.

While the minutes for half of the council meetings reflected some discussion of finances, the discussion primarily focused on the funding appropriated, with limited or no discussion of council expenditures and available balances. Although the administrative manager for Boards and Commissions reported she provided financial reports to the council, we saw no evidence the council received regular financial reports. The former coordinator and members of the council we interviewed reported they did not believe they consistently received adequate financial information from DHSS.

As reflected in the conclusions section and the following analysis of public need section, we believe the council accomplished its central mission and responsibility. However, the council was hindered by inadequate administrative support from DHSS – especially in the use of SSPC's FY 04 appropriation. Accordingly, we recommend the administrative manager develop a comprehensive, informative format for tracking and reporting expenditure activity for SSPC and develop understandable, reliable reports on a consistent basis to assist the council in the use of its appropriated funding.

Recommendation No. 3

The council should ensure it provides public notice of all council meetings.

Alaska Statute 44.62.310 requires public notice of all public entity meetings. Since its inception, the council did not give adequate public notice of two of its 12 meetings. No public notice was provided on either the State of Alaska's online public notice system or through publication in widely-circulated state newspapers. Additionally, the agendas for three of the council meetings did not provide periods for public comment.

By not publicly announcing all meetings and not scheduling periods for public comment, the council may inadvertently send the message that public participation is not essential to SSPC operations. Given the planning, coordination, education, training and technical support objectives of the council's statutory mandate, it is crucial that involvement of, and interaction with, the public be done.

We recommend the council ensure that all meetings are publicly noticed, ensure that the method of notice is consistent and provide opportunity for public comment. We also recommend the council consider posting its meeting schedule on SSPC website.

Recommendation No. 4

The Office of the Governor should make appointments to the council in a timely manner.

Besides the lack of effective access to FY 04 funding, SSPC activities were also hampered by delays in appointments made to the council. In March of 2003, four of the 11 seats for which the Office of the Governor was responsible for appointing were vacant. In March of 2004 there were again four seats vacant. Some of the positions on the council had been left vacant over a year. As of June 2004, all council seats had been filled.

These numerous and extended periods of vacancy in member seats hindered the council's operations. The council has many challenges related to its suicide prevention work, vacancies in member seats should not be one of them. For the council to operate effectively and efficiently, it must be fully appointed and appointments must be timely. We recommend the Office of the Governor makes appointments to the council in a timely manner.

# ANALYSIS OF PUBLIC NEED

The following analyses of council activities relate to the public need factors defined in AS 44.66.050(c). These analyses are not intended to be comprehensive, but address those areas we were able to cover within the scope of our review.

***The extent to which the board, commission, or program has operated in the public interest.***

To assess whether the council has operated in the public interest, we measured the council's activities against the six objectives set out by the legislature for SSPC in state law, at AS 44.29.350.[6] From our review of council activities, we conclude SSPC has reasonably addressed its statutory objectives. Activities and accomplishments of the council have included the following:

1. Advising the executive branch agencies and the legislature. The council advises the legislature and governor on suicide and suicide prevention efforts through annual reports, which are presented jointly to the House and Senate Committees on Health, Education and Social Services. Presentations to the legislature also include council member testimony.[7]

2. Increasing public awareness of the issue of suicide. To increase public awareness, the council maintains a website that provides information on suicide statistics, risk factors and prevention. The council's annual reports and the Statewide Suicide Prevention Plan are also available through the website. The council has conducted over 20 workshops and presentations.

   The council recently commemorated World Suicide Prevention Day on September 10, 2004. The event included various speakers, distribution of the final Statewide Suicide Prevention Plan and presentation of the suicide prevention posters commissioned by the council. Both this event and the council's June 30, 2004 meeting received media coverage.

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[6] AS 44.29.350 states *"The council shall serve in an advisory capacity to the legislature and the governor with respect to what actions can and should be taken to (1) improve health and wellness throughout the state by reducing suicide and its effects on individuals, families, and communities; (2) broaden the public's awareness of suicide and the risk factors related to suicide; (3) enhance suicide prevention services and programs throughout the state; (4) develop healthy communities through comprehensive, collaborative, community-based and faith-based approaches; (5) develop and implement a statewide suicide prevention plan; and (6) strengthen existing and build new partnerships between public and private entities that will advance suicide prevention efforts in the state"*.

[7] Due to turnover in the coordinator position, the council did not appear before the legislature to present its 2004 annual report

3. Providing technical assistance and support for activities related to suicide prevention. Other activities the council has been involved in include: certification of Careline;[8] Division of Behavioral Health's Targeted Gatekeeper Training[9] and training to help students, teachers and others recognize the signs of suicidal behavior and intervene appropriately.

4. Building and strengthening faith-based partnerships. The council has convened two clergy and clinician conferences, one in Wasilla and one in Fairbanks. The purpose of these events is to increase dialogue, collaboration and partnership between the faith-based and clinician-based approaches to suicide prevention.

5. Collaborating on planning activities with other related agencies. Recently, the council has begun collaborating on a comprehensive, integrated mental health plan with DHSS, the Alaska Mental Health Trust Authority, the Alaska Mental Health Board, the Advisory Board on Alcoholism and Drug Abuse, the Alaska Commission on Aging and the Governor's Council on Disabilities and Special Education.

***The extent to which the operation of the board, commission, or agency program has been impeded or enhanced by existing statutes, procedures, and practices that it has adopted, and any other matter, including budgetary, resource, and personnel matters.***

There are a variety of issues that have had a negative impact on the operations of the council including:

1. Misspent funding. In FY 04, DHSS spent 19 percent of the council's funding on office furnishings for a departmental agency that has no direct operational relationship to suicide prevention (see Report Conclusions section of this report).

2. Inadequate communication of financial information to SSPC. In FY 04, activities of the council were limited by the lack of clear and consistent financial information from DHSS (see Report Conclusions section of this report).

3. Coordinator turnover, council seat vacancies and meeting absenteeism. The council's operations have been impeded by high turnover in the coordinator's position and by numerous and long-term vacancies in council seats.

   In its relatively short existence, the council has had three coordinators. The first coordinator was hired directly by the council and served full-time from April 2002 to

[8] Careline refers to Alaska's statewide toll-free crisis intervention and assistance hotline.
[9] DBH has contracted for the development of a training curriculum specific to Alaska. Gatekeepers are individuals who have face-to-face contact with large numbers of people in their community. The council's role in the initiative is to review the curriculum developed and provide feedback.

June 2003. The second coordinator is an employee of DHSS and served as part-time staff from November 2003 to January 2004. The current coordinator is also an employee of DHSS who began her part-time service in February 2004.

On March 1, 2003 four of the 11 council seats the Office of the Governor is responsible for appointing were vacant and on March 1, 2004 four seats were again vacant. From council meeting minutes, it appears the Advisory Board on Alcoholism and Drug Abuse seat was vacant almost a year, the Alaska Mental Health Board seat was vacant one and a half years and the rural seat was vacant over one year. Reportedly these vacancies were due to delays in filling the positions, rather than lack of qualified applicants (see Recommendation No. 4).

Despite these challenges, the council has operated reasonably effectively over its three-year existence. SSPC did accomplish its primary operational objective – the development of the state's suicide prevention plan.

Additionally, the council requested and received an appropriation from the 2002 legislature to conduct a suicide prevention follow-back study.[10] The purpose of the follow-back study is to analyze retrospectively circumstances surrounding suicides, to develop profiles of victims and to identify potential interveners. To this end, the study includes reviewing records and interviewing individuals who had special relationships with the victims. The study benefits the public interest by gathering information that will be used to develop suicide prevention programs tailored to Alaskan needs. The study is expected to be completed the spring of 2005.

***The extent to which the board, commission, or agency has recommended statutory changes that are generally of benefit to the public interest.***

The council did not pursue statutory changes.

***The extent to which the board, commission, or agency has encouraged interested persons to report to it concerning the effect of its regulations and decisions on the effectiveness of service, economy of service, and availability of service that it has provided.***

In general, the council provides public notice of meetings and schedules public comment periods. The council holds four meetings per year, usually in Anchorage or Juneau.[11] Additionally, the public has the opportunity to contact the council through its website and offer feedback on the council's effectiveness.

[10] The funding consisted $300,000 in general funds and a $100,000 Mental Health Trust match.
[11] The council has also convened in Sitka and Kodiak.

While most council meetings are open to the public and, for the most part, provide periods for public comment, statutes require public notice of all meetings. We found no evidence that two of the 12 meetings were publicly noticed either through the state online public notice system or in the newspapers. Additionally, three meetings did not provide periods for public comment (see Recommendation No. 3).

***The extent to which the board, commission, or agency has encouraged public participation in the making of its regulations and decisions.***

Under AS 44.29.300, the council was tasked with developing and implementing a statewide suicide prevention plan. From the outset, the council's position has been that the plan is a collaborative effort between the state and the public. As such, the council has encouraged public involvement in a number of ways.

Before beginning work on the plan, the council sought input from service providers on what programs were needed. After the council drafted the first version, the plan was widely distributed[12] and made available on its website. The council received approximately 30 responses.

The final plan provides sample templates for four communities: a local church, a small Alaska Native village, the Alaska Mental Health Board and a residential school. Inclusion of templates in the final plan was in response to requests made by several members of the public at the council's June 2004 meeting.

***The efficiency with which public inquiries or complaints regarding the activities of the board, commission, or agency filed with it, with the department to which a board or commission is administratively assigned, or with the office of victims' rights or the office of the ombudsman have been processed and resolved.***

Nothing came to our attention in this area.

***The extent to which a board or commission that regulates entry into an occupation or profession has presented qualified applicants to serve the public.***

Since the Statewide Suicide Prevention Council does not regulate any occupations or professions, this criterion is not applicable.

[12] The draft plan was distributed to Alaska Native Tribal Health Consortium employees, Community-based Suicide Prevention Program grantees, drug and alcohol programs, community mental health centers, mayors and the State Library.

***The extent to which state personnel practices, including affirmative action requirements, have been complied with by the board, commission, or agency to its own activities and the area of activity or interest.***

Nothing in our review of the council indicated there were any complaints involving SSPC personnel practices.

***The extent to which statutory, regulatory, budgeting, or other changes are necessary to enable the agency, board, or commission to better serve the interest of the public and to comply with the factors enumerated in AS 44.66.050.***

As discussed in Report Conclusions, we recommend the council be continued. However, as reflected in Recommendation No. 1, we also suggest the council and DBH's CBSPP coordinator work together to ensure the community-based suicide prevention plans are consistent with the statewide suicide prevention plan.

As discussed in Recommendation No. 2, the department must improve its procedures for reporting financial information to the council. While not necessarily consistent with the legislation that established the council, DHSS has taken on a much larger role in the administration of SSPC. In such a role, with a council drawn in large part from the general citizenry, it is incumbent on the department to effectively communicate basic information to SSPC.

Failing that, we suggest the legislature consider making SSPC a separate appropriation item in DHSS, to limit the ability of the department's Finance and Management Services to legally reallocate and transfer funding between budgetary allocations and categories.

December 23, 2004

Ms. Pat Davidson
Legislative Auditor
Legislative Audit Division
P.O. Box 113300
Juneau, AK 99811-3300

Dear Ms. Davidson:

This letter is in response to your agency's November 15, 2004 Preliminary Report regarding a sunset review of the Statewide Suicide Prevention Council.

Recommendation No. 4

The Office of the Governor should make appointments to the council in a timely manner.

The Office of the Governor concurs with this recommendation.

Sincerely,

Linda J. Perez
Administrative Director

cc: Jim Griffin, Audit Manager
Laraine Derr, Director Boards & Commissions

December 27, 2004

Pat Davidson
Legislative Auditor
Division of Legislative Audit
P.O. 113300
Juneau, AK 99811-3300

RE: Sunset Review Preliminary Audit
Department of Health & Social Services
Statewide Suicide Prevention Council

Dear Ms. Davidson:

Thank you for allowing my staff and me the opportunity to respond to your recommendations.

Recommendation No. 1

The Division of Behavioral Health (DBH) Community-based Suicide Prevention Program Coordinator should ensure prevention programs conform to the Statewide Suicide Prevention Plan.

The Department of Health and Social Services concurs with this recommendation. The Division of Behavioral Health (DBH) agrees that the community-based suicide grants should be consistent with the Statewide Suicide Prevention Plan. The Division will continue to work with successful grantees to ensure that the Statewide Plan and the local plans are aligned.

In addition, due to upcoming changes in staff, the Division of Behavioral Health will take the opportunity to reconstruct the Prevention and Early Intervention Section, specifically

Community-based Suicide Prevention grants and activities. The Division also concurs that regular communication directly with the Statewide Suicide Prevention Council regarding community-based efforts and the links to the Statewide Plan will provide a more cohesive prevention system.

Recommendation No. 2

The Administrative Manager for DHSS Boards and Commissions and staff to the Statewide Suicide Prevention Council should develop a more formalized, informative system of reporting financial information to the council.

The DHSS in part disagrees with this conclusion. However, DHSS does acknowledge that during the time there was no Suicide Prevention Coordinator nor were their any personnel "acting" in that capacity, it was difficult for the Department to pass on information to the Council itself. Steps will be taken to remedy that situation when there is no SPC Coordinator or personnel "Acting" in place. The DHSS Administrative Manager will send financial information directly to Council President when there is no Coordinator or there is no personnel "Acting" in that capacity.

It should be noted that DHSS Administrative Manager did send monthly downloaded financial information as well as emailed financial information to staff (when requested) that were in "Acting" status. During conversations with the Legislative Auditor, the DHSS Administrative Manager informed the Auditor it was not possible to recreate the old monthly financial sheets as each time the download is performed it deletes the old information.

The DHSS does not believe that the Council was hindered by inadequate administrative support. The DHSS Administrative Manager supports five other Boards and Commissions in addition to other department staff. The DHSS Administrative Manager did ask the "Acting" coordinator monthly if she knew how the Council planned to expend its funds and made them aware of the balances. The "Acting" Coordinator always checked in with the Council and made the Administrative Manager aware of the Councils plans and these amounts were projected. It is the Council's decision on how to spend or not to spend funds. The DHSS fulfilled its obligations by informing on expenditure and unobligated balances monthly.

The DHSS did spend a portion of the funds on a department-wide project at the end of the fiscal year (June, 2004) when it was clear the Council was not going to spend these funds and that they would lapse. The Suicide Prevention Council was going to lapse over $130,000. The department had costs associated with department-wide information technology integration. This integration related to the Suicide Prevention Council as the Information Technology group supports this council. It was a department decision to use some of the funds rather than have them lapse.

Recommendation No. 3

The Council should ensure it provides public notice of all council meetings.

The Department of Health and Social Services concurs with this recommendation. The Council should ensure that all meetings are publicly noticed and that the method is consistent and provides an opportunity for public comment. The Council should also post its meeting schedule on its website.

Recommendation No. 4

The Office of the Governor should make appointments to the council in a timely manner.

The Department of Health and Social Services concurs with this recommendation and will work closely with the Office of the Governor to ensure the Council is fully appointed and that appointments are made in a timely manner.

Report Conclusions

The Department of Health and Social Services does not agree with the conclusion that department hindered the efforts of the Council by providing inadequate financial information and diverting funds.

The facts are clear on the matter:

1. Monthly reports were routinely sent to the council coordinator and ad hoc information was provided upon request.
2. Funds were not spent on other activities until it was clear that the Council would not use their entire budget (in fact, the Council lapsed $105,000 in FY04 as it was).
3. The acting Coordinator was mistaken in stating that the Director of Administrative Services instructed her not to spend further funds on Council operations. There is no evidence of this communication and the statement is not true or even credible.

The Department is concerned about the recommendation to extend the termination of the Suicide Prevention Council. The Department feels the Council should adopt specific outcome measures to reduce the suicide rate in Alaska. The Department believes the focus should be on implementing prevention efforts that work to reduce suicide and not solely on the existence of the Council. The Department has had a consistent message to consolidate or merge boards and council activity to become more efficient and believes that the continuation of the Council should be measured by the progress in reducing suicides in Alaska.

In addition, the department is concerned that the work of the Council be aligned with other statewide efforts focusing on enhanced efficiencies, integration of clinical practices and consolidation of administrative functions. The department would like to recommend that the Council continue to be an active participant of the Alaska Mental Health Trust Authority facilitated Governor's Advisory Board on Alcoholism and Drug Abuse and Alaska Mental Health Board staff merger planning and implementation process, ensuring that the statewide infrastructure for suicide prevention and education is integrated throughout our community-based system of care, ultimately ensuring that suicide efforts are sustained and embedded within the system well beyond 2009.

The work of the Council should interface closely with community plans around prevention and the Council should remain actively engaged with the Trust and the four planning boards making sure that beneficiaries receive the services they need.

Sincerely,

Joel Gilbertson
Commissioner

December 21, 2004

Legislative Budget and Audit Committee
Division of Legislative Audit
P.O. Box 113300
Juneau, Alaska 99811-3300

Dear Ms. Davidson

RE: Response to the Preliminary Audit Report
Statewide Suicide Prevention Council

As Chair of the Statewide Suicide Prevention Council, I would like to express my appreciation for the role in which the audit plays in helping our council with direction and accountability. In general, I found the audit to be supportive, accurate, and helpful.

The following will address the report's conclusions and recommendations:

Termination Date Extended:

I am very grateful for the audit's recommendation that the Statewide Suicide Prevention Council have an extended termination date from June 2005 to June 2009. Sustained efforts in reducing suicide in Alaska must be maintained if there is to be a reduction in the rate of suicide.

Funds:

I completely concur with the audit's findings in this matter. How is it that the legislature can budget a council with $200,000 to carry out its work, and in the end, had limited knowledge and access to only $34,700? Furthermore, when the acting coordinator - who was a state employee - inquired about funds and having access to the funds, she was sanctioned. I believe she was reprimanded for sending an email to Council members that the Commissioner thought contained erroneous information. Personally, I made several phone calls to the Commissioner and the Governor's office to resolve this issue. Eventually, I met with the Commissioner to advocate for the council and for the acting coordinator. After meeting with the Commissioner, a compromise was made allowing the acting coordinator to stay on the Council, but a new coordinator was immediately asked to step in. The new 2004 coordinator - also a state employee - has done an outstanding job. However, the whole experience left me disillusioned. Where was the council's money and why couldn't we have access to it? Why was it so difficult to have a current budget presented quarterly to the Council? As a volunteer appointed to the Council and a member of the general public who is unfamiliar with governmental financial procedure, I am dependent upon the coordinator to have full access and

knowledge of the Council's budget. However when the past acting coordinator did inquire, she was dealt with in a manner I found extreme and unjust. How ironic that this audit determined that $31,700 went to furniture during this state fiscal year.

Recommendation No. 1:

The suggestion to have community based suicide prevention programs conform to the statewide suicide prevention plan makes good sense and will ensure that the work of the Council and the department is aligned. The plan was written for all communities within Alaska and is a living document that is meant to be updated with current research and data. As community based programs go through the DBH grant application process, their knowledge, feedback, and recommendations regarding the plan will be invaluable. The statewide suicide prevention plan is general enough that communities can conform to the plan, yet be very distinct within their own community. The plan was not written with a specific prescription for every community. Rather it provides guidelines, data and suggestions for a community to create their plan. Our hope is that the plan empowers communities to create a plan that is relevant, meaningful, and culturally appropriate.

Specifically, the Council can assist the DBH Community-based Suicide Prevention Program coordinator in creating the criteria in the grant application process, as well as in the grant review process. This would be done in accordance with the normal grant process.

Recommendation No. 2:

The solution for a more formalized, informative system of knowing the council's budget is excellent. Furthermore, the council would like to know all expenditures and a balance of our budget on a quarterly basis. Perhaps the DHSS Financial and Management Services (FMS) staff should have a time on the quarterly agenda to review the budget, personally reporting the Council's expenditures to date and fielding questions from the Council members. If not, the Council feels that it is necessary that the coordinator automatically receive monthly and quarterly reports from FMS; be able to inquire about expenses that don't make sense, or seem inappropriate, all without fear of reprisal.

If the council is indeed permitted to continue until June of 2009, perhaps a review of the FY05 - FY09 budgets to ensure an increased adjustment that will allow the Council to adequately perform its duties and activities including hiring a full-time coordinator, (if the decision is made to do so) would be appropriate.

Recommendation No.3:

The finding that two out of twelve meetings were not given adequate notice is so noted, and the council will make certain that such notices are given 100% of the time. The audit's suggestions for greater publicity and receiving public comment will be done by consistently publishing meetings in the local papers and on the SSPC website. Furthermore, as the four annual meeting dates are established (ideally, at the beginning of the calendar year) they will be published on the SSPC website.

Recommendation No. 4:

The recommendation to have the Office of the Governor make timely appointments to the council is very much appreciated. It was difficult to hold council meetings when a quorum was impossible due to unfilled appointments. Keeping the momentum of a functioning Council is crucial to make progress in suicide prevention.

Additionally, I would like to point out that the legislation that created the Council also requires four legislators to serve on the Council. Specifically, the legislation appoints the Senate President and the Speaker of the House, as well as a member from the House and the Senate. When the Council was initially created, all four legislators regularly attended. However, it has become clear with the legislator's busy schedule it is difficult for them to make the meetings. I would like to recommend a change in statue whereby the either the President of the Senate or the Speaker of the House can appoint two members from the Senate and the House to serve on the council. By having consistence attendance from all Council members we will sustain a functioning Council.

In conclusion, it has been an honor to serve on the Council. This audit has helped, at least in part, to restore my faith in the checks and balances of government. It is my sincere hope that by working together we can reduce the tragedy of suicide in Alaska.

Please contact me if you need further information.

Sincerely,

Jeanine B. Sparks, Chair
Statewide Suicide Prevention Council
18931 Danny Drive
Eagle River, Alaska 99577

907-352-8237
907-694-6566

# State of Alaska
# FY2006 Governor's Operating Budget

## Department of Health and Social Services
## Suicide Prevention Council
## Component Budget Summary

# Component: Suicide Prevention Council

## Contribution to Department's Mission

The Council is the state planning and coordinating agency for issues surrounding suicide and suicide prevention.

## Core Services

The powers, duties and responsibilities of the Council are to act in the advisory capacity to the Governor and the legislature with respect to what actions can and should be taken to:

- Improve health and wellness throughout the state by reducing suicide and its effect on individuals, families, and communities;

- Broaden the public's awareness of suicide and the risk factors related to suicide;

- Enhance suicide prevention services and programs throughout the state;

- Develop healthy communities through comprehensive, collaborative, community-based approaches;

- Develop and implement a statewide suicide prevention plan; and

- Strengthen existing and build new partnerships between public and private entities that will advance suicide prevention efforts in the state.

## FY2006 Resources Allocated to Achieve Results

**FY2006 Component Budget: $119,000**

| Personnel: | |
|---|---|
| Full time | 0 |
| Part time | 1 |
| Total | 1 |

## Key Component Challenges

Develop and implement Youth and Survivor Advisory committees.

Implement the media and public relations campaign.

Secure funding to print media campaign products.

Secure funding to produce and air radio and television spots.

Support Careline.

Determine state and national data elements that should be collected for suicide prevention.

Interface with the 4 boards/commissions.

## Significant Changes in Results to be Delivered in FY2006

The Statewide Suicide Prevention Council is scheduled to sunset June 30, 2005 unless the legislation extends the council.

## Major Component Accomplishments in 2004

Statewide Suicide Prevention Council Planning Committee concentrated on finalizing the Suicide Prevention Plan to be released in FY05 at World Suicide Prevention Day, 9/10/04.

Completion of the FY04 Report to the Legislature.

Alaska Injury Prevention Center continues work on the Follow-Back Study and receives Institutional Review Board approval from University of Alaska, Anchorage and ANMC to work with human subjects.

Clergy/Clinician Initiative held a conference in Fairbanks.

Division of Behavioral Health awarded a SAMHSA Targeted Gatekeeper Training grant.

Office of the Governor appoints new members.

Developed a Statewide Suicide Prevention Council Website.

Department of Health and Social Services, Commissioner's Office designates staff as the new part-time Suicide Prevention Coordinator.

## Statutory and Regulatory Authority

Alaska Statute 44.29.300-390 Statewide Suicide Prevention Council

## Contact Information

**Contact:** Janet Clarke, Assistant Commissioner
**Phone:** (907) 465-1630
**Fax:** (907) 465-2499
**E-mail:** janet_clarke@health.state.ak.us

## Suicide Prevention Council
## Component Financial Summary

*All dollars shown in thousands*

| | FY2004 Actuals | FY2005 Management Plan | FY2006 Governor |
|---|---|---|---|
| **Non-Formula Program:** | | | |
| **Component Expenditures:** | | | |
| 71000 Personal Services | 24.4 | 36.6 | 38.2 |
| 72000 Travel | 8.2 | 41.5 | 41.5 |
| 73000 Services | 2.1 | 39.7 | 38.3 |
| 74000 Commodities | 31.7 | 1.0 | 1.0 |
| 75000 Capital Outlay | 0.0 | 0.0 | 0.0 |
| 77000 Grants, Benefits | 0.0 | 0.0 | 0.0 |
| 78000 Miscellaneous | 0.0 | 0.0 | 0.0 |
| **Expenditure Totals** | **66.4** | **118.8** | **119.0** |
| **Funding Sources:** | | | |
| 1037 General Fund / Mental Health | 66.4 | 118.8 | 119.0 |
| **Funding Totals** | **66.4** | **118.8** | **119.0** |

## Summary of Component Budget Changes
## From FY2005 Management Plan to FY2006 Governor

*All dollars shown in thousands*

| | General Funds | Federal Funds | Other Funds | Total Funds |
|---|---|---|---|---|
| **FY2005 Management Plan** | **118.8** | **0.0** | **0.0** | **118.8** |
| **Adjustments which will continue current level of service:** | | | | |
| -FY06 Cost Increases for Bargaining Units and Non-Covered Employees | 0.2 | 0.0 | 0.0 | 0.2 |
| **FY2006 Governor** | **119.0** | **0.0** | **0.0** | **119.0** |

## Suicide Prevention Council
## Personal Services Information

| Authorized Positions | | | Personal Services Costs | |
|---|---|---|---|---|
| | FY2005 Management Plan | FY2006 Governor | | |
| Full-time | 0 | 0 | Annual Salaries | 28,134 |
| Part-time | 1 | 1 | Premium Pay | 0 |
| Nonpermanent | 0 | 0 | Annual Benefits | 11,462 |
| | | | *Less 0.00% Vacancy Factor* | (0) |
| | | | Lump Sum Premium Pay | 0 |
| **Totals** | 1 | 1 | **Total Personal Services** | **39,596** |

## Position Classification Summary

| Job Class Title | Anchorage | Fairbanks | Juneau | Others | Total |
|---|---|---|---|---|---|
| Coordinator,Suicide Prev Cncl | 1 | 0 | 0 | 0 | 1 |
| **Totals** | **1** | **0** | **0** | **0** | **1** |

STATEWIDE
SUICIDE
PREVENTION
COUNCIL

February 3, 2005

Dear Senator Dyson,

I would like to thank you and the Senate Health, Education and & Social Services members for allowing Kathy Craft, Statewide Suicide Prevention Council Coordinator, the opportunity to testify on behalf of the recommendation to extend the termination of the Council's sunset. The work of the Council has only begun and we appreciate the opportunity to continue our suicide prevention and awareness efforts.

The Council's next meeting will be held February 22-23, 2005 in Juneau. At this time, I will facilitate a discussion on a realistic performance measure that will serve as a target outcome for reducing the suicide rate during FY06 and subsequent years.

Again I would like to thank you for your time and commitment on the issues surrounding suicides across Alaska.

Sincerely,

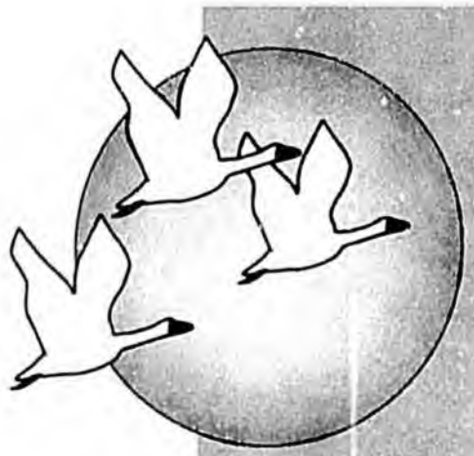
Jeanine Sparks

Jeanine Sparks, Chair
Suicide Prevention Council
by Kathy Craft

cc: Senator Ben Stevens
Senator Gary Wilken
Senator Lyda Green
Senator Kim Elton
Senator Donny Olson

# Statewide Suicide Prevention Council

## REPORT TO THE LEGISLATURE 2004



By statute, the Statewide Suicide Prevention Council consists of 15 members, 11 appointed by the Governor and 4 by the Legislature. The Governor appoints: two executive branch State employees; one member of the Advisory Board on Alcoholism and Drug Abuse; one member of the Alaska Mental Health Board; a designee from the Alaska Federation of Natives, Inc.; a counselor in a secondary school; an adult active in a statewide youth organization; a person who has experienced a family member's death by suicide; one person who resides in a rural community that is not connected by road or Alaska marine highway to the state's main road system; a member of the clergy; and a youth under eighteen. The senate president appoints one majority and one minority member of the Senate; the speaker of the house appoints one majority and one minority of the House.

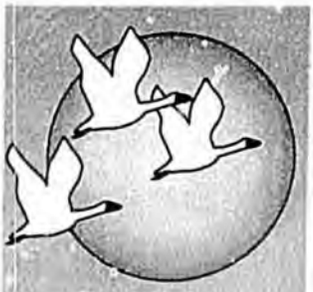
The Council shall serve in an advisory capacity to the legislature and governor with respect to what actions can and should be taken to:

- Improve health and wellness throughout the state by reducing suicide and its effect on individuals, families, and communities;
- Broaden the public's awareness of suicide and the risk factors related to suicide;
- Enhance suicide prevention services and programs throughout the state;
- Develop healthy communities through comprehensive, collaborative, community-based approaches;
- Develop and implement a statewide suicide prevention plan; and
- Strengthen existing and build new partnerships between public and private entities that will advance suicide prevention efforts in the state.

## 2003 Highlights

### *Alaska Suicide Prevention Follow-Back Study*

The Alaska Injury Prevention Center (AIPC) and its partners are conducting a psychological autopsy study which entails gathering extensive data for all suicide in Alaska over a 12 month period. Attempts will be made to conduct a comprehensive interview of at least two survivors for every suicide over the twelve month period (6 month extension is pending approval). Data are being collected from the Alaska Medical Examiners office and law enforcement records, as well as medical and school records.



Suicide Prevention Council

AIPC has obtained IRB (Institutional Review Board) approval from the University of Alaska Anchorage and from the Alaska Native Medical Center to work with human subjects for this research project. AIPC has written approval from half of the regional Native Health Corporations and is pursuing approval from the remaining half. AIPC is pursuing agreements for data sharing with Providence and other hospitals; train more interviewers in various locations (18 already trained); and continue to build a database.

As a result of the research on this project, an application was also submitted in mid-February to the Centers for Disease Control for a new grant to study protective factors in communities that have had no suicides or attempts from 1994-2000.

### *Targeted Gatekeeper Training*

The Division of Behavioral Health (DBH) was awarded a SAMHSA [Substance Abuse and Mental Health Services Administration] Targeted Gatekeeper Training grant to develop an Alaska-specific curriculum to train a broad range of providers to better understand and identify signs of suicidal behaviors and to intervene appropriately. The curriculum will be designed in a way that allows the training to be easily adjusted to fit different learning styles across a wide variety of professions from community health aides, to divorce attorneys, to basketball coaches and clergy. These trained "gatekeepers" will be able to assist with earlier identification and intervention, key strategies for preventing suicide. Once the curriculum is developed, a plan will be implemented for statewide training and evaluating the effectiveness of this approach. Currently, DBH is working with procurement to finalize the contracting process for the curriculum development and evaluation.

### *Clergy-Clinician Initiative*

A Clergy/Clinician Conference was held in Fairbanks during October 2003 allowing clergy, clinicians and remote health aides the opportunity to share information, discuss suicide prevention concerns and ways in which they could support one another and become better resources when working with an individual in crisis. An additional conference is tentatively scheduled for late spring in Point Hope.

### *Trust and Planning Board Relationship*

Staff from the Alaska Mental Health Trust Authority continue to facilitate discussions with the Alaska Mental Health Board (AMHB), the Governor's Advisory Board on Alcoholism and Drug Abuse (ABADA) and the Statewide Suicide Prevention Council on a restructuring effort that would merge the boards to reduce duplication and unify efforts. Given that the Suicide Prevention Council is due to end in FY05, with one additional year to conclude business, the Trust will advocate that the Council receive adequate funding to continue its work in FY05 and FY06, with FY06 used to develop permanent Suicide Prevention representation and function as a part of the AMHB, ABADA or a merged Behavioral Health Board.

## Statewide Suicide Council Plan

Dr. Margaret West, Region X, Maternal Child and Family Health and national suicide prevention expert worked on the draft Alaska Statewide Suicide Prevention Plan with staff from the Division of Behavioral Health in an effort to make the document more user friendly. The Council will assess the changes and decide if the new version allows for easier and more active use. The recommendation has been made that the Council continue to work on finalizing the draft and conduct a major release on Friday, September 10, 2004 – World Suicide Prevention Day coupled with a large public service announcement campaign.

## Council Members

**Jeanine Sparks**
Acting Chair & School Counselor

**Joel Gilbertson**
Health and Social Services

**Noelle Hardt**
Youth Organization

**Mike Irwin**
Public

**Representative Mary Kapsner**
Alaska State Legislature

**Representative Pete Kott**
Alaska State Legislature

**Judith Lethin**
Alaska Board of Education and Early Development

**Senator Georgianna Lincoln**
Alaska State Legislature

**Karen Perdue**
Citizen

**Susan Soule**
Health and Social Services

**Senator Ben Stevens**
Alaska State Legislature

**Vacant**
Youth under 18

**Vacant**
Alaska Mental Health Board

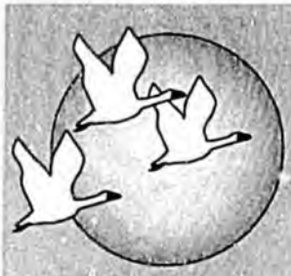
**Vacant**
Alaska Commission on Aging

**Vacant**
Public

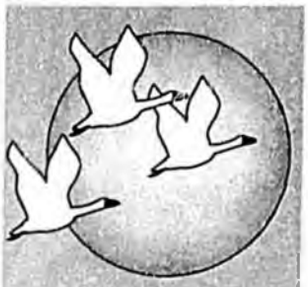
**Kathy Craft**
Director, Suicide Prevention Initiative, Division of Behavioral Health

## 2004 Central Priorities for the Council

- Complete and disseminate the Statewide Suicide Prevention Plan, Fall 2004
- Commemorate World Suicide Prevention Day; September 10, 2004
- Orient new Council Members



Report to the Legislature



Suicide Prevention Council

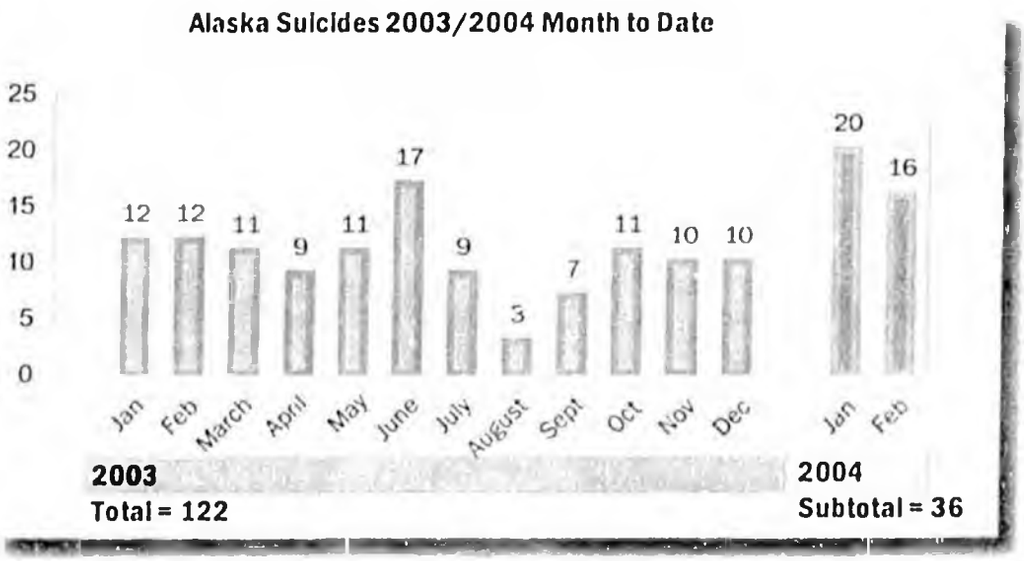
The Council would like to thank and extend their appreciation to Mark McDonald, Agnes Sweetsir and Carol Seppilu for their dedication and support during 2003.

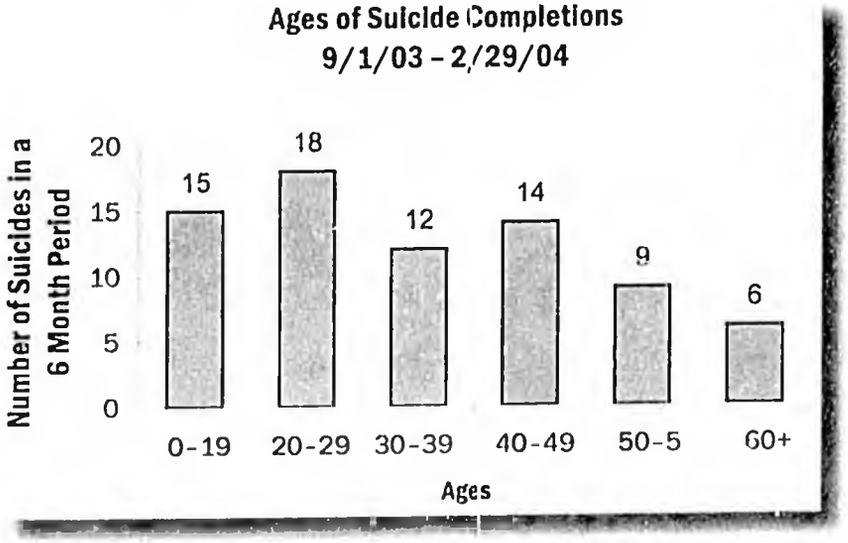
- For additional Alaska Suicide Prevention Council information, please visit: *http://www.hss.state.ak.us/suicideprevention/default.htm*
- Division of Public Health
- Injury Disparities in Alaska – Alaska Injury Resources
- Fact Sheets & Printable Resources: *http://www.hss.state.ak.us/dph/profiles/injuries/default.htm*

Additional Suicide Prevention Facts

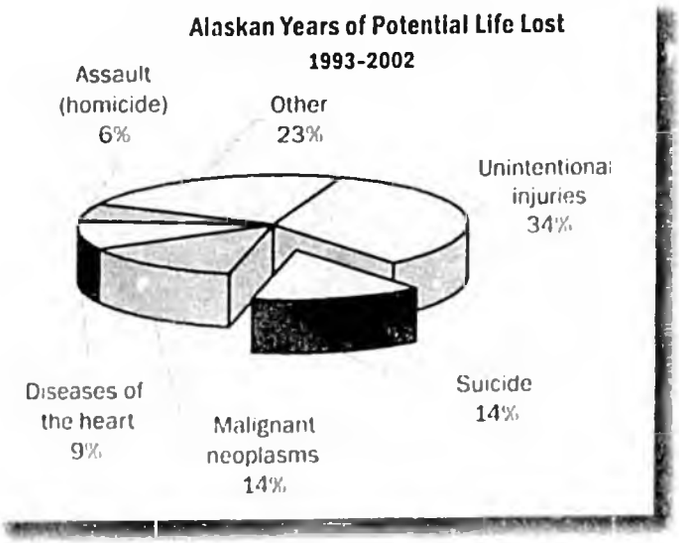
- *www.ninh.nih.gov/research/suifact.htm*
- *www.psych.org.public_info/teen.cfm*
- *www.acap.org/publications/factsfam/suicide.htm*
- *www.childrensdatabank.org*

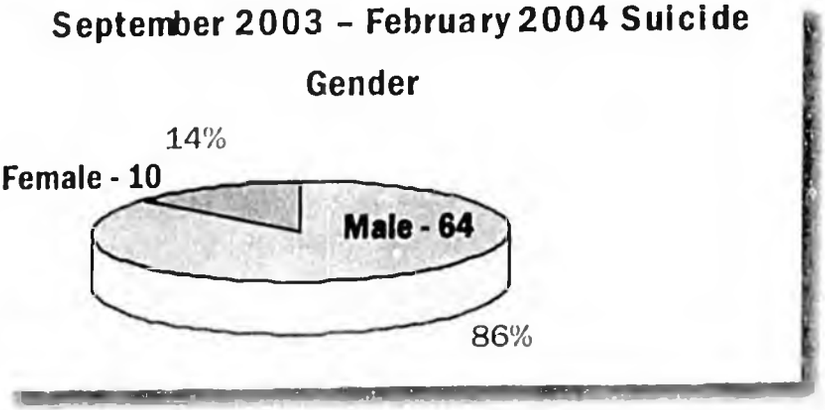
## Frank H. Murkowski, Governor





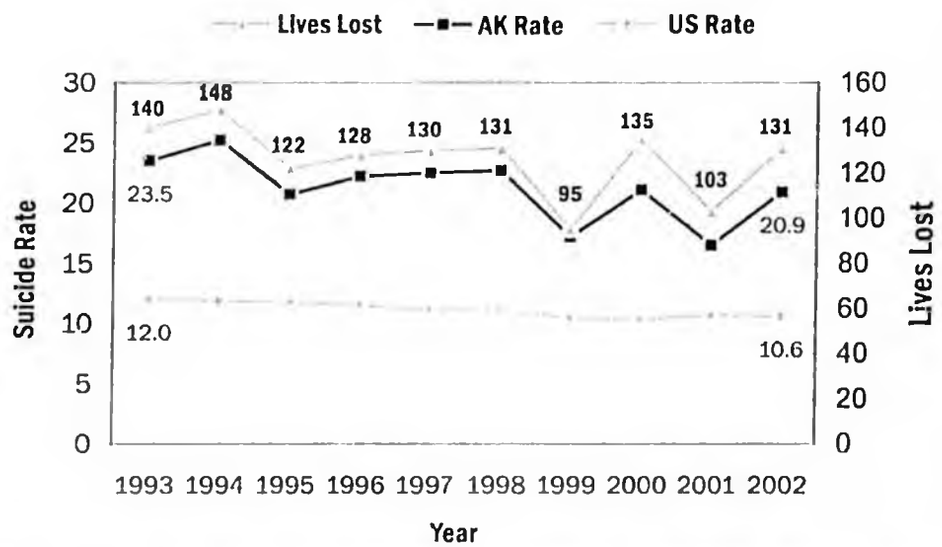

*Source: Alaska Injury Prevention Center Follow Back Study. September 2003 – February 2004*



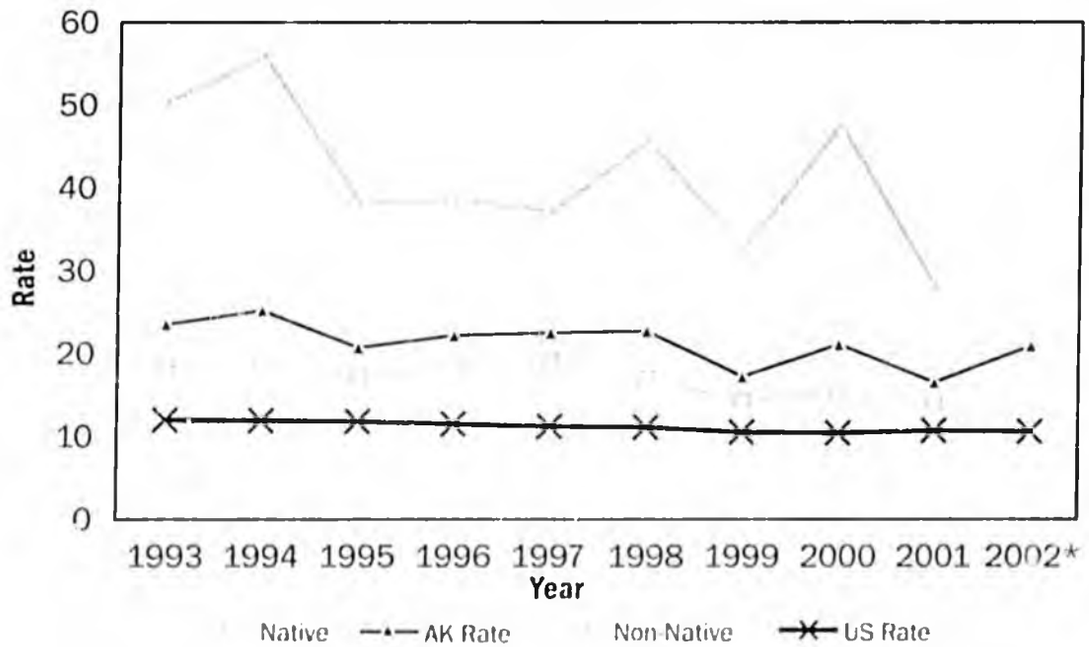




*Source: Alaska Injury Prevention Center Follow Back Study. September 2003 – February 2004*

## Alaska Suicide Rates
### 1993-2002

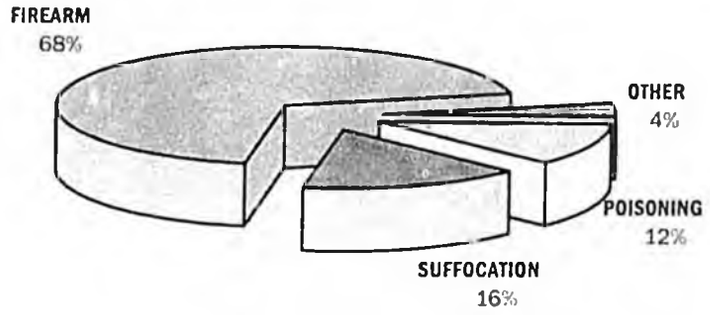



## Alaska, Alaska Native, and National Suicide Rates
### 1993-2002

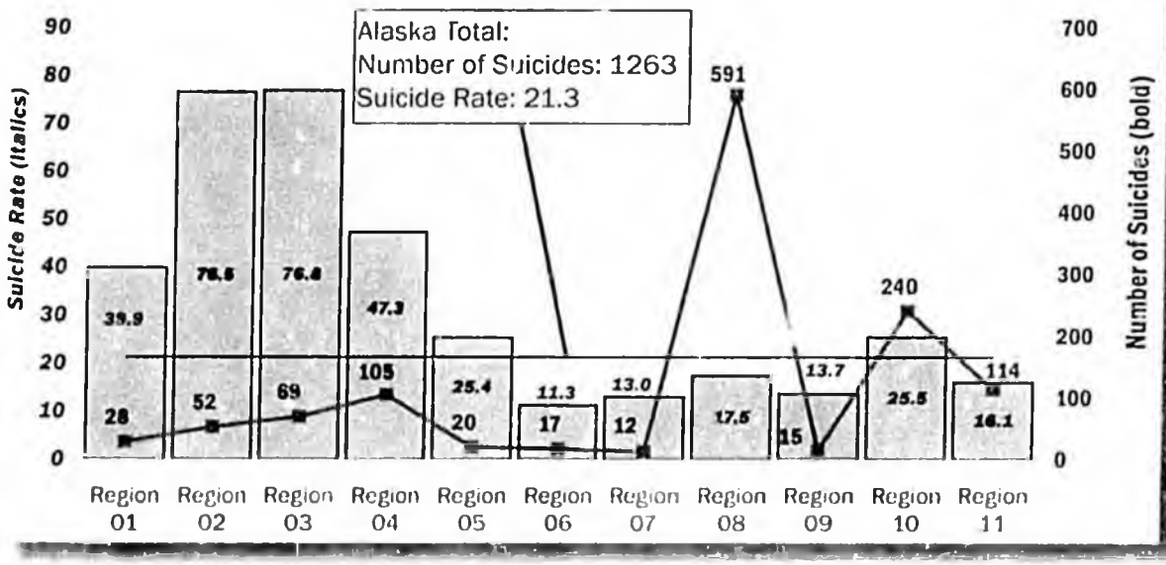



*Population estimates by race are unavailable for 2002. Therefore rates can not be calculated

**Suicide Methods in Alaska**
**1993-2002**



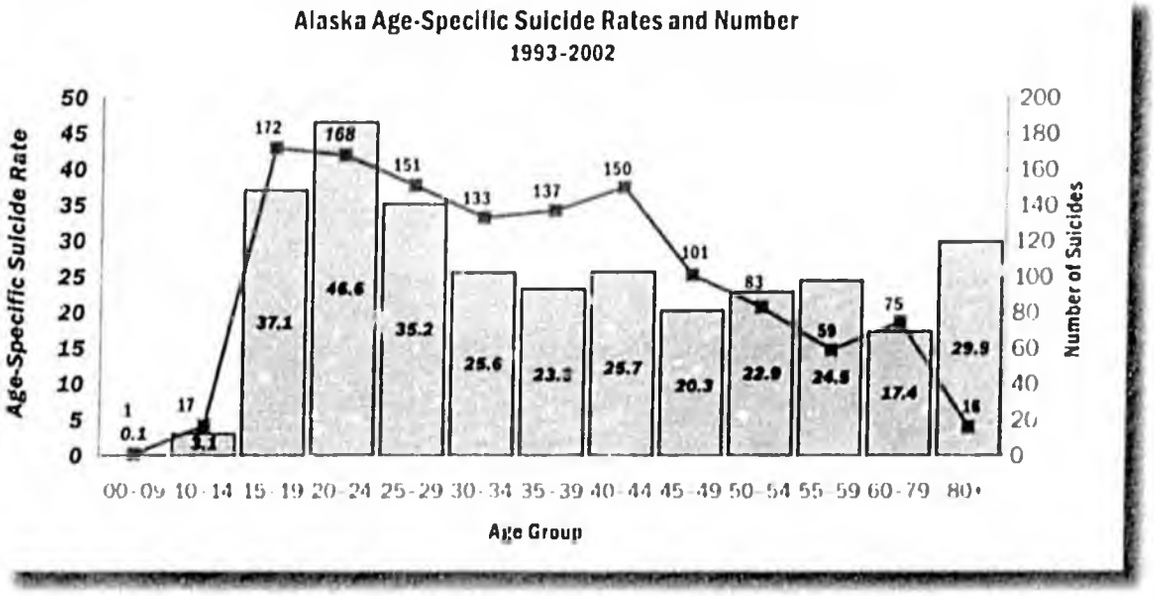

**Alaska Suicide Rates and Numbers by Region**
1993-2002

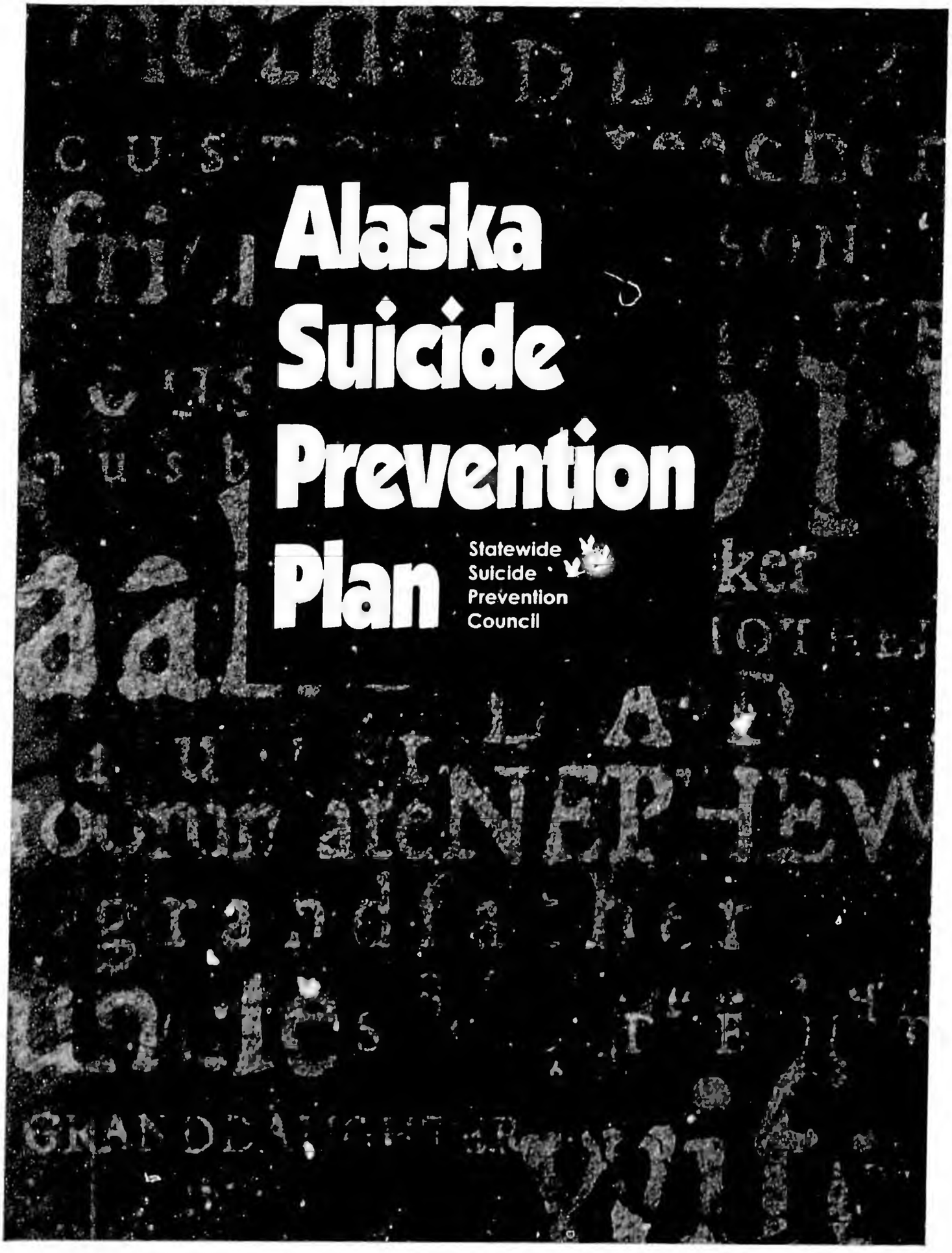



Region 01: North Slope Borough
Region 02: Northwest Arctic Borough
Region 03: Nome census area
Region 04: Wade Hampton census area, Bethel census area
Region 05: Dillingham census area, Bristol Bay Borough, Lake and Peninsula Borough
Region 06: Kodiak Island Borough
Region 07: Aleutians East Borough, Aleutian West census Area
Region 08: Mat-Su Borough, Municipality of Anchorage, Kenai Peninsula Borough
Region 09: Valdez-Cordova census area
Region 10: Yukon-Koyukuk census area, Fairbanks/North Star Borough, Southeast Fairbanks census area, Denali Borough
Region 11: Haines Borough, Juneau Borough, Ketchikan Gateway Borough, Sitka Borough, Wrangell-Petersburg census area, Prince of Wales-Outer Ketchikan census area, Skagway-Hoonah-Angoon census area

Suicide Prevention Council
Departmental Coordination Manager &
Suicide Prevention Council Staff
Department of Health and Social Services
Commissioner's Office
Office of Program Review
751 Old Richardson Hwy., Suite 100-A
Fairbanks, Alaska 99701-7802

# Suicide Prevention Council Annual Report to the Legislature: 2004





# Alaska Suicide Prevention Plan

Statewide Suicide Prevention Council

**ALASKA SUICIDE PREVENTION PLAN**
Correction – 9/17/2004

**STATEWIDE SUICIDE PREVENTION COUNCIL** (PAGE 8)

Tracy Barbee, *Alaska Mental Health Board*
NAMI Alaska

Noelle Hardt, *Statewide Youth Organization*
Boys and Girls Clubs of Southcentral Alaska

Bill Hogan, *Director, Member-at-Large*
Division of Behavioral Health

Kelsi Ivanoff, *Student*

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Jeanine Sparks, *Chair*
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Stan Tucker, *Clergy*

Kathy Craft, *Suicide Prevention Council Coordinator*

**Frank Murkowski, *Governor***
**State of Alaska**
**Joel Gilbertson, *Commissioner***
**Department of Health and Social Services**

**Pages 16-18:** Data provided by the Division of Public Health's Bureau of Vital Statistics

Statewide
Suicide
Prevention
Council

*Dear Alaskans,*

In October of 2001 the Alaska State Legislature helped to create the Statewide Suicide Prevention Council. This thoughtful group of fifteen has met quarterly with efforts to understand the complexities of suicide in Alaska. Through listening to experts in the field, examination of statistical data, as well as taking public testimony, the council provides annual reports to the legislature and recommendations to the Governor for suicide prevention.

Alaska has one of the highest rates of suicides, and with our many cultures and communities, there is not a "one-size-fits-all" approach to suicide prevention.

Furthermore, it is the council's conviction that prevention is up to all communities - whether the community is a small town, a religious community, a corporation, a school district, a city, or any group of people with a common goal or history. In other words, suicide prevention is up to each one of us. With this in mind, the council has written an Alaska Suicide Prevention Plan.

The Alaska Suicide Prevention Plan is meant to be educational and instrumental for individuals and communities to know more about the issue of suicide in Alaska, and to help guide them in creating a plan for their community. So often, the aftermath of completed suicides leave people and communities feeling helpless and overwhelmed. Hopefully, this plan will be a helpful document empowering communities in their response to suicide attempts and completion. This plan includes statistical data, goals, recommendations, and resources.

Finally, this plan is meant to be a working document. As we learn more through research and experience, this plan will need to be updated. Ultimately, our goal is to reduce the numbers of deaths by suicide in Alaska. Suicide prevention and appropriate intervention is everyone's responsibility. Please contact the council if we can be of assistance to you and your community.

*Sincerely,*

Jeanine B. Sparks

Jeanine Sparks, *Chair*
Alaska Suicide Prevention Council

## Dedicated to:

*All Alaskans – Who Have Been Touched by Suicide*

## Special Notes

This plan would not have been possible without the assistance from the many Alaskans who donated their time to share their wisdom, information and ideas about suicide awareness and prevention. The current members of the Statewide Suicide Prevention Council would like to express their gratitude by acknowledging the support and assistance the following individuals provided during the completion of this plan. Many thanks go to:

Merry Carlson
Julie Feero
Agnes Sweetsir
Mike Irwin
Julie Kitka
Carol Seppilu
Russ Webb
Kami Frenette
Jewelee Bell
Chris Aquino
Jay Livey
Daniel Bill
Senator Rick Halford
Bishop Mark MacDonald
Representative Brian Porter
Ryan Hill
Kimberlee Vanderhoof
Dr. Margaret West

*Elder Interviewers:*
Sophie Batt
Dorothy Brown
Patrick Frank
Helen Gregorio
Enid Lincoln
Etta Fornier
Judy Simeonoff

*Elders:*
Walter Austin
Ole Lake
Pete Abraham
Andrew Franklin
Ivan Field, Sr.
Dorcas Maupin
Hazel Snyder
Eddie Smith
David Eluska
Mary Peterson
Rita Blumenstein
Alice Petrivelli
Mary Bavilla
May Nanalook
Ramona Field
Kenneth Toovak
Esther Murray
David Pierren
George Inga
Herman Squartsoff
Others interviewed who wished to remain anonymous.

All current and former Community-Based Suicide Prevention Program Coordinators for their on-going efforts to reduce self-destructive behavior and promote wellness in communities throughout Alaska.

And finally a special thanks to Jeanine Sparks and Susan Soule, their vision and diligent work completed this plan.

# Contents

# Appendices

# Contents

# The Alaska Suicide Prevention Plan

***Reducing suicide in Alaska through education, advocacy, and collaboration with Alaska communities***

## The Vision

The Alaska Suicide Prevention Plan is based on the strong belief that everyone has a role to play in suicide prevention and that individuals and groups that address the physical, psychological, emotional and spiritual needs of individuals and communities in Alaska must work together if we are to be effective. It is our hope that Alaska Suicide Prevention Plan will provide a springboard for collaborative action: improved understanding; and increased wellness in communities across Alaska.

Toward that end, the plan is not a prescription, but rather a resource to be used by anyone or any entity concerned about preventing suicide and suicidal behavior.

## The Goal

*The goal of this plan is clear: reduce the incidence of suicide and non-lethal suicidal behavior in Alaska.*

Suicide is a not a disease or disorder. Rather it is a tragic ending in which a person dies as a result of an intentional self-inflicted act. Underlying suicide and suicidal behavior are complex painful feelings that have been termed "psychache", a mixture of hopelessness, depression, loneliness, burdensomeness, disconnection. There are many things that contribute to these feelings including biological, psychological, and social factors. There are also many possible strategies to prevent suicide. We can eliminate some of the causes of pain. We can help people develop the skills to avoid or cope with pain. We can encourage people in pain to seek help. We can learn to recognize people in pain and assist them in getting help. We can provide effective treatment to those in pain.

## Scope of Problem

### What Is Suicide?

Suicide is the act of voluntarily and intentionally taking one's own life. Most often people who chose suicide are suffering from intense psychological pain from which they see no other way to escape. There is no one cause of suicide, no one cause of psychological pain, and thus no easy answer to the "why did he do it" question.

The diagram on page15 illustrates the complexity of interrelated factors that can play a part in creating the pain. Inside the figure of the person are what we can call **Predisposing Factors.** These are things a person is born with, like temperament or genetic make-up, or born into, like family history or cultural group. These "givens" can make a person more or less vulnerable. For instance, some people are born with an easy going temperament. They can meet life's problems with a smile and keep on going. They are less vulnerable to psychological pain. Some people have an inherited tendency to develop depression. This makes them more vulnerable to extreme psychological pain. Some ethnic groups have a history that is full of trauma and cultural dislocation. Unresolved historical trauma appears to create vulnerability that is passed from generation to generation. Appendix VII includes a table that details Predisposing Factors in terms of what creates vulnerability or risk and what provides protection.

Inside the circle around the person are what we can call **Contributing Factors.** These factors exist in the various social environments in the community in which a person lives. They are also related to choices a person makes.

A supportive community that provides both supports and limits (mentors and curfews for instance) is protective. It makes extreme psychological pain less likely. On the other hand, choosing to use drugs or drink alcohol to excess creates pain and contributes to risk.

A mental disorder, especially a mood disorder or a substance use disorder like alcohol abuse or alcoholism is a major contributing factor. It has been estimated that as many as 90% of those who die by suicide are suffering from a diagnosable mental disorder. The disorder causes extreme psychological pain.

Appendix VII includes a table that details risk and protective Contributing Factors.

Last are what we can term Precipitating Factors. These are events that in a vulnerable person serve as the last straw. Most often they are associated with a loss of some kind, a death, the end of a relationship, loss of status or self-esteem. Sometimes people see these as the cause of a suicide, but there is never one cause, just the last in a string of factors that have created pain and vulnerability from which there seems no other escape.

People who have a lot of protective factors (sometimes called assets) tend to be able to survive and bounce back from losses and other bumps in the road of life. We refer these people as resilient. Preventing suicide is related to building resiliency and competency and to treating mental disorders.

While the complexity of the factors that contribute to suicide can make suicide prevention seem very difficult, in fact the opposite is true. The contributing factors are also all entry points or paths to prevention. Further, they are all interrelated so that you don't have to address every factor. It has been shown that if you address one, for instance poor problem solving skills, you also impact others. Teach a person good problem solving skills and you are also likely to raise his self esteem, increase ability to make good choices and you will probably reduce misuse of substances. If we think of suicide prevention in this way, we can see the many elements that interact to increase or decrease risk and the ways in which each of us can get involved.

## The Approach

The plan has thirteen specific goals. For each goal we explain why the goal is important, how it might be achieved, and what markers might be used to measure success. Then we ask "what does it look like in my community?" This is the heart of the plan. It is meant to stimulate community level discussion, planning and action. We have also included several appendices that offer guidelines and suggestions for ways to mobilize and energize communities. Note that community does not just refer to a place, but rather to any group that works together for a common purpose.

The "how" sections are not inclusive. We have listed some strategies but certainly not all. The "how" list is intended as a starting point. Each community, be it a village, a school, a church group, a survivor organization or a behavioral health agency, needs to determine the "how" that is right for its population, culture and capability. Staff at the Statewide Suicide Prevention Council and the State Division of Behavioral Health are available to assist.

The Alaska Suicide Prevention Plan focuses specifically on suicide prevention and intervention strategies. There are many critical issues relating to health and well being outside the scope of this plan, among them: advocacy for mental health parity; retention of providers with rural and Native experience; community wellness; economic development; and others. We encourage partnerships in these and other areas simultaneous with the more targeted strategies presented here.

# ALASKA PREVENTION GOALS

## Universal Prevention Goals

**Goal 1:** Alaskans understand that suicide is a preventable problem.

**Goal 2:** Suicide prevention has broad-based support.

**Goal 3:** Alaskans recognize that mental illness, substance use disorder and suicidality respond to specific treatments and are part of health care. Any stigma associated with these disorders will be eradicated.

**Goal 4:** Alaskans store firearms and other potential items of self-harm safely and insure that Alaskans, especially youth, are educated about their safe management.

**Goal 5:** Alaskan communities support the development of protective factors and resiliency across the entire life span.

## Selective Prevention Goals

**Goal 6:** Alaskans recognize the warning signs for suicide risk and respond appropriately.

**Goal 7:** People who work in institutions and groups that serve or work with high risk populations are able to identify warning signs and respond appropriately.

## Indicated Prevention Goals

**Goal 8:** Behavioral health programs to promote mental health and reduce substance abuse, and relevant social services are available and accessible to all Alaskans.

**Goal 9:** Alaskan Behavioral Health Programs treat suicidality effectively using appropriate current practice guidelines.

**Goal 10:** Alaskan Behavioral Health Programs include an appropriate on-going continuum of supportive services for suicidal individuals from identification through treatment.

**Goal 11:** Alaskan communities respond appropriately to suicide attempts and suicide completions.

## Program Evaluation and Surveillance Goals

**Goal 12:** Alaska suicide prevention and intervention research is supported and on-going.

**Goal 13:** Alaska has a suicide surveillance system that provides data necessary for planning services, targeting interventions and evaluating progress.

# Statewide Suicide Prevention Council

Tracy Barbee, *Alaska Mental Health Board*
NAMI Alaska

Noelle Hardt, *Statewide Youth Organization*
Boys and Girls Clubs of Southcentral Alaska

Bill Hogan, *Director; Member-at-Large*
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**Department of Health and Social Services**

# Reducing suicide in Alaska through education, advocacy, and collaboration with Alaska communities

## The Vision

The Alaska Suicide Prevention Plan is based on the strong belief that everyone has a role to play in suicide prevention and that individuals and groups that address the physical, psychological, emotional and spiritual needs of individuals and communities in Alaska must work together if we are to be effective. It is our hope that the Alaska Suicide Prevention Plan will provide a springboard for collaborative action; improved understanding; and increased wellness in communities across Alaska.

Toward that end, the plan is not a prescription, but rather a resource to be used by anyone or any entity concerned about preventing suicide and suicidal behavior.

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***The goal of this plan is clear: reduce the incidence of suicide and non-lethal suicidal behavior in Alaska.***

Suicide is a not a disease or disorder. Rather it is a tragic ending in which a person dies as a result of an intentional self-inflicted act. Underlying suicide and suicidal behavior are complex painful feelings that have been termed "psychache", a mixture of hopelessness, depression, loneliness, burdensomeness, disconnection. There are many things that contribute to these feelings including biological, psychological and social factors. There are also many possible strategies to prevent suicide. We can eliminate some of the causes of pain. We can help people develop the skills to avoid or cope with pain. We can encourage people in pain to seek help. We can learn to recognize people in pain and assist them in getting help. We can provide effective treatment to those in pain.

The goal of reducing suicide and suicidal behavior is supported in The Department of Health and Social Services Comprehensive Integrated Mental Health Plan, *In Step*. The Healthy Alaskans 2010 publication published by the Department of Health and Social Services, Division of Public Health sets the following specific targeted reductions.

## The Approach

The plan has thirteen specific goals. For each goal we explain why the goal is important, how it might be achieved, and what markers might be used to measure success. Then we ask "what does it look like in my community?" This is the heart of the plan. It is meant to stimulate community level discussion, planning and action. We have also included several appendices that offer guidelines and suggestions for ways to mobilize and energize communities. Note that community does not just refer to a place, but rather to any group that works together for a common purpose.

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Prevention Council and the State Division of Behavioral Health are available to assist.

## The Importance of Efforts Beyond Suicide-Specific Strategies

The Alaska Suicide Prevention Plan focuses specifically on suicide prevention and intervention strategies. There are many critical issues relating to health and well being outside the scope of this plan, among them: advocacy for mental health parity; retention of providers with rural and Native experience; community wellness; economic development; and others. We encourage partnerships in these and other areas simultaneous with the more targeted strategies presented here.

## Next Steps

The next steps are up to you. Read through the plan. Think about the communities that you belong to. What is your community already doing to prevent suicide? Did you read something in the plan and think "my community could do that!" The Appendices on how to use this plan and the templates are designed to assist you in developing your community or agency plan. Call the Statewide Suicide Prevention Council for sources of technical assistance if you want some help getting started.

This plan really only takes on value when it comes to life, when people and communities pick-up, get to work and make it their own.

### For More Information

Visit the Statewide Suicide Prevention Council website at http://www.hss.state.ak.us/suicideprevention/ for updates and additional information regarding the Alaska Suicide Prevention Plan. Learn more about suicide in Alaska, Alaska resources, potential partnerships, ongoing activities, and the Statewide Suicide Prevention Council.

| Indicator | Alaska Data Source | U.S. Baseline | Alaska Baseline | Alaska Target Year 2010 |
|---|---|---|---|---|
| Reduce the suicide rate (suicide deaths per 100,000 population | ABVS | 10.6 (1999) | 17.2 (1999) | 11 |
| Alaska Native | ABVS | | 32.6 | 11 |
| Reduce the rate of suicide attempts among adolescents (percent of high school students grades 9 –12 who attempted suicide requiring medical attention in the past 12 months) | YRBS | 2.6% (1999) | 2.7% | 1% |
| Alaska Native | YRBS | | 4.1% (1999) | 1% |

**The Alaska State Suicide Prevention** plan uses a public health prevention model adopted by the National Institutes of Health (NIH), the Institute of Medicine (IOM), Washington State (the first state to develop a statewide suicide prevention plan), and certain other states. It includes a continuum of universal, selective, and indicated prevention approaches.

**Universal preven ion** strategies target and benefit A.askan communities by providing information and education to all its members. The goal is healthy communities. Selective prevention strategies target and benefit specific high-risk groups. Alaska's high-risk groups include youth and Alaska Natives, particularly young adult Alaska Native males. The goal is to prevent suicidal behaviors in targeted groups. Indicated prevention strategies target and benefit high-risk individuals who show signs of suicide risk factors. The goal is to prevent further suicidal behaviors in high-risk individuals.

**Program Evaluation and Surveillance** measures the effectiveness of programs and strategies. Program evaluation increases our understanding of the effectiveness of our efforts. Surveillance systems track trends in rates; identify new problems; provide evidence to support programs; identify risk and protective factors; identify high risk populations for intervention; and assess the impact of prevention efforts.

**Table 1. Features of universal, selective, and indicated strategies.**

| Strategy | Benefits | Features | Examples |
|---|---|---|---|
| Universal | Village<br>Community<br>Region<br>Slate | • Aimed at the general public<br>• Raises public awareness<br>• Brief<br>• Low per person cost | • Regional and statewide suicide awareness education campaigns<br>• School-based educational programs for youth and their parents |
| Selective | High-Risk Groups | • Aimed at specific vulnerable groups<br>• Targets relevant risk and protective factors<br>• Length sufficient to have desired outcome<br>• Greater costs than universal interventions | • Depression and suicide screening programs for youth<br>• Gatekeeper training / peer programs<br>• Counseling friends and peers after a local or media-covered youth suicide |
| Indicated | High-Risk Individuals | • Individual risk factors and deficits in protective factors are identified<br>• Interventions specific to the individual's needs<br>• Length sufficient to have desired outcome<br>• Greater costs than universal and selective interventions | • Depression, anger-management, and decision-making classes for small groups of vulnerable youth who have thought about or attempted suicide<br>• Family support training<br>• Crisis intervention |

# Themes

1 **Suicide prevention is everyone's responsibility.** Suicide is not "just a mental health issue." As the fifth leading cause of death among Alaskans, suicide affects families and communities across the state. To be effective, programs must involve people, agencies, and organizations of the community. In order to engage communities in suicide prevention and community wellness, this plan presents a wide range of ideas, specific actions, and concrete resources so that specific activities can be developed to fit each region and its community members, as well as the various professional groups and individuals who provide related services.

2 **Successful suicide prevention requires local plans and actions, supported by, and integrated with, regional, state, and national resources.** Local autonomy and the cultural appropriateness of activities are key. Local planning should be informed by the current knowledge of suicide risk and protective factors, best practices, statistics, and other information. Local plans are likely to be most effective when activities complement existing efforts and resources and are part of a comprehensive, integrated strategy. Prevention activities are more effective when programs are long-term, with repeated opportunities to reinforce targeted attitudes, behaviors, and skills in settings where people normally spend their time: schools, community events, faith communities, and the workplace.

3 **Suicide is related to many other problems facing Alaska's communities and cannot be addressed alone.** Suicide prevention programs should coordinate with other prevention efforts such as those designed to help reduce substance abuse. New and ongoing health, mental health, substance abuse, education, and human services activities in naturally occurring settings such as schools, workplaces, clinics, medical offices, correctional and detention centers, elder facilities, faith communities, and community centers should be part of an integrated approach to suicide prevention. Reducing Alaska's suicide rate will require substantial, long-term, system wide changes that expand and enhance prevention services. Suicide will not be reduced through implementation of short term, one-time efforts. Prevention efforts must occur in the context of a comprehensive mental health services system.

4 **Suicide prevention efforts should target at-risk populations.** Young adult Native males are at most risk but interventions should address all disparities due to race, age, geographic location or other factors. These may vary by region and should be assessed locally and at a statewide level.

5 **To prevent suicide, we need to develop healthy communities across Alaska.** We can do this through coordinated prevention planning with a local focus. Each community needs to develop its own suicide prevention plan that is tailored to meet local needs and build on local strengths. Any activity that promotes community wellness and individual and community strengths may potentially contribute to lower suicide rates.

6 **Successful suicide prevention will require sufficient resources.** Statewide capacity building for activities will ensure the resources, skills, training, collaboration, and evaluation necessary for success. Suicide is complex and has many contributing factors. Emphasize early interventions to promote protective factors and reduce risk factors for suicide. The higher the level of risk, the stronger the suicide prevention effort must be and the earlier it should begin.

# Principles

Principles that apply to all suicide prevention programs

Note: In this section and throughout, the Plan uses "community" not just to mean city or village, but community of common interest – faith community, education community, corrections community, etc.

1. **Use evidence-based practices** where they exist and are appropriate. Evidence-based practices have been tried, evaluated and determined to be effective. Any given practice may have to be adapted for use with a population different from the one for which it was designed.

2. **Use data.** Data gives a clear picture of the size and nature of the problem, the who, what, when, where and how many. It enables us to design appropriate programs and evaluate their effectiveness.

3. **Establish a timeframe** for your program. Create a schedule for when specific activities are to take place. Set targets by time. This helps keep a program on track.

4. **Evaluate** your program. Plan how you will evaluate your program from the very beginning. This will help insure your goals and objectives can be measured and help determine if your program is effective. Remember to evaluate both the process of implementing the program (are we doing what we said we would when we planned to) and the outcome (is the program having the desired effect).

5. **Collaborate** with other groups in the community. Reach out to others. Build partnerships. Share the work.

6. **Pay attention to all age groups.** Suicide affects people of all ages. A comprehensive suicide prevention plan targets the entire community, is sensitive to the differences in suicide across the lifespan, and recognizes the varied roles different age groups can play in suicide prevention.

7. **Be culturally appropriate.** One size does not fit all. Know the values, beliefs, learning and communication styles of the group with whom you are working. Also keep in mind that culture varies not only by ethnic or national group, but also by age.

8. **Be appropriate to the community.** Communities vary in their readiness to recognize a problem and take action. It's important to determine what stage of readiness a community is at and design your program accordingly. If you "meet the community where it is at" you are more likely to get community support, ownership and action.

9. **Recognize and build on strengths.** Each individual and every community has qualities and abilities of which they are proud. Help identify these and use them to address problems. People and communities are energized when they work from their strengths.

See the appendices for additional information.

# What Is Suicide?

Suicide is the act of voluntarily and intentionally taking one's own life. Most often people who chose suicide are suffering from intense psychological pain from which they see no other way to escape. There is no one cause of suicide, no one cause of psychological pain, and thus no easy answer to the "why did he do it" question.

The diagram on page 15 illustrates the complexity of interrelated factors that can play a part in creating the pain. Inside the figure of the person are what we can call **Predisposing Factors.** These are things a person is born with, like temperament or genetic make-up, or born into, like family history or cultural group. These "givens" can make a person more or less vulnerable. For instance, some people are born with an easy going temperament. They can meet life's problems with a smile and keep on going. They are less vulnerable to psychological pain. Some people have an inherited tendency to develop depression. This makes them more vulnerable to extreme psychological pain. Some ethnic groups have a history that is full of trauma and cultural dislocation. Unresolved historical trauma appears to create vulnerability that is passed from generation to generation.

Inside the circle around the person are what we can call **Contributing Factors.** These factors exist in the various social environments in the community in which a person lives. They are also related to choices a person makes. A supportive community that provides both supports and limits (mentors and curfews for instance) is protective. It makes extreme psychological pain less likely. On the other hand, choosing to use drugs or drink alcohol to excess creates pain and contributes to risk.

A mental disorder, especially a mood disorder or a substance use disorder like alcohol abuse or alcoholism is a major contributing factor. It has been estimated that as many as 90 percent of those who die by suicide are suffering from a diagnosable mental disorder. The disorder causes extreme psychological pain.

Last are what we can term **Precipitating Factors.** These are events that in a vulnerable person serve as the last straw. Most often they are associated with a loss of some kind, a death, the end of a relationship, loss of status or self-esteem. Sometimes people see these as the cause of a suicide, but there is never one cause, just the last in a string of factors that have created pain and vulnerability from which there seems no other escape.

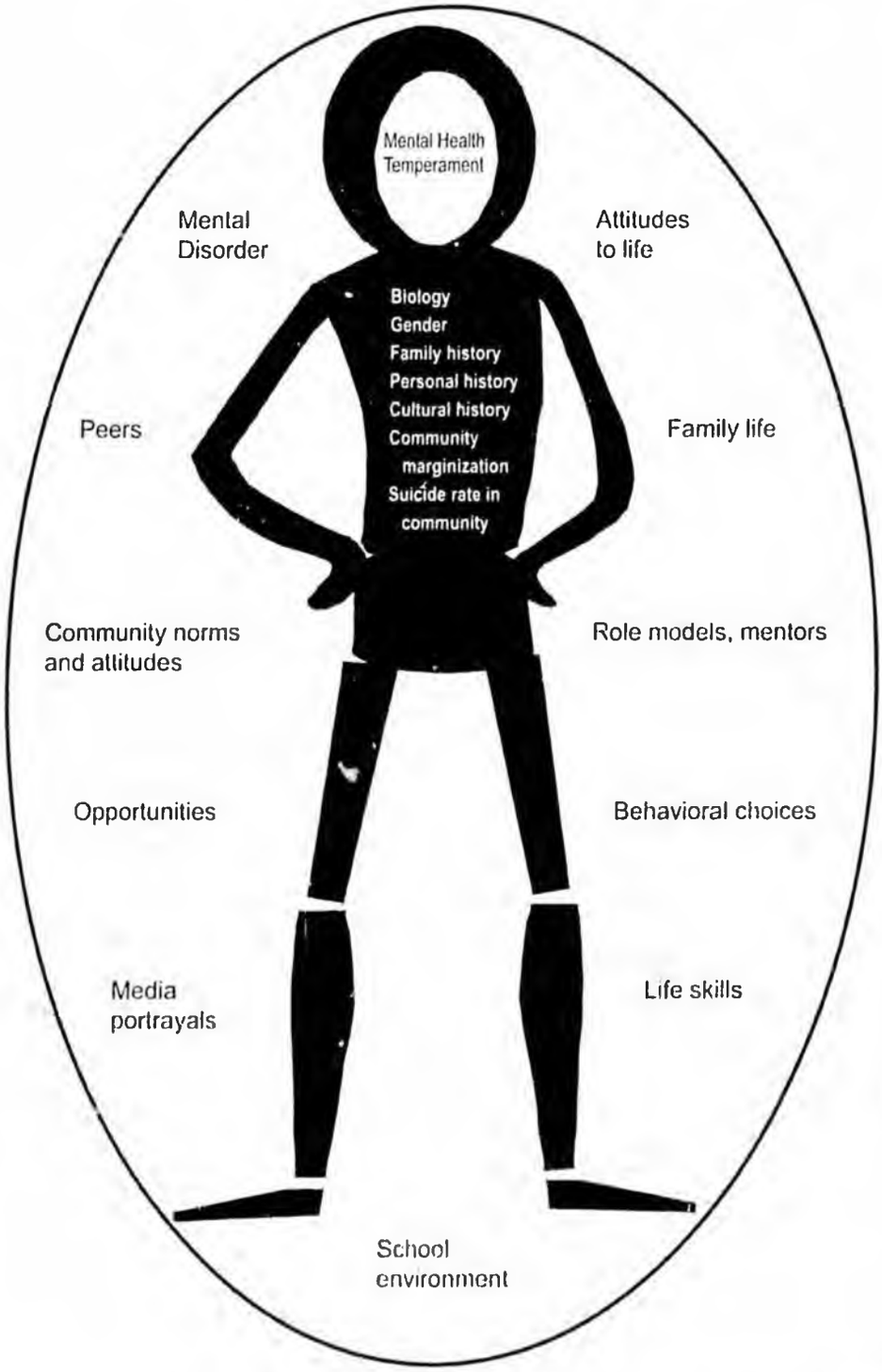
People who have a lot of protective factors (sometimes called assets) tend to be able to survive and bounce back from losses and other bumps in the road of life. We refer these people as resilient. Preventing suicide is related to building resiliency and competency and to treating mental disorders.

While the complexity of the factors that contribute to suicide can make suicide prevention seem very difficult, in fact the opposite is true. The contributing factors are also all entry points or paths to prevention. Further, they are all interrelated so that you don't have to address every factor. It has been shown that if you address one, for instance poor problem solving skills, you also impact others. Teach a person good problem solving skills and you are also likely to raise his self esteem, increase ability to make good choices and you will probably reduce misuse of substances. If we think of suicide prevention in this way, we can see the many elements that interact to increase or decrease risk and the ways in which each of us can get involved.

Appendix VII includes a table that lists the variety of factors that can make suicidal behavior more or less likely to occur.

# The Complexity of Interrelated Factors

## Predisposing and Contributing Factors




## Precipitating Factors

Loss
- Death
- Suicide
- Relationship
- Divorce
- Self-esteem

Teasing
Cruelty
Humiliation
Rejection
Failure

Loss of Health

Conflict with law
Incarceration

Celebrity death
esp. by suicide

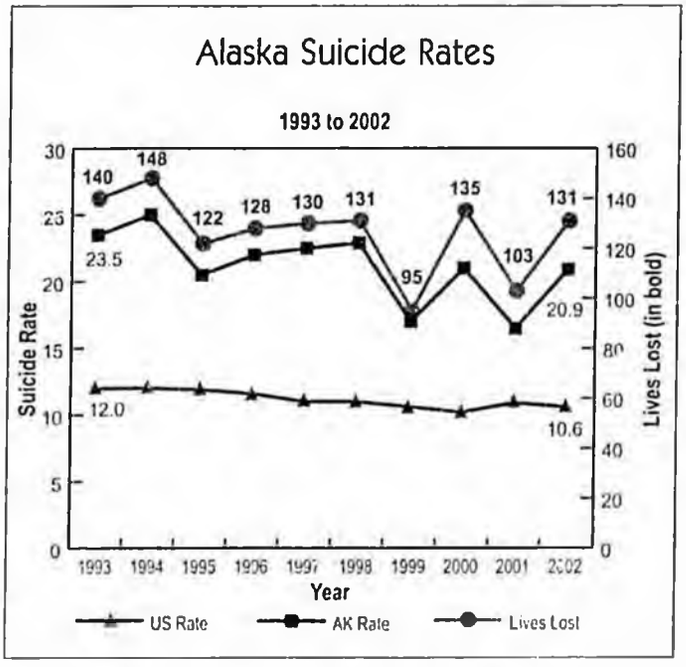
# Suicide in Alaska—the Patterns and Numbers

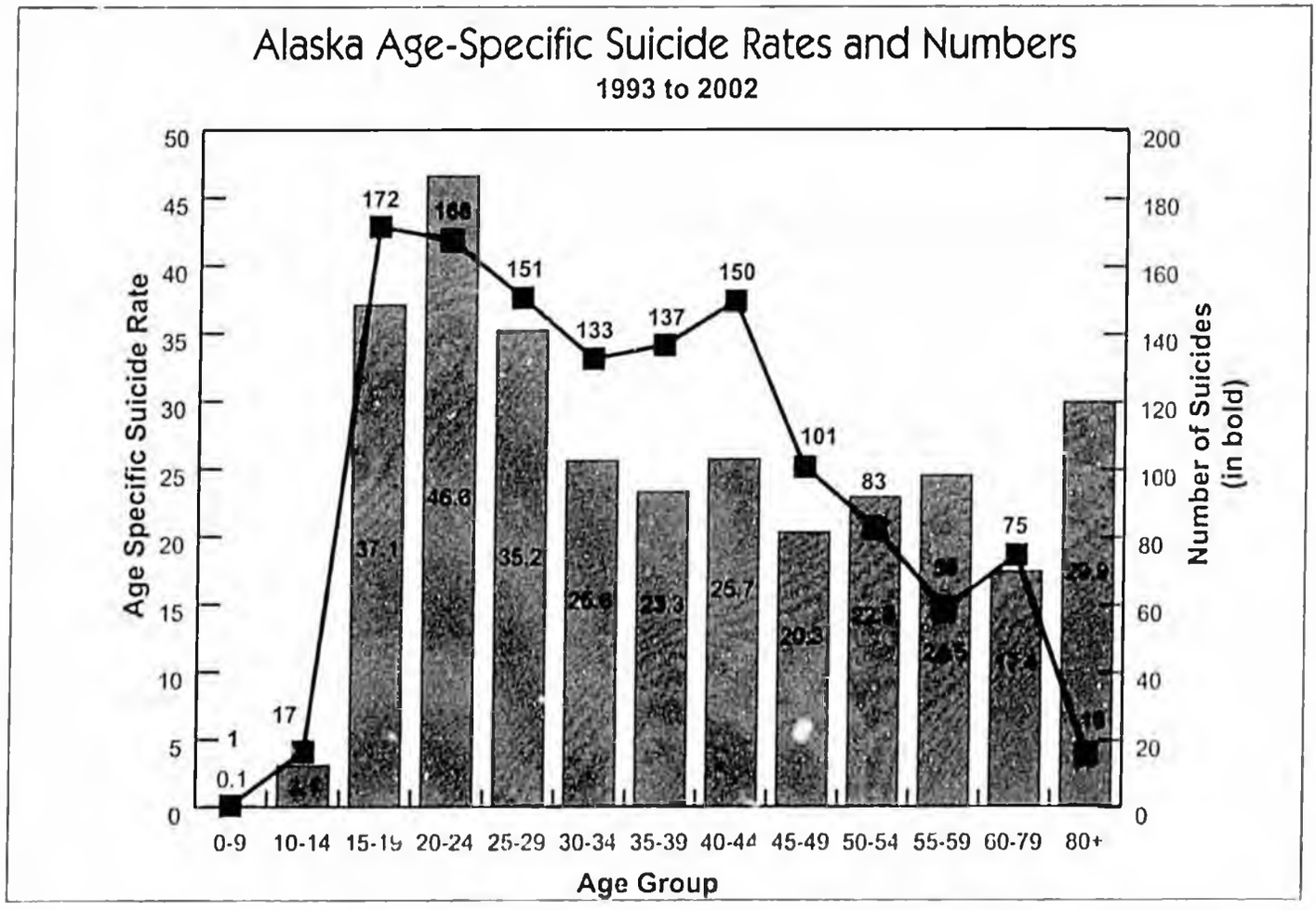
## The Overall Picture of Suicide in Alaska

Few Alaskans have not been touched directly by the grief, anger, pain, confusion, and loss of suicide. 7

Every suicide intimately affects an estimated 6 other people. Suicide is twice as common as homicide and more frequent than motor vehicle deaths. An average of 126 Alaskan lives are lost each year by suicide. With a suicide rate of 20.9 suicide deaths per 100,000 population in 2002, which is twice the national average (10.6). Alaska is ranked 6th in the nation (2001 AAS data) for suicides.

Suicide is consistently the fifth leading cause of all deaths in Alaska and is the leading cause of injury-related death. The rate of suicide in Alaska varies dramatically by age, region, race, and gender. The majority of suicides (70%) are by firearm.



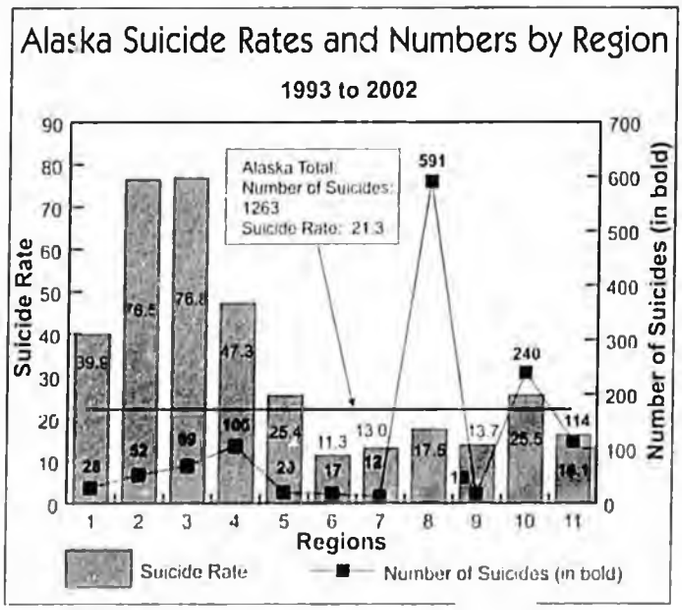
## Risk of Suicidal Acts by Age and Gender

**Completed Suicide.** Suicide rates are highest in young Alaskan adults between 15 and 29, with the highest rates between the ages of 20–24. Over the past decade, 40.3% of suicides occurred before age 30; 33.3% in ages 30 to 44; and 26.4% in ages 45 and older. In Alaska, males were over four times likely than females to die of intentional self-harm (33.9 per 100,000 vs. 7.6) during 2000. Suicide was the eighth leading cause of death for females and the fourth leading cause for males (BVS 2002 Annual Report).

**Attempted Suicide.** There were 3,266 non-fatal hospitalized suicide attempts for 1994–99, almost 550 per year. 42% were among Alaska Natives, 63% among women, and 53% among those ages 20–39. Although males complete suicide more frequently, females attempt suicide almost twice as often. Natives attempt rates are four times that of non-Natives.

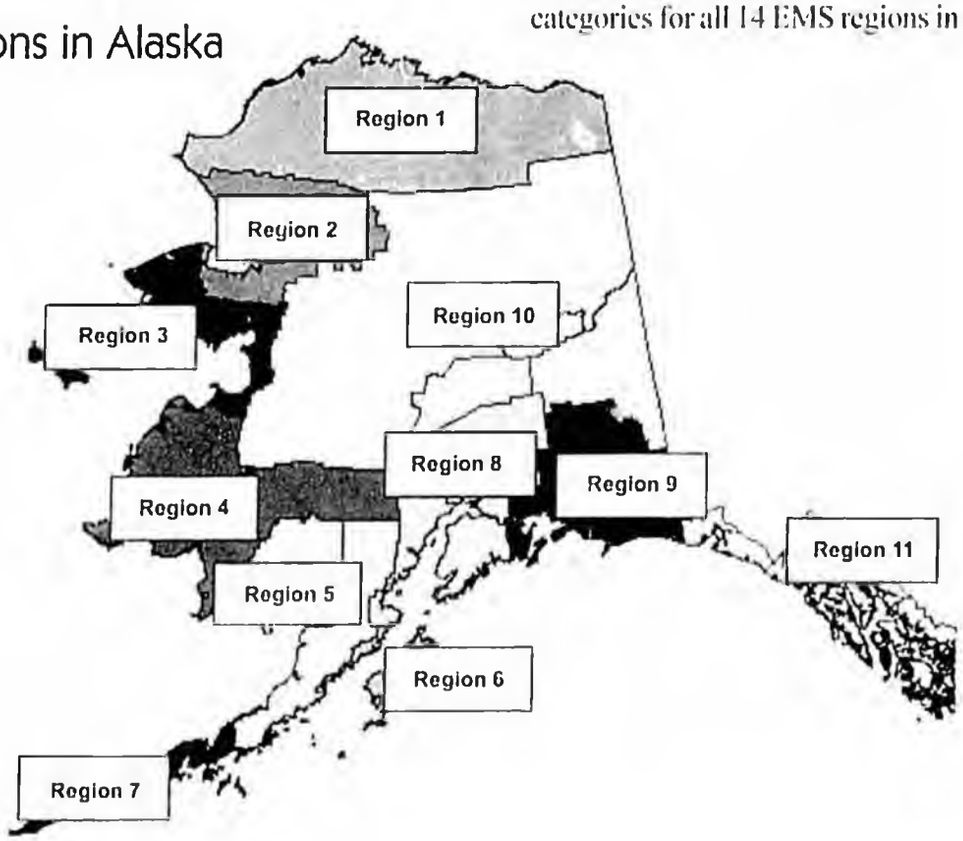
## Regional Differences

Rural and bush areas experience suicide rates double those of urban Alaska. Suicide rates are highest in the western and northern regions. Five regions, all southern, have suicide rates below Alaska's suicide rate.




Suicidal injuries in children were in the top five injury categories for all 14 EMS regions in Alaska, 1994-1998.

## EMS Regions in Alaska



## Risk of Suicide for Alaska Natives

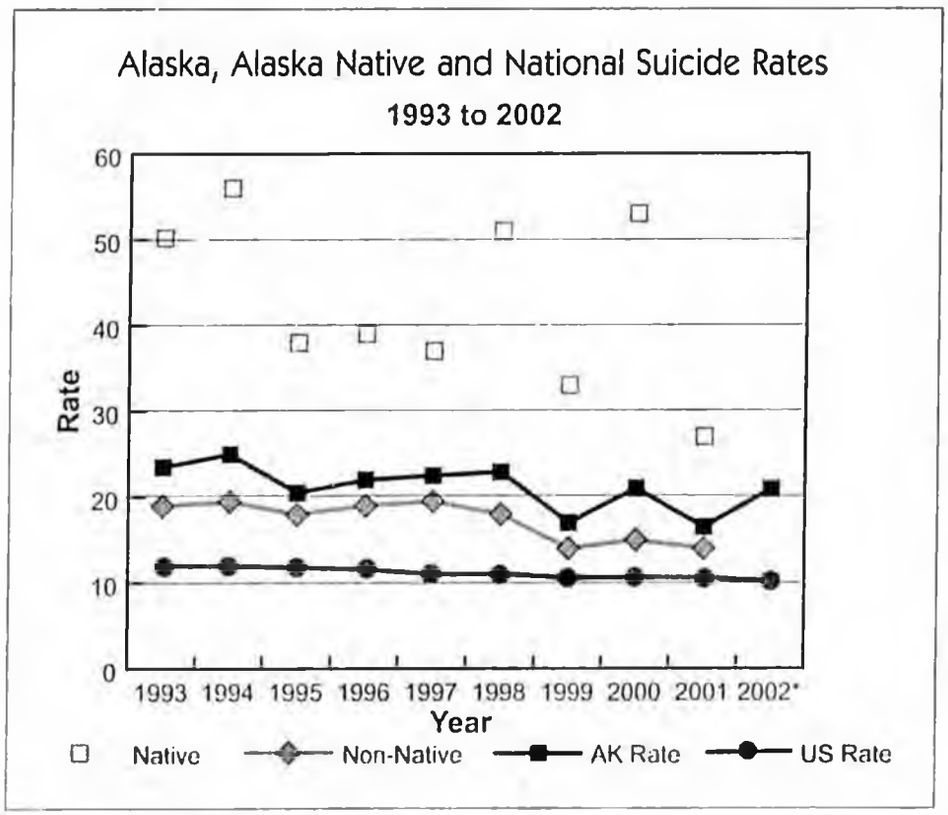
Among Natives, intentional self-harm was the fourth leading cause of death accounting for almost one of every 12 (8.1%) Native deaths (BVS 2002 Annual Report).

Alaska Natives experience suicide rates of 42.7 per 100,000 population, four times the national rate of 10.6.

Between 1994 and 2000, 286 of 834 suicides were by Alaska Natives. Alaska Natives account for less than 20% of the state's population (16%), yet account for one-third (34%) of the suicides in Alaska.

Alaska Native males commit suicide at rates of 68.5 per 100,000 population, more than 6 times the national average.

Alaska Native teens are much more likely than their non-Native peers to commit suicide. Between 1990 and 1999, Alaska Native teens killed themselves at a rate of 110 per 100,000-nearly six times greater than the rate of 20 per 100 000 among non-Native teenagers.




*Rates by Race not available for 2002

# What Alaska Native Elders Tell Us About Suicide

"We need to know how we got to such a place that our people, especially the young people, have decided that suicide is the only alternative. Then we need to talk among ourselves, the villages, individuals and whole regions, have to discuss what it is we need to do to become whole." *—Harold Napoleon*

It was Paul Jumbo of Toksook Bay who suggested that we turn to Alaska Native Elders to explore the questions raised by Harold Napoleon. With the help of people in many parts of Alaska, we were able to interview over 20 Elders. This section summarizes the interviews, using direct quotes where transcripts were available.

There is a perhaps not surprising consistency to what the Elders told us. Very few remembered any suicides when they were growing up. For most, suicide just did not exist and although many of those interviewed had lives that weren't always easy, almost all reported they had never considered suicide.

All spoke of having to work hard when they were growing up and saw that as a good thing.

*Ramona Field, Noorvik,* "Those days we were busy whole day even if we were children. Our parents or grandparents let us work whole day long. When they fish, they let us fish. When they need water we pack water or we get ready for the winter, summer, all day long we use to work for our parents."

Ramona and Ivan Field, Sr. of Noorvik

*Alice Petrivelli, Atka and Anchorage,* "My father believed God gave you daylight and you had to be productive during the daylight, o.k. It was a privilege. So he made us work, you know. Summer time you were at the camp gathering food. You learn how to fillet fish, how to dry fish. Winter time you did your homework. You carry in wood. Ladies taught you how bead and sew, more or less how to be productive…..It was just a nice, safe world for me."

Along with hard, meaningful work came instruction and discipline. Older people taught, and younger people listened.

*Pete Abraham, Togiak,* "At an early age young children were taught in the Qasgi (traditional men's house) about the facts of life, how to live clean healthy lives and respect for each other."

*Rita Blumenstein, Tununak and Anchorage,* "They didn't spank us. They didn't yell at us. Just like normal, you know, normal going but it teaches you to think that you are going to try to do it better. That's the way I grew up, by listening and following their instructions."

Rita Blumenstein, Tununak and Anchorage

*Andrew Franklin, Togiak,* "Our grandfather always instructed us especially about how to treat other people. How I treat others will come back to me. ..The Elders instructed on safety, good life, being helpful and having a good mind or thoughts toward people."

Most Elders agreed that things are different today. One difference is that children and young people don't seem to listen very well and don't handle criticism well.

*Ramona Field,* "You love your kids you gotta scold them and talk to them. They gotta know what's right. When you scold your little kids now-a-days, they get mad and think the other way. We never use

to do when our grand parent scold us and tell us the right thing. Today the kids quit real easy when they get scolded."

*Alice Petrivelli,* "My aunt and the elders taught us. They're the ones that weeded out the punishment and the discipline, ok. If you sassed an elder back, you knew about it. You just did not do that. That was not allowed. If someone says you don't to that, you stopped. Today, to make a comparison, when I was home in Atka some little boys were doing things. You better stop that. And they asked me what are you going to do about it. I'll make you stop. And he looks at me…. This was a five, six year old kid. I'll tell my mother and she'll sue you, ok. You hear the difference in how I grew up and the kids today?"

*Hazel Snyder, Noorvik,* "Today kids when you ask for them to help you, they don't listen. They just stand up and wait for the money. It's not the way we were raised up. It's not good at all to me."

Hazel Snyder, Noorvik

In addition to not listening, Elders said that young people seem not to be as busy as the Elders were when they were young, and that the things young people do and are exposed to today are not as healthy. Alcohol and drugs were mentioned by many.

*Pete Abraham,* "Young people are exposed to too many wrong things at an early age….. There is too much exposure to TV violence and drugs and alcohol."

*Walter Austin, Wrangell and Anchorage,* "The children in my time they were pretty well off because there was not alcohol or drugs that we have today."

*Esther Murray, Elim,* "Drinking has a lot to do with suicide today."

*Ramona Field,* "Right now when we start eating white man food or easy life nothing to do maybe that's why our kids change. There is nothing to do just watch TV."

*Ivan Field, Noorvik,* "We have to stop all the liquor and drug use."

To use the language of prevention and health promotion, the Elders saw meaningful work done together as a family and the active teaching by the Elders as protective or resiliency building factors that were strongly present in their childhoods, but are much less present or absent today. Conversely, drugs, alcohol, boredom and too much TV (especially violent TV) are cited as risk factors present today, but absent in the past.

Perhaps these changes account for the difficulties the Elders noted between today's parents and children. Parents are being asked to help their children with problems they themselves never experienced. Young people are not sure their parents and Elders really can understand what life is like for them today.

*Pete Abraham,* "Young people now days are exposed to too many wrong things at an early age. Nobody listens to them. Children are not open with parents or anybody. They are scared. There is no understanding between parents and young people."

*Andrew Franklin,* "Sometimes when you tell a younger person something they think you don't like them. Now days children don't get instruction from their parents."

Walter Austin, Wrangell and Anchorage

*Rita Blumenstein,* "When I work with them (young people) they say 'my parents are never home'. And so we have to do something at home. See they're trying to get their attention. And then parents get mad at them."

Change complicates communication between the generations in most cultures and the degree of complication is related to the pace of change. The "generation gap" is a feature or Western cultures where change itself often seems to be a value and information comes not just from families and tribal members, but from strangers via books, radio, television, and most recently the internet. Traditional, subsistence based cultures left to themselves evolve and change too but the pace is slower and most knowledge comes from within. For Alaska Natives contact with Western cultures is relatively recent and change has come at an amazing pace and with a considerable amount of pain and loss, both physical and spiritual.

Ole Lake, Hooper Bay and Anchorage

*Ole Lake, Hooper Bay and Anchorage,* "I think when there is a change of autonomy in the village that something takes over the cultures and traditions; I think there is a sense of great loss with the people. First it starts with the Elders and grandparents and then the parents mourn the loss of the cultural traditional ways of doing things and the spiritual beliefs."

*Alice Petrivelli,* "World War II came and changed our whole lifestyle… And after that came the land claims. Land claims was a great thing in a lot of respects, but it kind of divided the people…And then people lost their identity. I think when we was rushed into the western society. It was not a slow progress. So we didn't have a suicide problem until the '80s."

That perhaps is at the heart of what these interviews tell us about suicide and the Native community. Alaska Native people did not always have a problem with suicide. Suicide is not a Native tradition. The high rates of suicide have come about relatively recently as rapid change and the introduction of conflicting values weakened the protective factors that were so strongly present in traditional cultures and lifestyles.

The Elder interviews suggest that Alaska Natives cannot go back to the old ways of life, but can go forward and regain the resiliency that was such a part of that life. An important element in going forward is to honor, respect and teach traditional cultural values, and to insist that others respect those values as well.

*Andrew Franklin,* "We can't go back to the Qasgi but we need to instruct our youth. Our leaders need to be leaders and model to our community."

Alice Petrivelli, Atka and Anchorage

*Alice Petrivelli,* "No matter if we're corporate president or not, we are who we are. Our place of origin comes from our village. Like me, I'm an Aleut and I'll always be an Aleut no matter what. And you have to let the kids be proud of who they are… I think the state and the feds have to listen to the Elders in the village. They have to work as one unit and not come in and try to tell you how to do it."

*Rita Blumenstein,* "See if you are going to fix our people, you have to understand their culture. Teach it from their culture. Accept them who they are."

The Elders also suggested ways to talk to someone who expressed suicidal feelings. Their suggestions appear throughout the plan. For now we return to Harold Napoleon's request to "discuss what it is we need to do to become whole" and end with the words of Pete Abraham of Togiak:

"Villagers need to work together, take pride in who they are. We need to show young people that we care about them, maybe talk in a circle. Then the generation gap would close; we would have more communication between Elders and the younger generation. Things would be better so we could prevent suicide. We need to appreciate what we have and take pride in it."

# Alaska Prevention Goals

## Universal Prevention Goals

**Goal 1:** Alaskans understand that suicide is a preventable problem.

**Goal 2:** Suicide prevention has broad-based support.

**Goal 3:** Alaskans recognize that mental illness, substance use disorder and suicidality respond to specific treatments and are part of health care. Any stigma associated with these disorders will be eradicated.

**Goal 4:** Alaskans store firearms and other potential items of self-harm safely and insure that Alaskans, especially youth, are educated about their safe management.

**Goal 5:** Alaskan communities support the development of protective factors and resiliency across the entire life span.

## Selective Prevention Goals

**Goal 6:** Alaskans recognize the warning signs for suicide risk and respond appropriately.

**Goal 7:** People who work in institutions and groups that serve or work with high risk populations are able to identify warning signs and respond appropriately.

## Indicated Prevention Goals

**Goal 8:** Behavioral health programs to promote mental health and prevent substance abuse, and relevant social services are available and accessible to all Alaskans.

**Goal 9:** Alaskan Behavioral Health Programs treat suicidality effectively using appropriate current practice guidelines.

**Goal 10:** Alaskan Behavioral Health Programs include an appropriate on-going continuum of services for suicidal individuals from identification through treatment.

**Goal 11:** Alaskan communities respond appropriately to suicide attempts and suicide completion.

## Program Evaluation and Surveillance Goals

**Goal 12:** Alaska suicide prevention and intervention research is supported and on-going.

**Goal 13:** Alaska has a suicide surveillance system that provides data necessary for planning services, targeting interventions and evaluating progress.

# Universal Prevention Strategies

## Goal 1: Alaskans will understand that suicide is a preventable problem.

Why – If people understand that suicide and suicidal behavior can be prevented, they are more likely to be willing to learn how to prevent suicide. When people are made aware of the roles they can play in suicide prevention, they become more willing to get involved and lives can be saved.

How – Increase understanding through varied educational efforts that replace myths with facts.

Increase people's willingness to get involved by replacing a sense of helplessness with the knowledge that there are specific actions we can take that will make a difference.

Inform about the warnings signs and signals of depression and suicidal thinking.

Teach how to respond when we see the signs, and educate about community resources that can help.

### Some specific things we can do

- Implement public awareness campaigns using a variety of mass media.
- Get suicide prevention on the agenda at meetings of service and professional organizations.
- Make suicide prevention information available in a wide variety of settings including primary care, churches, courts, bars, beauty parlors etc.
- Ensure that mental health education with age appropriate suicide prevention is part of the basic school curriculum starting in elementary school.
- Work with the media so that press and broadcast reporting about suicide, mental health and related issues is accurate, responsible and follows the guidelines established by the American Foundation for Suicide Prevention.

### Baseline data

No data is available at this time.

### Markers for Success

- More Alaskans, including those in high-risk groups, will know basic information about suicide, depression, warning signs, how to offer help, and where to go for help.
- More Alaskans will report offering or seeking help.

- Track number of individuals who attend or participate in these activities.
- Track number of trainings or meetings given.

## WHAT DOES IT LOOK LIKE IN MY COMMUNITY?

Do people in my community see suicide as preventable?

What can we do to increase the number of people who see suicide as preventable?

What are our markers for success?

## Some suggested resources to assist you in reaching this goal.

American Association of Suicidology

American Foundation for Suicide Prevention

Suicide Prevention Resource Center

CDC – Centers for Disease Control, Injury Center

SAVE – Suicide Awareness Voice of Education

SPAN - Suicide Prevention Advocacy Network

National Institute of Mental Health

Alaska Statewide Suicide Prevention Council

Alaska Division of Behavioral Health

Community Based Suicide Prevention Program, Alaska Division of Behavioral Health

Community Mental Health Centers / Behavioral Health Centers

Alaska Injury Prevention Center

Alaska Native Tribal Health Consortium

See Appendix I on page 48 for website addresses.

## Goal 2: Suicide Prevention will have broad-based support.

**Why –** Just as there are many factors that contribute to suicide, so there are many approaches to preventing suicide: mental, emotional, biological, social, cultural, spiritual. With broad-based support all groups - schools, health care providers, faith-based organizations, youth groups, senior citizens centers, and local and tribal governments to name but a few – will recognize the roles they can play and the ways in which they can collaborate.

Broad-based support can lead to additional public and private funding for prevention and treatment programs and for research and evaluation.

**How –** Broad based support is created when individuals understand that there are many approaches to suicide prevention and therefore many ways to get involved.

### Some specific things we can do

- Prepare written reports and make presentations to a wide variety of public and private organizations to encourage them to explore ways they can incorporate suicide prevention into their work.
- Provide regular reports to the legislature and the Alaska Mental Health Trust Authority on suicide and related issues.
- Provide information to Alaskans about national suicide prevention advocacy groups, such as SPAN USA.
- Work with community leaders to insure widespread distribution of appropriate suicide prevention educational materials in all Alaskan communities.

### Baseline data

Number of communities participating in Community-Based Suicide Prevention Program in FY04 – 57 (52 funded by state).

FY04 State funding:

**Services**

Community-Based Suicide Prevention grant awards - $763,697
Rural Human Services grant awards - $1,323,028
Total Division of Behavioral Health funding was $50,100,961

**Training**

Gatekeeper program development – $248,375 – federal funds

**Research**

Follow-Back Study – $195,925

## Markers for Success

- More organizations and agencies will include suicide prevention in their programs.
- More communities will be actively involved in suicide prevention activities.
- Suicide prevention, intervention, treatment, and research programs in Alaska will help reduce the number of suicides and suicide attempts.
- Communities will see a decline in the suicide rate.

## WHAT DOES IT LOOK LIKE IN MY COMMUNITY?

How much interest in suicide prevention is there in my community? What does my community do to support suicide prevention?

How can we increase support for suicide prevention in my community?

What are our markers for success?

## Some suggested resources to assist you in reaching this goal

American Association of Suicidology

American Foundation for Suicide Prevention

Suicide Prevention Resource Center

CDC – Centers for Disease Control, Injury Center

SAVE – Suicide Awareness Voice of Education

SPAN - Suicide Prevention Advocacy Network

National Institute of Mental Health

Alaska Statewide Suicide Prevention Council

Alaska Division of Behavioral Health

Community Mental Health Centers / Behavioral Health Centers

Alaska Injury Prevention Center

Alaska Native Tribal Health Consortium

See Appendix I on page 48 for website addresses.

**Goal 3: Alaskans recognize that mental illness, substance use disorder and suicidality respond to specific treatments and are part of health care. Any stigma associated with these disorders will be eradicated.**

**Why –** We know that there are links between suicide, mental illness and substance use, and we know that there are many effective treatments for mental illness and substance use. But if there is shame or guilt associated with these disorders, or if people fear they will be discriminated against if others know they suffer from them, they are less likely to seek help. Sometimes family members try to hide the disorders or suicidal behavior because they feel ashamed or guilty or just plain scared of what might happen if people know. Sometimes people believe that there is no help, that treatment doesn't work.

The fact is that with appropriate treatment, those disorders often get better. Untreated they usually get worse. And, research is giving us new medications and new therapies that promise even more successful treatment. We know that most people who feel suicidal do not want to die. They want their pain to stop and cannot figure out any other way. Treatment helps them find ways to reduce the pain and go on living.

**How –** Misinformation and stigma can be reduced through comprehensive public information and education campaigns.

## Some specific things we can do

- Collaborate with mental health and substance abuse agencies to implement public information campaigns that present mental health and substance abuse treatment as part of basic health care.
- Develop public service announcements that feature those who have recovered from mental illness, substance abuse or suicidality after treatment.
- Where appropriate, honor and celebrate those who have successfully sought and completed treatment.
- Develop a speaker's bureau on mental health, substance abuse and suicide prevention and include consumers of treatment services, as well as treatment providers and researchers.
- Provide information to the media that educates about safe, responsible reporting and portrayal of suicide, mental illness and substance abuse.
- Hold ongoing Clergy/Clinician Forums for mutual education and to promote closer working relationships.

## Baseline data

No data is available at this time.

## Markers for Success

- More community members, treatment providers, and consumers view mental disorders as illnesses that respond to specific treatment and see mental health as equal in importance to physical health in overall well-being.

## WHAT DOES IT LOOK LIKE IN MY COMMUNITY?

How do people in my community see mental illness, substance abuse and suicidality? Do they see these as treatable disorders, as permanent weaknesses, as moral problems or …?

How can we increase the number of people who see these conditions as disorders that can be successfully treated?

What are our markers for success?

## Some suggested resources to assist you in reaching this goal

American Association of Suicidology

American Foundation for Suicide Prevention

Suicide Prevention Resource Center

CDC – Centers for Disease Control, Injury Center

SAVE – Suicide Awareness Voice of Education

SPAN - Suicide Prevention Advocacy Network

National Institute of Mental Health

Alaska Statewide Suicide Prevention Council

Alaska Division of Behavioral Health

Community Mental Health Centers / Behavioral Health Centers

Alaska Injury Prevention Center

Alaska Native Tribal Health Consortium

National Alliance for the Mentally Ill

National Institute of Mental Health

Alaska Mental Health Trust Authority

Alaska Mental Health Board

Governor's Advisory Board on Alcoholism and Drug Abuse

Commission on Aging

Governor's Council on Disabilities and Education

See Appendix I on page 48 for website addresses.

## Goal 4: Alaskans store firearms and other potential items of self-harm safely and insure that Alaskans, especially youth, are educated about their safe management.

Why – There is a great deal of research evidence indicating that limiting access to the means of suicide - weapons, pills, harmful gases, and the like - is an effective way to prevent suicide and suicide attempts. Sometimes suicidal behavior appears to be impulsive. Especially when alcohol is involved, the move from thought to action can be very fast. When the means are easily available, it is too easy for the person to act on the impulse. When the available means are highly lethal, the consequences are often tragic and fatal.

How – Encourage safe storage of firearms and other potential items of self-harm through an education campaign that acknowledges the role that firearms play in Alaskan lifestyles and recognizes that potential items of self harm are commonly found in homes.

### Some specific things we can do

- Implement broad-based public information campaigns about responsible gun ownership, gun safety and safe storage of medications and household poisons.
- Work with health provider organizations to encourage including basic information about safe storage of firearms and medications as a part of routine medical care.
- Educate health care providers about ways to talk to those at high-risk for suicide and their families about decreasing access to firearms and other means of self-harm.
- Provide information to emergency room staff and emergency medical technicians about the importance of advising those treated or admitted for a suicide attempt and their families about the importance of the removal or safe storage of firearms or other lethal means of self harm.
- Work with law enforcement to ensure that officers responding to domestic emergencies and suicide-related crises ask about the presence of firearms and other lethal means and advocate for their safe removal or storage.
- Work with Injury Prevention Practitioners to develop materials to educate parents about how to safely store firearms, medications and household poisons.

### Baseline data

State of Alaska Department of Fish and Game – www.adfg.state.ak.us/ or call 907-267-2241

### Markers for Success

- More communities are actively considering and implementing ways to reduce access to lethal means of self harm within their community.

- More primary care providers, community health aides, emergency room staff and public safety officers routinely ask about the presence of lethal means of self-harm including firearms, drugs and poisons in the home, and provide education about actions to reduce associated risks.

## WHAT DOES IT LOOK LIKE IN MY COMMUNITY?

Do people in my community store and handle firearms safely and teach their children to do so? Do people in my community store medications and other potential items of self-harm safely?

Do health care providers in my community ask about and encourage safe storage of firearms, medications and poisonous household items?

How can we encourage more people to store and handle firearms safely and take appropriate precautions with other items?

What are our markers for success?

## Some suggested resources to assist you in reaching this goal

Alaska Native Tribal Health Consortium

Local Health Corporations

National Rifle Association

Alaska Injury Prevention Center

Law Enforcement – Troopers, Police and VPSO

Office of Children Services

Girl and Boy Scouts

Local Hospitals

See Appendix I on page 48 for website addresses.

## Goal 5: Alaskan communities will support the development of protective factors and resiliency across the entire life span.

**Why -** Resilience is the natural ability to "bounce-back" from hardships and become stronger. Resilient people understand that life is full of challenges, joys, losses, disappointments, and unexpected events. Resilient people learn from their mistakes, get support from others, and keep a broader perspective. They are less likely to succumb to the feelings of hopelessness and helplessness that are associated with suicidal behavior.

**How -** Build resilience by creating opportunities for young people to succeed through exercising judgment, discretion and imagination. Success helps young people grow and develop a sense of competence and mastery. Equally important, resilience is developed when young people are treated with respect and feel supported and valued even when they don't succeed, when they feel loved and encouraged when they make mistakes or experience hard times. Resilience is reinforced and sustained when people feel connected to each other and their community and feel that their life has meaning.

### Some specific things we can do

Organizations, community members, faith communities, teachers, Elders, friends and family can help build resilience by:

- Being good role models.
- Being mentors.
- Upholding, honoring and respecting cultural traditions.
- Sharing the lessons of experience that help young people to cope with the challenges of inexperience.
- Teaching and modeling culturally appropriate life and communication skills.
- Creating environments, in schools, churches, and other structured settings, in which people feel welcome and accepted.
- Creating opportunities for people to experience new things, take on responsibilities and succeed.
- Reaching out to those in need (helping with groceries, caring for children, making sure there is heat, providing companionship and support during times of stress and loss.)

### Baseline data

The 2003 Youth Risk Behavior Survey (YRBS) reports:
46.94% of boys and 47.26% of girls have three or more adults (other than parents) they feel comfortable seeking help from.

59.96% of boys and 55.04% of girls believe that their teachers really care about them and give encouragement.

YRBS data will be updated in 2005.

## Markers for Success

- An increase in cultural, or intergenerational events and activities.
- Youth report they have adults they can turn to discuss personal problems.
- Students report that their teachers care about them.
- Adults report they have friends they can turn to discuss personal problems.
- Youth and adults can identify healthy ways they cope with stress and life problems.
- Youth and adults are hopeful about the community's future.
- Youth and adults are positive about their own future.
- Youth and adults believe their efforts can make the community a better place.

## WHAT DOES IT LOOK LIKE IN MY COMMUNITY?

Do young people have lots of safe opportunities to try out new skills and experience new things?

Do adults spend time helping youth learn new skills and explore new ideas?

Do young people feel welcome in schools, libraries, health clinics, other organizations?

Are there frequent events that bring people of all ages together and are they well attended by all ages?

What are our markers for success?

## Some suggested resources to assist you in reaching this goal

Division of Behavioral Health

Initiative for Community Engagement (ICE) – Alaska Association of School Boards

Alaska Association of Sports

Boys and Girls Clubs

Big Brothers/Big Sisters

4-H Clubs

Camp Fire Kids

Boy and Girl Scouts

See Appendix I on page 48 for website addresses.

# Selective Prevention Strategies

## Goal 6: Alaskans will recognize the warning signs for suicide risk and respond appropriately

**Why –** Most people who consider suicide do not want to die, rather they want to end the pain they feel and cannot see any other way. Most people considering suicide display behaviors or say things that are clues to how they are feeling. If others recognize and respond to the clues in appropriate ways, we can get people into treatment and help them find other ways to reduce their pain and go on living.

**How –** Provide widespread appropriate educational materials and training to the general public and to community gatekeepers, first responders, education, healthcare, social service, recreation and law enforcement personnel and clergy so that people can recognize and respond appropriately to individuals at risk for suicide. Community gatekeepers are those in non-mental health or social service roles to whom people frequently talk openly about their problems and feelings – hairdressers, bartenders, coaches, lawyers, etc. We refer to them as gatekeepers because they can open a pathway to getting help.

### Some specific things we can do

- Collaborate with national, state and local agencies to develop appropriate education materials.
- Make well designed appropriate gatekeeper training widely available.
- Inform people about the Yellow Ribbon campaign.
- Develop creative ways to post warning signs and crisis line numbers.
- Promote peer education programs such as natural helpers in schools and youth organization.

### Baseline data

In FY04 the Injury Prevention Program of the Division of Public Health distributed 94 copies of their Gatekeeper Training video to EMS programs.

Four ASIST Gatekeeper trainings were conducted in 2003–2004. Each training was attended by 15 to 30 people

- Two in Akiachak
- Two in Mat-Su Valley

In FY04 95 people participated in the Community-Based Suicide Prevention Project Coordinators Conference.

### Markers for Success

- More Alaskans will know the warning signs for suicide risk and will know how to respond when the recognize them.
- Appropriate gatekeeper training will be readily available throughout Alaska and the number of gatekeepers who believe they can and will effectively respond to potentially suicidal individuals will increase.

- Relevant professional groups including healthcare, social service and law enforcement will require gatekeeper training as part of their initial and continuing education programs.

## WHAT DOES IT LOOK LIKE IN MY COMMUNITY?

Do people in my community know the warning signs of suicide? (See Appendix VII for a list). Do people know how to respond?

How can we increase the number of people in my community who can identify the warning signs for suicide and know how to respond appropriately?

How can we insure that relevant professionals in my community receive gatekeeper training?

What are our markers for success?

## Some suggested resources to assist you in reaching this goal

ASIST – Applied Suicide Intervention Skills Training – contact 907-352-8237 or jeaninesparks@gci.net

Living Works, Calgary - http://cmhabrant.tripod.com/ASIST.htm

QPR Training, Spokane - http://www.qprinstitute.com/aboutus.htm

Alaska Division of Behavioral Health – Gatekeeper Training

American Association of Suicidology

Suicide Prevention Resource Center

CDC – Center for Disease Control, Injury Center

SAVE – Suicide Awareness Voice of Education

Suicide Prevention Council - SPC

Community Mental Health Centers / Behavioral Health Centers

SPAN – Suicide Prevention Advocacy Network

American Foundation for Suicide Prevention

National Alliance for the Mentally Ill

National Institute of Mental Health

See Appendix I on page 48 for website addresses.

## Goal 7: People who work in communities and institutions with a concentration of known higher risk populations are able to identify warning signs and respond appropriately.

Why – Data tells us that suicide is not evenly distributed across Alaska by place, age, gender, or by cultural group. Some communities have higher rates of suicide than others. The rate of suicide is higher in some age groups than others and these age groups may be concentrated in certain settings. We need to be especially vigilant to insure that the people who work in these settings, those most likely to come into contact with high risk populations, are trained to recognize and respond to warning signs.

How – People need to know the groups in Alaska at highest risk for suicide. We need to provide training for people working with these groups so that they are able and willing to recognize and respond promptly to suicide warning signs.

High risk populations include people in correctional institutions and those awaiting trial, people with substance use disorders, and people experiencing depression. Data indicate that rates of suicide are high among people in their late teens and twenties and we know that people in this age group concentrate in universities, the National Guard and the military. We know that rates of suicide are higher among older Caucasian people and younger Alaska Native males. We know that the rate of suicide is higher among some occupational groups than others. We know that gay and lesbian youth are at higher risk for suicide attempts.

### Some specific things we can do

- Encourage institutions and agencies with a high concentration of those in a group at higher risk to develop suicide prevention plans and to require all staff be trained in suicide prevention.
- Incorporate screening and referral of persons at risk into naturally occurring settings, including schools, colleges, correctional institutions, substance abuse treatment programs and programs serving youth and young adults.
- Incorporate suicide education and prevention programs into the professional development activities of associations of those in high risk occupations.

### Baseline data

No data is available at this time.

### Markers for success

- There is an increase in the number of institutions and agencies serving high risk populations that have regular, on-going suicide prevention training programs.
- More professional associations of higher risk occupations include suicide prevention in their professional development programs.

- More schools, institutions and treatment programs routinely screen and refer for suicide risk.

## WHAT DOES IT LOOK LIKE IN MY COMMUNITY?

- Can the people who work in my institution or agency identify the warning signs of suicide and respond appropriately? (see appendix VII for a list of warning signs)
- Does my professional association provide suicide prevention education?
- Do the schools, institutions or agencies screen for suicide risk?
- How can we work with the institutions, schools, agencies or associations to help implement appropriate training, education and screening programs?
- What are our markers for success?

## Some suggested resources to assist you in reaching this goal

P-FLAG (Parents and Friends of Lesbians and Gays)

Tribal Health Organizations

ASIST – Applied Suicide Intervention Skills Training – contact 907-352-8237 or jeaninesparks@gci.net

Living Works, Calgary - http://cmhabrant.tripod.com/ASIST.htm

QPR Training, Spokane - http://www.qprinstitute.com/aboutus.htm

Alaska Division of Behavioral Health – Gatekeeper Training

American Association ofSuicidology

National Institute of Mental Health

Suicide Prevention Resource Center

CDC – Centers for Disease Control, Injury Center

SAVE – Suicide Awareness Voice of Education

Alaska Statewide Suicide Prevention Council

Community Mental Health Centers / Behavioral Health Centers

SPAN – Suicide Prevention Advocacy Network

American Foundation for Suicide Prevention

National Alliance for the Mentally Ill

See Appendix I on page 48 for website addresses.

# Indicated Prevention Strategies

**Goal 8: Behavioral health programs to promote mental health and prevent substance abuse and relevant social services are available and accessible to all Alaskans.**

Why – The easier and more acceptable it is to seek and receive treatment and social services, the more likely it is that people will do so. With timely and appropriate treatment and social services most people can recover and rebuild healthy productive lives.

How – Services become more available when they exist close to the recipient's home. They become more accessible when barriers are removed and service providers are consistently welcoming.

Some of the recognized barriers to treatment include cost, the availability of health insurance, cultural and/or language differences between the provider and the recipient, perceived stigma attached to receiving treatment, and fears about confidentiality.

Different barriers are addressed in different ways. Village-based counselors or behavioral health aides help insure that treatment is available in Alaska's smaller communities. Employing traditional healers, and staff who culturally and ethnically reflect the client population helps to reduce cultural and language barriers. Education programs and an informed media help to eliminate stigma.

Crisis lines can also make services more available by providing an easy to access, anonymous source of help 24 hours a day, 7 days a week. The CareLine (1-877-266-4357) is Alaska's only certified statewide crisis line and should be adequately supported to insure the 24/7 availability of trained listeners.

## Some specific things we can do

- Increase support for CareLine so it is more adequately supported.
- Inform Alaskans about CareLine using a variety of strategies such as bumper stickers, wallet cards, posters in public places, and public services announcements.
- Support parity for mental health in health insurance.
- Increase support for village based counselors and village health aides.
- Ensure that services are available in all languages spoken in Alaska, either by employing bilingual service providers or translators.

## Baseline data

In FY04 149 village-based counselors who had completed or were currently attending the Rural Human Services Training program were working across Alaska. Ninety-five of them worked in 87

different villages and 54 worked in agencies in hub communities, in cities, or itinerated to several communities.

## Markers for Success

- Services are available in an increased number of communities.
- More treatment and social service programs employ traditional healers and staff that culturally and ethnically reflect their client population.
- More Alaskans are aware of the CareLine and how to access it.

## WHAT DOES IT LOOK LIKE IN MY COMMUNITY?

How easily available are mental health and substance abuse programs, and relevant social services in my community?

How comfortable are people about using these services and how confident are they about their ability to help?

How can we insure that people experience these services as easy to access, welcoming, effective, and respectful?

What are our markers for success?

## Some suggested resources to assist you in reaching this goal

Denali KidCare

Alaska Statewide Suicide Prevention Council
Division of Behavioral Health

Community Mental Health Centers /
Behavioral Health Centers

NAMI - National Alliance for the Mentally Ill

National Institute of Mental Health

Alaska Mental Health Trust Authority

Alaska Mental Health Board
Resource Directory on website

Governor's Advisory Board on
Alcoholism and Drug Abuse

Commission on Aging

Governor's Council on
Disabilities and Special
Education

Alaska Native Tribal Health
Consortium

See Appendix I on page 48 for website addresses.

## Goal 9: Alaskan Behavioral Health Programs will treat suicidality effectively using appropriate current practice guidelines.

**Why –** Research and evaluation tells us more and more about how to assess suicidality and about the relative effectiveness of different treatments. Effective assessment and treatment of the underlying personal stressors and feelings associated with suicidal behavior and of any underlying mental illness reduce the risk of suicide.

**How –** Provide the treatment community with up to date information about current best practices in assessing and treating suicidality.

### Some specific things we can do

- Provide information which can be presented at conferences, in professional newsletters, through in-house staff training, through continuing education courses at the University and other educational institutions.
- Insure that information about current best practices is widely disseminated.

### Baseline data

No data is available at this time.

### Markers for Success

- The number of presentations and workshops on best practice guidelines increase.
- There are regular articles on clinical guidelines for treating suicidality in the newsletters of relevant professional organizations and agencies.
- The University and other educational institutions offer seminars and courses on suicide including best clinical practice guidelines.

### WHAT DOES IT LOOK LIKE IN MY COMMUNITY?

Do providers in my behavioral health program treat suicidality using current practice guidelines and recognized best practice treatments?

How do we increase the number of behavior health providers and programs that follow best practice guidelines and use best practice treatments?

What are our markers for success?

### Some suggested resources to assist you in reaching this goal

See Appendix VI.

## Goal 10: Alaskan Behavioral Health Programs will include an appropriate ongoing continuum of supportive services for suicidal individuals from identification through treatment.

**Why –** Suicide is not a disease. Rather it is a tragic ending, the result of a complex and varied mixture of biology, illness, feelings, thoughts, beliefs, behaviors, relationships, cultural history, community attitudes, and life events. Comprehensive treatment helps a suicidal individual address all of these areas. It provides support along the entire journey from hopelessness to health.

**How –** Provide education and adequate resources to behavioral health programs so they understand the need for and have the ability to offer appropriate care throughout the course of treatment.

### Some specific things we can do

- Treatment programs must recognize the need for and institute mechanisms to provide ongoing support after an immediate crisis is resolved.
- Centrally located or residential treatment programs need to develop strong linkages with local service providers and develop and maintain referral systems so that clients can move between programs with minimal disruption of services.
- Treatment programs need to work with the families of suicidal individuals to help the individual re-integrate into the family and community.

### Baseline data

No data is available at this time.

### Markers For Success

- More behavioral health programs have and follow written policies regarding how clients are referred for ongoing support when treatment ends.
- More behavioral health programs include families in the treatment process.
- More clients report satisfaction with the support they received in re-integrating into their families and communities.

### WHAT DOES IT LOOK LIKE IN MY COMMUNITY?

Does my behavioral health program provide seamless services from admission through discharge, including on-going community-based support as appropriate?

Do people from my community receive seamless services from admission through discharge, including on-going community-based support as appropriate?

How can my behavioral health program provide any services that are missing?

How can my community help insure that all needed services are available?

What are our markers for success?

### Some suggested resources to assist you in reaching this goal

Substance Abuse and Mental Health Services Administration

Alaska Department of Health and Social Services

Alaska Division of Behavioral Health

National Institute of Mental Health

Indian Health Services

See Appendix V and see Appendix I on page 48 for website addresses.

## Goal 11: Alaskan communities respond appropriately to suicide attempts and deaths by suicide.

**Why –** It is said that every suicide directly impacts six other people. In small communities where everyone knows each other, everyone is impacted to some degree. Those closely impacted by a suicide are often referred to as survivors. In the immediate aftermath of a suicide and for some time thereafter, all survivors need support. Some may need treatment. Suicide is a difficult death to grieve because it raises so many unanswerable questions and contradictory feelings. A suicide may put some survivors at risk for suicide. Sometimes suicide appears to be contagious, in that one suicide seems to lead to other suicides or suicide attempts. Appropriate responses to suicide reduce the risk of other suicides.

Suicide attempts provoke similar confused and painful feelings in others. Friends, classmates, family members and colleagues often need guidance as to how to welcome back and resume normal relationships with someone who has attempted suicide. The attempter also needs advice, support and assistance in reintegrating into the community when treatment is complete.

**How –** Communities can learn how to respond to a suicide in ways that reduce the risk of other suicides and help promote healing. Communities can learn how to help someone who has attempted suicide feel comfortable back in the community. Treatment centers can help those who have attempted suicide understand how to talk with family and friends about the attempt and the treatment.

### Some specific things we can do:

- Behavioral health programs can provide needed information and training in how to respond to a suicide and how to help a suicide attempter.

- Schools, universities and similar communities should have suicide (and other crisis) response plans, and provide regular training to all staff in how to implement them. Crisis response plans include information on appropriate memorials.
- Survivors and survivor groups can play a big part in assisting others who are impacted by suicide.
- Clergy can learn safe, responsible ways to help those who have lost someone to go through the greiving process, come to terms with the loss and heal.

### Baseline data

No data is available at this time.

### Markers for Success

- The number of programs available that train communities to respond appropriately to suicide and the number of communities that have accessed these programs.
- The number of schools and universities that have crisis response plans.

### WHAT DOES IT LOOK LIKE IN MY COMMUNITY?

Does my community know the appropriate ways to respond to a suicide or to someone who attempts suicide?

Does my community have a crisis response plan?

How can I help my community gain the knowledge to develop appropriate plans?

What are our markers for success?

### Some suggested resources to assist you in reaching this goal

See Appendix VIII, "After A Suicide: Recommendations for Religious Services and Other Public Memorial Observances" by David Litts

Community Mental Health Centers / Behavioral Health Centers

Alaska Statewide Suicide Prevention Council

Alaska Injury Prevention Center

SAVE – Suicide Awareness Voice of Education

Department of Education and Early Development

Alaska Division of Behavioral Health

# Program Evaluation and Surveillance Strategies

**Goal 12: Alaska suicide prevention and intervention will be guided by research and program evaluation.**

**Why –** Research and evaluation tell us what programs are most effective. Resources for implementing programs are always limited and it only makes sense to put the resources into the programs that are most likely to work.

**How –** Create a climate that values evaluation and provides for its incorporation into all suicide prevention programs.

## Some specific things we can do:

- Funding for all programs should include adequate funds for evaluation and programs should be required to conduct evaluations. Training in how to do so should be provided.
- Establish a registry of programs that have demonstrated effectiveness in Alaska. Establish a linkage with the national Suicide Prevention Resource Center's database on effective programs elsewhere in the nation and the world.
- Advocate for increased funding for suicide prevention research nationwide and within Alaska.

## Baseline data

In FY04 and FY 05 there are two research/evaluation projects in Alaska, the Follow Back Study funded through the Alaska Injury Prevention Center, and the development of the Targeted Gatekeeper Training.

## Markers for Success

- More suicide prevention-research is available at the state and federal level.
- There is more Alaska specific research on suicide and suicide prevention including psychological autopsy and follow-back studies.
- There are more resources and more technical support to implement and evaluate Alaskan suicide prevention programs.

## WHAT DOES IT LOOK LIKE IN MY COMMUNITY?

Is there on-going Alaska specific research and program evaluation to guide suicide prevention and intervention?

How can we insure that adequate research and evaluation are on-going?

What are our markers for success?

## Some suggested resources to assist you in reaching this goal.

See Appendix IV and see Appendix I on page 48 for website addresses.

National Institute of Mental Health

Centers for Disease Control

Substance Abuse and Mental Health Services Administration

American Foundation for Suicide Prevention

## Goal 13: Alaska has a suicide surveillance system that provides data necessary for planning services, targeting interventions and evaluating progress.

**Why –** Data provide information about the pattern of suicide and who, by age, race, sex, location, is most at risk. Data tell us which communities and groups have higher rates of suicide and suicide attempts. Such data allow us to target our programs and interventions more precisely and increase the likelihood of their effectiveness.

**How –** Work with a variety of agencies that currently collect data to create a comprehensive uniform surveillance system for suicide and suicide attempts.

### Some specific things we can do:

- Find out who is collecting what data at the present time and develop data sharing procedures.
- Develop and implement standardized protocols for death scene investigations in rural and urban Alaska.
- Integrate questions on suicidal behavior into health-related surveys.
- Provide adequate support for the collection and analysis of vital statistics and the trauma registry.
- Integrate data collected from investigations into a statewide suicide database in a timely manner, so that emerging patterns and problems can be promptly identified and an appropriate response initiated.

### Baseline data

Division of Behavioral Health – AKAIMS (Alaska Automated Information Management Services)

Division of Juvenile Justice – JOMIS (Juvenile Offender Management Information System)

Office of Children's Services – ORCA (Online Resources for the Children of Alaska)

Division of Health Care Services – MMIS (Medicaid Management Information System)

Division of Public Health – Bureau of Vital Statistics

### Markers for Success

- More comprehensive and consistent data about suicide and suicidal behavior will be available in a timely manner.
- More questionnaires and surveys will include questions related to suicide and suicidal-related behaviors.

## WHAT DOES IT LOOK LIKE IN MY COMMUNITY?

Does the suicide surveillance system(s) Alaska has provide adequate data to plan services, target interventions and evaluate progress at the community level?

Can this information be easily accessed?

What do we need to do to insure that it does and can?

What are our markers for success?

## Some suggested resources to assist you in reaching this goal

Alaska Bureau of Vital Statistics

Alaska Trauma Registry

Division of Behavioral Health – AKAIMS (Alaska Automated Information Management Services)

Division of Juvenile Justice – JOMIS (Juvenile Offender Management Information System)

Office of Children's Services – ORCA (Online Resources for the Children of Alaska)

Division of Health Care Services – MMIS (Medicaid Management Information System)

Law Enforcement

National Violent Death Reporting System

Medical Examiner

Indian Health Services

Alaska Child Fatality Review Team

Alaska Injury Prevention Center

National Center for Health Statistics

Centers for Disease Control

Suicide Prevention Resource Center

See Appendix I on page 48 for website addresses.

*"Well, if a stream on the mountains get clogged up, the stream dries out and it's not flowing. And you wonder what happened. And the same thing with your body. When you hold things inside you it gets clogged up. And then all of a sudden suicide becomes..... because you give up and you don't want to get it out.....then it burst out somehow and anger comes out and that's when you get violent. Holding things, it comes out and then you get into trouble."*

*— Rita Blumenstein, Tununak and Anchorage*

# Appendices Contents



*"One time I see a young guy and he missing _____ so bad. I talk to him of how I would feel, I would feel worst if he do that. I tell him "don't do that please." I sure talk to him. Ever since I see that guy I always say "Hi son take care I love you". That's what we have to do we have to talk to young people. Gotta love them. I always tell them my house is always be open."*

*— Anonymous from Noorvik*

## Appendix I

## Resources
## State Data Sources

**State of Alaska Bureau of Vital Statistics**
www.hss.state.ak.us/dph/bvs/death_statistics/default.htm
www.hss.state.ak.us/dph/bvs/publications/default.htm (for annual reports)
www.chems.alaska.gov/Injury_Prevention/TraumaRegistry.htm

**Statewide Suicide Prevention Council**
www.hss.state.ak.us/suicideprevention/

**Department of Health and Social Services**
www.hss.state.ak.us/

**Division of Behavioral Health**
www.hss.state.ak.us/dbh/

**Governor's Advisory Board on Alcoholism and Drug Abuse**
www.hss.state.ak.us/abada/

**Governor's Council on Disabilities and Special Education**
health.hss.state.ak.us/gcdse/

**Alaska Mental Health Board**
www.alaska.net/~Eamhb/

**Alaska Commission of Aging**
www.alaskaaging.org/

**Community Based Suicide Prevention Program, Alaska Division of Behavioral Health**
health.hss.state.us/suicidePrevention/Resources/AKSPP Programs.htm

**Community Mental Health Centers / Behavioral health Centers**
health.state.ak.us/suicideprevention/AboutUs/MHCenters.htm

**Alaska Injury Prevention Center**
www.alaska_ipc.org

**Alaska Native Tribal Health Consortium**
www.anthc.org

## National Data Sources

**Centers for Disease Control**
www.cdc.gov/ncipc/wisquars/ (an interactive database)
www.cdc.gov/nchs/fastats/suicide.htm

**American Association of Suicidology**
www.suicidology.org

**Suicide Prevention Resource Center**
www.sprc.org

**Suicide Prevention and Advocacy Network**
www.spanusa.org/ (not just data, lots of useful information about suicide prevention and links to other sites)

**American Foundation for Suicide Prevention**
www.afsp.org

**National Institute of Mental Health**
www.nami.org

**National Institute of Mental Health Suicide Research Consortium**
www.nimh.nih.gov/research/suicide.cfm

**Indian Health Services**
http://www.ihs.gov/

**Suicide Awareness Voices of Education**
www.save.org/

## World Data Source

**United Nations World Health Organization**
www.who.int/mental_health/prevention/suicide/country_reports/en/

## Appendix II

### Suicide Prevention/Intervention Participation Points

Different kinds of communities and individuals in various occupations and roles can all participate in suicide prevention and intervention. The ways in which they participate vary with the nature of the community and the occupation. Here is a list of some of key communities and occupations that are important participation points in the prevention of suicide.

**Education System**
- Elementary School
- Middle School
- High School
- University/College
- Boarding Schools

**Medical System**
- Emergency Room Staff
- EMTs/ETTs
- Health Aides
- Public Health Nurses
- School Health Clinics
- Primary Care Physicians
- Gerontologists & others who treat the elderly

**Justice/Corrections System**
- Jails
- Prisons
- Youth facilities
- Probation Officers
- Attorneys
- Judges

**Behavioral Health System**
- Outpatient
- Residential
- Substance use disorder treatment programs
- Crisislines
- Village-based Counselors
- Behavioral Health Aides

**Social Welfare System**
- Social Workers
- Fee Agents
- Public assistance workers

**Churches/Clergy**

**Community Organizations**
- Youth Groups
- Senior Citizen Groups
- Neighborhood Associations
- Athletic Teams and Coaches
- Cultural Associations

**Professions with "public intimacy"**
- bartenders
- hairdressers
- tailors
- massage therapists

**Employers**

**The Media**
- print
- radio
- TV

**Artists/Musicians**

**Local governments**

**Survivors**

## Appendix III

### How to Use this Plan in Your Community

Whether you are in a village, a church group, a city neighborhood, a school, or in any other community, it is valuable to develop a clear roadmap to guide you towards your specific goals and objectives for suicide prevention. We hope that you will use the goals, activity suggestions and markers for success outlined in the Alaska Suicide Prevention Plan to help you in the development of your own suicide prevention project.

This section may assist in your community planning.

**Why do we need to plan our suicide prevention activities?**
Our experience with other suicide prevention projects teaches us that the most successful projects are ones in which there is good planning that involves the community and, also, are flexible enough to take advantage of changes and opportunities that come up in the villages from time to time. Before talking about specific activities, though, it is important to remember that the overall goal of the project is to reduce suicide and self-destructive behavior and to increase individual, family and community health. So, as you plan your activities, you should be sure that you can see a logical connection between your chosen activities and this overall goal.

**How do I get input from community members in the planning for the project?**
It is important to get the ideas of many individuals in the community. **A community meeting** where people can talk about their ideas is a wonderful idea and can lead to a lot of interesting activities. You probably should hold a community meeting at least once a year, but you may decide to hold more. You can even pass out survey forms at the community meeting and allow everyone to write their ideas down. Be prepared for some disagreement on activities since (fortunately) not everyone has the same ideas. The important thing, of course, is to allow everyone to express their ideas and to use the ideas as much as you can. There are times when you are able to take advantage of a group that is gathered for another purpose, such as a class or a community gathering, to get some quick ideas.

You may decide to distribute copies of the Alaska Suicide Prevention Plan in your meeting and discuss the goals and the suggestions for activities. Your community may already be working towards some of these goals. You should discuss these preexisting activities, as well as the possible need for other ones.

**What if a community meeting is not possible (or not well attended)?**
In this case, you must go out and talk to individuals or small groups to get their ideas. Sometimes you might visit with people to hear what they have to say but you can also try to take advantage of "chance meetings" where you run into community members at church, the store, or the community center. Finally, you can also try to post flyers around the community that invite people to either come see you and talk about their ideas or to just write you a quick note with ideas. If you feel more people would be willing to share, you may decide to keep suggestions confidential.

Who should be involved with planning for the project?
In thinking about your suicide prevention activities, it is valuable to get as many ideas about available resources and specific community challenges as possible. It is also important to involve community members from the beginning to facilitate better participation and communication throughout your project. Members of your planning team should come from different backgrounds and represent different interests. This might include: Elders, elected officials, clergy, media, business owners, community health workers and counselors, law enforcement, parents and youth.

**How do I get community leaders to participate in the planning for the project?**
The best place to start involving the community is with local leaders. There is no one "best way" to get the input of community leadership, but here are some ideas:

- Meeting with community leaders as a group and hearing what they have to say about activities they would like to see.
- Meeting with them individually and letting them tell you about their ideas for activities.
- Taking a survey of community leaders (you can design a form, if you like) and letting them put their ideas in writing.

You may discuss some of the goals outlined in the Alaska Suicide Prevention Plan and share your support for efforts towards suicide prevention and community health promotion. The most important thing about this process is for you to listen to their ideas and use the ideas as a foundation for your project.

**What should we discuss in our planning?**
The first thing to talk about when we consider planning is what kind of planning to do. One of the most important questions that you must answer is what kind of activities are going to be best for your community. This is an important question because different communities have different needs and what works best in one community may not work well in another. This can also be a difficult question because different people within a community may have different ideas. It is important to remember that you are representing the interests and desires of the community. It is also important that as many community members as possible participate in the design. The Alaska Suicide Prevention Plan provides several ideas for specific activities under each goal.

Once you have identified the activities that your community would like to see, you must then identify the resources that are needed and determine if you have those resources. For example, if the community would like to have educational suicide prevention classes, there must be someone who has enough skill to teach the classes and who is willing to teach them. You must also look at the timing of the activities and make sure that they do not conflict with other community activities that may be going on at the same time.

**Other questions to consider are:**

- What is the interest in suicide prevention in our community?
- How can we use the Alaska Suicide Prevention Plan to help guide our activities?
- What projects, resources and activities already exist that work for suicide prevention? Looking at the goals of the Alaska Suicide Prevention Plan, what are our goals and expectations?
- What kind of training will we need to achieve our goals?
- How can we increase support for suicide prevention in our community?
- How will we make decisions about our activities and how will we prioritize the activities?
- What roles and responsibilities should individuals have in the activities?
- How will we inform and educate the community about our activities?
- Looking at the markers for success in the Alaska Suicide Prevention Plan, how will we know that we are doing a good job with our activities?
- Who will be responsible for keeping track of all of the activities that are done?
- How will we recognize individuals for a job well done?

**Why is it important to get the input of the community?**
You should use all of the ways that work in your community to engage people and get their ideas. The value in getting input and ideas from different people in the community is that:

- The more ideas you have, the more likely you are to come up with activities that work for the community.
- The more that you get engagement and ideas from the community, the more likely the community is to support your project once it is up and running.
- When you are reporting your progress to the community and local leaders during the year, the more that they have been involved in the process, the more they will understand your report and your needs.

## Appendix IV

### About evaluation and determining markers for success and where to find more information

"If you don't know where you are going, how will you know when you arrive?"

Evaluation establishes goals that tell you where you want to go. It sets up a map (or plan) of how you are going to get there with landmarks (or objectives, or markers for success) that can tell you how far you have come toward reaching the goal.

It is important to plan your evaluation at the same time you plan your project.

There are many resources on evaluation. Here are a few.

**Centers for Disease Control**

www.cdc.gov/eval/framework.htm

www.cdc.gov/eval/evalcbph.pdf

**The Community Toolbox**

http://ctb.ku.edu/tools/en/part_J.htm This is specific to evaluation, but the website http://ctb.ku.edu/ contains helpful information on all areas of project planning, implementation, management etc. as well as information on organizing communities, social marketing and the like.

**Empowerment Evaluation plus lots of links to other useful sites.**

http://www.stanford.edu/~davidf/empowermentevaluation.html

## Appendix V

### About practice guidelines and evidence-based practices and programs and where to find more information

Practice guidelines and best or evidence-based practices represent the most current thinking about what works best to prevent and treat suicidal behavior.

The list below is current as of June, 2004.

*Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors* The American Psychiatric Association 2003. It is available at: www.psych.org/psych_pract/treatg/pg/pg_suicidalbehaviors.pdf

*Reducing Suicide: A National Imperative* The Institute of Medicine. 2002

Includes chapters on medical and psychotherapeutic inte4rventions and program for suicide prevention. It is available at: www.nap.edu/catalog/10398.html

The Harborview Injury Prevention and Resource Center in Washington reviews some best practices in adolescent suicide prevention. The article is located here: http://depts.washington.edu/hipre/practices/topic/suicide/

The Suicide Prevention Resource Center has begun a project to identify evidence-based practices in suicide prevention. You can read about the project at: www.spre.org/whatweoffer/ebp.asp

*Aboriginal Youth: A manual of Promising Suicide Prevention Strategies* is distributed by the Centre for Suicide Prevention in Alberta Canada. It is available to order at: www.suicideinfo.ca/esp/assets/promstrat_order.pdf or as a free (but almost 300 page) download at: www.suicideinfo.ca/esp/go.aspx?tabid=144

## Appendix VI

### Warning Signs

Warnings signs alert us that a person might be considering suicide. If we observe a warning sign and suspect a person is considering suicide, the appropriate response is to show our concern, ask the person if he or she is thinking about suicide, and assist the person to get help. This is often referred to as "gatekeeping". There are numerous training programs that train potential "gatekeepers" in how to recognize warning signs, intervene and refer. Two of the best known are:

QPR – Question Persuade Refer, http://www.qprinstitute.org/

ASIST – Applied Suicide Intervention Skills Training, www.livingworks.net/ for more information

Contact the Statewide Suicide Prevention Council for the names of trained Alaskan ASIST trainers.

The Alaska Division of Behavioral Health and the Statewide Suicide Prevention Council are currently developing gatekeeper training specifically for the different communities and groups in Alaska. It should be available beginning in July 2005.

### Warning Signs

**Verbal – some of the things a person might say:**

I'm thinking of ending it all.
I might as well shoot myself.
I might just jump in the river.
I can't go on.
Life is not worth living.
Nothing matters anymore.
I wish I were dead.
I'm a loser.
I can't do anything right.
No one can help me.
What's the use?
I just can't keep my thoughts straight anymore.
If I killed myself, then people would be sorry.
If I wasn't around no one would miss me.
All of my problems will end soon.
I won't be needing these things any more.
I'm going to be with (names someone who has died).

**Behaviors – some of the things a person might do:**

Drop out of usual activities.
Withdraw from friends and family.
Act recklessly.
Put affairs in order.
Give away valued possessions.
Increase use of drugs or alcohol.
Crying.
Fighting.
Getting into trouble in school or with the law.
Impulsiveness.
Self-mutilation.
Writing about death and suicide.
Not taking care of physical needs and appearance.
Sleeping or eating too much or too little.

Be especially concerned if you observe several of these signs and/or if you are aware that the person has recently experienced a loss of some kind.

**The most significant predictor of suicide is a prior suicide attempt.** If you observe warning signs in someone you know has attempted suicide in the past, it is especially important to intervene and assist the person in getting help.

## Appendix VII

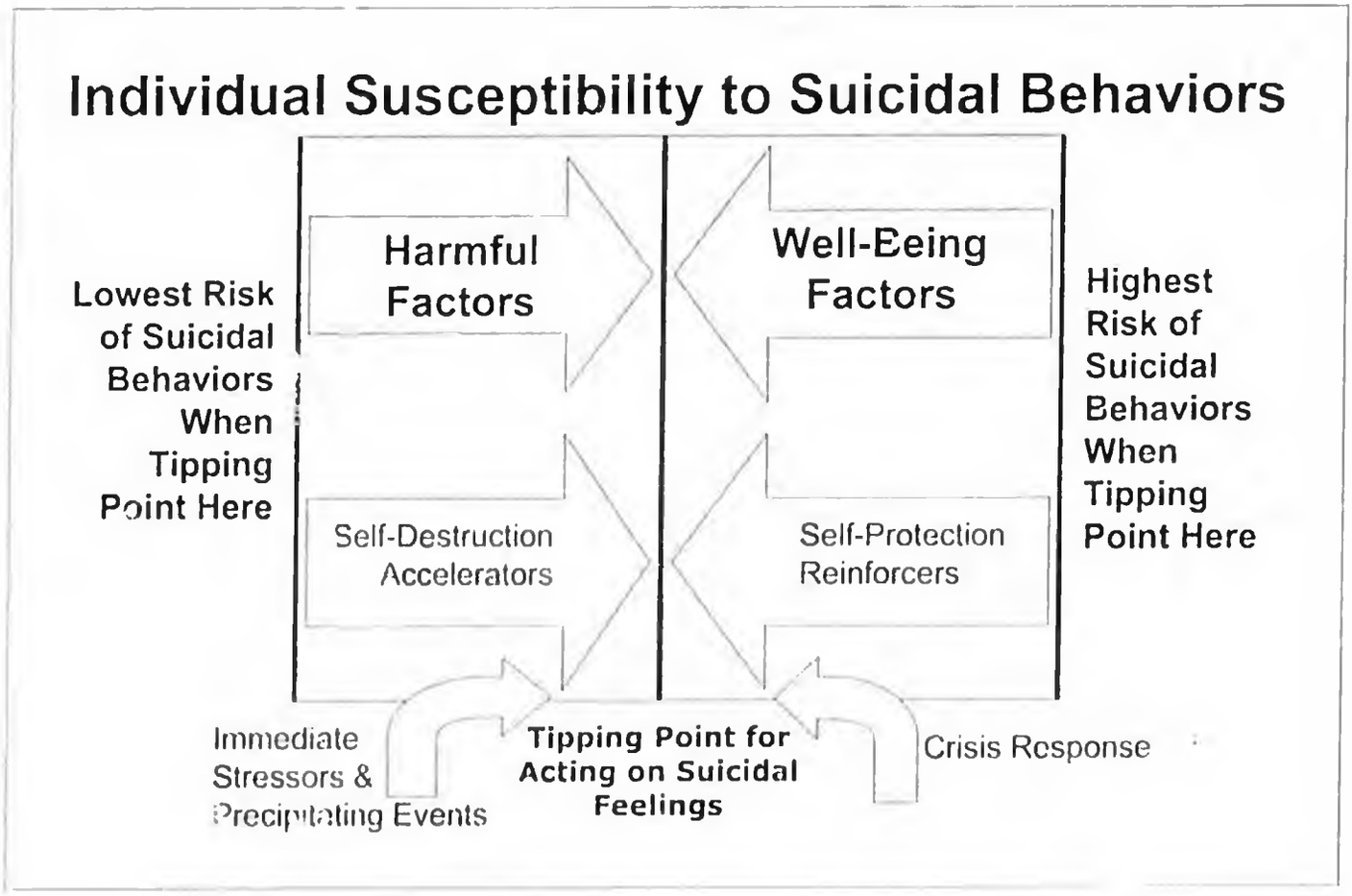
### Factors making suicidal behaviors more or less likely to occur

These tables and the chart following were contributed by Lucy Davidson, MD, EdS, President-Elect of the American Association of Suicidology. They offer a slightly different model for looking at the factors that contribute to (harmful) or protect from (Well-Being) suicidality. Dr. Davidson's chart portrays the factors as operating like "force vectors" that move the individual's tipping point for acting upon suicidal feelings towards or away from self-destructive behavior. Special thanks to Dr. Davidson for sharing this very interesting and useful formulation.

| Harmful Factors | Well-Being Factors |
|---|---|
| **Poor Mental Health**<br>Presence of a mental disorder, especially mood disorders (depression, bipolar disorder) or substance use disorders (alcohol abuse, alcoholism, other drug abuse)<br>Not enough treatment or barriers to treatment<br>Genetic predisposition to suicide | **Good Mental Health**<br>Absence of mental disorders<br>Effective treatment of existing mental disorders or substance use disorders<br>No family history of suicide |
| **Negative Attitudes Towards Life and Self**<br>Pessimistic, hopeless<br>Loner, isolated<br>Feels useless, of no value<br>Feels there is no meaning to life | **Positive Attitudes Towards Life and Self**<br>Optimistic, hopeful, sense of autonomy<br>Feels part of community & peers<br>Feels useful, has role in community<br>Faith, spirituality, church attendance |
| **Harmful Behaviors**<br>Substance abuse<br>Risk taking actions<br>Defiant, hostile, sullen towards others | **Healthy Behaviors**<br>Clean and sober<br>Bases actions on foreseeable consequences<br>Social connectedness |
| **Deficient Life Skills**<br>Poor problem solving skills<br>Poor communication skills<br>Unable to share feelings or seek help | **Strong Life Skills**<br>Creative problem solver<br>Good communicator<br>Able to ask for help when needed<br>Cultural reinforcement |
| **Unstable Family Life**<br>Substance abuse in home/family<br>Ongoing conflict or violence<br>Neglect | **Supportive Family Life**<br>Parents model healthy behaviors<br>Warm, respectful relationships<br>Stability and consistency<br>Parents have high and realistic expectations, set clear limits |

| Harmful Factors | Well-Being Factors |
|---|---|
| **Destructive Relationships**<br>Peers abuse substances<br>"Outlaw" peers, get into trouble, alienated<br>"Tough guys/girls"<br>Negative attitude to adults<br>Poor adult role models<br>Adults pay little or no attention esp. to teens<br>Generations are disconnected<br>Adults put youth down, non-supportive | **Positive Relationships**<br>Peers that model healthy behaviors<br>Community engagement<br>Supportive "natural helpers"<br>Have adult mentors and positive role models<br>Good role models<br>Create opportunities for youth to contribute<br>Elders are involved with youth<br>Adults keep faith in youth, never give up on them |
| **Adverse School Environment**<br>Allows bullying, harassment<br>Disconnected from community, parents do not feel welcome<br>Teachers, staff uncertain how to help<br>Students feel belittled, shamed<br>Abusive boarding school | **Constructive School Environment**<br>All students feel safe, welcomed<br>Parents are involved in school, school is part of community<br>Teachers, staff trained as natural helpers<br>Students feel supported by school<br>Community school |
| **Economic Decline**<br>High unemployment<br>Poverty | **Economic Resurgence**<br>Opportunities for meaningful work<br>Opportunity to live comfortably |
| **Disengaged Communities**<br>Substance abuse is high and tolerated<br>Violence is high and tolerated<br>Suicide seen as ordinary and typical<br>Firearms are openly available<br>Bootlegging is common and open<br>Feeling politically powerless<br>Media sensationalizes suicide<br>Fragmented medical, behavioral health, and social services | **Communities That Care**<br>Drunkenness is not acceptable<br>Ordinances and laws are enforced<br>Suicide is seen as preventable by addressing its underlying causes<br>Safe storage of firearms, lockboxes<br>Enforced local option laws<br>Feeling that one can have an impact on political processes<br>Responsible reporting, follows guidelines for media<br>Coordinated medical, behavioral health, and social services |

| Self-Destruction Accelerators | Self-Protection Reinforcers |
|---|---|
| Local clusters of suicide that have a contagious influence<br>Loss: relationship, financial, job, social<br>Stigma associated with seeking help<br>Previous suicide attempt(s)<br>Hopelessness<br>Aggressive/impulsive tendencies<br>Unwarranted self-criticism<br>Previous trauma or abuse<br>Unrelieved anxiety or agitation<br>General medical conditions, such as stroke, that can produce depressive illness | Purposefulness and social support<br>Optimistic nature, sense of future<br>Ability to tolerate own emotions and use foresight<br>Realistic self-acceptance<br>Healing, peer support<br>Restoration of sleep, appetite, and daily routine<br>Appropriate medical care, pain relief, and palliative care; vigorous treatment of depression |



## Appendix VIII

### AFTER A SUICIDE: RECOMMENDATIONS FOR RELIGIOUS SERVICES AND OTHER PUBLIC MEMORIAL OBSERVANCES

**DRAFT DRAFT DRAFT DRAFT DRAFT DRAFT DRAFT**

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When an act of suicide causes the end of a life it affects the community of survivors in a very profound way—much different than a death caused by heart disease, cancer, or an accident. The unique social, cultural, and religious contexts regarding suicide are complicated by nearly pervasive misinformation and misunderstanding. Consequently, stigma, shame or embarrassment, and unwarranted guilt add *unnecessarily* to the already heavy burden on those grieving. Only by paying special attention to these factors can community and faith-based leaders effectively support the surviving family members and intimate friends as they progress on their journeys of grieving and healing. Ideally, the survivors of a suicide would be surrounded by people who accurately understand the special ramifications of a suicide.

The information that follows is provided as part of the implementation of the National Strategy for Suicide Prevention. It is designed to aid members of the clergy and other community and faith leaders as they care for those who have survived the loss a loved one due to suicide and confer with them in planning the memorial observance. The suggestions are based both on the common experience of those who have worked extensively in the field, as well as, a considerable body of scientific research. Most importantly, though, it is the result of extensive consultations with clergy and counselors who represent the broadest range of religions and cultural communities and who have provided care during the aftermath of suicide.

The material that follows (1) provides background information, (2) suggests ways to care for and support survivors, and (3) makes important recommendations for memorial services that will not only help heal, but could also help prevent future suicides. Due to its brevity, it cannot begin to answer all the questions that will come in the wake of a suicide. Hopefully, though, it is complete enough to help faith and community leaders avoid the most common pitfalls while guiding them to additional resources.

#### BACKGROUND

#### Understanding Why

Although many questions are left unanswered when someone takes his or her life, in retrospect suicide is rarely entirely unexplainable. Those who end their lives do not act out of moral weakness or a character flaw, as some used to think. They are nearly always suffering from intense psychological pain, from which they cannot find relief. This pain may be associated with a brain illness like depression, schizophrenia, bipolar disorder, or alcohol or other substance abuse. (Ninety percent of those who die by suicide are suffering from some diagnosable brain disorder.) It may have existed for an extended time or be of relatively recent onset. They are commonly constrained in their thinking and unable to make rational choices the way most of us do under normal circumstances. There are effective treatments for these brain illnesses, but too often people suffering with this psychological pain are not able to find access to those treatments or choose not to. In some instances, even when treatments are given they are not able to prevent the suicide.

In a proportion of cases, suicidal acts are responses—sometimes impulsive—to difficult life situations, however temporary they may be. It is possible that even very close family members and friends may not have been sufficiently aware of the issues to understand the true severity of the crisis.

Although some suicidal individuals go to great lengths to hide evidence of their self-destructive intents, most individuals communicate their intent in some way or display signs of suicide risk. For a variety of reasons, these often pass by without eliciting a response. Sometimes the communications may be obtuse, making them difficult to recognize as warning signs. Even when someone *does* recognize the signs, they may not know how to respond effectively. In yet other cases, even the most determined responses by loved ones do not prevent a tragic end.

**Grieving**

Grieving after a suicide can be distinctly different than other grieving experiences due to the complexities discussed above. The grief may be marked by extremely intense emotional pain—one that may persist, though waxing and waning, for an extended time. Some survivors may also experience nightmares or flashbacks to the event associated with post-traumatic stress. It is not unusual for well-meaning friends, fellow workers, classmates, and others, to inappropriately criticize those closest to the deceased for the manner or the duration of their grieving.

Every one grieves at their own pace and in their own way. Sometimes, the difficult life of the deceased has caused such intense conflict and suffering for the loved ones that grief is complicated by a sense of relief. Whatever the mix, the emotions are usually intense, complex, and require unusual sensitivity and understanding by those in roles of support.

**Special Populations—The Aging and Infirmed**

Suicide among the aging, disabled or terminally ill involves an additional set of unique and complex issues. In most cases these suicides occur in the context of hopelessness, depression, or both, and are undoubtedly influenced by societal attitudes around these issues. We know that between eight and twenty percent of older Americans suffer from depression and a substantial proportion receives no treatment or inadequate treatment. Although the health care system needs to respond with significant improvements, the faith-community can also improve its understanding and support (see box).

*Faith communities can help prevent suicide among its aging members by:*

1. *Striving to recognize signs of depression and encouraging those suffering to seek effective treatments.*
2. *Improving the emotional, psychological, and spiritual support provided to those with physical infirmities.*
3. *Supporting community providers of end-of-life care, such as hospice, to ensure wider availability of this important service.*
4. *Honoring its older community members, regardless of their current health, in a way that contributes to their feelings of worth and diminishes their sense of being a burden*

### Theological Issues

A suicide within a local faith community may provide the first opportunity for some clergy members to carefully examine their own theological views of suicide. It will almost certainly require them to answer theological questions raised by the surviving family members as well as the greater faith community. Fortunately, the perspectives held by many faith groups have developed over recent years to reflect today's more complete understanding of the complexities of suicide. Members of the clergy now have an opportunity to bring healing and comfort to survivors if they frame an informed response with sensitivity, compassion, grace, and love. (See the internet resources below for theological statements on suicide from a variety of faith groups.)

### Taking Care of Yourself

The faith and community leaders are frequently as personally involved as family members and friends in the grief following a suicide, especially if they had provided care, counseling, or support in a direct way to the deceased prior to the suicide. Consequently, these leaders *must* pay attention to their own emotional, psychological, and spiritual needs while they are also providing essential support to the greater community.

## SUPPORT AND CARE OF SURVIVORS

### Educating the Community

As a society, we have not informed ourselves well about suicide. Misinformation and inaccurate religious views of suicide create an environment that leaves survivors isolated and embarrassed even though they may have been powerless to prevent the tragic event. This should be a time for healing, not judging. The individual act cannot be undone. A community will be able to bring healing to its members if it has a better awareness and more accurate understanding of suicide. (A better informed community is also better equipped to recognize and respond to signs that someone else they know and love is at risk of taking his or her life.)

### Care and Support

The community can support survivors by:

1. Recognizing the unique challenges in grieving the loss of a loved one by suicide and supporting them in their grief journey.

2. Reaching out to intentionally draw them into the fabric of the community's normal activities. Deliberate inclusiveness is an important antidote to the inappropriate stigma that so often accompanies a death due to suicide. The faith-community should be an important source of love and grace for the grieving.

3. Supporting them with the same gestures of kindness (taking in meals, etc.) that are extended to others who have deaths in the family.

4. Talking with the survivors about the deceased in the same sensitive way they would any other person who had recently died. This openness will help the surviving family overcome any embarrassment or shame they may be feeling.

5. Encouraging them to seek specialized support in their grieving process, either through support groups for survivors of suicide or by seeking professional grief counseling with a therapist experienced with suicide survivors.

## RECOMMENDATIONS FOR MEMORIAL SERVICES

In preparing for memorial services, it is important to recognize that public communication after a suicide has the potential to either increase or decrease the suicide risk of those receiving the communication. By following the recommendations below, speakers can facilitate healing in their communities, and at the same time, reduce the risk of imitative suicides. These memorial services are also important opportunities to increase awareness and understanding of the issues surrounding suicide and thereby rid the community of some of its unfounded stigma and prejudice. The ultimate goal is to foster an atmosphere that will help the survivors understand, heal, and move forward in as healthy a manner as possible.

### 1. Comfort for the Grieving

Recognize that a death by suicide often leaves surviving family and friends with a most excruciating emotional pain. This point may be illustrated by observing that just as some types of physical pain are more intense than others, those suffering the loss of a loved one by suicide are likely to experience an emotional pain of extreme intensity—one that may persist, though waxing and waning, for an extended time. Help the survivors find comfort within the context of their faith and their faith community.

### 2. Dealing with Guilt

Observe that survivors are almost invariably left with a sense of unwarranted guilt or an exaggerated sense of responsibility from not being aware, or not acting in time to prevent the suicidal death. Others may feel unfairly victimized by the act of their family member or friend and by the stigma that society inappropriately places on them. Consequently, it is common to relive for weeks, months, and even years a continuous litany of "What if. . .?" "Why did. . .?" and "Why didn't. . .?" Rehearsing or rehashing these questions, although a nearly universal experience, will not necessarily produce answers that satisfy the longing for understanding and closure. Once again, it is helpful to offer survivors solutions that can be found within their faith traditions. After sufficient time, a better understanding of why suicide occurs may provide the beginning of healing for some.

### 3. Facing Anger

Feelings of anger commonly occupy the minds and hearts of those mourning the loss of a loved one to suicide. It may take several forms: anger at others (doctors, therapists, other family members or friends, bosses, the deity, etc.), anger at self (because of something done or not done), or anger at the deceased (for abandoning the survivor, throwing away all plans for a future, and abrogating responsibilities and obligations.) Surviving family and friends should be assured that feeling or expressing the anger is often part of the normal grieving process. Even when anger is directed toward the deceased, it does not mean they cared for their loved one any less.

### 4. Attacking Stigma

Stigma, embraced by ignorance, can be the greatest hindrance to healing if it is not dealt with directly. Take this opportunity to make as much sense as possible of what could have led to this person's tragic end. One way to approach this is by disclosing selected information about the context of the specific suicide, such as a mental illness from which the deceased may have been suffering. (Do not describe the suicidal act itself.) An alternative approach is to discuss the factors commonly associated with suicidal acts (e.g., psychological pain, hopelessness, mental illness, impulsivity) without mentioning the specifics in this death. As a minimum, dispel the common myths about moral weakness, character flaws, or bad parenting as causes (except in cases where domestic violence or abuse was a contributing factor). Recognition of the role of a brain illness may help the community understand suicide in the same way they appreciate heart disease, another common cause of death.

### 5. Using the Right Language

Although common English usage includes the phrases "committed suicide," "successful suicide," and "failed attempt," these should be avoided because of their connotations. For instance, the verb "committed" is usually associated with sins or crimes. Regardless of theological perspective, it is more helpful to understand the phenomenon of suicide as the worst possible outcome of mental health or behavioral health problems as they are manifested in individuals, families, and communities. Along the same lines, a suicide should never be viewed as a success, nor should a non-fatal suicide attempt be seen as a failure. Alternatively, phrases such as "died by suicide," "took his life," "ended her life", or "attempted suicide" are more accurate and less offensive.

### 6. Preventing Imitation and Modeling

Some types of communication about the deceased and their actions may influence others to imitate or model the suicidal behavior. Consequently, it is important in this context not to glamorize the current state of "peace" the deceased may have found through their death. Although some religious perspectives consider the afterlife as much better than life in the physical realm, particularly when the quality of physical life is diminished by a severe or unremitting mental illness, this contrast should not be over-emphasized in a public gathering. If there are others in the audience who are dealing with psychological pain or suicidal thoughts, the lure of finding peace or escape through death may add to the attractiveness of suicide. (Information about resources for treatment and support should be made available to those attending the observance.) In a similar way, one should avoid normalizing the suicide by interpreting it as a reasonable response to particularly distressful life circumstances.

Instead, make a clear distinction, and even separation, between the positive accomplishments and qualities of the deceased and his or her final act. Make the observation that although the deceased is no longer suffering or in turmoil, we would rather (s)he had lived in a society that understood those who suffer from mental or behavioral health problems and supported those who seek help for those problems without a trace of stigma or prejudice. Envision how the community or general society could function better or provide more resources (such as better access to effective treatments) to help other troubled individuals find effective life solutions. The goal of this approach is to motivate the community to improve the way it cares for, supports, and understands all its members, even those with the most pressing needs and not to contribute to the community's collective guilt.

### 7. Special Considerations For Youth

In a memorial observance for a young person who has died by suicide, service leaders should address the young people in attendance very directly; since they are most prone to imitate or model the suicide event. The death of their peer may make them feel numb or intensely unsettled. Regardless of how disturbing this sudden loss may be, impart a sense of community to the audience highlighting the need to pull together to get through this. Make specific suggestions that will unite the community around the purpose of caring for one another more effectively. Also, ask the young people to look around and notice adults on whom they can call for help in this or other times of crisis. Consider pointing out examples of adults who are known to be particularly caring and approachable. These may be teachers, counselors, youth leaders, coaches, etc. Note their desire to talk and listen to anyone who is feeling down or depressed, including having thoughts of death or suicide. In the course of this discussion, endeavor to normalize the value of seeking professional help for emotional problems in the same way one would seek professional help for physical problems.

Focus attention on the hope of a brighter future and the goal of discovering constructive solutions to life's problems—even when these problems include feelings of depression or other signs of mental or emotional problems. Encourage the youth to reach outside themselves to find resources for living lives to their fullest potential and to talk with others when they are having difficulties in life. Additionally, it is critically important that the young people who are present watch each other for signs of distress and never keep thoughts of suicide a secret, whether those thoughts are their own or a friend's. Stress the importance of telling a caring adult if they even *think* one of their friends may be struggling with these issues.

Note: Schools and faith communities may wish to organize individual classes or small discussion groups with prepared adult leaders where the youth can more comfortably discuss their thoughts and feelings regarding their loss and where questions may be more easily raised and addressed.

### 8. Memorials

There have been several cases where dedicating public memorials after a suicide have facilitated the suicidal acts of others, usually youth. Consequently, dedicating memorials in public settings, such as park benches, flag poles, or trophy cases soon after the suicide is discouraged. In some situations, however, survivors feel a pressing need for the community to express its grief in a tangible way. Open discussion with proponents about the inherent risks of memorials for youth should help the community find a fitting, yet safe outlet. These may include personal expressions that can be given to the family to keep privately, such as letters, poetry, recollections captured on videotape, or works of art. Alternatively, suggest that surviving friends honor the deceased by living their lives in concert with community values, such as, compassion, generosity, service, honor, and improving life. Activity-focused memorials might include organizing a day of community service, sponsoring mental health awareness programs, supporting peer counseling programs, or fund-raising for some of the many worth-while suicide prevention non-profit organizations. Purchasing library books that address related topics, like how young people can cope with loss or how to deal with emotional problems like depression, is yet another example of life-affirming ways to remember the deceased. While artistic expression is often therapeutic for those experiencing grief, public performances of poems, plays or songs may contain messages or create a climate that inadvertently increases thoughts of suicide among vulnerable youth.

*Additional Resources.*

For more information about suicide and suicide prevention, please visit the National Strategy for Suicide Prevention Web site at www.mentalhealth.org/suicideprevention.

Links to other faith-based resources, including statements on suicide issued by a variety of denominations is available on the Web site of the Organization of Attempters and Survivors of Suicide in Interfaith Services (OASSIS) at www.oassis.org.

Information on specialized grief support services and groups for survivors of a suicide is available through:

American Association for Suicidology: www.suicidology.org, 4201 Connecticut Avenue, NW, Suite 408, Washington, DC 20008, (202) 237-2280

American Foundation for Suicide Prevention: www.afsp.org, 120 Wall Street, 22nd Floor New York, New York 10005, phone: (212) 363-3500 or toll-free: (888) 333-AFSP

The Compassionate Friends, Inc., www.compassionatefriends.org, P.O. Box 3696, Oakbrook, IL, 60522-3696, (630) 990-0010 or toll-free: (877) 969-0010.

The National Resource Center for Suicide Prevention and Aftercare: http://www.thelink.org/, 348 Mt. Vernon Highway, Atlanta GA 30328, (404) 256-2919

Additional information on the special characteristics of suicide bereavement:

Jordan, John R. (2001). "Is Suicide Bereavement Different? A Reassessment of the Literature," *Suicide and Life-Threatening Behavior*, 31(1) Spring 2001, 91-102.

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## Appendix IX

### GLOSSARY

**Activities** – the specific steps that will be undertaken in the implementation of a plan; activities specify the manner in which objectives and goals will be met.

**Advocacy groups** – organizations that work in a variety of ways to foster change with respect to a societal issue.

**Best practices** – activities or programs that are in keeping with the best available evidence regarding what is effective.

**Community** – a group of people residing in the same locality or sharing a common interest (ex. a town or village, and faith, education and correction communities, etc.).

**Comprehensive suicide prevention plans** – plans that use a multi-faceted approach to addressing the problem; for example, including interventions targeting biopsychosocial, social and environmental factors.

**Connectedness** – closeness to an individual, group or people within a specific organization; perceived caring by others; satisfaction with relationship to others, or feeling loved and wanted by others.

**Consumer** – a person using or having used a health service.

**Contagion** – a phenomenon whereby susceptible persons are influenced towards suicidal behavior through knowledge of another person's suicidal acts.

**Contributing factors** – see risk factor.

**Culturally appropriate** – a set of values, behaviors, attitudes, and practices reflected in the work of an organization or program that enables it to be effective across cultures; includes the ability of the program to honor and respect the beliefs, language, interpersonal styles, and behaviors of individuals and families receiving services.

**Culture** – the integrated pattern of human behavior that includes thoughts, communication, actions, customs, beliefs, values, and institutions of a racial, ethnic, faith or social group.

**Depression** – a constellation of emotional, cognitive and somatic signs and symptoms, including sustained sad mood or lack of pleasure.

**Effective** – prevention programs that have been scientifically evaluated and shown to decrease an adverse outcome or increase a beneficial one in the target group more than in a comparison group.

**Elderly** – persons aged 65 or more years.

**Evaluation** – the systematic investigation of the value and impact of an intervention or program.

**Evidence-based** – programs that have undergone scientific evaluation and have proven to be effective.

**Follow-back study** – the collection of detailed information about a deceased individual from a person familiar with the decedent's life history or by other existing records. The information collected supplements that individual's death certificate and details his or her circumstances, the immediate antecedents of the suicide, and other important but less immediate antecedents.

**Gatekeepers** – those individuals in a community who have face-to-face contact with large numbers of community members as part of their usual routine; they may be trained to identify persons at risk of suicide and refer them to treatment or supporting services as appropriate.

**Goal** – a broad and high-level statement of general purpose to guide planning around an issue; it is focused on the end result of the work.

**Health** – the complete state of physical, mental, and social well-being, not merely the absence of disease or infirmity.

**Healthy People 2010** – the national prevention initiative that identifies opportunities to improve the health of all Americans, with specific and measurable objectives to be met by 2010.

**Impulsive** – a suicidal act that occurs with little planning or forethought.

**Indicated prevention intervention** – intervention designed for individuals at high risk for a condition or disorder or for those who have already exhibited the condition or disorder.

**Intentional** – injuries resulting from purposeful human action whether directed at oneself (self-directed) or others (assaultive), sometimes referred to as violent injuries.

**Intervention** – a strategy or approach that is intended to prevent an outcome or to alter the course of an existing condition (such as providing lithium for bipolar disorder or strengthening social support in a community).

**Means** – the instrument or object whereby a self-destructive act is carried out (i.e., firearm, poison, medication).

**Means restriction** – techniques, policies, and procedures designed to reduce access or availability to means and methods of deliberate self-harm.

**Mental disorder** – a diagnosable illness characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress that significantly interferes with an individual's cognitive, emotional or social abilities; often used interchangeably with mental illness.

**Mental health** – the capacity of individuals to interact with one another and the environment in ways that promote subjective well-being, optimal development and use of mental abilities (cognitive, affective and relational).

**Mental health problem** – diminished cognitive, social or emotional abilities but not to the extent that the criteria for a mental disorder are met.

**Mental health services** – health services that are specially designed for the care and treatment of people with mental health problems, including mental illness; includes hospital and other 24-hour services, intensive community services, ambulatory or outpatient services, medical management, case management, intensive psychosocial rehabilitation services, and other intensive outreach approaches to the care of individuals with severe disorders.

**Mental illness** – see mental disorder.

**Objective** – a specific and measurable statement that clearly identifies what is to be achieved in a plan; it narrows a goal by specifying who, what, when and where or clarifies by how much, how many, or how often.

**Outcome** – a measurable change in the health of an individual or group of people that is attributable to an intervention.

**Predisposing factor** – a precursor that provide the rational or motivation for a behavior.

**Prevention** – a strategy or approach that reduces the likelihood of risk of onset, or delays the onset of adverse health problems or reduces the harm resulting from conditions or behaviors.

**Protective factors** – factors that make it less likely that individuals will develop a disorder; protective factors may encompass biological, psychological or social factors in the individual, family and environment.

**Public information campaigns** – large scale efforts designed to provide facts to the general public through various media such as radio, television, advertisements, newspapers, magazines, and billboards.

**Rate** – the number per unit of the population with a

particular characteristic, for a given unit of time.

**Resilience** – capacities within a person that promote positive outcomes, such as mental health and well-being, and provide protection from factors that might otherwise place that person at risk for adverse health outcomes.

**Risk factors** – those factors that make it more likely that individuals will develop a disorder; risk factors may encompass biological, psychological or social factors in the individual, family and environment.

**Screening** – administration of an assessment tool to identify persons in need of more in-depth evaluation or treatment.

**Screening tools** – those instruments and techniques (questionnaires, check lists, self-assessments forms) used to evaluate individuals for increased risk of certain health problems.

**Selective prevention intervention** – intervention targeted to subgroups of the population whose risk of developing a health problem is significantly higher than average.

**Self-harm** – the various methods by which individuals injure themselves, such as self-laceration, self-battering, taking overdoses or exhibiting deliberate recklessness.

**Social services** – organized efforts to advance human welfare, such as home-delivered meal programs, support groups, and community recreation projects.

**Stigma** – an object, idea, or label associated with disgrace or reproach.

**Substance use disorder** – a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to repeated use; includes maladaptive use of legal substances such as alcohol; prescription drugs such as analgesics, sedatives, tranquilizers, and stimulants; and illicit drugs such as marijuana, cocaine, inhalants, hallucinogens and heroin.

**Suicidal act (also referred to as suicide attempt)** – a potentially self-injurious behavior for which there is evidence that the person probably intended to kill himself or herself; a suicidal act may result in death, injuries, or no injuries.

**Suicidal behavior** – a spectrum of activities related to thoughts and behaviors that include suicidal thinking, suicide attempts, and completed suicide.

**Suicidal ideation** – self-reported thoughts of engaging in suicide-related behavior.

**Suicidality** – a term that encompasses suicidal thoughts, ideation, plans, suicide attempts, and completed suicide.

**Suicide** – death from injury, poisoning, or suffocation where there is evidence that a self-inflicted act led to the person's death.

**Suicide attempt** – a potentially self-injurious behavior with a nonfatal outcome, for which there is evidence that the person intended to kill himself or herself; a suicide attempt may or may not result in injuries.

**Suicide attempt survivors** – individuals who have survived a prior suicide attempt.

**Suicide survivors** – family members, significant others, or acquaintances who have experienced the loss of a loved one due to suicide; sometimes this term is also used to mean suicide attempt survivors.

**Surveillance** – the ongoing, systematic collection, analysis and interpretation of health data with timely dissemination of findings.

**Unintentional** – term used for an injury that is unplanned; in many settings these are termed accidental injuries.

**Universal preventive intervention** – intervention targeted to a defined population, regardless of risk; (this could be an entire school, for example, and not the general population per se)

## Appendix X

### Sample Templates and Draft Plans

**Community Suicide Prevention Plan Template**

1. Which goal from the Statewide Suicide Prevention Plan are we addressing?
Goal Number:_____
Goal Statement:

2. What will it look like in our community?
What is our community specific version of this goal? What are we trying to accomplish? What will be the end result?

3. Where are we now?
What is the problem we are trying to solve or situation we are trying to change?

4. Who is willing to work on this?
Form a work group, task force or committee.
Members and Contact Information

5. What are we going to do: developing an action plan.
   5.1 Information Gathering
      A. What information do we need?
      B. Who will get the information?
      C. Start and Completion Dates for getting information
   5.2 Decision Making
      Meet with work group or community, share information, brainstorm, and decide on a plan. Decide on how we will know if our plan is successful (evalaation).
   5.3 Step by Step Planning
      For each step in the plan be sure to state:
         Resources needed (human, financial, other)
         Who is responsible
         Start and end dates,
         Marker(s) for success
         Costs (budget)

6. Implement the Plan.
   Schedule meetings of work group to review progress and solve problems.

7. Evaluate Success in Achieving Goal(s)

8. Revise plan if needed, continue successful activities.

## Step by Step Planning

**State Plan Goal #**

**Goal Coordinator:**

| Community Goals | Steps | Resources Needed | Responsible Party | Start Date | End Date | Marker for Success | Costs |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

## Community Suicide Prevention Plan

### Sample – a local church

1. Which goal from the Statewide Suicide Prevention Plan are we addressing?
Goal Number: ___3__
Goal Statement: **Alaskans recognize that mental illness substance use and suicidality are disorders that respond to specific treatments and that are part of health care. There is no stigma associated with these disorders.**

2. What will it look like in our community?
What is our community specific version of this goal? What are we trying to accomplish? What will be the end result?
The church congregation will support members and families who experience mental health, substance abuse or suicidal behavior. We will be better informed about these problems.

3. Where are we now?
What is the problem we are trying to solve or situation we are trying to change?
**A family who experienced a suicide said they felt isolated in their grief. Other parishioners reported feeling they didn't know what to do or say.**

4. Who is willing to work on this?
Form a work group, task force or committee.
Members and Contact Information
**Minister Jack**
**Sunday school teacher Alice**
**Member Peter who is a psychologist**
**Dan and Betty, suicide survivors**
**Members of religious education committee, Paul, Elizabeth, Sarah**
**Etc.**

5. What are we going to do; developing an action plan.
5.1 Information Gathering
A. What information do we need?
**Other churches that have addressed this problem and how they have done it. Basic facts about Mental Illness, Substance Abuse, Suicide**
B. Who will get the information?
**Minister Jack and Psychologist Peter**
C. Start and Completion Dates for getting information
February 1 start March 1 complete

5.2 Decision Making
Meet with committee share information, brainstorm, and decide on a plan to meet the goals. Decide on how we will know if our plan is successful. (evaluation).

5.3 Step by Step Planning

For each step in the plan be sure to state:

Resources needed (human, financial, other)
Who is responsible
Start and end dates,
Marker(s) for success

Develop a budget and seek funds if needed.

6. Implement the Plan.

Schedule meetings of work group to review progress and solve problems.

7. Evaluate Success in Achieving Goal(s)

8. Revise plan if needed, continue successful activities.

***(see the sample Step by Step Plan on the following page)***

**Step by Step Planning** (sample Goal 3 – a local church)

**State Plan Goal 3 Alaskans recognize that mental illness substance use and suicidality are disorders that respond to specific treatments and that are part of health care. There is no stigma associated with these disorders.**

**Goal Coordinator: Pastor Jim**

| Community Goals | Steps | Resources Needed | Responsible Party | Start Date | End Date | Marker for Success | Costs |
|---|---|---|---|---|---|---|---|
| 1. The church congregation will support members and families who experience mental health, substance abuse or suicidal behavior. We will be better informed about these problems. | 1. Select or develop materials on mental illness, substance abuse and suicide that are appropriate to adult and teen members of church. | 1. Internet, phone, computer, possibly writer and artist. Printer. | 1. Peter and Paul | 3/2/04 | 3/31/04 | 1. Posters, pamphlets for adults and teens. | 1. $200 |
| | 2. Plan and schedule sermons, discussion groups, speakers and religions school classes on mental illness, substance abuse and suicide. | 2. Expert speakers, information, videos. Contact appropriate professional and membership organizations. | 2. Minister Jack, teacher Alice, survivor family. | 3/5/04 | 3/31/04 | 2. Coordinated schedule for education efforts. | 2. video rental $100 |
| | 3. Deliver activities as planned. | 3. Time, meeting space. | 3. Minister Jack | 4/1/04 | 5/15/04 | 3. Number of sermons, classes, discussion groups, lectures etc. | 3. $50. coffee/ cookies etc. |
| | 4. Form on-going committees for continuing education and support. | 4. People who agree to serve. | 4. Elizabeth for education, Survivor family for support. | 5/1/04 | On-going | 4. Committees have at least 5 members, meet regularly, provide educational programs, 4x year and offer support and en-couragement. | 4. none |

## Community Suicide Prevention Plan
### Sample – a small Alaska Native village plan

1. Which goal from the Statewide Suicide Prevention Plan are we addressing?

Goal Number:__4__
Goal Statement: **Alaskans manage guns and other potential items of self-harm safely and insure that Alaskans, especially youth, are educated about their safe management.**

2. What will it look like in our community?
What is our community specific version of this goal? What are we trying to accomplish? What will be the end result?
**The community would like to manage their guns and other potential items of self-harm.**
**1. 90% - All the rifles/handguns in this village have trigger locks or guns are locked in safes; Ammo and guns are kept in separate locations**
**2. All children by the age of 10 have successfully passed a certified gun safety course.**
**3. 90% of all of the homes have locks on their medicine cabinets and household poisons.**
**4. Health care providers, educators, and health aides in my community routinely use a screening tool for asking the question.**
**5. 90% of the homes have the poison control number posted by their telephone**

3. Where are we now?
What is the problem we are trying to solve or situation we are trying to change?
**Guns and other items of potential self-harm are too readily accessible. People handle guns when they are intoxicated. People don't know about poison control. People aren't being asked or informed about safe storage issues.**

4. Who is willing to work on this?
Form a work group, task force or committee.
Members and Contact Information
**Health Aide Mary.....**
**VPSO Tom.....**
**Council member Jack .....**
**Community member(s) Ella .....**
**Bill .....**
**Etc.**

5. What are we going to do: developing an action plan.
5.1 Information Gathering
A. What information do we need?
**Other places or programs that have addressed this problem and how they have done it.**
B. Who will get the information?
**Tom and Mary**
C. Start and Completion Dates for getting information

5.2 Decision Making

Meet with work group or community, share information, brainstorm, and decide on a plan to meet the goals. Decide on how we will know if our plan is successful (evaluation).

5.3 Step by Step Planning

For each step in the plan be sure to state:

Resources needed (human, financial, other)
Who is responsible
Start and end dates,
Marker(s) for success

Develop a budget and seek funds if needed.

6. Implement the Plan.

Schedule meetings of work group to review progress and solve problems.

7. Evaluate Success in Achieving Goal(s)

8. Revise plan if needed, continue successful activities.

*(see the sample Step by Step Plan below)*

**Step by Step Planning** (sample Goal 4 – a small Alaska Native village plan)

**State Plan Goal 4 Alaskans manage guns and other potential items of self-harm safely and insure that Alaskans, especially youth, are educated about their safe management.**

**Goal Coordinator: Tom VPSO**

| Community Goals | Steps | Resources Needed | Responsible Party | Start Date | End Date | Marker for Success | Costs |
|---|---|---|---|---|---|---|---|
| **1. 90% - All the rifles/handguns in this village have trigger locks or guns are locked in safes; Ammo and guns are kept in separate locations.** | 1. Posters and flyers to inform village of project | 1. Artist, writer, paper, copy machine | 1. Mary Jane | 8/1/04 | 8/10/04 | 1. 200 posters and flyers distributed. | 1. $50 for paper and copying |
| | 2. Survey village: count guns by type and whether person prefers lock or safe. | 2. Two people, tracking form, pen, time. | 2. Ella | 8/10/04 | 8/1704 | 2. Completed tracking form with info from 90% of households. | 2. None. Paper, pens donated by council. |
| | 3. Order # of locks and safes from ANTHC. | 3. One person, phone. | 3. Tom | 8/18/04 | 9/1/04 | 3. locks & safes arrive in village. | 3. None. ANTHC donation |

| Community Goals | Steps | Resources Needed | Responsible Party | Start Date | End Date | Marker for Success | Costs |
|---|---|---|---|---|---|---|---|
| | 4. Community Potluck to teach how to use and distribute | 4. Room, food, dishes etc., publicity, printed information, instructors | 4. Sarah Jane | 9/6/04 | 9/6/04 | 4. 90% of households attend. | 4. $25 paper plates etc. $25 turkeys $25 pop Contributions from families and stores |
| | 5. One week follow-up home visits. | 5. information sheets, tracking forms | 5. Tom | 9/13/04 | 9/15/04 | 5. 60% of households visited with 90% of those using locks or safes. | none |
| | 6. 3 month follow-up sample home visits. | 6. Information sheets, tracking form | 6. Tom | 2/15/05 | 2/17/05 | 60% of households visited, 90% continue to use locks or safes | none |
| | 7. 1 year follow-up sample home visits. | 7. Information sheets, tracking form | 7. Tom | 9/15/05 | 9/17/05 | 60% of households visited, 90% continue to use locks or safes | none |
| | 8. Evaluation report and continuation plan. | 8. Tracking forms | 8. Tom and committee | 9/18/05 | 10/18/05 | Report and plan to continue to support safe storage project completed and presented to community. | none |
| Goal 2. All children have successfully passed a certified gun safety course by age 10. | STEP BY STEP | PLAN | DEVELOPED | AS IN | GOAL | ONE | |
| Goal 3.90% of all homes store medicines and household poisons in locked cabinets. | STEP BY STEP | PLAN | DEVELOPED | AS IN | GOAL | ONE | |
| Goal 4. 90% of homes have the poison control number posted by their telephone. | STEP BY STEP | PLAN | DEVELOPED | AS IN | GOAL | ONE | |

## Community Suicide Prevention Plan
### Sample – Alaska Mental Health Board

1. Which goal from the Statewide Suicide Prevention Plan are we addressing?

Goal Number 9
Goal Statement: **Alaskan Behavioral Health Programs will treat suicidality effectively using appropriate current practice Guidelines.**

2. What will it look like in our community?
What is our community specific version of this goal? What are we trying to accomplish? What will be the end result?
**This pertains to the statewide behavioral health provider community.**
**1. All Alaska Behavioral Health Programs will become and remain knowledgeable about current evidence based practices for treating suicidality.**
**2. All Alaska Behavioral Health Programs will use current evidence based practices appropriate to their client population and clinical capabilities.**

3. Where are we now?
What is the problem we are trying to solve or situation we are trying to change?
**Currently it is up to each program to keep current with evidence based practice guidelines and it can be difficult, especially for smaller programs to do so. Similarly, there is no uniform application of appropriate evidence based practices.**

4. Who is willing to work on this?
Form a work group, task force or committee.
Members and Contact Information
**Two members of Ak. Mental Health Board**
**Mental Health Board research analyst**
**Two representatives of Behavioral Health Programs**

5. What are we going to do: developing an action plan.
5.1 Information Gathering
A. What information do we need?
**We need information about evidence based practices. We need to contact the American Association of Suicidology; the American Foundation for Suicide Prevention, The Suicide Prevention Resource Center, the American Psychiatric Association, the American Psychological Association, the National Institute of Mental Health, the Alaska Division of Behavioral Health, the Alaska Statewide Suicide Prevention Council.**

B. Who will get the information?
**Research Analyst and one Board member**
C. Start and Completion Dates for getting information
**January 1 – January 30**
5.2 Decision Making
**Meet with entire committee, share information, agree on guidelines to disseminate and develop preliminary plan for dissemination and continued updating. Develop Step by Step Plan which will include: development and distribution of evidence based guidelines in written form, websites references, a face to face training plan, development of procedures to insure clinical licensing requires the CEUs include training in**

**evidence based guidelines for treatment of suicidality, plan to work with DBH to include documented use of evidence based treatment guidelines in quality assurance reviews.**

5.3 Step by Step Planning
For each step in the plan be sure to state:
Resources needed (human, financial, other)
Who is responsible
Start and end dates,
Marker(s) for success
Develop a budget and seek funds if needed.

6. Implement the Plan.
Schedule meetings of work group to review progress and solve problems.

7. Evaluate Success in Achieving Goal(s)

8. Revise plan if needed, continue successful activities.

## Community Suicide Prevention Plan
## Sample – a residential school

1. Which goal from the Statewide Suicide Prevention Plan are we addressing?

Goal Number 11
Goal Statement: **Alaskan communities respond appropriately to suicide attempts and deaths by suicide.**

2. What will it look like in our community?
What is our community specific version of this goal? What are we trying to accomplish? What will be the end result?
1. We will have a written plan to provide guidance and direction to all staff in responding to a death by suicide or a suicide attempt.
2. All staff will be trained 2x/year at the start of each semester so that they understand the plan and their part in it.
3. There will be no additional suicides and suicide attempts will be reduced by 75% from the number in the academic year 2003-4.

3. Where are we now?
What is the problem we are trying to solve or situation we are trying to change?
Two students completed suicide during the 2003-4 school year and there were 10 suicide attempt with 6 of those requiring inpatient treatment.

4. Who is willing to work on this?
Form a work group, task force or committee.
Members and Contact Information
**School Principal**
**School Counselor**
**Director of Dormitory Life Program**
**House parents Judy and Jack**
**Teachers Ed and Jane**
**Student representative Evan**

5. What are we going to do: developing an action plan.
5.1 Information Gathering
A. What information do we need?
**Policies and programs from other residential schools (Mt. Edgecumbe and ??)**
Information from suicide prevention organizations including Suicide Prevention Resource Center, American Association of Suicidology, American Foundation for Suicide Prevention, Alaska Division of Behavioral Health, Alaska Statewide Suicide Prevention Council.
Information from Alaska Department of Education and Early Development.
B. Who will get the information?
**Counselor, Ed and Judy**
C. Start and Completion Dates for getting information
**June 1 start June 30 complete.**
5.2 Decision Making
**Meet with entire committee, share information, brainstorm, and develop preliminary outline for crisis response plan. Develop Step by Step Plan which will include: who will write the plan; who will develop**

**the training on the plan; a schedule for the committee to review drafts; target date for completion of the plan; target dates for training; evaluation plan for training, cost of any materials needed.**

5.3 Step by Step Planning

For each step in the plan be sure to state:

Resources needed (human, financial, other)
Who is responsible
Start and end dates,
Marker(s) for success

Develop a budget and seek funds if needed.

6. Implement the Plan.

   Schedule meetings of work group to review progress and solve problems.

7. Evaluate Success in Achieving Goal(s)

8. Revise plan if needed, continue successful activities.

Statewide
Suicide
Prevention
Council


*Department of Health and Social Services*
*Commissioner's Office*
*Suicide Prevention Council Coordinator*
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**State of Alaska**
Frank H. Murkowski, *Governor*
**Department of Health & Social Services**
Joel Gilberson, *Commissioner*



September 2004

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AARP Alaska

February 11, 2005

The Honorable Lyda Green, Co-Chair
Senate Finance Committee
Alaska State Capitol, Room 516
Juneau, AK 99801-1182

, Co-Chair
...mittee
...ol, Room 518
...au, AK 99801-1182

RE: SB 60 (Stevens, B)--Support

Dear Co-Chairs Green and Wilken:

On behalf of the members of AARP in Alaska, we encourage you and your colleagues on the Senate Finance Committee to support SB 60, authored by Senate President Ben Stevens and co-sponsored by Senator Gene Therriault.

Unfortunately, Alaska has a high rate of suicide. Many of these suicides include mid-life and older Alaskans. The Statewide Suicide Prevention Council needs to continue its work and address this issue for our citizens. The Council still has much to do and, in our opinion, should be allowed to continue for another four years.

We urge an "AYE" vote on SB 60.

Should you have any questions about our position, please feel free to contact me (586-3637) or Patrick Luby, AARP Advocacy Director (907-762-3314).

Thank you for your consideration.

Sincerely,

Marie Darlin

Marie Darlin, Coordinator
AARP Capital City Task Force
415 Willoughby Avenue, Apt. 506
Juneau, AK 99801
586-3637 (voice)
463-3580 (fax)

CC: Vice-Chair Con Bunde
Senator Fred Dyson
Senator Bert Stedman
Senator Lyman Hoffman
Senator Donald Olson
Senator Ben Stevens

# SENATE COMMITTEE REPORT
## First Committee of Referral

DATE: 1/14/05

FURTHER: (Finance)

**Date of 5-Day Notice:** 1/27/05
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: 2.2.05

Health, Education and Social Services Committee considered

SENATE BILL NO. 60

SB 60 EXTEND SUICIDE PREVENTION COUNCIL

"An Act extending the termination date of the Statewide Suicide Prevention Council; and providing for an effective date."

and recommends:

[ ] be **replaced** with _____ **CS** _____ (_____)

[ ] adcpt **previous** _____ **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt Letter of Intent by _____ Committee

[ ] further referral to _____ Committee

**Senate Bill:**
[ ] Same Title
[ ] New Title

**House Bill:**
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #____

**NEW** FISCAL NOTE(S):

| Department | Date | Fiscal | Indet. | Zero | FN# |
|---|---|---|---|---|---|
| HSS | 1/26 | | | x | 1 |
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**PREVIOUS** FISCAL NOTE(S):

| Department | Date | Fiscal | Indet. | Zero | FN# |
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[ ] APPROPRIATION - no fiscal note

| SIGNATURES AND RECOMMENDATIONS: | DO PASS | DO NOT PASS | NO REC | AMEND |
|---|---|---|---|---|
| Green | ✓ | | | |
| Ellis | ✓ | | | |
| Williams | ✓ | | | |
| ~~[illegible]~~ | | | | |
| | | | | |
| | | | | |
| CHAIR: Dyson | ✓ | | | |