

2/10/11

OVERVIEW:

STATEWIDE

SUICIDE

PREVENTION

COUNCIL

<TARGET><BILL></BILL><SUBJECT>2-10-11 OVERVIEW
STATEWIDE SUICIDE PREVENTION
COUNCIL</SUBJECT><COMM>HCRA27</COMM></TARGET>

Statewide Suicide Prevention Council: An Overview

A presentation by the
Statewide Suicide Prevention Council
to the House Community & Regional Affairs Committee

February 10, 2011

The Role of the Council



A.S. 44.29.350

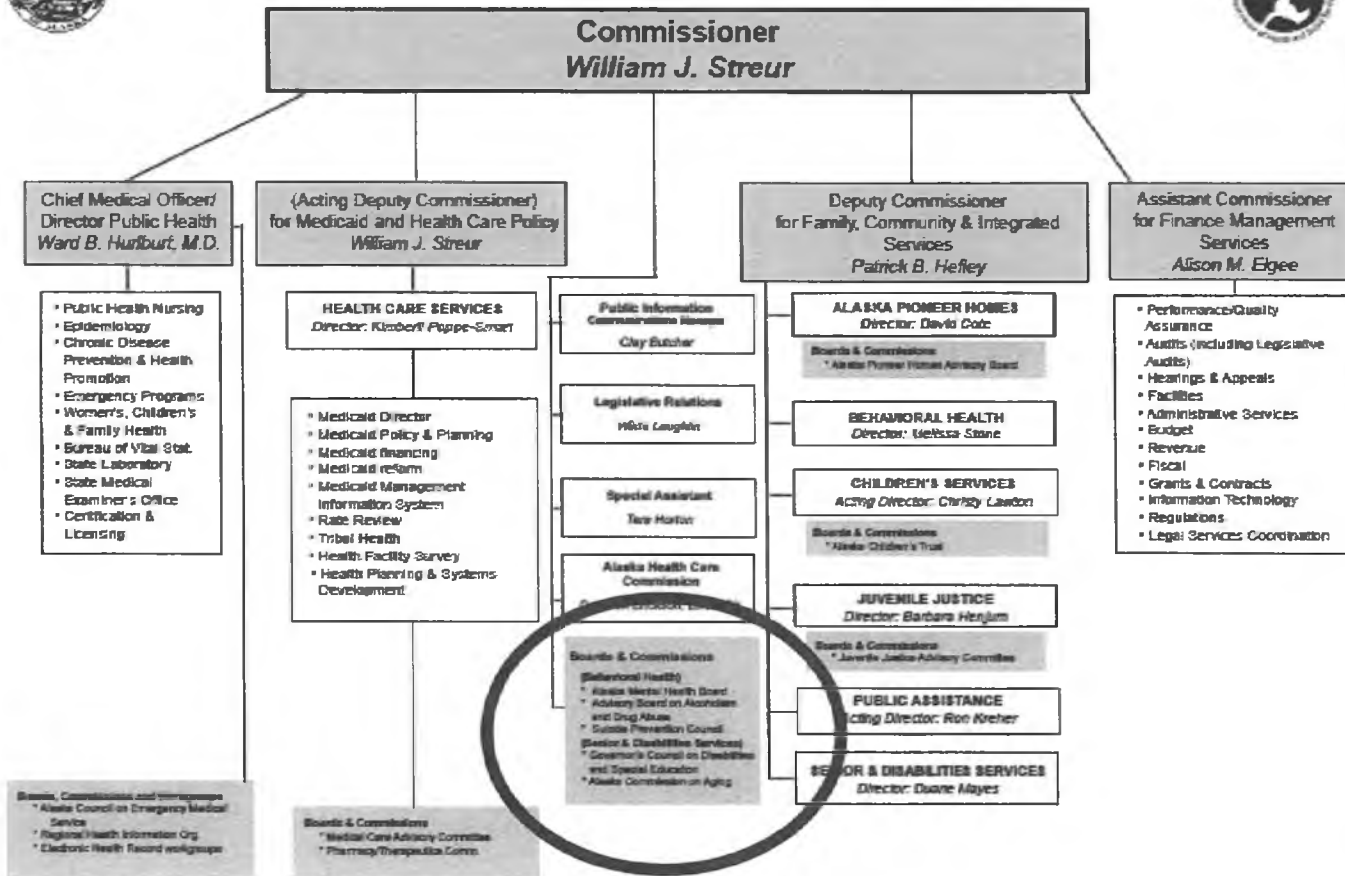
The council shall serve in an advisory capacity to the legislature and the governor with respect to what actions can and should be taken to

- (1) improve health and wellness throughout the state by reducing suicide and its effect 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;
- (6) strengthen existing and build new partnerships between public and private entities that will advance suicide prevention efforts in the state.

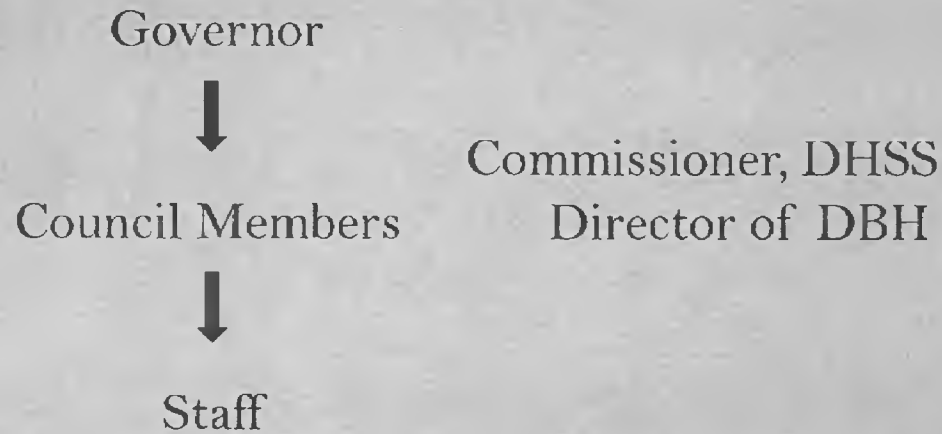
Organizational Chart



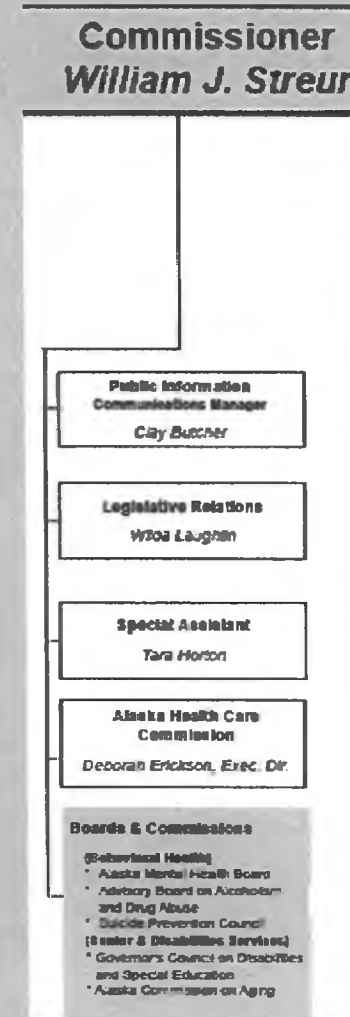
Alaska Department of Health and Social Services Organization Chart



Organizational Chart



Co-located with the Alaska Mental Health Board and Advisory Board on Alcoholism and Drug Abuse



History

Established by the Legislature in 2001 after a series of “suicide clusters”
First meeting on November 12, 2001 in Anchorage

Moved from Commissioner’s Office to Section of Prevention and Early
Intervention, DBH in 2007/2008

Co-located with AMHB and ABADA on July 1, 2010; staff hired August, 2010

The Council has twelve voting members from the public and four non-voting
members from the Legislature.

FY11 Chair, William Martin

FY11 Vice-Chair, Barbara Franks



Activities in FY 10

- ☞ Statewide Suicide Prevention Summit, January 2010
- ☞ Meetings in Dillingham, Anchorage, Toksook Bay
- ☞ Quorum achieved at all meetings
- ☞ StopSuicideAlaska.org (with Alaska Mental Health Board, Advisory Board on Alcoholism and Drug Abuse, DHSS, and Alaska Mental Health Trust funding)
- ☞ Planning for co-location, transition



The **TRUST**

The Alaska Mental Health
Trust Authority

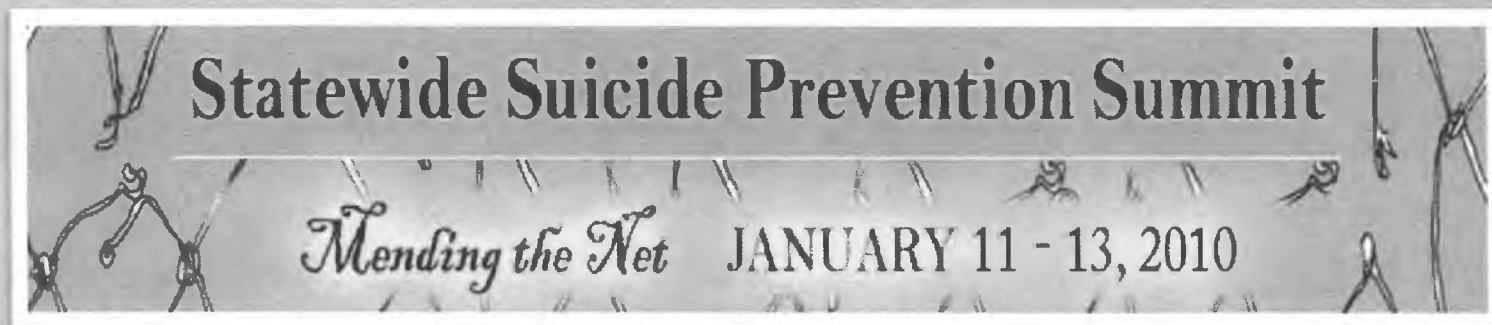
Suicide Prevention Summit

For a while, Alaska has had two suicide prevention systems. One is funded by the tribal health system. One is funded by the State of Alaska.

For a while, the two systems didn't communicate much. The state system didn't always know about the efforts supported by the Alaska Native Tribal Health Consortium and tribal organizations. ANTHC and the tribal organizations didn't always know what the State and its grantees were doing to prevent suicide.

For a while, we walked out of step.

That began to change slowly in 2008 and 2009, leading us to the first ever Statewide Suicide Prevention Summit.



Summit Findings ~ Strengths



ASIST ~ Applied Suicide Intervention Skills Training
CISM ~ Crisis Intervention Stress Management
Mental Health First Aid & Gatekeeper
Careline & SEARHC crisis line
Behavioral Health Aides
Peer-to-peer connections in some high schools, colleges, drop in centers
NAMI Remembrance Tree
Identity, Inc. crisis line/services
Elders
Alaska National Guard Family Programs, Child and Youth Programs
Signs of Suicide Screening in some schools
Strong non-profit community
Community Mental Health Centers & Community Health Centers
Community suicide prevention coalitions/task forces
Faith based organizations
Traditional healing resources

Summit Findings ~ Weaknesses

Stigma still prevalent

Lack of substance abuse treatment services in many communities

Lack of services/supports for survivors of suicide

Lack of community responses/services for bullying

Easy access to lethal means (guns, alcohol, medication, etc.)

Lack of financial security (individuals, agencies, communities)

Labeling suicide a mental health issue rather than a public health issue

Workforce recruitment, retention, pay, stress

Lack of culturally relevant prevention programs (many cultures living in AK)

Fragmented systems of prevention, care, and support

Lack of cross-training, multi-disciplinary approach to prevention

At-risk populations are underrepresented in prevention efforts

Lack of or delayed postvention resources for communities after a suicide occurs

Not all communities have prevention programs for youth, young adults

Lack of attention to, resources for senior/elder suicide

Summit Findings ~ Strategies

BUILD COMMUNITY READINESS

MAXIMIZE EXISTING RESOURCES

EMPLOY EVIDENCE BASED & OTHER EFFECTIVE PRACTICES

SUPPORT SURVIVORS OF SUICIDE

SUPPORT, TRAIN FIRST RESPONDERS

TAILOR EFFORTS TO SPECIFIC POPULATIONS

**ADEQUATELY FUND THE PREVENTION SYSTEM &
CONTINUUM OF CARE**

After the Summit

In discussing our strategies for the future, we focused the group on what each one of them could do personally, with their community, and then with the larger group as a sort of coalition. We asked each person to make a commitment to do something related to addressing the weaknesses or maximizing the strengths when they got home. What happened?

An attendee asked GCI to donate air time to air suicide prevention media. GCI agreed, not just for that community but the whole state.

Alaska Children's Services and the Alaska State Troopers are working together to offer Gatekeeper training to all troopers over the next 2 years.

NAMI and ANTHC are partnering to start a survivors' group.

The Alaska National Guard is offering veterans and others ASIST training in communities not yet visited by ANTHC (complementing efforts).

NO NEW FUNDING WAS REQUIRED FOR THESE ACTIVITIES



The Council's Strategic Plan

Four Areas of Work

Coordination of Efforts

Education, Awareness and Media

Training

Prevention Programs

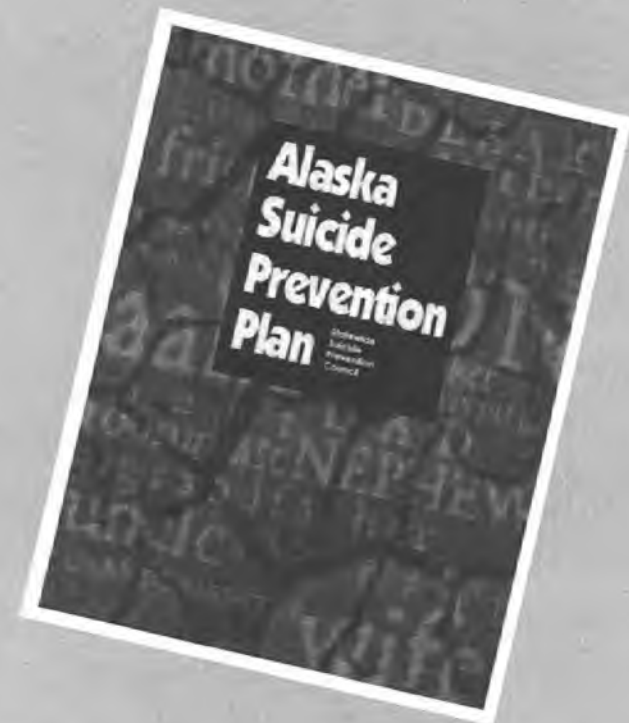


Statewide Suicide Prevention Plan

It is the Council's statutory duty to create and help implement Alaska's suicide prevention plan.

The current plan was carefully designed to be a resource for communities looking for ways to prevent suicide:

"... 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."



Statewide Suicide Prevention Plan

Given the lack of improvement in Alaska's suicide rate in the last decade, the Council will be developing a plan based upon the input received from the people of Alaska, as well as the expertise available from prevention specialists, elders, survivors, youth, and others.



This plan will provide recommendations to the state, communities AND individuals in a format consistent with the National Strategy for Suicide Prevention. (online at <http://store.samhsa.gov/product/SMA08-3518>).

Suicide Prevention in Alaska

Rates & Numbers

The **number** of suicides is the actual number of people who have been confirmed to have died by committing suicide.

The **rate** is the number of deaths by suicide divided by the total population.

A **crude rate** is a basic division of the number of deaths by the population. An **age-adjusted rate** is a weighted average that accounts for the distribution of people of different ages in different regions (some communities are “younger” or “older” than others). It reflects the rate that would occur if every region had the same mix of people of different age ranges.

This does not take into account those people who may have committed suicide but whose death was classified accidental (i.e. accidental overdose, firearm accident, etc.) or due to other causes (i.e. exposure, etc.)

Rates & Numbers

In 2009, the statewide age-adjusted suicide rate was **20.2/100,000**.

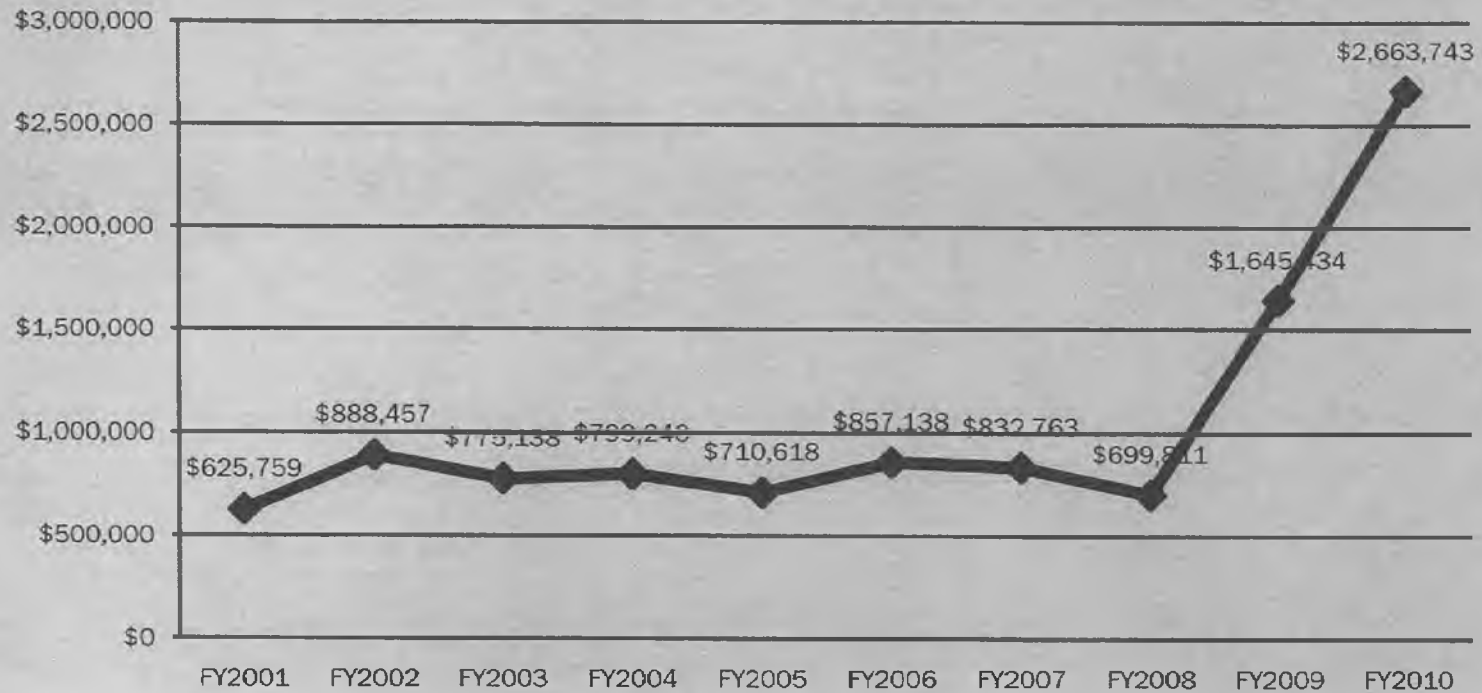
In 2009, **140 people** died by suicide.

Between 2000-2009, the mean rate was
20.98/100,000.

In the same period, **1,369 people** were confirmed to have died by suicide – in 176 communities.

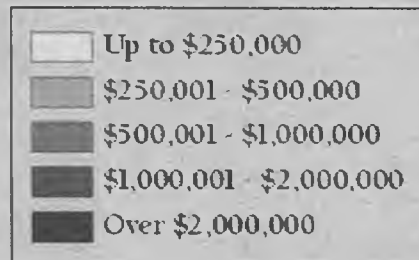
Funding

Cumulative Suicide Prevention Grants Funded by State of Alaska,
FY2001-FY2010



Funding

Suicide Prevention Funding from State of Alaska by Department of Labor Economic Region, FY2001-FY2009



Total Suicide Prevention Funding from the State of Alaska, FY 2001 - FY 2009 = \$7,834,538

Source: Alaska Mental Health Board

The background of the slide is a dark, charcoal grey color with a fine, embossed texture. A faint, light-colored map of the United States is visible, centered on the page. The map shows the outlines of the states and is rendered in a way that blends with the background texture.

On the Horizon

Systems Change?



Coordination of Effort

- ⌘ Support communication among stakeholders
- ⌘ Collaboration between traditional and non-traditional prevention stakeholders
- ⌘ Community-based ideas, efforts
- ⌘ Support individual, community, and statewide efforts – find the excitement, passion and capitalize on it

Awareness

- ⌘ Continue to address stigma, fear
- ⌘ Continue to educate people about warning signs, how to help
- ⌘ Provide a voice for survivors of suicide
- ⌘ Promote responsible reporting and discussions of suicide

Training

- ⌘ Continue to educate people about warning signs, how to help
- ⌘ Make prevention and intervention trainings available AND accessible
- ⌘ Share resources and tools for how to deal with a suicide when it happens

Prevention Programs

- ⌘ Continue to support efforts to identify suicide prevention and intervention models that work in Alaska – and the sharing of those models across the state
- ⌘ Increase access to funding, resources for suicide prevention programs
- ⌘ Include the role of protective factors and resilience, as well as risk factors
- ⌘ Evaluate the impact of specific and comprehensive prevention efforts on suicide rates and numbers
- ⌘ Promote culturally relevant models

Questions? Comments?

J. Kate Burkhart, Executive Director

Statewide Suicide Prevention Council

Alaska Mental Health Board

Advisory Board on Alcoholism and Drug Abuse

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Mending the Net: Suicide Prevention in Alaska

Annual Report FY2010

Governor Sean Parnell



Statewide Suicide Prevention Council

William Martin, Chair 2010-2011



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Acknowledgements

The Statewide Suicide Prevention Council recognizes the contributions of the following people to the FY2010 Annual Report:

Brenda Moore, chair of the Council from 2008-2010, for her tireless efforts to guide and support the Council in the activities on which it is reporting;

Andrew Jessen, Research Analyst III, Bureau of Vital Statistics, Division of Public Health, Department of Health and Social Services, for assisting with the effective use of suicide data in this report;

Brian Laurent, MPA Candidate, Boise State University, for his analysis of funding patterns and the creation of the maps used in the report;

Patrick Sidmore, Research Analyst III, Alaska Mental Health Board and Advisory Board on Alcoholism and Drug Abuse, for analyzing incidence and unemployment data used in the report, assuring accuracy in reporting, and creating charts and graphs for the report;

Thomas Chard, Planner II, Alaska Mental Health Board and Advisory Board on Alcoholism and Drug Abuse, for his work with the Council in the activities reported;

Tim Spengler, Legislative Analyst II, Legislative Research, for his work on the November 12, 2010 report, "Suicide Rates, Prevention Funding, and Prevention Efforts in Alaska;"

Martha Moore, Public Health Specialist II, Alaska Trauma Registry, Division of Public Health, Department of Health and Social Services, for assisting with the effective use of suicide attempt data in this report;

the **Alaska Mental Health Board and Advisory Board on Alcoholism and Drug Abuse**, for providing support (financial, staff, and moral) in advocacy, education, outreach, and planning in the activities on which the Council is reporting; and

Eric Morrison, Council Assistant, and **Kate Burkhardt**, Executive Director, for their work on the report.



A Letter from the Chair

On behalf of the Statewide Suicide Prevention Council, thank you for your interest in learning about the state of suicide prevention in Alaska. What you will learn from our report is both inspiring and disappointing. Despite substantial efforts by communities and organizations statewide, and millions of dollars of funding, over the last ten years, the number of suicides in Alaska and the rate of suicide has not decreased. What has changed is that people in Alaska are talking — and talking a lot — about how suicide affects us and how we can prevent it.

Years ago, no one talked about suicide. There was stigma and fear. Now, even though there is still stigma and there is still fear, people are showing greater courage and speaking out. I am grateful for the leaders in our tribal organizations and communities who are standing up with the Council to speak about suicide and how to prevent it. I have seen more and more openness to talking about suicide, more awareness of how important talking about suicide is to healing from its wounds.

One of our biggest achievements of FY2010 was the Statewide Suicide Prevention Summit we hosted, with the help of the Alaska Native Tribal Health Consortium and many partners. Since then, there have been listening sessions and public meetings all over Alaska. Suicide prevention providers have come together to better support each other, share ideas, and take care of each other. The message that every life has value is being spread in communities all over our state. My hope is that, in the coming year, the Council will continue to support and encourage people to speak out, to share their loss and grief, to heal, and to come together to prevent suicide.

Thank you again for your interest in the Council's work.

Gunalchéesh,



William Martin, Chair

Mending the Net: Suicide Prevention in Alaska

Annual Report FY2010

INTRODUCTION

The Statewide Suicide Prevention Council was established by the Alaska Legislature in 2001, in response to what was characterized as “an on-going epidemic” of suicide.¹ The Council, after a legislative audit in 2008, was extended by the Legislature to June 30, 2013.²

The Council is responsible for advising legislators and the Governor on ways to improve Alaskans’ health and wellness by reducing suicide, improving public awareness of suicide and risk factors, enhancing suicide prevention efforts, working with partners and faith-based organizations to develop healthier communities, creating a statewide suicide prevention plan and putting it in action, and building and strengthening partnerships to prevent suicide.³



Each year, the Council provides an annual report on its activities and the impact of suicide prevention efforts over the past year. The FY2010 report takes its title from the theme of the Suicide Prevention Summit, “Mending the Net.” Many individuals and organizations are working to prevent suicide all over Alaska — but often, these dedicated people feel disconnected and unsupported. Focus is often placed on practices or strategies that may or may not fit a community’s needs. Creative community-based solutions often operate in isolation.

By “mending” the suicide prevention systems’ “net,” the Council hopes to increase the effectiveness of local suicide prevention efforts, support the spread of effective ideas to other Alaskan communities, recognize the work of every person trying to prevent suicide, and honor the losses to families and communities caused by suicide.

The Council has increased its efforts related to its statutory duties. The State of Alaska, tribal organizations, and communities all over the state have continued to work to prevent suicide. Even so, Alaska is still faced with an “on-going epidemic.” Therefore, in addition to fulfilling the yearly reporting requirements, this Annual Report will include a look back at the last ten years of data and will offer the opportunity to look with fresh eyes at how Alaskans can work together to prevent suicide.

¹ SB198 Sponsor Statement, Senator Rick Halford, April 24, 2001.

² HB123, sponsored by Representative Anna Fairclough, passed in April 2009 and was signed into law on August 5, 2009.

³ AS 44.29.350. The Council’s statutory authority is included in Appendix A.

HISTORY OF THE COUNCIL

The Statewide Suicide Prevention Council was established in 2001 after a series of “suicide clusters” throughout Alaska led state leaders to more closely examine the issue. Former Department of Health and Social Services Commissioner Karen Perdue requested funding in March of 2001 to support communities experiencing high rates of suicide and to examine Alaska’s suicide prevention strategies. The passage of SB 198, on May 7, 2001 established the Council. The Council had its first meeting on November 12, 2001 in Anchorage.

The Council has twelve voting members from the public and four non-voting members from the Legislature. The twelve voting members are appointed by the Governor to four-year terms. Members include:

- ♦ one person representing the Department of Health and Social Services;
- ♦ one person representing the Department of Education and Early Development;
- ♦ one person from the Advisory Board on Alcoholism and Drug Abuse;
- ♦ one person from the Alaska Mental Health Board;
- ♦ one person recommended by the Alaska Federation of Natives;
- ♦ one person who works for a high school;
- ♦ one person who is active in a youth organization;
- ♦ one person who has experienced the death by suicide of a member of their family;
- ♦ one person who resides in a rural Alaska community not on the road system;
- ♦ one person who is a member of the clergy;
- ♦ one person who is enrolled in grades 9-12 of a secondary school in Alaska;
- ♦ and one public member.

The President of the Alaska State Senate and the Speaker of the House appoint the four non-voting members of the council. The Senate President appoints one majority and one minority member of the Senate, and the Speaker appoints one majority and one minority member of the House of Representatives.



2010-2011 Council Chair Bill Martin with Vice-Chair Barbara Jean Franks

SUICIDE IN ALASKA

Suicide was considered an “epidemic” when the Council was created. Back then, in 2000, the age-adjusted rate of suicide for all Alaskans was 21.2/100,000 — an average of 135 lives lost each year.⁴ In 2000, the suicide rate in rural Alaska was nearly three times that in urban Alaska.⁵ Not much has changed since then. In 2009, the (provisional) age-adjusted rate was 20.2/100,000 with 140 lives lost.⁶

Conversations about suicide rates versus numbers can be confusing. The **number** of suicides is the actual number of people who have been confirmed to have died by committing suicide.⁷ The **rate** is the number of deaths by suicide divided by the total population. That means that, if 100 people die by suicide in Alaska, the rate is $100/6.92314$ or $14.4/100,000$ (which should not be confused with percentage).⁸ A **crude rate** is a basic division of the number of deaths by the population (the example given is a crude rate). An **age-adjusted rate** is a weighted average that accounts for the distribution of people of different ages in different regions (some communities are “younger” or “older” than others). It reflects the rate that would occur if every region had the same mix of people of different age ranges.



Why does it matter whether we talk about rates or numbers?

The impact of suicide on a community isn't always clear if you just look at one or the other. For example, in 2008 there were 33 suicides in the Interior Region and 75 in the Anchorage/Mat-Su/Kenai Peninsula region.⁹ Based solely on those numbers, you might think that suicide is a bigger problem in Anchorage/Mat-Su/Kenai Peninsula area. Except, the age-adjusted suicide rate in the Interior Region in 2008 was 33.7/100,000 and for the Anchorage/Mat-Su/Kenai Peninsula area it was 17.6/100,000.¹⁰ If you look at that alone, you would come to the opposite conclusion. This is why it's important to look at **both** numbers and rates.

⁴ Data from the Alaska Bureau of Vital Statistics.

⁵ FY2002 Statewide Suicide Prevention Council Annual Report at 5 (available online at www.hss.state.ak.us/suicideprevention/pdfs_sspc/2002sspcannualreport.pdf).

⁶ Data from Alaska Bureau of Vital Statistics. All data for 2009 is considered provisional and subject to change until all deaths by suicide have been confirmed.

⁷ This does not take into account those people who may have committed suicide but whose death was classified accidental (i.e. accidental overdose, firearm accident, etc.) or due to other causes (i.e. exposure, etc.)

⁸ The Alaska Department of Labor and Workforce Development July 1, 2009 population estimate is 692,314, which is 6.92314 when divided by 100,000. For more information, go to <http://almis.labor.state.ak.us/?PAGEID=67&SUBID=115>.

⁹ Data from Alaska Bureau of Vital Statistics.

¹⁰ Data from Alaska Bureau of Vital Statistics.

It's also important to consider the local impact of suicide. Between 2000 and 2009, there were 1,369 confirmed suicide deaths in Alaska; at least one suicide occurred in 176 Alaskan communities.¹¹

Suicide Data

Over the last ten years, the rate of suicide has remained consistently high. The statewide age-adjusted rate has been 20/100,000 people or higher for eight of the ten years. Some regions have had age-adjusted rates much higher than that.

Suicides By Region of Residence: Age-Adjusted Rates¹

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
North Slope Borough	103.3*	**	**	**	**	**	**	**	**	**
Northwest Arctic Borough	**	**	93.5*	**	**	**	102.1*	**	99.4*	**
Nome	63.5*	63.2*	118.2*	**	63.7*	106.0*	65.0*	**	59.9*	84.9*
Bethel/Wade Hampton	62.5*	**	36.7*	57.8*	96.2	60.2*	46.0*	55.0*	75.4*	55.8*
Dillingham/Bristol Bay/Lake and Peninsula Borough	**	**	**	**	**	**	**	**	0.0	**
Kodiak Island Borough	**	0.0	**	**	0.0	**	**	**	**	**
Aleutians	**	**	0.0	**	**	**	**	0.0	**	**
Anchorage/Mat-Su Borough/Kenai Peninsula	17.6	14.1	18.3	18.6	20.4	16.0	16.6	20.7	17.6	16.7
Valdez-Cordova	**	**	**	**	**	**	**	**	**	**
Interior	18.4	19.2*	17.0*	19.8*	19.7	13.9*	17.3*	21.3	33.7	12.9*
Southeast	13.4*	15.2*	19.5*	7.8*	14.3*	10.6*	14.0*	25.0*	23.3*	27.4*
Total	21.1	16.5	20.9	20.5	23.3	19.5	20.0	23.1	24.7	20.2

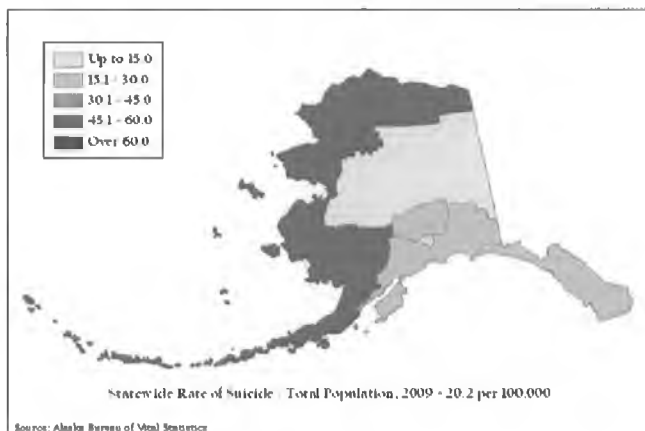
Data provided by Bureau of Vital Statistics. 2009 data is provisional.

*Rates based on fewer than 20 occurrences are not statistically reliable and should be used with caution.

** Rates based on fewer than 6 occurrences are not reported.

The table above shows age-adjusted rates (weighted averages). The crude rates (the simple number of suicide deaths divided by the population) by economic region are a little different. This map shows the regional breakdown.¹² The Southwestern Region and the Northern Region had crude rates of 60/100,000 people or higher — three times the statewide crude rate of 20.2/100,000 people. The Interior Region and Municipality

Crude Rate of Suicide by Alaska Department of Labor Economic Region per 100,000 Population, 2009



¹¹ Data from Alaska Bureau of Vital Statistics.

¹² For a map of the Department of Labor and Workforce Development's economic regions, see Appendix B. The Department of Labor and Workforce Development uses six regions, but we have separated the Municipality of Anchorage and the Mat-Su Borough to better understand any differences in the communities.

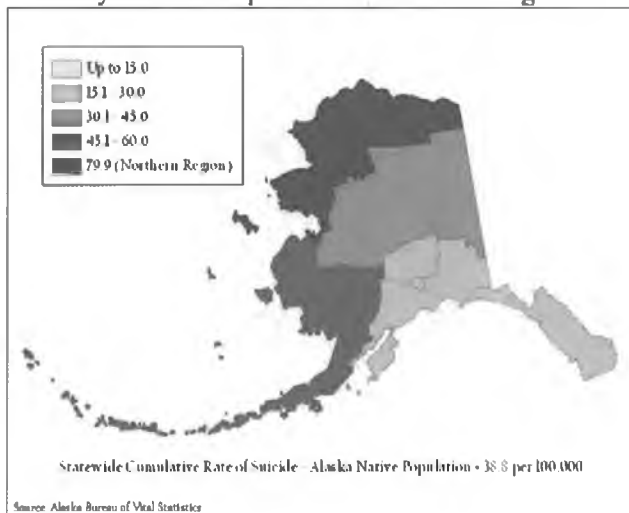
of Anchorage had crude rates below the statewide rate.

Suicide and Ethnicity

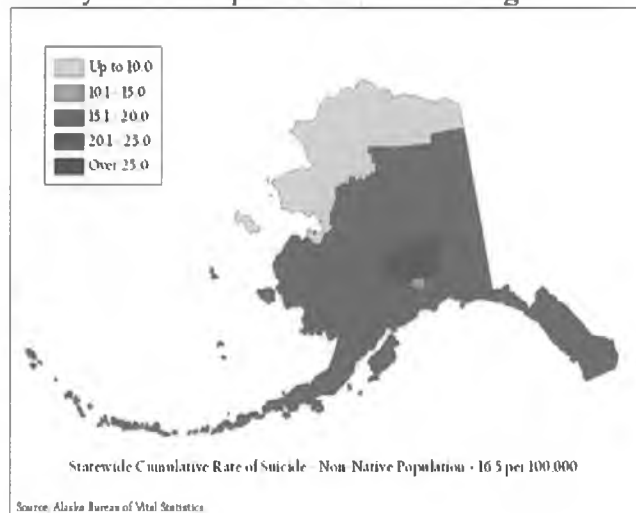
Suicide rates among Alaska Native peoples are higher than for any other ethnicity in the state, and are the highest of any ethnicity in the United States. In 2009, the age-adjusted rate for Alaska Native peoples was 32.8/100,000 people.¹³ For White or Caucasian people, the age-adjusted rate was 17.7/100,000.¹⁴ That is a difference of nearly 2:1.

Looking at Alaska suicide rates over time shows that same disparity, with a cumulative crude rate of 38.8/100,000 for Alaska Native peoples and 16.5/100,000 for non-Native peoples. Alaska Native individuals are twice as likely to commit suicide as individuals of other ethnicities.

**Crude Rate of Alaska Native Suicide
by Alaska Department of Labor Region**



**Crude Rate of Non-Native Suicide
by Alaska Department of Labor Region**



Looking at the suicide rates according to ethnicity tells one side of the story. The actual numbers of suicides tell another. In 2009, twice as many White or Caucasian Alaskans (89) committed suicide as Alaska Natives (44).¹⁵ Since 2001, 847 White or Caucasian Alaskans have committed suicide and 411 Alaska Natives have committed suicide.¹⁶ What this tells us is that suicide is not confined to one ethnic group. Suicide is an **Alaskan** problem.

¹³ Data provided by the Bureau of Vital Statistics.

¹⁴ Data provided by the Bureau of Vital Statistics.

¹⁵ Data provided by the Bureau of Vital Statistics. 2009 data is provisional.

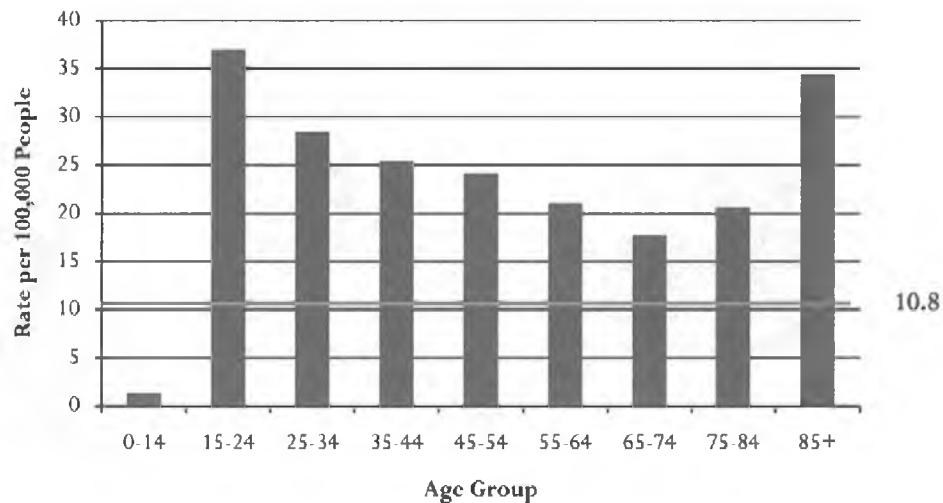
¹⁶ Data provided by the Bureau of Vital Statistics.

Suicide and Age

In Alaska, young people age 15-24 continue to have the highest rates of suicide. The age-specific suicide rate for young men age 15-24 is 56.1/100,000 and for young women is 16.6/100,000.¹⁷ For Alaska Natives, the rate for this age group is 141.6/100,000 for young men and 50.3/100,000 for young women.¹⁸ For White or Caucasian young men, the rate is 33.8/100,000.¹⁹ For White or Caucasian young women, it is 6.1/100,000.²⁰

The rates for other age groups²¹ are less dramatic, but no less important. For all age groups above 0-14, the age-specific rate is above the 2007 national rate of 10.8.²²

Age-Specific Suicide Rates, 2000-2009



From review of the suicide rates over time, it appears that risk of suicide decreases as Alaskans age, at least until age 75. For the most senior group (age 85+), the high rate of 34.4 should be taken in the context of a small number of suicides (13) among a relatively small population. The age groups of 75-84 and 85+ bear further scrutiny over the next 10 years, as Alaska's senior population continues to grow.²³

¹⁷ Data is for the period 2000-2009, provided by the Bureau of Vital Statistics.

¹⁸ Data is for the period 2000-2009, provided by the Bureau of Vital Statistics.

¹⁹ Data is for the period 2000-2009, provided by the Bureau of Vital Statistics.

²⁰ Data is for the period 2000-2009, provided by the Bureau of Vital Statistics. This rate is based on fewer than 20 occurrences and is therefore statistically unreliable. It is offered for comparison purposes only and should be used with caution.

²¹ Data is for the period 2000-2009, provided by the Bureau of Vital Statistics.

²² 2007 rate, reported on the Alaska Scorecard at www.hss.state.ak.us/dhcs/healthplanning/scorecard/assets/scorecard.pdf

²³ The Alaska Commission on Aging reported that the population of Alaskans over age 65 grew by 19.6% between 1997 and 2007. February 17, 2009 Press Release, online at <http://www.hss.state.ak.us/acoa/assets/SeniorGrowth.pdf>

Suicide and Substance Abuse

Alcohol and drugs play a role in the suicide problem in Alaska, but are not a cause of suicide. We know this from three sources of Alaska-specific information. First, the Alaska medical examiner's office performs a post mortem examination (autopsy) in some — but not all — suicide deaths. From those exams, there is an indication that alcohol and/or drug use was involved in the majority of suicide decedents examined. The Alaska Suicide Follow-Back Study reported that, of the 33% of suicide decedents tested for drugs and/or alcohol, 44% tested positive for alcohol and 48% one or more other drugs.²⁴



The Alaska Psychiatric Institute reports that alcohol and/or drug use is involved in an average of 48.44% of all admissions to the state psychiatric hospital. To be admitted to API under the law, a person must be a danger to himself or to another person, so not all of these admissions involved the risk of suicide. However, the data does show that substance abuse is a factor in a significant number of psychiatric emergencies requiring hospitalization.

The Alaska Trauma Registry tracks hospitalizations for poisonings — of which overdoses on alcohol and/or drugs account for the majority. In 2005, the Alaska Trauma Registry published a review of suicide hospitalizations for 2001-2002.²⁵ During that time, 77% of hospital visits resulting from suicide attempts (or other self-harm) involved an overdose on medications. Of those medication overdoses, 64% were prescription medications. Tylenol was the most common medication on which children age 0-19 years overdosed.

Do numbers and rates tell the whole story?

Rates and numbers are helpful in describing the problem of suicide in Alaska, but the stories of people who have survived a loss to suicide provide an important context for understanding the true impact of the problem.

- ♦ “We have an epidemic, a Hurricane Katrina and a Gulf oil spill but in a magnitude much more devastating because it is humanitarian.” (Nick Tucker, Sr., Emmonak)
- ♦ “Over the past few years, a large number of people took their lives and caused a lot of pain to our friends and family. We try to move on in our lives but the pain never leaves.” (Kyle M., Galena)

²⁴ The Alaska Suicide Follow-Back Study at 16. This study reviewed data on all 426 suicides that occurred between 2003 and 2006. It is available online at http://www.hss.state.ak.us/suicideprevention/pdfs_sspc/aipc_suicide_followback207.pdf.

²⁵ Alaska Suicide Hospitalizations 2001-2002, Alaska Injury Prevention Center, July 2005 at 4. Available online at http://www.hss.state.ak.us/suicideprevention/pdfs_sspc/hospitalsuicides01-02.pdf.

- ♦ "The war that engulfs us today is a war fought on the battlefield of substance abuse. Self-hatred. Suicide. Rape. Child molestation. This is a war within ourselves." (Elizabeth Hensley, Alaska Federation of Natives 2009 Convention)
- ♦ "It's a lot for a small town to go through. It's amazing that a lot more people's spirits haven't been broken by this." (James Hoelscher, Hooper Bay)
- ♦ "Everybody in Southeast has lost friends and loved ones to suicide, so it's pretty hard to talk about it." (Bill Martin, Juneau)
- ♦ "The process of waiting for my son's body to be sent to Anchorage from Bethel and to be sent back to here was the longest four to five days I have ever felt. The emotions we went through cannot be described in human terms. I tried to do something and I would feel lost while I was doing it. I tried working on my (fish) nets but found myself lost in my mind. We should never ever put our parents through this no matter how low we feel or how mad we may be." (Harley Sundown, Scammon Bay)



Photographs courtesy of Thomas Chard

There is empirical information that supports what Alaskans say about the tragic consequences of suicide. Suicide claims more lives in the United States than homicide. Suicide is one of the top ten causes of death in Alaska. Between 2000 and 2008, 4.26% of all deaths in Alaska were due to suicide. In the Wade Hampton Census Area (which includes Hooper Bay, Emmonak, Chevak, Scammon Bay, Mountain Village, Nunam Iqua, and nine other villages), 14% of all deaths were due to suicide. In the Northwest Arctic Borough,

which includes Kotzebue, 13.54% of all deaths were due to suicide. In Anchorage, 3.49% of all deaths in that time period were due to suicide.

2000-2008 Percentage of Census Area Deaths Attributed to Suicide

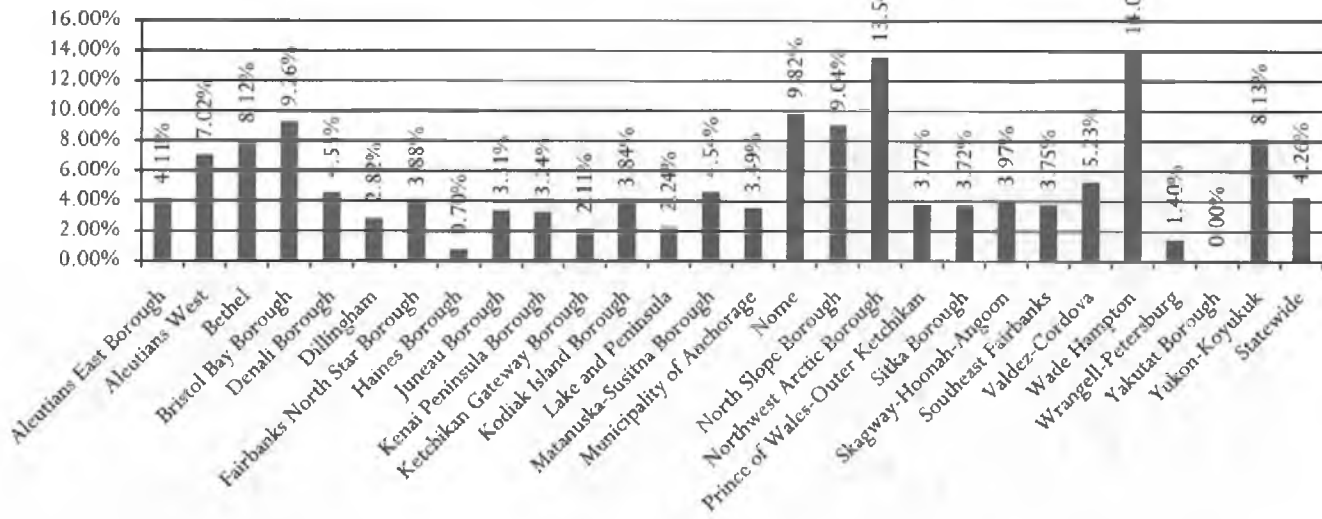


Chart created by Alaska Mental Health Board staff. Sources: Alaskan Bureau of Vital Statistics, Detailed Causes of Death by Census Area & Department of Labor and Workforce Development Population Estimates.

For more information, go to <http://laborstats.alaska.gov/?PAGEID=67&SUBID=171>,

http://www.hss.state.ak.us/dph/bvs/death_statistics/Detailed_Causes_Census/default.htm

Does unemployment affect suicide rates?

The availability of jobs and economic opportunities has a lot to do with personal feelings of self-worth and the health of a community. Research has documented a connection between unemployment, poverty and other social determinants and low self-esteem, anxiety, and isolation.²⁶ Unemployment and economic distress are factors that can increase the risk of suicide.²⁷ Review of Alaska's unemployment data shows a weak connection between unemployment and suicide rates.

The average state unemployment rate in 2009 was 8%.²⁸ For the census areas in economic regions with the highest suicide incidence rate, the average annual unemployment rates in 2009 varied from very low to very high. Bristol Bay Borough had the lowest unemployment rate in 2009 at 4.3%. Wade Hampton had the

²⁶ *Mental Health, Resilience, and Inequalities*, Dr. Lynne Friedli, World Health Organization 2009 (available online at www.euro.who.int/_data/assets/pdf_file/0012/100821/E92227.pdf).

²⁷ *Getting Through Tough Economic Times*, A SAMHSA Guide (available online at www.samhsa.gov/economy/#suicide).

²⁸ All unemployment data for 2009 provided by the Department of Labor and Workforce Development, online at <http://almis.labor.state.ak.us/?PAGEID=67&SUBID=188>

highest 2009 unemployment rate at 21.2%. Unemployment rates in regions with lower suicide rates are equally variable, ranging from 6.6% in Anchorage to 15.7% in the Yukon-Koyukuk Census Area.

Looking at unemployment rates for 2000-2008, there is a weak statistical correlation between unemployment rates and suicide rates.⁷⁹ There is no clear connection between an increase in the unemployment rate and an increase in the suicide rate, as there were periods of time when suicide rates fell in regions experiencing increases unemployment. What this means is that unemployment, while **not a cause of suicide**, is apparently a factor in suicide incidence — and there is room for more research and study of the impact of the health of the economy on the suicide rate.



*Photographs courtesy of the Alaska
Department of Commerce, Community
and Economic Development*

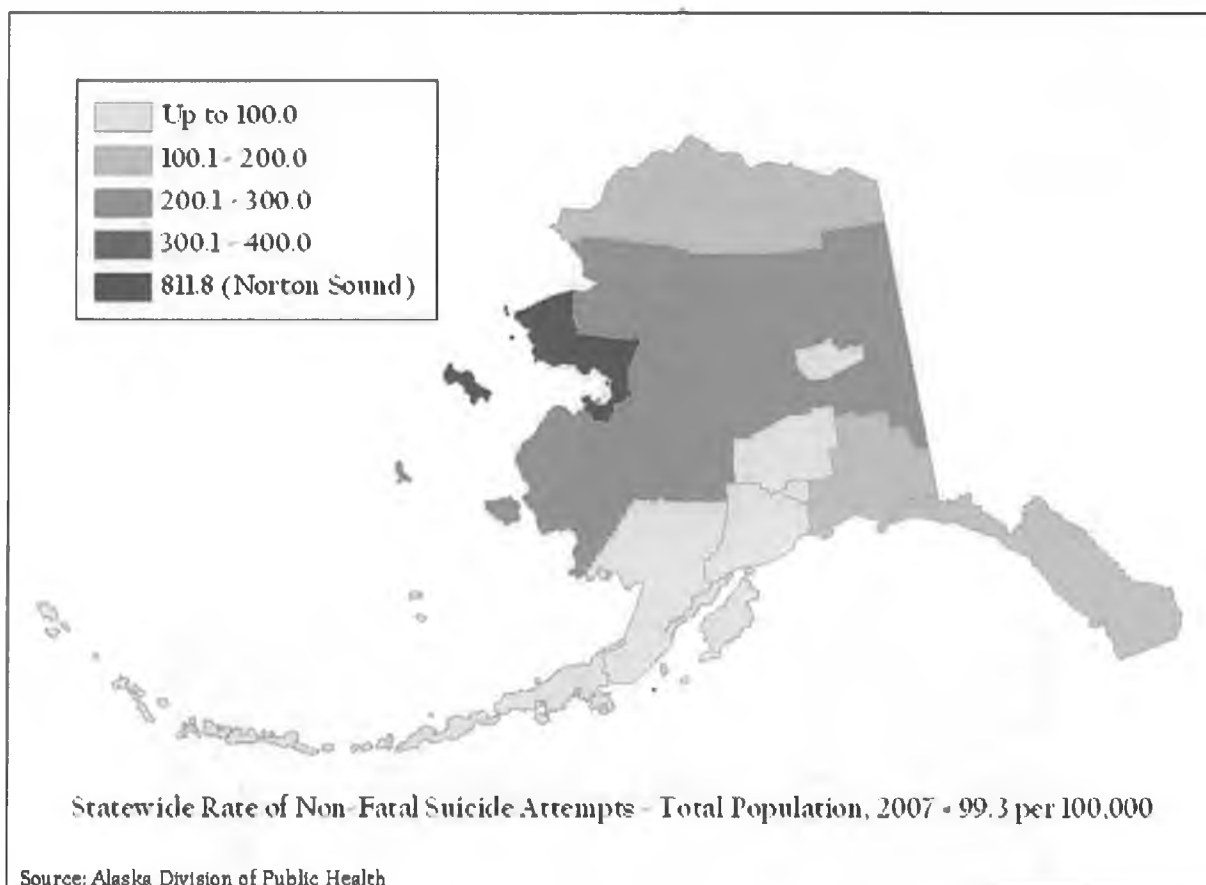
Suicide Attempts

The number of attempted suicides is just as important as completed suicides. The Alaska Department of Health and Social Services tracks this information through the Alaska Trauma Registry. In 2007 (the most

⁷⁹ Analysis of unemployment rates and suicide rates for 2000-2008 was conducted by Alaska Mental Health Board staff.

recent year's data available), the suicide attempt rate was 99.3/100,000 people.³⁰ That's nearly five attempted suicides to each completed suicide.

In 2007, the Norton Sound area (Nome, St. Lawrence Island, and the Seward Peninsula) had the highest rate of non-fatal suicide attempts. That same year, Fairbanks, Anchorage, Mat-Su and the Aleutians had a rate of less than 100 non-fatal attempts per 100,000 people.



Depression and suicidal ideation occurs with alarming frequency among Alaska's high school students. This information is collected every two years through the Youth Risk Behavior Survey, an anonymous survey developed by the Centers for Disease Control and Prevention. In 2009, the survey was administered in alternative high schools as well as traditional high schools. The information was alarming.

³⁰ Data provided by the Alaska Trauma Registry, Division of Public Health.

2009 Youth Risk Behavior Survey Data

2009	Traditional High Schools % of students surveyed	Alternative High Schools % of students surveyed	National Average % of students surveyed
Depression, hopelessness	25.2%	37.5%	26.1%
Considered attempting suicide in the past 12 months	13.9%	18.1%	13.8%
Attempted suicide at least once in the last 12 months	8.5%	11.3%	6.3%
Suicide attempt resulted in injury, poisoning, or overdose requiring medical treatment	2.6%	4.4%	1.9%

Alaska data provided by the Division of Public Health, Chronic Disease Prevention and Health Promotion (available online at <http://www.hss.state.ak.us/dph/chronic/school/YRBSresults.htm>).

National data reported by the Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report, June 4, 2010 (available online at <http://www.cdc.gov/mmwr/pdf/ss/ss5905.pdf>).

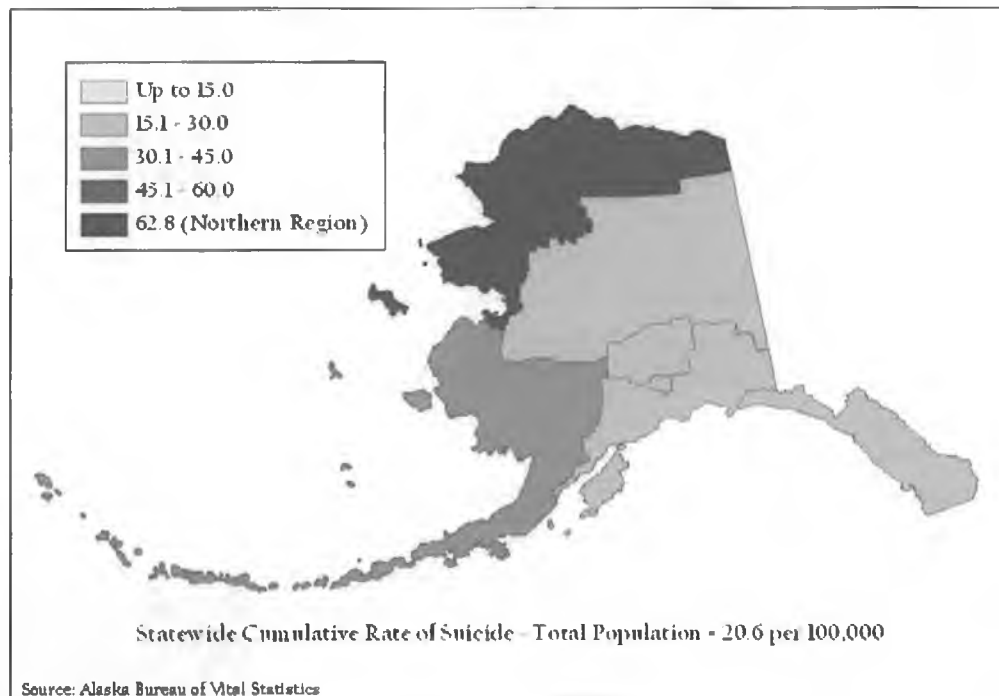
In 2009 Alaskan high school students, especially those attending alternative high schools, presented a much higher incidence of suicidal ideation, suicide attempts, and suicide attempts requiring medical treatment than students nationally.



What does the data tell us?

In 2009, more people died by suicide in the Anchorage area than any other region. However, rural Alaska had higher rates of suicide, indicating a more dramatic impact on communities. We typically look at the suicide rates by year, and measure from year to year whether it is getting better or worse. However, since some regions have a low number of suicides, we don't always have rates for every region. Also, looking year by year doesn't show the long-term effects of suicide on communities. If you look at the cumulative rate since 2001, the statewide rate remains consistent — 20.6/100,000 people. But the rate by region varies considerably.

Cumulative Crude Rate of Suicide by Alaska Department of Labor Economic Region per 100,000 Population, 2001-2009



The Alaska Trauma Registry reports data using different geographical regions than the census boroughs or economic regions used by the Alaska Bureau of Vital Statistics and Department of Labor and Workforce Development.

The 2001-2009 crude rate for the majority of the state is between 15.1 and 30 per 100,000 people. This is the case for the Anchorage area, where most of Alaska's population resides.³¹ However, the rate for the Northern Region (which includes the North Slope Borough, Northwest Arctic Borough, and Seward Peninsula) is 62.8/100,000. Less than 5% of the state population lives in that region.³² This is a good

³¹ According to the Alaska Department of Labor and Workforce Development, the 2009 population for the Anchorage Mat-Su region was 374,902 (54% of the state population). Data available at <http://laborstats.alaska.gov/?PAGEID=67&SUBID=247>.

³² According to the Alaska Department of Labor and Workforce Development, the 2009 population for the Northern Region was 23,664. Data available at <http://laborstats.alaska.gov/?PAGEID=67&SUBID=247>.

example of how looking solely at rates can be misleading. The number of people who died by suicide in that period of time in the Anchorage area was 626; in the Northern Region it was 152.¹³ Again, we see that looking solely at rates — or solely at numbers — is not enough.



SUICIDE PREVENTION EFFORTS

In Alaska, suicide prevention efforts are supported by the State of Alaska, the tribal health system and Alaska Native Tribal Health Consortium, the federal government, and local communities. Some suicide prevention efforts are large-scale professionalized prevention programs. Others are community driven efforts staffed by volunteers.

Until 2009, very little effort was put into linking the state and tribal suicide prevention systems with other community efforts. Many prevention providers were unaware of other suicide prevention projects in other parts of Alaska. In FY2010, the Council and its partners, the Alaska Mental Health Board, the Department of Health and Social Services Division of Behavioral Health, the Advisory Board on Alcoholism and Drug Abuse, and others prioritized strengthening the connections between suicide prevention efforts. Thus, the Council can better report the scope of suicide prevention in Alaska (though is not yet able to comprehensively identify every suicide prevention program or project in the state).

Careline

Careline, located in Fairbanks, is the statewide suicide hotline. Careline's focus is the safety of the caller and helping the caller access appropriate services to preserve that safety. Careline partners with community mental health centers and clinicians statewide to ensure callers' mental health needs are appropriately addressed.

Careline offers telephone-based crisis intervention and online chat for people who would rather connect with a counselor that way. When someone calls in crisis, the trained counselor assesses the person's safety by identifying whether or not the person is at imminent risk of suicide.

In 99% of calls, the Careline counselors are able to provide effective interventions to keep the callers safe until they can access services they need. In the 1% of cases that are judged to be so acute that the caller is found to be in "imminent risk of death," Careline engages with local emergency services to provide immediate interventions to preserve the caller's safety.

CRISIS INTERVENTION
CARELINE

**24-hours a day,
seven days a week.**

Calls are caring and confidential.
Call **452-4357** in Fairbanks,
or toll-free statewide at
877-266-4357 or **800-273-8255**

¹³ Data provided by the Bureau of Vital Statistics.

Careline provides prevention materials through its website, at community events, and through partners like the Council, Alaska Mental Health Board, and community coalitions. As an agency, Careline has used social media like Facebook to reach out to individuals and to link prevention providers to better serve people in crisis.

Careline reported a 55% increase in total call volume in the second half of FY2010, compared to the same period in FY2009.³⁴ Of calls received, 223% more involved suicidal ideation.³⁵ Careline staff attributes this increase in suicide-related calls to increased outreach through partnerships with the Alaska Native Tribal Health Consortium, Alaska Mental Health Trust Authority, NAMI chapters, military Family Advocacy Centers, and statewide outreach efforts. A 23% increase in calls involving addiction and a 54% increase in calls from individuals experiencing mental illness occurred in this same time period.³⁶

Careline has received state funding from the Department of Health and Social Services and the Alaska Mental Health Trust since 2006.

Suicide Prevention ~ State Funded

In FY2010, the Department of Health and Social Services made 28 grants totaling \$2,663,743 for suicide prevention. These grants were funded with General Funds, receipts from the Alcohol Excise Tax, and federal grant funds received by the State of Alaska. While many more comprehensive community prevention grants were made to address substance abuse, violence, etc. — all contributing factors to suicide — only 28 grants targeted suicide (in whole or in part). Grantees in FY2010 included:

- ♦ Juneau School District (Juneau, Douglas)
- ♦ Iditarod School District (McGrath)
- ♦ Central Peninsula Hospital (Kenai)
- ♦ Big Brothers Big Sisters (Fairbanks, Juneau, Sitka)
- ♦ City of Nulato (Nulato)
- ♦ Mt. Edgecumbe High School (Sitka)
- ♦ Mat-Su Health (Palmer, Wasilla)
- ♦ PeaceHealth (Prince of Wales Island)
- ♦ Stone Soup Group (Statewide)

Examples of suicide prevention projects funded through these grants include community coalitions, creation of community resources, public education and outreach. The Juneau School District (which has received grant funding since FY2008) has implemented a school-based screening and intervention program using the Signs of Suicide Prevention Program. This is an evidence based prevention program that addresses depression, suicide risk, and self-harm. Of Juneau alternative high school students screened in September 2009, 40% met the diagnostic criteria for major depression.³⁷ In the two traditional high schools, 23% and 31% of students screened presented with characteristics of a major depressive episode and/or suicidal ideation. In Juneau, the grantee has added additional interventions and referrals to address contributing factors like poverty, domestic violence, and access to health care to provide a more comprehensive

³⁴ Data reported by Careline Executive Director Kimberlee Jones to the Statewide Suicide Prevention Council, August 24, 2010.

³⁵ Data reported by Careline Executive Director Kimberlee Jones to the Statewide Suicide Prevention Council, August 24, 2010.

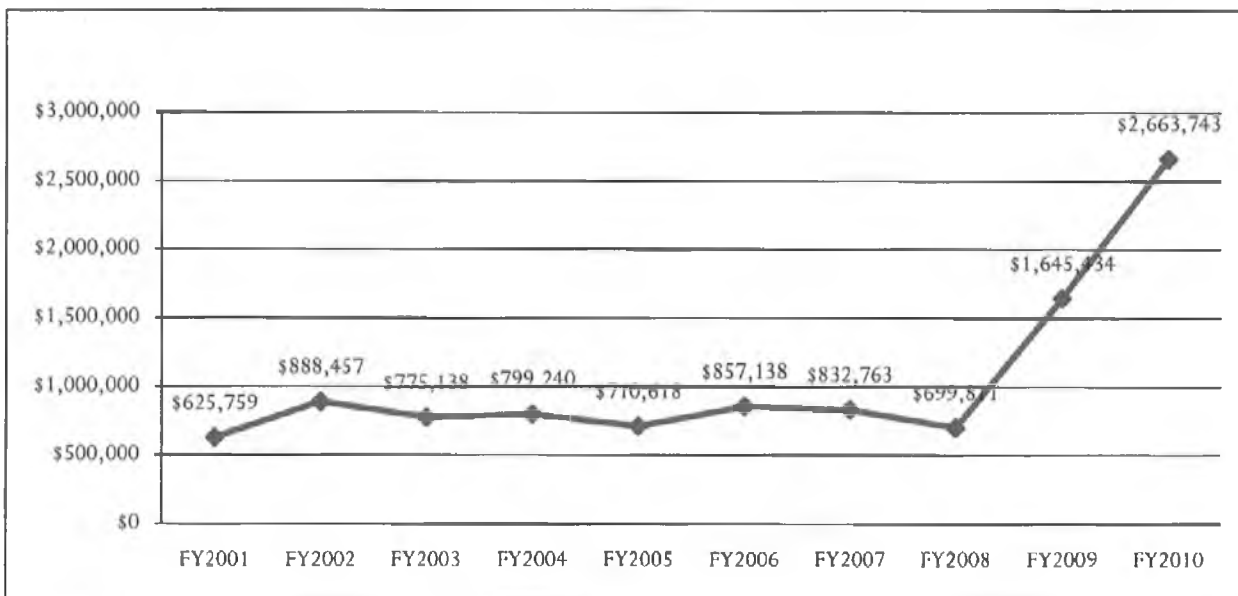
³⁶ Data reported by Careline Executive Director Kimberlee Jones to the Statewide Suicide Prevention Council, August 24, 2010.

³⁷ Reported by Juneau Douglas School District for FY2010.

response to students at risk for suicide. In cooperation with the local suicide prevention task force, the grantee created a valuable internet-based community resource guide: JuneauSuicidePrevention.org.

Since 2001, the State of Alaska has invested over \$10 million in suicide prevention. Funding remained consistent from year to year, until 2009 when available grant funds were substantially increased. This was made possible by the State of Alaska's receipt of a Garrett Lee Smith Grant from the federal government.³⁸

Cumulative Suicide Prevention Grants Funded by State of Alaska, FY2001-FY2010



The distribution of grant funds has changed over the last ten years. Before 2006, large numbers of communities received small grants of less than \$20,000 per year to engage in community driven suicide prevention efforts.³⁹ These small grant projects included Alaska Native culture camps, "alternative activities" that promoted healthy relationships between adults and youth, community wellness and suicide prevention coalitions, and a natural helper programs for youth in the Lower Yukon School District.

Since FY2006, the number of grantees has dropped steadily as the amount of the awards has risen. In FY2001, grants were made to 48 communities. In FY2010, only 28 grants were made, even though **four times as much money** was available for grants.

Beginning in FY2006, the Department of Health and Social Services adopted a funding mechanism that blended and braided multiple funding streams available for prevention programs and implemented the

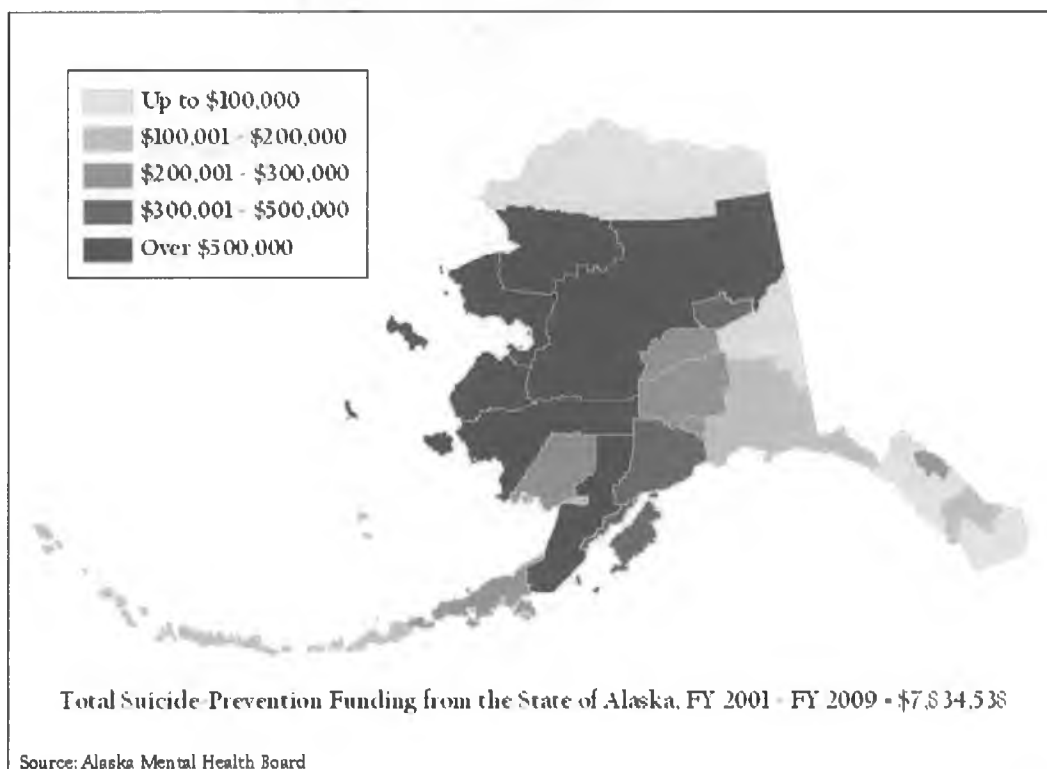
³⁸ \$1.5 million was awarded by the Substance Abuse and Mental Health Services Administration to the State of Alaska, payable in \$500,000 increments over three years (2008-2010).

³⁹ For a full list of grantees between 2001 and 2009, see "Suicide Rates, Prevention Funding, and Prevention Efforts in Alaska," Legislative Research Report (November 12, 2010) at Attachment D (available online at <http://archives2.legis.state.ak.us/PublicImageServer.cgi?lra/2011/11-015m.pdf>).

Strategic Prevention Framework model established by the federal Substance Abuse and Mental Health Services Administration. This model is a public health model that emphasizes community readiness and planning, as well as outcomes, in prevention efforts. Community collaborations are a major part of prevention projects funded under the Strategic Prevention Framework model. This model is more complicated than what was previously used (before FY2006), and requires more from grant writers and managers, as well as community coalitions and partnerships, than the previous structure.

With the evolving funding mechanisms, and the move to a more competitive grant process in FY2006, the distribution of funding has depended more on communities' sophistication in grant writing and management — and their willingness to apply for funding. The map below shows how this funding has been distributed from FY2001-FY2009.

Suicide Prevention Funding from the State of Alaska, by Borough and Census Area FY2001-FY2009

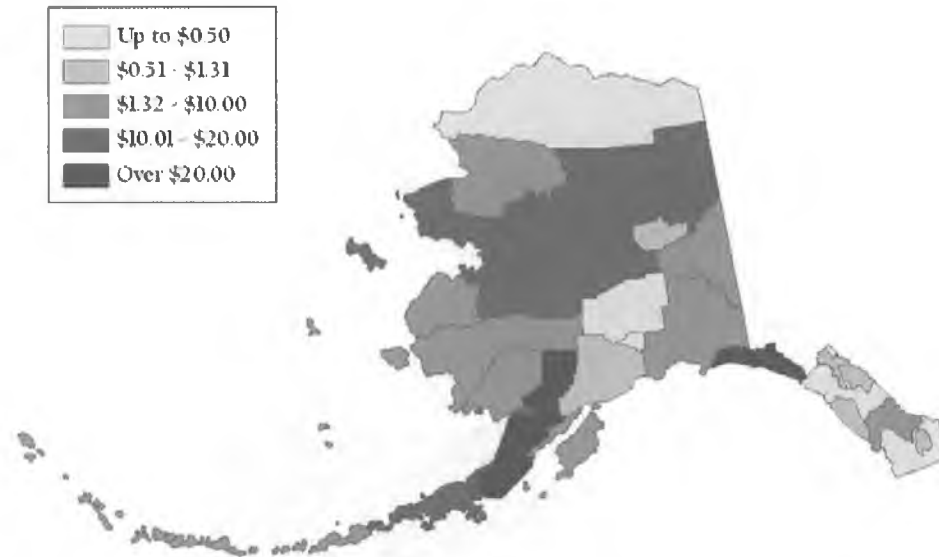


Because not all communities apply for suicide prevention grants, not all regions receive suicide prevention funding from the State of Alaska. Between FY2001 and FY2009, the State of Alaska spent \$1.31 per capita per year on suicide prevention.⁴⁰ Annual per capita per year spending ranged from \$0.08 per capita — in

⁴⁰ Average annual per capita numbers were calculated by dividing each geographic area's nine-year funding total by the corresponding nine-year population total. The State of Alaska provided \$7.8 million in suicide prevention grants between FY2001 and FY2009. The denominator in this equation is 5,964,093, the sum of the statewide population figures from each of

the North Slope Borough (which received the benefit of less than \$5,000 in suicide prevention funding from statewide projects like Careline over this time period), Municipality of Anchorage, Hoonah-Angoon Census Area, and Municipality of Skagway — to \$35.24 per capita in the Lake and Peninsula Borough.

Annual Per Capita Suicide Prevention Funding from the State of Alaska, by Borough and Census Area FY2001-FY2009



Annual Statewide Per Capita Suicide-Prevention Funding from the State of Alaska, FY 2001 - FY 2009 = \$1.31

Sources: Alaska Mental Health Board; Department of Labor and Workforce Development

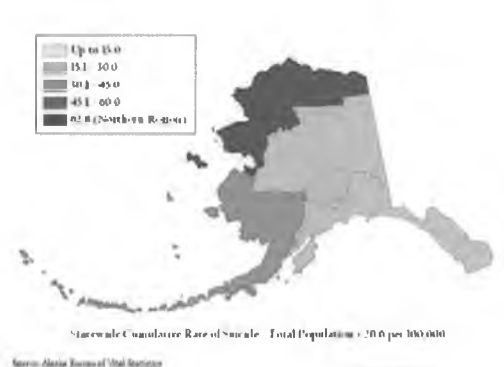
Analysis⁴¹ of the distribution of suicide prevention funding shows that incidence is not clearly affected by the amount of funding received. Between FY 2001 and FY 2009, grantees in the Southwest Region received \$2.6 million in grant funds (approximately one-third the total provided by the State of Alaska). That region had the second-highest cumulative suicide rate during the same period. However, funding peaked in FY2004 (the year when the region experienced its highest suicide rate of 67.9/100,000). Since FY2005, funding has decreased annually. This region received only \$72,931 in FY 2009. Incidence of suicide has come down in the Southwest Region from its peak in FY2004 (during years of decreasing funding), though the rate is still twice the statewide average.

Grantees in the Interior Region received \$1.6 million (20% all funding provided by the State of Alaska) in suicide-prevention funding between FY 2001 and FY 2009. Grants averaged about \$100,000 per year from FY 2001 to FY 2005. The average from FY2006 to FY2008 was about \$180,000 per year. In FY 2009, the

the nine years in the study period. Dividing the former number by the latter gives us \$1.31. This means that the State of Alaska distributed the equivalent of \$1.31 annually for every Alaska resident between FY 2001 and FY 2009.

⁴¹ Analysis provided by Brian Laurent, former research analyst with the Alaska Department of Labor and Workforce Development and MPA candidate at Boise State University. Because FY2010 grant information was not available until December, 2010, it was not available at the time the analysis was performed.

Cumulative Crude rate of Suicide by Department of Labor Economic Region, FY2001-FY2009

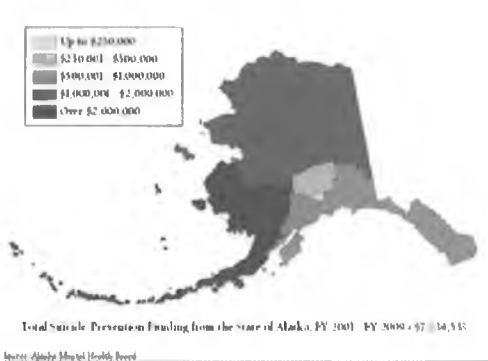


\$580,989 in grant funds went to the Interior Region. The suicide rate in this region was lower than the statewide rate between 2002 and 2007. In 2008, it spiked to 30.7/100,000 people. In 2009, it fell to 13.8 /100,000 people.

In the Northern Region, which had the highest cumulative suicide rate between 2001 and 2009, grantees received 18.8% of total funding from the State of Alaska (\$1.5 million). The amount of grant funding received fell by 37.2% in FY2008 and 51.6% in FY2009, when grantees in this region received \$70,500 (the lowest in the state outside of Anchorage).⁴²

Funding in the Southeast Region was consistent from FY 2001 to FY 2008. Average annual funding was about \$41,000. In FY 2009, grants to the region totaled \$406,247 (more than the previous eight years combined). The suicide rate in the Southeast Region increased from 2001 to 2009. Between 2001 and 2006, the rate was between 8.4 and 18.1/100,000 people (below the statewide average). The suicide rate since 2006 has ranged from 23.1 to 27.4 per 100,000/people.

Suicide Prevention Funding from State of Alaska by Department of Labor Economic Region, FY2001-FY2009



Further detail and disparities can be discerned in an analysis of funding by the smaller regional designations used by the Department of Health and Social Services. For example, the department of Labor's "Northern Region" includes the North Slope and Northwest Arctic boroughs, and the Norton Sound Region. The Norton Sound Region had extreme rates of non-fatal suicide attempts suicide in 2008 and 2009, specifically in the Alaska Native community. This region received close to \$900,000 between FY2001 and FY2009. Conversely, the North Slope Borough, with a suicide-attempt rate close to double the statewide average, received less than \$5,000.⁴³

Suicide Prevention ~ Federally Funded

Seventeen tribal organizations received prevention grants from the Indian Health Service as part of the Methamphetamine and Suicide Prevention Initiative. These grants, totaling over \$5 million over three years) were funded as part of the 2009 Recovery Act. The intent of these grant programs is to expand

⁴² The Municipality of Anchorage received no suicide prevention grant funds from the State of Alaska in FY 2009. The only grant awards that went to Anchorage between FY2001 and FY2009 were part of larger statewide grants. It received no specifically allocated funds during this period. All funds attributed to the region were apportioned, based on population, from statewide suicide prevention grants.

⁴³ Like the Municipality of Anchorage, none of the North Slope Borough's suicide prevention funds were to grantee organizations in the borough. All were apportioned, based on population, from statewide grants to organizations like Carline.

community prevention efforts to reduce methamphetamine use and incidence of suicide. Grantees include the Alaska Native Tribal Health Consortium, Southcentral Foundation, Maniilaq Association, Ketchikan Indian Community, Arctic Slope Native Association, Chugachmiut, Bristol Bay Area Health Corporation, and others.



*Photograph courtesy of
Southcentral Foundation*

These grants have funded a variety of projects. Southcentral Foundation is using its grant for the Lead the Change project, a contest that provides outreach, awareness, and education and technical assistance to help youth produce short video messages focused on protective factors that reduce risk for suicide. Rather than a stark suicide prevention message, videos focused on positive aspects of life and hopefulness. The FY2010 winner was a team of youth from Wendler Middle School in Anchorage.

In addition to the current IHS Methamphetamine and Suicide Prevention Initiative grantees, several tribal organizations have received federal Garrett Lee Smith funding. As mentioned above, Maniilaq in the Kotzebue region was awarded a three year Garrett Lee Smith Grant in 2006, which supported a digital storytelling project for students in schools in twelve regional villages and efforts to improve suicide prevention practices in local agencies.

Kawerak, Inc. in the Norton Sound region also received a three year Garrett Lee Smith Grant in 2008. It is funding the Bering Strait Suicide Prevention Program, focusing on all youth age 12-18 and young Alaska Native men age 19-30 in the region's 15 villages. This prevention program includes a "Peer Helpers" project to provide peer support for youth.

Southcentral Foundation received a three year Garrett Lee Smith Grant in 2009. The grant will fund a screening, referral, and case management program targeting high risk Alaska Native youth age 10-24. Suicide prevention and intervention training and youth engagement in media outreach and awareness campaigns are also anticipated.

Suicide Prevention ~ Tribal Health

Tribal health organizations all over Alaska have worked to prevent suicide among their client/customer populations. Along with individual tribal health organizations, the Alaska Native Tribal Health Consortium (ANTHC) has been engaged in ongoing efforts to reduce suicide among Alaska Native peoples. These include a Suicide Prevention Initiative begun in 2009, ongoing suicide prevention and intervention training

(discussed below), assisting regional tribal health organizations with community readiness, and projects to reduce access to “lethal means” (guns, etc.) of suicide. Examples of these efforts are described below.⁴⁴

Bristol Bay Area Health Corporation (BBAHC), a tribal health organization serving Dillingham and 34 regional villages, developed a gun locker program in partnership with ANTHC and the local housing authority. BBAHC targeted access to guns as a “lethal means” of suicide, because firearms are involved in 2/3 of suicides by men in Alaska.⁴⁵ In the course of this project, BBAHC has installed over 300 gun safes in homes throughout the region.⁴⁶

In FY2010, ANTHC and its partners worked to develop a culturally relevant postvention resource for Alaska Native peoples. *Doorway to a Sacred Place* is a tool for communities after a suicide or other tragedy has occurred. It incorporates traditional ways of knowing to provide resources for healing — which in turn can prevent suicide contagion, or the domino effect of suicides that so many rural communities have experienced. *Doorway to a Sacred Place* is expected to be finalized and ready for use in FY2011.

Southcentral Foundation offers a suicide prevention program called *Denaa Yeets'* — “Our Breath of Life” in Athabascan. This program provides case management, information and referrals to services to Alaska Native adults who are at risk of suicide. *Denaa Yeets'* also provides supportive services to the family members of clients.

Suicide Prevention ~ Training

There are multiple prevention and intervention models available in Alaska. Training is provided through the State of Alaska, ANTHC, and other organizations.

ASIST, which stands for Applied Suicide Intervention Skills Training, is an evidence based suicide prevention model used all over the world. ANTHC has supported trainings throughout the tribal health system in Alaska. At the end of FY2010, there were 585 Alaskans who had been trained in the ASIST model. Communities like Barrow have emphasized training in identifying warning signs of suicide and appropriate responses and referrals.

CISM, Critical Incident Stress Management, is another suicide prevention model. It is most effective after a suicide or other tragic event. The Alaska Police and Fire Chaplain's Ministries, as well as other organizations offer training in this model. CISM is a comprehensive model that focuses on how individuals and communities can debrief and react to a suicide or other crisis in a healing way. By partnering together, organizations have expanded the



*ASIST Training in Barrow
Photograph courtesy of Audrey Saganna*

⁴⁴ Contact the [Injury Prevention Program](#) at the Alaska Native Tribal Health Consortium (907-729-3799) for a more comprehensive review of tribal health organizations' suicide prevention efforts.

⁴⁵ Reported by the Division of Public Health Epidemiology, Department of Health and Social Services, September 14, 2010 (available online at http://www.epi.alaska.gov/bulletins/docs/b2010_28.pdf).

⁴⁶ Reported to the Statewide Suicide Council by Eric Holland, deputy director of Behavioral Health, BBAHC, November 13, 2009.

reach of this model. For example, ANTHC, the Chaplain's Ministry, and the Arctic Slope Native Association partnered to train 50 individuals in CISM in FY2010. Participants included public safety officers and behavioral health providers.

Gatekeeper is another suicide prevention and intervention model. Training in this model is offered by the State of Alaska through the Division of Behavioral Health, Department of Health and Social Services. Anyone can be trained as a Gatekeeper. The model focuses on teaching people to listen and connect with someone, assess that person's risk for suicide, and act appropriately when someone is in crisis. Gatekeeper trainings include a basic overview of suicide, active listening skills, how to assess someone's risk of suicide, and how to be comfortable intervening to keep someone safe. Knowledge of local and statewide resources is also provided, to help Gatekeepers make referrals to the right services when someone is in need.



COUNCIL ACTIVITIES

The Council held meetings in Dillingham, Anchorage and Toksook Bay in FY2010. At all of these meetings, extensive public comment was provided to council members. Council members have characterized the Toksook Bay meeting in May, 2010 as one of the most meaningful and informative meetings held so far. Not only was much of the meeting held in Yupik (with English translation), but a significant amount of time was spent listening and learning from the local elders.



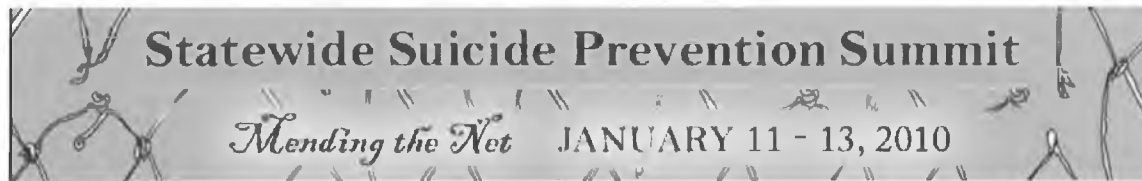
Photographs courtesy of Teri Tibbett

The Council provided anti-stigma and public education materials to communities around the state and online. In addition to conducting regular business, the Council worked with the Division of Behavioral Health, the Alaska Mental Health Board, and the Advisory Board on Alcoholism and Drug Abuse to develop a transition plan for co-locating the Council with the Boards beginning in FY2011.

The Council's major achievements, however, involved extensive efforts to identify and connect suicide prevention stakeholders to "mend" and strengthen the suicide prevention system "net." These efforts, the first ever Suicide Prevention Summit in January 2010 and the development of the web portal StopSuicideAlaska.org, were only possible because of the Council's partnerships with the Alaska Mental Health Board, Advisory Board on Alcoholism and Drug Abuse, and the Alaska Mental Health Trust.

Alaska Suicide Prevention Summit

In January, 2010 the Statewide Suicide Prevention Council and the Alaska Native Tribal Health Consortium partnered with several state agencies to convene the first ever Alaska Suicide Prevention Summit (Summit). More than 60 individuals, representing agencies and communities statewide, gathered to review and assess the state of Alaska's suicide prevention system and to determine what immediate, short-term and long-term steps can be taken to strengthen the system.



The tribal health system and state-funded health system both support suicide prevention efforts in Alaska. Often these suicide prevention systems operate along parallel tracks rather than in concert. The Summit was the first time that the tribal health suicide prevention system and the state-funded suicide prevention system have come together to identify their unique and common strengths, and how together these systems could build upon those strengths to fill in the gaps in our suicide prevention efforts overall. The Summit started a more collaborative partnership between the tribal and state prevention systems, to begin to have a more meaningful impact on Alaska's suicide rate.

Summit participants identified the strengths and weakness of the suicide prevention systems in Alaska. **Partnerships**, where they occur, between the state and tribal suicide prevention systems were identified as strengths. After the Summit, the level of cooperation between tribal and state entities, as well as other stakeholders, has increased dramatically:

- ◆ ANTHC, Southcentral Foundation, and NAMI-Anchorage are partnering to form and host a support group for survivors of suicide in Anchorage.

- ◆ SSPC, ANTHC, the Alaska Mental Health Board, the Alaska Mental Health Trust, non-profit organizations, and many survivors of suicide partnered in advocacy to secure funding for suicide prevention, postvention, and technical assistance. Through this partnership, an increment of \$200,000 general funds per year was appropriated for postvention funding.
- ◆ Alaska Children's Services and the Alaska State Troopers are partnering to deliver Gatekeeper training to state troopers statewide between 2010-2012.
- ◆ The Alaska Federation of Natives identified suicide and suicide prevention as a major focus of the 2010 convention.



Photograph courtesy Thomas Chard

Summit participants identified many different avenues of **health promotion** that is now or could more fully be part of suicide prevention efforts. These include a wide range of efforts undertaken at the individual, community, and state levels. Elders and cultural leaders model healthy lifestyles and encourage connections with youth to foster leadership and growth. Depression and substance abuse screening in clinics and other primary care settings, like Anchorage Neighborhood Health Center, help people access treatment and recovery services before they are in crisis. This is an especially effective model for rural and older populations. The tribal health system offers many health promotion programs that help Native Alaskans and people living in rural communities. These include primary and dental health programs, as well as substance abuse prevention and overall wellness programs. These services are culturally appropriate for the target populations. The Rural Human Services program provides culturally relevant education for the behavioral health aides, family service workers, and other human services providers in Alaska's villages and rural communities. This helps expand the wellness promotion services available throughout the state.



Summit participants identified the power of **young Alaskans** as a strength. The Statewide Suicide Prevention Council includes a youth member with full voting privileges. The new youth suicide prevention effort coordinated by Central Council of Tlingit and Haida Indians has a youth advisory board. These are just two examples of how suicide prevention organizations reach out to and include the perspectives of young people in their work.

Current suicide prevention efforts were also identified by Summit participants as system strengths. Some are evidence based practices implemented in clinical settings, some are community based, and some are built on other models. **School-based screenings** of students, like the model in Juneau discussed above, are an effective way of identifying children at risk of suicide before they are in crisis. In some districts, there are student clubs and support groups related to mental wellness that help de-stigmatize mental illness and the seeking of help for a crisis.

Community coalitions involve partnerships between local agencies and individuals interested in preventing suicide emphasize the importance of diverse stakeholder participation. They include multi-disciplinary collaborations between public health, primary care, and behavioral health systems. Since the Summit, a new coalition – SPEAK – has formed in Ketchikan and is an active part of the community's larger wellness coalition.

Careline, Alaska's 24/7 crisis call line, was identified as a strength. Careline and the Alaska Native Tribal Health Consortium offer dynamic and information web pages with prevention resource information. The Juneau Suicide Prevention Task Force and SPEAK in Ketchikan have equally effective webpages with local information and resources. All of these websites link back to each other, to help make sure people can access all the information they need. The Anchorage gay, lesbian, bisexual organization, Identity, Inc., provides a toll-free helpline.

Both the tribal and state systems emphasize the importance of **locally developed prevention solutions**, to ensure that each community has a relevant and respectful way of addressing the problem of suicide as it occurs in their community. The wide availability and acceptance of ASIST, CISM, Gatekeeper, and other suicide prevention and intervention models were identified as strengths. The Rural Human Services program includes a suicide prevention curriculum. The Alaska National Guard is a partner in providing ASIST trainings in communities statewide.

While many strengths were noted, weaknesses and gaps were also identified. Few Alaska communities have an active **support groups for survivors of suicide**. Survivors of suicide can find support groups in only six of the 143 communities: Anchorage, Barrow, Bethel, Fairbanks, Juneau, and Wasilla. Not all of these meet regularly. There are two active support groups and one developing support group in Anchorage, where the largest number of suicides occur each year. In the four census areas with suicide rates of 30 or more per 100,000 people, there are only two communities with support groups for survivors of suicide (Barrow has an active group and Bethel is developing a group). In the Nome census area, where the rate has been the highest, there are no active support groups for survivors of suicide. Increasing access to support for survivors, whether in person or through other means, was identified as a next step for participants and the state as a whole.

Many different models for support services are available, based on specific community needs and capacity. Cultural healing circles help individuals, families and communities deal with the feelings that come immediately after a loss to suicide. They also can provide ongoing support to survivors of suicide. Fairbanks Counseling and Adoption developed the structure for the Fairbanks group directly with participants to ensure that the group provides meaningful support and assistance to people who attend.

Summit participants spoke often of suicide as a taboo subject in families and communities. The pervasiveness of this silence on the issue of suicide was reflected in experiences individual and communal, in public and private space. Family members' deaths left unexplained for generations, ostracism of survivors, suicide deaths listed as accidental by local physicians, media outlets avoidance of even the term "suicide" – these are just a few of the ways that the long-standing culture of silence weakens the suicide prevention system. Contributing to the social norm that suicide is not a subject openly discussed is the fact that, in

many communities, the lack of confidentiality presents an obstacle to developing trust necessary to seek services. Stigma and labeling of both the person who has committed suicide, as well as those affected by the loss to suicide, further impairs access to services and their effectiveness.

Since the Summit, the number of public forums to discuss suicide and its impact on Alaska's communities and families has exploded. Media coverage in newspapers large and small, and by television news programs, has also increased. State and federal policymakers have taken greater interest in the state of the suicide prevention system in Alaska.

IF, FOR NOTHING ELSE, FY2010 IS RECOGNIZED AS THE YEAR THE COUNCIL HELPED ALASKANS END THE SILENCE ABOUT SUICIDE, IT WILL HAVE BEEN A SUCCESSFUL YEAR.

Summit participants identified a lack of cohesion among the different prevention systems (tribal, faith-based, state, federal, local) as a weakness. Efforts to bridge the gaps between these systems were begun immediately after the Summit, and continue today. Other weaknesses included:

- ♦ Lack of support services for populations made vulnerable by loss of structure (veterans, transition age youth, immigrants, individuals displaced due to economic or environmental hardships);
- ♦ Lack of effective prevention and intervention programs to address bullying;
- ♦ Lack of age appropriate services for individuals age 18-25 years;
- ♦ Lack of follow up services for individuals who have attempted suicide; and
- ♦ Lack of communication among and support for suicide prevention providers.

The Council, along with the Alaska Mental Health Board, prioritized the lack of communication among and support for suicide prevention providers as a weakness that could be addressed in FY2010. Together, they implemented initiatives to improve "net"-working among suicide prevention providers statewide.

StopSuicideAlaska.org

The Alaska Mental Health Board had in, 2009, successfully advocated for a one-time increment of \$75,000 in Alaska Mental Health Trust receipts for a web-based suicide prevention resource. This funding, with the input from the Summit, led to the development of StopSuicideAlaska.org.

StopSuicideAlaska.org is not a website. It is a web portal that provides a forum for community groups and stakeholders to come together, share information and ideas, and support each other in suicide prevention efforts. Design and content development was the focus for FY2010, with StopSuicideAlaska.org going live in FY2011.

Given the time necessary to develop and launch the suicide prevention web portal, a companion page for StopSuicideAlaska.org was created on Facebook. Like Careline, the Council has begun to use social media outlets like Facebook to improve outreach efforts and strengthen communication with stakeholders.



Set up in May, 2010, the StopSuicideAlaska.org page on Facebook had nearly 100 members by the end of June (it now has 275 members from all over Alaska). Research, data, news, upcoming events, and words of strength and support are now constantly streaming to stakeholders through these online resources.

Outreach and Education

The Council receives a small grant from the Alaska Mental Health Trust for anti-stigma efforts. In FY2010, this funding supported print media based awareness ads. The Council also provided education, materials, and in-person discussion at a booth at the Alaska Federation of Natives convention (October, 2010). Council members spoke at regional and community events to help raise awareness about suicide, its warning signs, and the effect it has on the people left behind. Council member Barbara Franks coordinated the National Survivors of Suicide day event at the University of Alaska Anchorage in November 2009 (the second survivors' event at UAA).



LOOKING AHEAD

After a year spent assessing the suicide prevention system, gathering stakeholders together, and identifying its own resources, the Council is ready to look forward at the next five (or even ten) years. Council members will use all the public comment received, the information from the Summit participants, as well as the data and information compiled and reported on here to develop a true state suicide prevention plan for Alaska. That plan will include strategies and recommendations for the State of Alaska, as well as communities and individuals, to prevent suicide.

With the August 2010 hire of a full-time assistant, and the co-location with the advisory boards most closely related to the issue of suicide, the Council can now maximize its resources to better serve the people of Alaska. Strengthening relationships with the tribal suicide prevention system, as well as non-traditional partners like law enforcement and members of the clergy, will ensure that the work of the Council stays fresh and relevant. With the help of the Governor's Office, the Council has begun active recruitment of diverse and energetic candidates for membership. Use of social media, the StopSuicideAlaska.org web portal, and other easily access communication channels will provide ongoing information and feedback from the public — and ensure that the Council stays connected to the people it serves.



CONCLUSION

This Annual Report is offered to inform Alaskans about the problem of suicide in our state, and to show how many people all over the state are working very hard to prevent suicide. A substantial financial investment in suicide prevention is being made by the State of Alaska, tribal health organizations, and the federal government. An even greater personal, emotional and spiritual investment is being made by each and every Alaskan dedicated to preventing suicide. And yet, Alaska still experiences suicide at a rate twice the national average.

We hope that this Annual Report starts conversations — in the Legislature, in classrooms, in assembly chambers, in doctors' offices, and in living rooms — about how we can better prevent suicide. The Council deliberately avoided coming to conclusions or providing answers in this report. Instead, we invite you to join us as we plan for the future and share the message that every life is valuable across Alaska.

THE MEMBERS OF THE STATEWIDE SUICIDE PREVENTION COUNCIL

William Martin, Chairman
Barbara Jean Franks, Vice-Chair
Bernard Gatewood, Officer-at-large
Melissa Stone, Recorder/Treasurer
Brenda Moore
Phyllis Carlson
Meghan Crow
Alana Humphrey
Sharon Norton
Pastor Lowell Sage, Jr.
Senator Johnny Ellis
Senator Fred Dyson
Representative Anna Fairclough
Representative Woodie Salmon
Representative Berta Gardner

APPENDIX A

STATUTORY AUTHORITY

AS 44.29.300 Council Established

(a) There is established in the Department of Health and Social Services the Statewide Suicide Prevention Council, consisting of 16 members, as follows:

(1) two members of the senate, appointed by the president of the senate, one of whom shall be a member of the majority and one of whom shall be a member of the minority;

(2) two members of the house of representatives, appointed by the speaker of the house of representatives, one of whom shall be a member of the majority and one of whom shall be a member of the minority;

(3) 12 members appointed by the governor, as follows:

(A) two persons who are employed in the executive branch of state government, one of whom shall represent the Department of Health and Social Services and one of whom shall represent the Department of Education and Early Development;

(B) one member of the Advisory Board on Alcoholism and Drug Abuse;

(C) one member of the Alaska Mental Health Board;

(D) one person recommended by the Alaska Federation of Natives, Inc.;

(E) one person who is an employee of a secondary school;

(F) one person who is active in a youth organization;

(G) one person who has experienced the death by suicide of a member of the person's family;

(H) 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;

(I) one person who is a member of the clergy;

(J) one person who is enrolled in grade nine, 10, 11, or 12 of a secondary school in the state; and

(K) one public member.

(b) Members of the council appointed under (a)(1) and (2) of this section are nonvoting members.

AS 44.29.310 Term of Office

(a) The governor shall appoint the members of the council under AS 44.29.300(3)(D) - (J) for staggered terms of four years.

(b) The governor shall fill a vacancy of a member on the council appointed under AS 44.29.300(3)(D) - (J) by appointment for the unexpired part of the vacated term.

(c) Members of the council serve at the pleasure of the governor. The governor shall replace a member who, by poor attendance or lack of contribution to the council's work, demonstrates ineffectiveness as a member. In this subsection, "poor attendance" means the failure to attend three or more consecutive meetings.

AS 44.29.330 Officers and Staff

(a) The council, by a majority of its membership, shall annually elect a presiding officer and other officers it considers necessary from among its membership.

(b) The council may employ a coordinator to assist the council. The coordinator is in the partially exempt service. The coordinator shall be directly responsible to the council in the performance of the coordinator's duties. The council shall annually review the performance of the coordinator.

(c) The council may appoint an advisory panel to provide further advice on suicide prevention. The advisory panel serves at the pleasure of the council. Members of the advisory panel are not entitled to compensation, per diem, or reimbursement of travel expenses.

AS 44.29.340 Meetings

(a) The council may meet and vote, by teleconference or otherwise, as often as considered necessary by the presiding officer of the council.

(b) Seven voting members of the council participating in a meeting in person or by teleconference constitute a quorum for the transaction of business and the exercise of the powers and duties of the council.

AS 44.29.350 Duties

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 effect 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;
- (6) strengthen existing and build new partnerships between public and private entities that will advance suicide prevention efforts in the state.

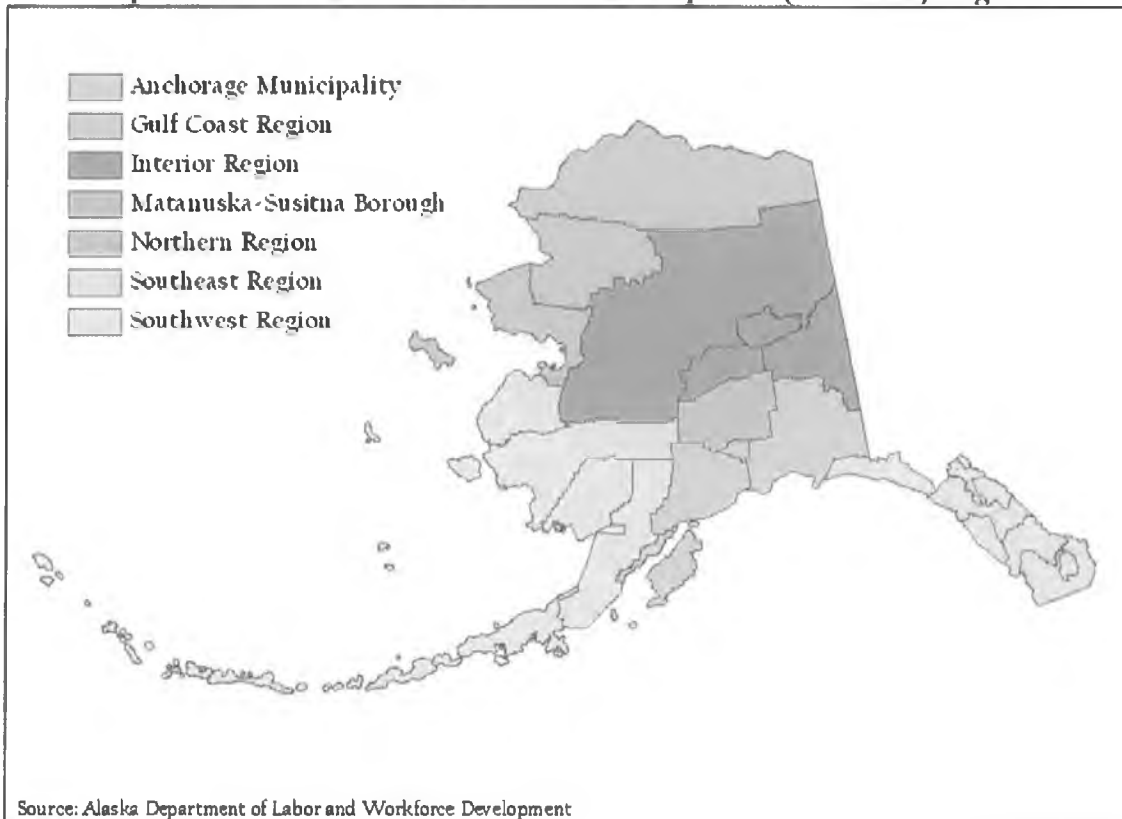
AS 44.29.360 Annual Report

The council shall annually report its findings and recommendations in a report to the governor, the president of the senate, and the speaker of the house of representatives by March 1 of each year.

APPENDIX B

MAP OF REGIONS USED BY THE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT

Department of Labor and Workforce Development (DOLWD) Regions



*This report was web published, resulting in reduced paper and waste
and savings of approximately \$3,000.00.
Printed copies, free and available upon request, are prepared in-house
at a cost of approximately \$3.00 per copy.*

Governor Sean Parnell

Statewide Suicide Prevention Council

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Yup'icimara
Asva'ituumallerkaa
Elluam Tungiinun
Yuuyaraq
Kiwpaqmiut
Yuuciat



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The **Qungasvik (Toolkit) Project** participates in a prevention trial funded by the National Center for Minority Health and Health Disparities at the National Institutes of Health. This research, conducted by the Center for Alaska Native Health Research, is testing the program's effectiveness as an evidence based practice to prevent suicide and alcohol use in youth. There are currently four Qungasvik Projects ongoing in southwest Alaska; the **Elluam Tungiinun (Towards Wellness) Project in Alakanuk** serves as the training community for the newer projects.

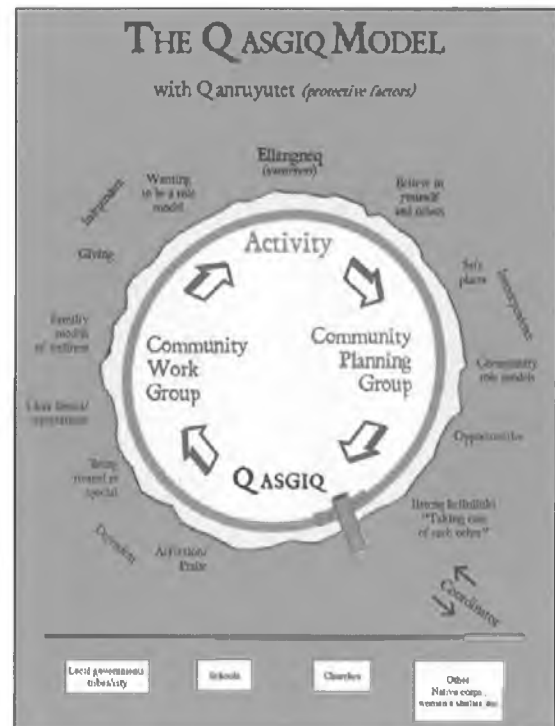


The Qungasvik toolkit has 36 cultural and bicultural activities designed to build protection from suicide and alcohol abuse in communities, families, and youth. Every rural community is different. Qungasvik activities include a careful process to develop the prevention activities to fit the local customs and practices of the community. **The program provides a strengths-based cultural approach to increase reasons for life and wellbeing.**

The Qungasvik Projects are based in the **Qasgiq** model, shown at right using the Yup'ik /Cup'ik drum as its center. The qasgiq is a traditional Yup'ik/Cup'ik gathering place. It is also a traditional Yup'ik/Cup'ik way of coming together to teach and learn, make important decisions, and give thanks and prayer.

Qungasvik Activities build protection in communities, families, and individuals. Activities connect youth with elders and other respected adults to teach young people how to protect themselves on the land and in their lives.

Elder Placid Joseph from Alakanuk shows a youth how to make an *ayaruq* (traditional ice safety pick). Later they will test the *ayaruq* on the spring ice.



Research conducted by UAF has established community readiness and capabilities to prevent suicide and alcohol abuse increased in the Elluam Tungiinun Project community, and that **protective factors from suicide and alcohol increased in families and communities, and reasons for life and reflective processes increased in youth in relationship to the number of prevention program sessions attended.** (Allen et al., *Int J Circumpolar Health* 2009; 68(3):274-291)



For more information about the project contact:

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http://www.uaf.edu/aurora/archives/fall-2009/canhr/Aurora_Fall2009_CANHR.pdf

