

ALASKA LEGISLATURE

HOUSE and SENATE FINANCE COMMITTEE FILES, 2005-2006 2982

## 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.

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### **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](http://www.cdc.gov/eval/framework.htm)

[www.cdc.gov/eval/evalebph.pdf](http://www.cdc.gov/eval/evalebph.pdf)

#### **The Community Toolbox**

[http://ctb.ku.edu/tools/en/part\\_J.htm](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](http://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 interventions and program for suicide prevention. It is available at: [www.nap.edu/catalog/10398.html](http://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](http://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](http://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](http://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/](http://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.

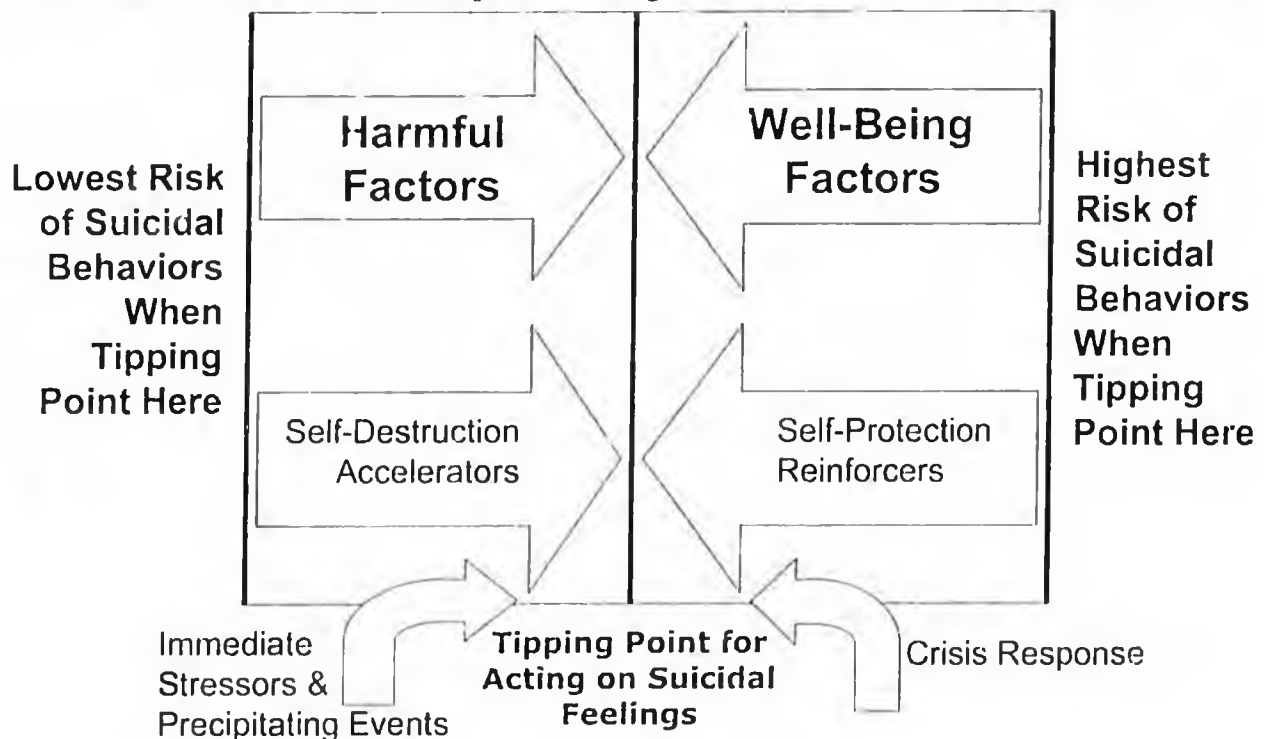
Harmful Factors	Well-Being Factors
<p><b>Poor Mental Health</b>                      Presence of a mental disorder, especially mood disorders (depression, bipolar disorder) or substance use disorders (alcohol abuse, alcoholism, other drug abuse)                      Not enough treatment or barriers to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

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

# Appendices

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

## Individual Susceptibility to Suicidal Behaviors



**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.

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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 Infirm

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 relishing 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](http://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): [www.oassis.org](http://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](http://www.suicidology.org), 4201 Connecticut Avenue, NW, Suite 408, Washington, DC 20008, (202) 237-2280

American Foundation for Suicide Prevention: [www.afsp.org](http://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](http://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.nrcsuk.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

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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 (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

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.

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## 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).

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### 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 encouragement	4. none

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## 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; Amma 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	8/17/04	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

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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**

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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

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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  
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SENATE FINANCE COMMITTEE REPORT

REPORTED OUT  
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 SENATE FINANCE  
 COMMITTEE

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

<b>Senate Bill:</b>	
<input type="checkbox"/>	Same Title
<input type="checkbox"/>	New Title
<b>House Bill:</b>	
<input type="checkbox"/>	Same Title
<input type="checkbox"/>	Technical Title Change
<input type="checkbox"/>	New Title w/ SCR # _____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Ind.	Zero	FN#
HSS	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
<i>[Signature]</i>	✓			
<i>[Signature]</i>	✓			
<i>[Signature]</i>	✓			
COCHAIR:				
COCHAIR: <i>[Signature]</i>	✓			

**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**

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

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

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

5 (8) Statewide Suicide Prevention Council (AS 44.29.300) - June 30,

6 2009 [2005];

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



FISCAL NOTE  
FN #

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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Senate President

## 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 22<sup>nd</sup> 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 fulfills 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](http://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



P.O. Box 113300  
Juneau, AK 99811-3300  
(907) 465-3830  
FAX (907) 465-2347

November 16, 2004

Internet e-mail address:  
legaudit@legis.state.ak.us

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

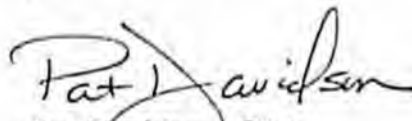
Audit Control Number

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, CPA  
Legislative Auditor

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## 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.<sup>1</sup> 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 Barbec, 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.

<sup>1</sup> 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<sup>2</sup> requested by DHSS.

<sup>2</sup> 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)<sup>3</sup> 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.<sup>4</sup>

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)

	<u>Expenditures</u>	<u>As Percentage of Authorization</u>
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	<u>3,400</u>	<u>2.0%</u>
	<u>\$171,400</u>	<u>100.0%</u>

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,<sup>5</sup> 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

<sup>3</sup> Now Finance and Management Services under the most recent DHSS reorganization.

<sup>4</sup> As of October 15, 2004, \$27,524 of the commitment was spent.

<sup>5</sup> 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.<sup>6</sup> 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.<sup>7</sup>
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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<sup>6</sup> 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".

<sup>7</sup> 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;<sup>8</sup> Division of Behavioral Health's Targeted Gatekeeper Training<sup>9</sup> 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

<sup>8</sup> Careline refers to Alaska's statewide toll-free crisis intervention and assistance hotline.

<sup>9</sup> 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.<sup>10</sup> 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.<sup>11</sup> Additionally, the public has the opportunity to contact the council through its website and offer feedback on the council’s effectiveness.

<sup>10</sup> The funding consisted \$300,000 in general funds and a \$100,000 Mental Health Trust match.

<sup>11</sup> 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<sup>12</sup> 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.

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<sup>12</sup> 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

Ms. Pat Davidson  
Legislative Auditor  
1/5/2005  
Page 2 of 4

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 there 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 Council's 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.

Ms. Pat Davidson  
Legislative Auditor  
1/5/2005  
Page 3 of 4

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.

Ms. Pat Davidson  
Legislative Auditor  
1/5/2005  
Page 4 of 4

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 DISS 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 statute whereby 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 consistent 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**

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## 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

<b>Personnel:</b>	
Full time	0
Part time	1
<b>Total</b>	<b>1</b>

### 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
<b>Non-Formula Program:</b>			
<b>Component Expenditures:</b>			
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
<b>Expenditure Totals</b>	<b>66.4</b>	<b>118.8</b>	<b>119.0</b>
<b>Funding Sources:</b>			
1037 General Fund / Mental Health	66.4	118.8	119.0
<b>Funding Totals</b>	<b>66.4</b>	<b>118.8</b>	<b>119.0</b>

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

*All dollars shown in thousands*

	<u>General Funds</u>	<u>Federal Funds</u>	<u>Other Funds</u>	<u>Total Funds</u>
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
<b>FY2006 Governor</b>	<b>119.0</b>	<b>0.0</b>	<b>0.0</b>	<b>119.0</b>

**Suicide Prevention Council  
Personal Services Information**

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

**Position Classification Summary**

Job Class Title	Anchorage	Fairbanks	Juneau	Others	Total
Coordinator, Suicide Prev Cncl	1	0	0	0	1
<b>Totals</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1</b>



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.

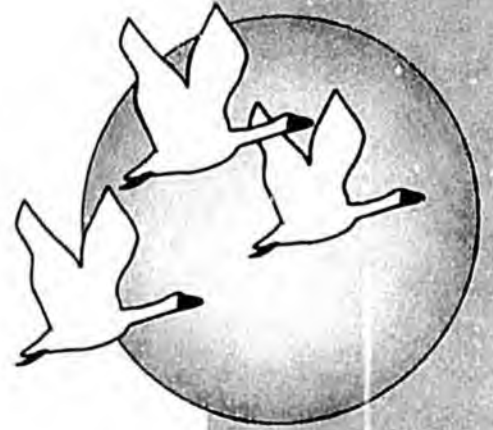
Sincerely,

Jeanine Sparks, Chair  
Suicide Prevention Council

- 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.



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

Academy 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 Developmental Disabilities  
Chair

### Senator Georgianna Lincoln

Alaska State Legislature

### Karen Perdue

Public

### Susan Soule

Health and Social Services

### Senator Ben Stevens

Alaska State Legislature

### Vacant

Youth under 18

### Vacant

Alaska Maternal Health Center

### Vacant

Alaska Department of Behavioral Health

### Vacant

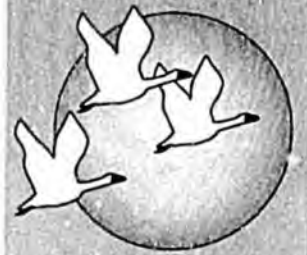
Public

### Kathy Craft

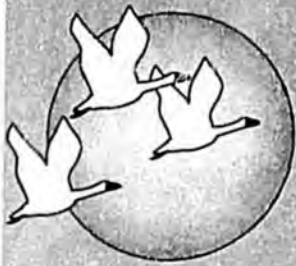
Director of Evaluation  
Kathleen Craft, PhD, Director  
Alaska  
1-907-270-4500

## 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.

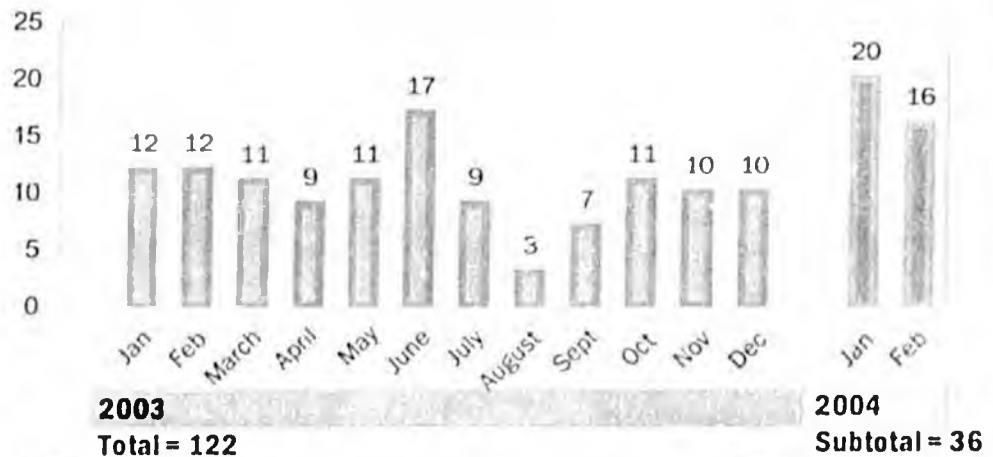
- ◆ For additional Alaska Suicide Prevention Council information, please visit: <http://www.hss.state.ak.us/suicideprevention/default.htm>
- ◆ Division of Public Health
- ◆ Injury Disparities in Alaska – Alaska Injury Resources
- ◆ Fact Sheets & Printable Resources:  
<http://www.hss.state.ak.us/dph/profiles/injuries/default.htm>

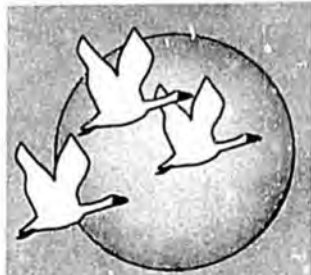
## Additional Suicide Prevention Facts

- ◆ [www.nlm.nih.gov/research/suifact.htm](http://www.nlm.nih.gov/research/suifact.htm)
- ◆ [www.psych.org/public\\_info/teen.cfm](http://www.psych.org/public_info/teen.cfm)
- ◆ [www.acap.org/publications/factsfam/suicide.htm](http://www.acap.org/publications/factsfam/suicide.htm)
- ◆ [www.childrensatabank.org](http://www.childrensatabank.org)

## Frank H. Murkowski, Governor

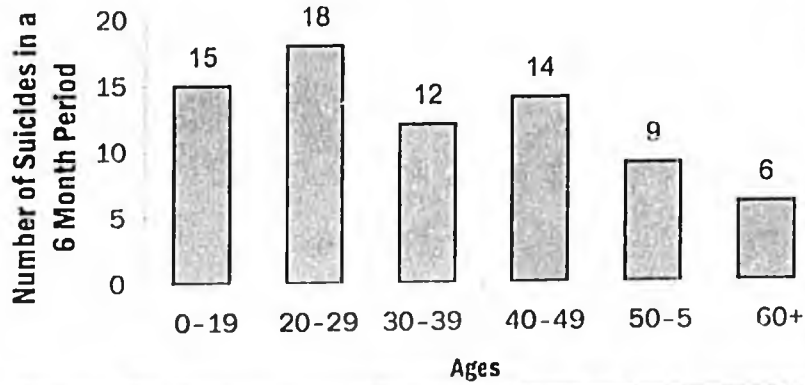
Alaska Suicides 2003/2004 Month to Date





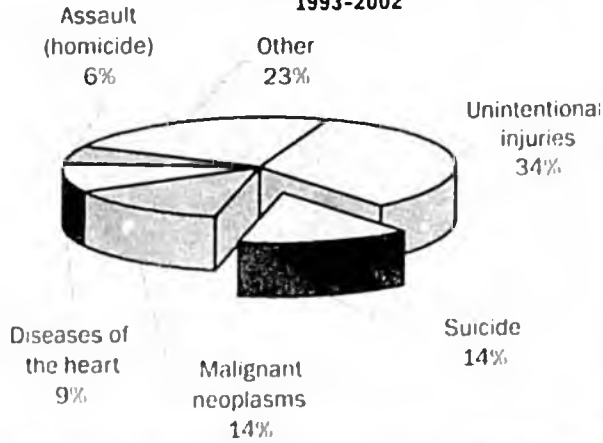
# Report to the Legislature

## Ages of Suicide Completions 9/1/03 - 2/29/04

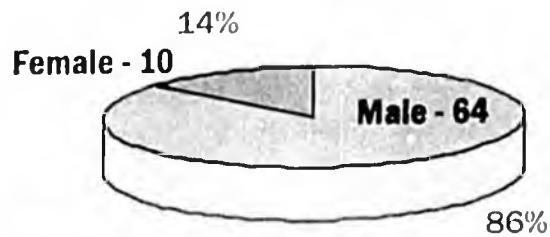


Source: Alaska Injury Prevention Center Follow Back Study. September 2003 - February 2004

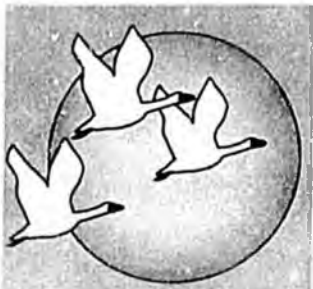
## Alaskan Years of Potential Life Lost 1993-2002



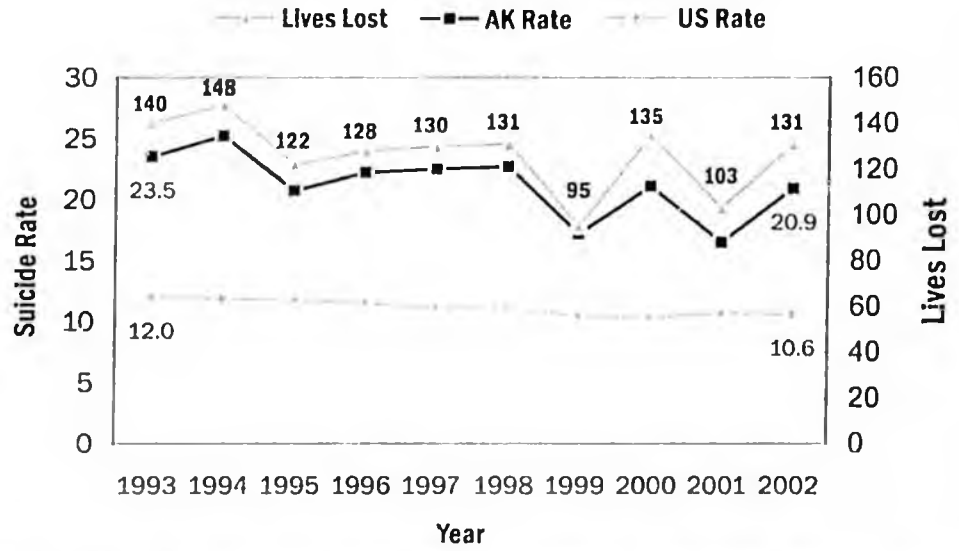
## September 2003 - February 2004 Suicide Gender



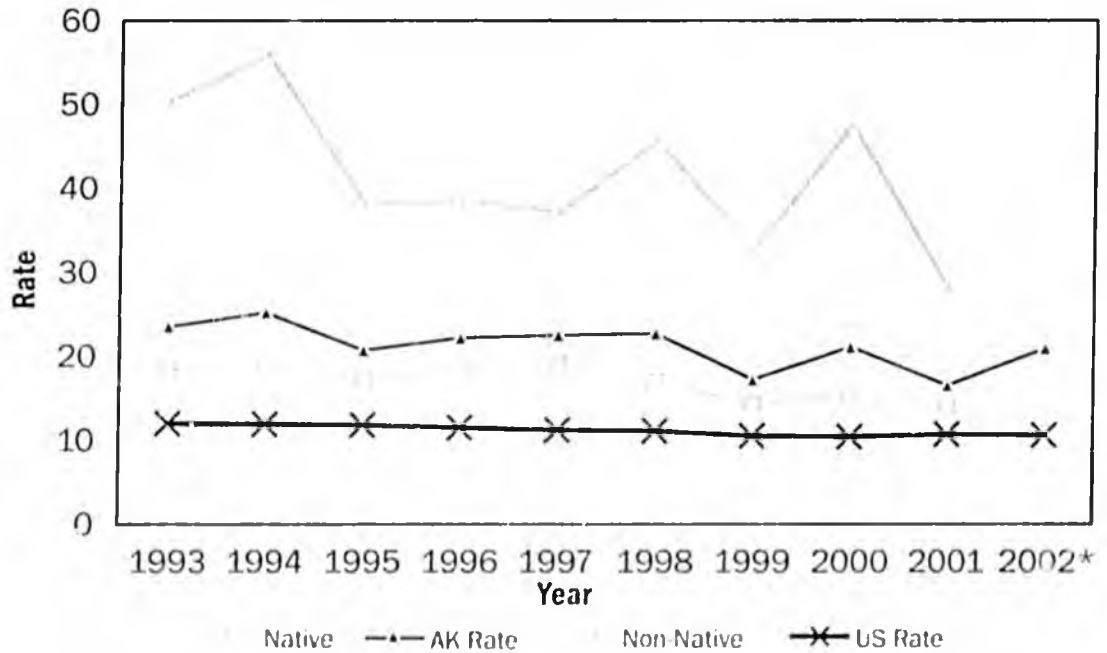
Source: Alaska Injury Prevention Center Follow Back Study. September 2003 - February 2004



### Alaska Suicide Rates 1993-2002

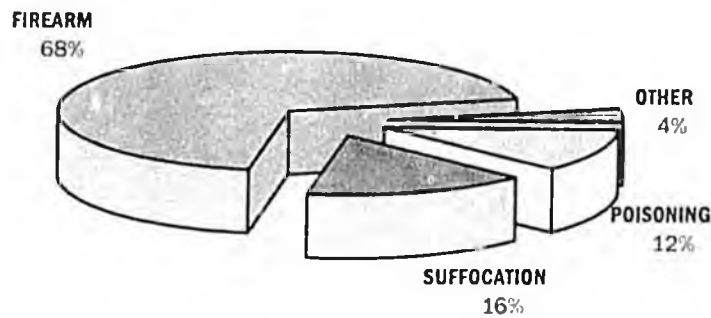


### Alaska, Alaska Native, and National Suicide Rates 1993-2002

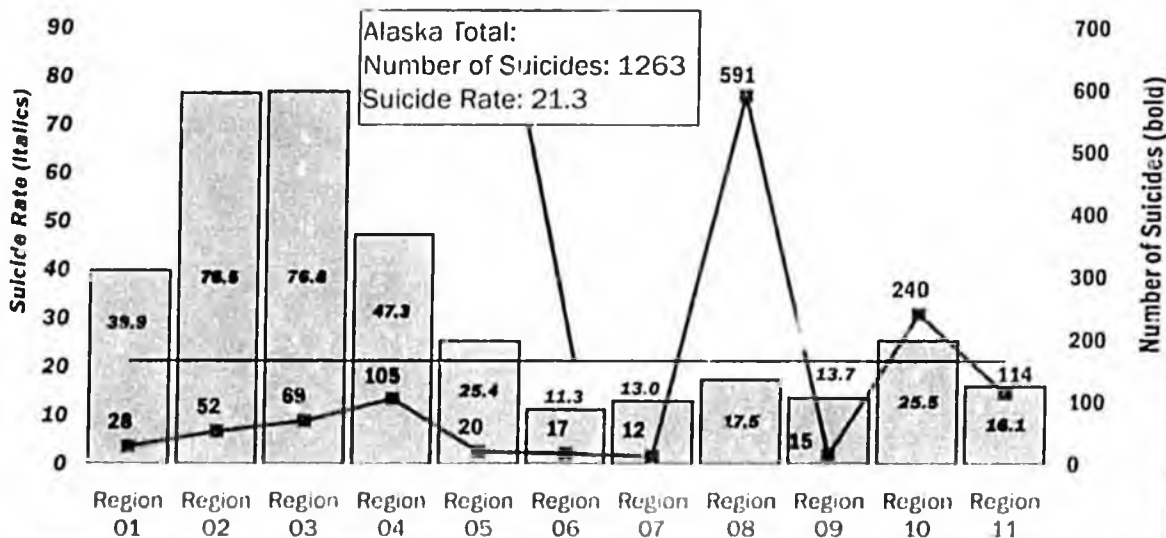


\* Population estimates by race are unavailable for 2002. Therefore rates can not be calculated

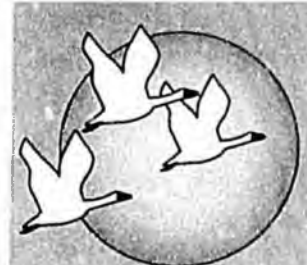
### Suicide Methods in Alaska 1993-2002



### 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



Report to the Legislature

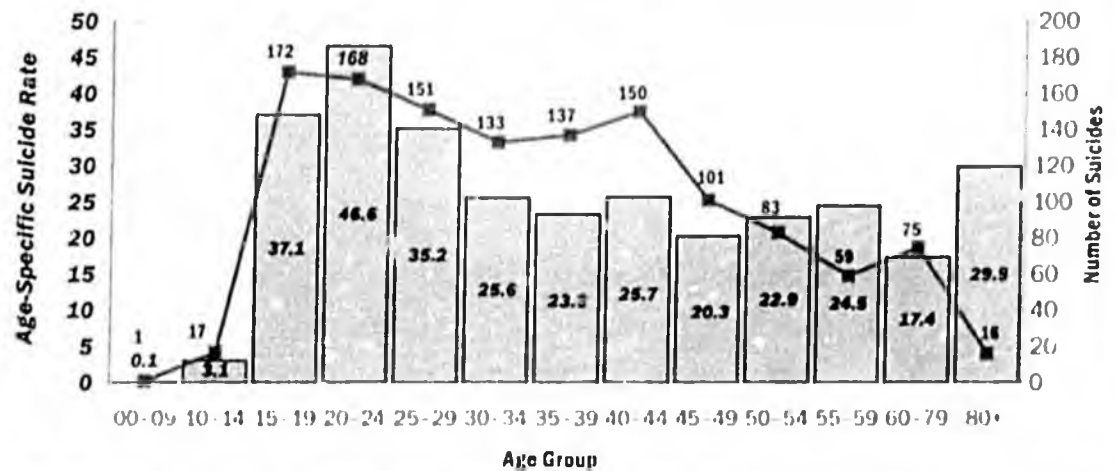


**Suicide Prevention Council**  
 Departmental Coordination Manager &  
 Suicide Prevention Council Staff  
 Department of Health and Social Services  
 Commissioner's Office  
 Office of Program Review  
 751 Old Richardson Hwy., Suite 100-A  
 Fairbanks, Alaska 99701-7802



# Suicide Prevention Council Annual Report to the Legislature: 2004

Alaska Age-Specific Suicide Rates and Number  
1993-2002



# Alaska Suicide Prevention Plan

Statewide  
Suicide  
Prevention  
Council



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

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

Tracy Barbec, *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*

Charles Jones, *Public*

Representative Mary Kapsner

Representative Pete Kott, *Speaker of the House*

Judith Lethin, *Chair-Elect*  
Advisory Board on Alcoholism and Drug Abuse

Senator Georgianna Lincoln

William Martin, *Recorder/Treasurer*  
Alaska Federation of Natives

Karen Perdue, *Public*

Susan Soule, *Division of Behavioral Health*

Jeanine Sparks, *Chair*  
Secondary School Counselor

Senator Ben Stevens, *Senate Majority Leader*

Stan Tucker, *Clergy*

Kathy Craft, *Suicide Prevention Council Coordinator*

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



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 Sparks, *Chair*  
Alaska Suicide Prevention Council