

**Helping Our Communities Heal:
The Alaska Postvention Resource Guide**

Summer 2011

Acknowledgments

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Disclaimer

Although the many aspects of suicide have been and continue to be studied, no single standard of care has been identified as an absolutely effective means of suicide assessment, prevention or postvention efforts. This resource guide is not intended to provide a perfect suicide postvention model, as no model for preventing suicide is guaranteed.

Helping Our Communities Heal does provide information, resources, and suggested guidelines that may be helpful to Alaskans who respond after a suicide occurs and/or work with individuals, families, and communities who experience a loss to suicide. In order for postvention efforts to be effective, individuals, families, organizations and communities must be prepared to step in after a suicide — to support those who have experienced a loss to suicide and help prevent subsequent suicide attempts and completions. This guide can help with that preparation.

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A Letter from a Survivor

My son joined the 1997 era of suicide statistics. He was 23 and Alaska Native. He used a firearm. There were no drugs in his body, so he was not included in that category. I am not a data person, but I had someone figure out how many months since my son completed his suicide: 13 years and two months or 158 months. And then some days, it feels like it was yesterday.

My first reaction to the idea of a postvention resource guide excited me. I looked at my invisible badge titled “survivor,” remembering the long and difficult journey, a journey I pray no one else ever takes. I am glad to see work is being done on the postvention piece of a suicide, what happens *after* the suicide.

With surviving any suicide, things do not happen overnight. There are no quick fixes. I found out for myself, the choices I make to help me on the journey to healing are my own. Each person’s crisis is personal, no two are alike, and there should be no comparison from one to the other.

Each healing journey has its own timetable, and each person grieves in her own special way. As I have discovered, even that person who completed his suicide had *his own reason*. All those unanswered questions we ask ourselves remain out there, in their own cosmic zone. It is not an easy road. I would be lying if I said that. Each day is a learning experience for me. Am I a Veteran Survivor? No, because there are days that see limp on the sofa, unable to move from the grief. But there are long periods of time between one of those days and the next.

What I discovered the hard way is that, to try to keep your head above water without bringing those you love down, it is difficult to ask for help. Even though they do not know “*how*” to talk to you, remember they are just an arm’s length away, willing and ready to help. That big boulder set on your heart will become lighter and then one day, you’ll awake to look at the calendar and count your surviving days.

I hope you keep an open mind with the suggestions in this resource guide. It is an open door, to many different rooms that hold ideas of how to approach life once again. Thanks to modern technology, we can breeze through different kinds of material that might meet our needs. This is a stepping stone to a greater understanding.

Peace be with you.



Barbara J. Franks
Barbara J. Franks
Mother of a Child Who Completed His Suicide
Ron D. II (Born 5/13/74, Died by Suicide 12/14/97)

Introduction

What is Postvention?

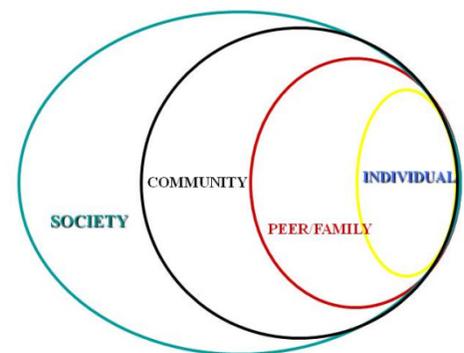
Postvention is the term for actions taken after a suicide. Examples include offering grief counseling for families and close friends, debriefing with first responders like health aides and police, coordinating support from local communities of faith, and talking circles held at schools, churches or community centers. The concept of postvention is based on the idea that a single suicide will affect many people.

The ecological model (Figure 1) shows how suicide affects not just the friends and family members of the person who died by suicide, but also the entire community and society. This creates a risk for suicide “contagion,” the domino effect of subsequent suicides and the primary event. Suicide contagion is a real phenomena affecting Alaska. Dealing with it must be a part of any postvention plan.

Postvention includes activities that support and promote help-seeking behaviors by people who might be at risk for depression and/or suicide as a result of the loss of a loved one. These activities can occur in the workplace, in schools, or other community or civic groups. They should connect with behavioral health resources in the community.

Postvention includes teaching people how to talk about a suicide death, which is key to changing how people perceive suicide. Talking about suicide in a public forum or in the media requires care and thought, to ensure that suicide is not glamorized or sensationalized. Comments must not lead to the belief that suicide is a normal reaction or solution for common life problems. Safe messaging guidelines are included in this guide to help frame the discussion of suicide in our communities.

Figure 1: Ecological Model of Impact of Suicide



Source: Suicide Prevention Resource Center

Primary Goals of Postvention

- Assist survivors of a loss to suicide, including family, friends and community members, in the grief process.
- Identify vulnerable individuals that may be at risk of suicide contagion and provide appropriate services to reduce that risk.
- Provide accurate information and safe messaging after a suicide, to reduce the risk of suicide contagion.
- Help a community heal by providing ongoing prevention efforts and services.

When is Postvention?

Postvention occurs after a suicide or attempted suicide. There is no set time table for effective postvention, though ideally efforts begin as soon after the suicide or attempt as possible. Planning and preparing to help heal our communities after a suicide must be considerate of the unique needs of the survivors of a suicide loss, as well as the wider community. It must also include support and assistance for the Alaskans engaged in postvention. For all of these people, healing “is not an easy road,” and it can be longer and more difficult for some than for others.

When a suicide occurs, the friends, family and neighbors affected by the loss can be expected to experience the usual grief and bereavement that occurs when someone dies. This is complicated by feelings of guilt, anger, depression, confusion, shock, and other emotions. Along with the survivors of the loss to suicide, the people who responded to (or may even have witnessed) the event may experience strong emotional and physical reactions like shock, anxiety, fear and confusion. Effective postvention efforts recognize the need for ongoing supports and assistance to survivors and providers.

Who Does Postvention?

Everyone can (and should) be involved in postvention – preventing suicide contagion and promoting healing. Community postvention efforts should include people who are trained to respond to emergencies, as well as people who can gather information quickly, assess safety, and communicate with others in order to provide safe, supportive resources to individuals, families and the community after a suicide. In addition to these professionals, community leaders, teachers, leaders of faith communities, and citizens all have a role in postvention.

Crisis intervention models and services are recommended and even mandated in a wide variety of community and occupational settings, to help mitigate the impact of a suicide on the survivors.¹ A care support team or emergency response team can be organized to meet the specific needs of your

CISM teams provide immediate relief or support during a suicide crisis. They are not designed to provide on-going counseling in the long term. It is important to understand how CISM fits in to the overall postvention plan.

Go to www.stopsuicidealaska.org for more information on available CISM trainings in your area.



¹ A Primer on Critical Incident Stress Management, George S. Everly, Jr., Ph.D., C.T.S. and Jeffrey T. Mitchell, Ph.D., C.T.S. The International Critical Incident Stress Foundation.

community and make the most of local and regional resources. Care support team members are often trained in Critical Incident Stress Management (CISM). CISM offers a specialized sort of response designed to be provided early in the postvention process.

Postvention requires more than a short-term emergency response. Some individuals, families and communities will need long-term counseling, support and care. Mental health, education, social services, and spiritual providers will need to be engaged in postvention over time to ensure that these needs are met.

POSTVENTION BECOMES PREVENTION*

GUIDING PRINCIPLES:

- Structure and information reduces chaos and insecurity; factual communication and open support reduces stigma and increases access to resources.
- Safe Messaging should guide all informal and formal communication.
- Grief will be expressed in many different ways and levels of impact/length of grieving will vary.
- How a suicide is handled affects the risk factors for others, especially youth and other vulnerable individuals.
- Traumatic loss and healing is a community issue, and does not belong to just one organization or group to resolve.
- Cultural practices and norms may guide responses to grief expressions.
- Be prepared to see the process through the long term.
- Self care and help seeking is important for EVERYONE to practice!

POSSIBLE KEY STAKEHOLDERS:

- Public health network
- Clergy/spiritual leaders
- Mental health center
- Substance abuse treatment center
- Law enforcement/first responders
- School crisis team members
- Behavioral health response team
- Community coordinator/disaster response team
- Social services
- Funeral director
- Medical examiner/coroner
- Media
- Survivors/survivor supports

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Postvention Planning

A suicide in your community is like throwing a stone in a pond, because the ripples expand out in every direction. Each suicide is unique in some ways, but all suicides cause a great deal of pain, sorrow and grief for many people in a community. How a community reacts to a suicide affects the overall well-being and health of a community and its residents. That is why postvention is so important — it is a way for a community to heal together from a suicide and to prevent suicide contagion among its most vulnerable citizens, particularly young people.

Postvention is the word used for responsibly reacting to a suicide. Postvention can include supporting and providing resources to people grieving the loss to suicide, promoting safe messaging to reduce suicide contagion, providing additional support services to those affected by and most vulnerable from the suicide, and implementing procedures for healthy community recovery. Postvention strategies can be carried out in many different ways depending on the size of the community, the age of the person who died, how and where the suicide occurred, the standing in the community of the person that committed suicide, etc.

The State of Alaska encourages communities and/or regions to create local suicide prevention coalitions, task forces or working groups to help promote suicide prevention, intervention and postvention. One of the important roles of these groups is to help plan and implement postvention efforts in a community after a suicide has occurred.

Suggestions for Creating a Suicide Prevention Group

Many communities throughout Alaska have created suicide prevention coalitions, task forces and work groups² in an effort to save lives, reduce stigma associated with suicide, and provide support and resources after a suicide has occurred. For some areas, particularly rural Alaska where villages are spread out, it might make more sense to create a regional group to better utilize limited resources. Setting up a suicide prevention group will take a lot of work, but the benefits could be saving a friend or loved one from suicide.

Consider the following questions when creating a suicide prevention group:

2 It doesn't matter what you call your suicide prevention group, as long as you have the right people engaged in the right work in the right way.

Who should be involved? No single person or agency can solve the problem of suicide in Alaska. It will take teamwork to prevent suicide in each community. School officials, tribal leaders, law enforcement, mental health professionals, doctors, first responders, clergy, veterans, elders, elected officials, youth leaders, social workers — all can provide a unique and important voice in a suicide prevention group. Consider the size of your community, the availability of participants, the cultural dynamics of the region and the practical size of a group that can work responsibly and effectively together. Then, invite them together to discuss forming a group (and what to call it).

Who is the leader? Your group will be more effective if it has an agreed-upon structure. Your group should select a coordinator or chair to help provide leadership and structure. Some suicide prevention groups have co-coordinators, so that it can continue its business if one coordinator is out of town or otherwise unavailable. Select someone to lead the group who is dependable, shows good leadership skills, works well with others, and has a strong reputation and working relationship in the community.

What is the mission? Suicide prevention is a broad topic and can have different realities in different communities. Your group should consider creating clear, concise and achievable suicide prevention goals that are tailored to the needs and experiences of your particular community. Goals will be different for a group in rural Alaska as opposed to a group in an urban area. One group might decide to focus on culturally relevant suicide prevention practices for the youth, while another may choose to focus on implementing a community-wide postvention plan. Write a mission statement that will guide the work of your suicide prevention group that can be shared with the community, local officials and the state.

How much time? Finding the time to conduct meetings with lots of people can be a challenge. Your group should decide on how often it wants to meet, considering the goals you set and how many people are involved. You may want to meet frequently at first, to get the initial work done and gain momentum. Or you may decide to meet more frequently in the winter and less frequently in the summer, because members' schedules prevent regular meetings during fishing/vacation/hunting seasons. Committed and consistent attendance at meetings by group members is imperative, so schedule meetings in a way that promotes attendance.

Where do we meet? It is important to decide on a regular, reliable location to hold meetings. Depending on the size of a community, it might be difficult to find adequate space for a large group, but try to find room for everyone to attend comfortably. Consider public meeting spaces like the local library, school, police station, or tribal organization board room, so that members of the public can attend. Find accessible places so that no one is excluded because of limited mobility. Consider multiple meeting

locations over the course of a year in order to reduce the burden on any single location (just remember to advertise when the location changes).

How do we pay for it? After the difficult job of creating and organizing a suicide prevention group will come the equally difficult job of sustaining it. If the group decides to apply for state or federal grants, it will need to become a non-profit organization or partner with an existing non-profit organization that is willing to administer suicide prevention grants. The group may also be able to partner with a city or village assembly/council to serve in an advisory capacity for the entire community.

How do we get the work done? If you assemble a large suicide prevention group, consider forming committees that focus on individual goals. Some members may want to focus their efforts on a certain area, such as public outreach, youth prevention, or postvention planning and response. Smaller groups might have to work as a committee of the whole, prioritizing goals and working on one or two at a time. Remember that you can invite other community members and organizations to participate in your committees on specific projects, without having to commit to membership in the suicide prevention group, when you need special skills, expertise or help.

Creating a Community Postvention Plan

Few communities in Alaska have policies or procedures in place for what to do when a suicide occurs. Communities should develop postvention policies and procedures, collaborating with local suicide prevention groups, tribal health organizations, city or village officials and others to agree upon on how to help residents cope and heal during a difficult time and reduce the risk of suicide contagion. Even a small postvention effort after a suicide has the potential to significantly reduce the risk of suicide for vulnerable members of a community.

A community postvention plan should include the goals of assisting survivors of a loss to suicide through the grief process; identifying vulnerable individuals at risk of suicide contagion and connecting them to needed services; providing accurate information about suicide; and helping provide ongoing prevention efforts and services. Consider the following suggestions when creating a community postvention plan:

Assemble the Right People. First, identify stakeholders, mental health professionals and community leaders who are willing and able to be part of a postvention response team. Not everyone involved in the local suicide prevention group may be right for the postvention response team, and there may be key members of the postvention response team that you will need to engage in your planning and response. You'll also need to identify a community coordinator who can lead the postvention efforts when they are needed.

Communicate Effectively. Set up a way to communicate with your postvention response team if a suicide occurs. An email list or phone tree are good ways to reach people quickly. Remember that some of your postvention response team members may not be part of your usual suicide prevention group (and so not part of those regular communications), so make sure you have a way to reach everyone on the team quickly. You may also consider establishing a meeting location where the response team can gather if a suicide occurs.

Provide Safe and Accurate Messaging. Your postvention response team will need a protocol to request and receive accurate information about the suicide. This may require formal memoranda of understanding/agreement with local law enforcement and health officials, to ensure that all legal and privacy protections are observed. Develop a relationship with your local news and media outlets so that you can inform them about safe messaging practices and establish an expectation that they will be observed. Also decide on a protocol for how the postvention response team will communicate with the general public if a suicide occurs to reduce the risk of contagion.

Be Ready. Everyone on your postvention team will need to know what services are available to survivors of a loss to suicide and wider community members, and how to effectively connect people to those services. While you can create your own resource guide, consider using directories from Alaska 2-1-1, the Alaska Mental Health Board, RurAL Cap, and others to help reduce expense and effort. Partner with social services organizations to create comprehensive service directories that serve many different needs. Once your team knows what is available, take time to connect to those service providers and discuss how referrals will be made and followed up on as part of the community postvention response. With these partners, identify those services/service providers that need to be automatically engaged after a suicide versus those that will be activated as needed.

Be Careful. Postvention response team members should be familiar with best practices and evidence or research-based postvention procedures to follow. The team should also be open to promising practices and those postvention efforts proven effective in other, similar communities.

Be Thoughtful. Create a protocol for how – and when – to interact with the family and friends of the deceased. Decide who will contact the survivors of the loss to suicide and how. Discuss how the team members will react when help is declined, and how to provide appropriate and helpful services when help is requested.

Once the postvention response plan is created, it should be made public so that everyone in the community understands what will happen, when and how.

Implementing a Community Postvention Plan

Postvention efforts need to be timely and consistent in order to effectively prevent suicide contagion. The postvention response team coordinator should convene a meeting of the response team, ideally within 24 hours, to discuss how the plan will be implemented and if any necessary modifications to the plan are required to appropriately respond to the specific suicide.

Focus on Facts. After a suicide occurs it is vital to ensure that misinformation is not circulating around the community, because this could lead to a greater risk of contagion. To make sure that rumors and misinformation are squashed, the postvention community coordinator should begin communicating with the response team as soon as it has been established that a suicide has occurred. Once the postvention response team has accurate information about what happened, decide whether to respond to any misinformation in the community. Be sure to follow your protocols carefully, so that every postvention response is consistent and fair.

Prepare. Take time to review response team protocols and best practice procedures, to be sure response efforts do not inadvertently cause more grief in the community. Contact identified service providers and have resources ready to go.

Reach Out. Reach out to the family, friends, and other survivors according to agreed upon protocols. These efforts should be coordinated, rather than team members reaching out in an independent or uncoordinated manner. Ensure that resources and services are provided if requested. Also identify potential vulnerable individuals in the community — people who are connected with the person who died by suicide through school, work, church, etc. and provide resources and services where needed. Determine if a community meeting is needed to discuss the risk of contagion and warning signs that someone is at risk of suicide, as well as resources and services available to people and families in crisis.

Communicate Carefully. Follow established protocols for communicating with media to ensure safe messaging is being followed in newspapers, on radio and television. There may be information team members have pursuant to a partnership with local law enforcement or health officials that cannot or should not be shared publicly. Team members must be careful to follow their own communication protocols to ensure safe and lawful communications about the suicide.

Follow Up. A suicide can have a long-lasting affect on a community. Grief can last for weeks, months or even years in some cases. Postvention response teams should consider following up after responding to a suicide to ensure the community is grieving in healthy and productive ways. The group might consider follow-up meetings after a

week or two, and another after a month or two. It is not only a benefit to the community to follow-up, but also to the response team itself.

Take Care. Recognize that some of the people working on the postvention response team may also have a personal or other connection to the person who has died by suicide, and that working to prevent suicide is emotional and sometimes heartbreaking work. Be sure that team members themselves know how to access support and counseling services, and provide the opportunity to meet to debrief. You may want your team members to be trained in Critical Incident Stress Management or another post-crisis debriefing model.

Evaluate. After the postvention efforts have concluded, the response team should meet to evaluate their effectiveness. Determine the successes and difficulties during the response efforts. Review the postvention plan and your protocols, updating any to reflect lessons learned. Review resources and resource providers and make any necessary changes to your directories or protocols. Major changes to your plan or protocols should be made public, so that your community has reasonable expectations for what will happen after a suicide.

Community Postvention Planning Resources

Connect Suicide Prevention Project

www.theconnectproject.org

A comprehensive, community-based approach to suicide prevention, intervention and postvention (actions taken after a suicide) developed by NAMI NH. Using a public health approach, the program encourages the development of a community network of service providers and citizens, trained to recognize persons at risk and connect those individuals in an integrated, systematic and comprehensive way with help to prevent suicide and/or respond after a suicide occurs.

Family Members

If you live in Alaska, you probably know about someone that has died by suicide. It could be a brother, a mother, an uncle, a friend, a neighbor, a coach. You are not alone. Alaska consistently has the highest per capita rate of suicide in the country, and so there are many Alaskans that have lived through the pain of suicide.

Experiencing the loss of someone you care about to suicide is difficult for anyone to go through. There may be many overwhelming feelings, including guilt, sorrow, shame, anger, shock and heartache. Depression and thoughts of suicide are common among people who have experienced a loss to suicide. Survivors of a loss to suicide do not have to struggle with these feelings alone.

Postvention efforts focus on the sources of help and support for survivors, and reinforce that suicide is not a solution to pain and distress. There are people and agencies throughout the state that are ready to provide help and reassurance after a suicide.

There is still a great deal of stigma related to suicide in Alaska. Many people find it uncomfortable to talk about suicide, or to talk to someone who has lost someone to suicide. People drift away from survivors because they feel awkward or don't know what to say or are afraid talking about what happened might cause more harm than good. However, there are other people who are able to support survivors of a loss to suicide in grieving and healing.

It is essential to have a support system during the grief and healing process. This support system can include family, friends, and other survivors of a loss to suicide. Suicide contagion is a very real concern after a suicide, particularly for those close to the person who died, so having a group of people to reach to out during the ups and downs of the grieving cycle is extremely important. It is also important to know when the love and support of friends and family is not enough – and to seek help from mental health providers and other health care professionals when appropriate.

Recovering from a loss by suicide is unique to each individual person. Here are some things to think about during the grieving process:

Guilt. It is natural to feel a sense of guilt after a friend or loved one has died by suicide. Most people will ask why they didn't do anything to prevent their friend or loved one from choosing suicide and will feel guilty for not being able to stop them. However, survivors should not assume blame for someone's suicide. Most people who die by suicide have a diagnosable mental illness, such as depression, bipolar disorder or schizophrenia.³ Survivors of suicide may feel guilt at new milestones in life (weddings, promotions, graduations), because they feel joy from the accomplishments. Postvention efforts should reinforce that it is okay to live life and feel joy.

3 National Institute of Mental Health. (2003). In harm's way: Suicide in America (Rev.).

Anger. It is natural to feel angry after a friend or loved one has died by suicide. Survivors feel anger toward people who “could have done something,” and that sometimes includes the survivor herself. Survivors may also feel anger at the person who died for choosing to commit suicide, to cause pain and grief to the people still living.

Time. As Barbara Franks shared in her letter at the beginning of the resource guide, the road to recovery is long. No one ever really “gets over” a loved one’s suicide. They just learn to cope with the loss over the time. Recovery will take different amounts of time for different people; there is no set time for grieving and healing. There will be good days and there will be bad days. Expect setbacks during the healing process and be prepared to support the survivor of the loss to suicide throughout the recovery process.

One Step at a Time. In the days and weeks after a suicide, help the survivors of the loss focus on immediate responsibilities and encourage them to wait to make any major decisions. As the recovery process goes on, help the survivors take on more. Recognize that some days will be much more painful than others, such as birthdays, anniversaries, graduations, holidays. Encourage survivors of a loss to suicide to reach out for support when they need it. Recognize that small things — a song, a favorite restaurant, a favorite sports team — can bring back sorrowful emotions. Encourage survivors to associate those small things with pleasurable memories of the person who died.

Take Care. Remember to take care of yourself. Grieving can be stressful both physically and emotionally. Supporting someone through the grief process can cause stress too. Encourage survivors to take care of basic needs, like sleeping enough, eating well and exercising, and then do the same for yourself. Sometimes professional help from a doctor or mental health provider might be needed, by the person who lost someone to suicide and by the person providing the support. Accessing that sort of help is important to healing and recovery.

Resources

Careline Crisis Intervention

www.carelinealaska.com

Careline is the statewide crisis intervention hotline. To speak with a trained Alaskan suicide prevention specialist, call 1-877-266-4357 from anywhere in Alaska or text 907-2-LISTEN. Crisis intervention by email and live chat are available online at Careline’s website. Friend Careline on Facebook for regular updates and information.

StopSuicideAlaska.org

www.stopsuicidealaska.org

StopSuicideAlaska.org is the state’s suicide prevention web portal. StopSuicideAlaska.org provides information, a calendar of events, interactive data references, and free hosting of

suicide prevention group sites. The purpose of the site is to provide education and ongoing support for Alaskans engaged in suicide prevention by creating an online suicide prevention community. You can also friend StopSuicideAlaska.org on Facebook to connect with almost 500 people supporting suicide prevention in Alaska.

Statewide Suicide Prevention Council

www.hss.state.ak.us/suicideprevention/

The Statewide Suicide Prevention Council has a variety of resources and information available on its site.

National Suicide Prevention Lifeline

www.suicidepreventionlifeline.org

Call 1-800-273-TALK (8255) 24 hours a day, 7 days a week to talk to a crisis intervention specialist.

American Association of Suicidology (AAS)

www.suicidology.org

A listing of support groups by state, as well as support groups in Canada, is provided through the American Association of Suicidology website. Also provided are extensive educational and research materials about suicide prevention, intervention and postvention. The Suicide Survivors' Handbook included in this packet is also available on their website, free for printing.

American Foundation for Suicide Prevention (AFSP)

www.afsp.org

You can search for support groups by state on the AFSP site and find information about suicide prevention, intervention and postvention. It provides a search tool to find support groups by state.

Suicide Prevention Resource Center

www.sprc.org

The Suicide Prevention Resource Center is the national center for excellence for the field of suicide prevention. The SPRC website includes postvention resources for general as well as specific populations, as well as prevention and intervention tools and materials. The SPRC website also has community education resources that are free for use.

SAVE: Suicide Awareness Voices of Education

www.save.org

An organization dedicated to education about suicide and mental illness, SAVE was founded by survivors of a loss to suicide. The organization's website contains a "Coping with Loss" section for survivors.

SPAN: Suicide Prevention Action Network

www.spanusa.org

The Suicide Prevention Action Network is dedicated to advocacy for suicide prevention.

Community Behavioral Health Providers

Alaska's community behavioral health centers have very specific responsibilities for their communities' health and well-being. These include linking with local partners to provide follow-up services to community members and families after a suicide occurs, which in turn supports the state suicide prevention plan. As part of a community postvention effort, behavioral health providers offer outreach, assessment, treatment, and recovery supports.

Outreach. After a suicide, family and community members are likely to be too upset to access services on their own. It is important for community behavioral health providers to reach out to survivors of a loss to suicide, to inform them of the services available and how to access them. By coordinating with other local health providers, teachers, employers, family members, friends, and spiritual leaders, behavioral health providers become part of an important network of support, of people staying in touch with those affected by the suicide and making sure that they know they are supported.

Gatekeepers. In addition to the survivors of a loss to suicide, there may be other emotionally vulnerable people in the community who see the event as encouragement to make the same choice. This is an especially important time to be vigilant and watch for warning signs of suicide among family, friends and neighbors — and to be available to provide behavioral health treatment services — to reduce the possibility of suicide contagion.

Taking Care. Providing care in the aftermath of a suicide can be a complex job. It can also be stressful and emotionally draining. Do not be afraid to talk with colleagues and to learn from each other's experiences.

Coping. Survivors of a loss to suicide often focus on finding answers, causes, people or things to blame for the suicide. Dwelling on how or why the suicide occurred may increase emotional distress and risk for depression. Ways of coping with the loss to suicide are more important, to the provider and to the survivors.

Safe Messaging. Community members may sensationalize or glorify the suicide. It is possible that inaccurate information and rumors may spread through the community. Special attention must be paid to ensure that public information follows safe messaging guidelines. Suicide is a complex phenomenon, so it's important to talk to people about suicide in clear and simple terms. Educate people about how suicide is often the result of serious mental health problems but be careful to note that, sometimes, people choose to commit suicide because of circumstances and life experiences that we do not always understand.

Debriefing. The community may require time to debrief after a suicide. Behavioral health providers are an ideal resource for this process, and can ensure that individuals identify as at higher risk during the process access the appropriate treatment and support. Partnering with youth organizations, communities of faith, and other civic organizations to offer talking circles, safe places to talk and ask questions, helps make

sure that people in need of behavioral health services after a suicide know who to go to and how to access services.

Resources

SAMHSA's Practice Guidelines: Core Elements in Responding to Mental Health Crises

<http://store.samhsa.gov/home>

People with mental illnesses are vulnerable to repeated clinical and life crises that can have profound effects on the individual, families, and communities. These crises are not the inevitable result of mental illness, but a result of many factors: lack of access to essential services and supports, poverty, homelessness or risk of homelessness, co-occurring substance use disorders, co-morbid health conditions, discrimination, abuse and victimization.⁴ Situations involving mental health crises may include intense feelings of personal distress (anxiety, depression, anger, panic, or hopelessness), obvious changes in functioning (neglect of personal hygiene), or catastrophic life events. For people experiencing serious mental illness, the loss of a loved one to suicide can significantly increase the risk of self-harm and suicide.

Behavioral health providers should consider the special needs of individuals experiencing mental illness and/or addiction in the aftermath of a suicide. A new resource from the Substance Abuse and Mental Health Services Administration (SAMHSA), [Practice Guidelines: Core Elements for Responding to Mental Health Crises](#), defines appropriate responses to mental health crises. Developed by a diverse expert panel that included mental health professionals, consumers and others promote two essential goals: ensure that standards consistent with recovery and resilience guide mental health crisis interventions and replace reactive and cyclical approaches to mental health crises with treatment services designed to reduce the likelihood of future emergencies and produce better outcomes.

Community Action Plans

[http://www.hss.state.ak.us/dbh/PDF/Community Planning Service Areas Policy 04-05-10.pdf](http://www.hss.state.ak.us/dbh/PDF/Community_Planning_Service_Areas_Policy_04-05-10.pdf)

The Alaska Community Service Planning Area Policy includes the communities which all community mental health center agencies serve.

Suicide Prevention Resource Center

<http://www.sprc.org/>

The Suicide Prevention Resource Center is the national center for excellence for the field of suicide prevention. The SPRC website includes postvention resources for general as well as specific populations, as well as prevention and intervention tools and materials. The SPRC website also has community education resources that are free for use.

4 Paolo del Vecchio, M.S.W., Associate Director for Consumer Affairs at SAMHSA's Center for Mental Health Services.

Community Gatekeepers

A gatekeeper is anyone in the community who can identify a person at risk of suicide and can connect the person to immediate help or resources. Alaska gatekeepers receive training in order to learn the risk factors and warning signs for suicide, as well as protective factors that protect a person against suicide. Gatekeepers have a general knowledge about the data and research that explain the circumstances of people who are suffering from severe psychological and emotional pain, possible depression, effects of drugs and alcohol, past trauma, or unhealthy relationships.

Gatekeepers practice intervention skills such as active listening, relationship building, assessment of suicide risk, and developing action plans with the individual to help identify community resources and making appropriate referrals as necessary. There are several models of suicide intervention and gatekeeping training. The Alaska Department of Health and Social Services offers a basic Gatekeeper training. Mental Health First Aid, an internationally recognized model of suicide prevention and intervention, is available through Denali Family Services (thanks to a grant from the Alaska Mental Health Trust Authority and other funders). The Alaska Native Tribal Health Consortium (ANTHC) has trained hundreds of Alaskans in Applied Suicide Intervention Skills Training (ASIST), an evidence-based model used nationwide. ANTHC is expanding their efforts to include SafeTalk, a model focused on training youth as gatekeepers.

Gatekeepers are an important part of postvention efforts. They have the skill and training to help identify survivors of a loss to suicide and other emotionally vulnerable individuals who might be at risk of suicide, and then to connect them to the right services and supports to keep them safe. Gatekeepers can serve as part of an emergency response team, providing unique insight and information (as members of the wider community) to the other team members. They can help survivors and community members reduce access to lethal means after a suicide, by educating community members about the need to secure firearms, weapons, pills, etc.

Resources

Mental Health First Aid

www.mentalhealthfirstaid.org

Mental Health First Aid is a public education program that helps the people identify, understand, and respond to signs of mental illnesses and substance use disorders. Mental Health First Aid USA is managed, operated, and disseminated in part by the National Council for Community Behavioral Healthcare. Training on Mental Health First Aid is available through Denali Family Services. Contact Chris Gunderson cgunderson@denalifs.org for more information.

ASIST and SafeTalk

<http://www.livingworks.net/>

<http://isafetalk.livingworks.net/>

ASIST is a model developed by Living Works. The Alaska Native Tribal Health Consortium (ANTHC) has been very active in developing prevention, intervention and postvention supports for tribal organizations and Native communities and have trained hundreds of people in ASIST. To learn more about how ASIST trained Alaskans can contribute to postvention efforts, contact Hillary Strayer, hstrayer@anthc.org.

SafeTalk is a similar model developed by Living Works, targeting youth as gatekeepers. ANTHC is beginning to expand their suicide intervention training program to include SafeTalk. For more information, contact Barbara Franks, bjfranks@anthc.org.

Gatekeeper

The Department of Health and Social Services, Division of Behavioral Health provides Gatekeeper training. To learn more about how Alaskans trained as Gatekeepers can contribute to postvention efforts, contact James Gallanos, james.gallanos@alaska.gov.

Members of the Media

Journalists and members of the media play an important role in preventing suicide. If a reporter covers a suicide properly and ethically, the story can help a community come together, heal, and learn from the tragedy. If a reporter covers a suicide with disregard for the individual, the family and the community, the story could result in subsequent suicides.⁵ It is important to avoid misinformation — which can actually lead to an increase of stigma on the subject — and to offer hope in coverage when it is appropriate.

National suicide prevention organizations — including the American Association of Suicidology and the American Foundation on Suicide Prevention — have created recommendations on how to report on suicide. The Statewide Suicide Prevention Council feels it is imperative that news organizations consider these guidelines when reporting on suicide in Alaska to help reduce potential contagion, reduce stigma, and create a culture that encourages help-seeking.

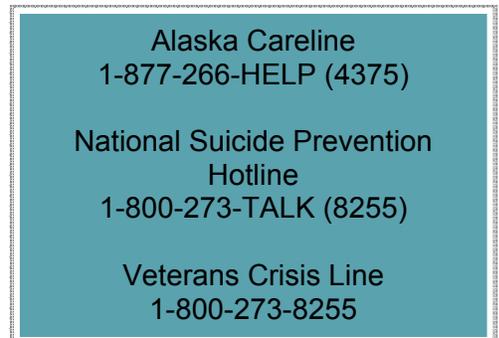
Suicide is a complex issue that cannot easily be explained or described in the media. Researchers are still learning about the web of causality that leads to suicide. Thus, reporters should avoid making assumptions as to why someone committed suicide or providing events in a person's life that may have preceded a suicide. This can oversimplify the issue and mislead the readers, as well as create an inaccurate picture of the individual.

Guidelines and Best Practices

Not all suicides are newsworthy. Editors and news managers may feel that suicides committed in public or by a public person need to be covered, which is understandable. However, it is important that those suicides are covered carefully and with the understanding that a news story can change public perception positively or negatively.

5 American Association of Suicidology, www.reportingonsuicide.org.

Members of the media need to be aware of the risk of suicide contagion, the “domino effect” of suicides after a primary event, and how their work can increase or decrease that risk. Suicide contagion has been linked by researchers to dramatic headlines, images or graphics used to describe/depict the suicide; sensationalizing or glamorizing a death by suicide by the media; news stories that describe the method of death in detail (identifying the caliber of gun, how and where a person shot himself, describing what type of medication and the quantities used, etc.); and prolonged or excessive news coverage of a suicide.⁶



News stories about a suicide should always include the local and national crisis line information. Stories should also include information about the warning signs that someone is at risk of suicide, to help readers better understand how to identify when someone is in crisis.

Well-documented suicide warning signs⁷ include:

- Threatening to hurt or kill oneself, or talking about wanting to hurt or kill oneself;
- Looking for ways to kill oneself by seeking access to firearms, available pills, or other means;
- Talking or writing about death, dying or suicide when these actions are out of the ordinary for the person;
- Uncharacteristically acting recklessly or engaging in risky activities — seemingly without thinking;
- Experiencing dramatic mood changes; and
- Seeing no reason for living or having no sense of purpose in life.

Consider including information about who may be at risk of suicide⁸, such as people who:

- Feel hopeless, worthless, trapped or intolerably alone;
- Have a firearm in the home;
- Have increased their use of alcohol or are binge drinkers;
- Have attempted suicide in the past;
- Have been exposed to the suicide of another person;

6 American Association of Suicidology, www.reportingonsuicide.org.

7 Information is from the American Association of Suicidology

8 Information is from the American Association of Suicidology

- Have a history of violence;
- Have become isolated from friends, family, society and support systems; or
- Are not receiving the mental health care they need.

Resources

Careline Crisis Intervention

www.carelinealaska.com/

Careline is the statewide crisis intervention hotline. To speak with a trained Alaskan suicide prevention specialist, call 1-877-266-4357 from anywhere in Alaska or text 907-2-LISTEN. Crisis intervention by email and live chat are available online at Careline's website. Friend Careline on Facebook for regular updates and information.

StopSuicideAlaska.org

www.stopsuicidealaska.org

StopSuicideAlaska.org is the state's suicide prevention web portal. StopSuicideAlaska.org provides information, a calendar of events, interactive data references, and free hosting of suicide prevention group sites. The purpose of the site is to provide education and ongoing support for Alaskans engaged in suicide prevention by creating an online suicide prevention community. You can also friend StopSuicideAlaska.org on Facebook to connect with almost 500 people supporting suicide prevention in Alaska.

Statewide Suicide Prevention Council

www.hss.state.ak.us/suicideprevention/

The Statewide Suicide Prevention Council has a variety of resources and information available on its site.

National Suicide Prevention Lifeline

www.suicidepreventionlifeline.org

Call 1-800-273-TALK (8255) 24 hours a day, 7 days a week to talk to a crisis intervention specialist.

American Association of Suicidology (AAS)

www.suicidology.org

A listing of support groups by state, as well as support groups in Canada, is provided through the American Association of Suicidology website. Also provided are extensive educational and research materials about suicide prevention, intervention and postvention. The Suicide Survivors' Handbook included in this packet is also available for on their website, free for printing.

American Foundation for Suicide Prevention (AFSP)

www.afsp.org

You can search for support groups by state on the AFSP site and find information about suicide prevention, intervention and postvention.

Suicide Prevention Resource Center

www.sprc.org

The Suicide Prevention Resource Center is the national center for excellence for the field of suicide prevention. The SPRC website includes postvention resources for general as well as specific populations, as well as prevention and intervention tools and materials. The SPRC website also has community education resources that are free for use.

SAVE: Suicide Awareness Voices of Education

www.save.org

An organization dedicated to education about suicide and mental illness, SAVE was founded by survivors of a loss to suicide.

Schools⁹

Suicide by a member of the school community is tremendously sad, often unexpected, and can leave a school questioning what to do next. Faced with students struggling to cope and a community struggling to respond, schools need reliable information, useful tools, and practical guidance. The American Foundation for Suicide Prevention (AFSP) and the Suicide Prevention Resource Center (SPRC), two of the nation's leading suicide prevention organizations, have collaborated to produce resources to help schools determine what to do, when, and how after a suicide occurs.

Suicide contagion is the term for the “domino effect” of suicides that occur soon after a primary suicide. Sometimes suicide contagion can occur after a young person dies by other means, such as an accident. Although suicide contagion is comparatively rare nationally, adolescents appear to be more at risk after the loss of a peer to suicide than adults. This may be because they identify more readily with the behavior and qualities of their friends and peers.

Suicide contagion is a serious concern in Alaska. If there appears to be a risk for suicide contagion, school administrators should consider taking additional steps beyond the basic crisis response. This should include stepping up efforts to identify other students who may be at heightened risk of suicide, collaborating with community partners in a coordinated suicide prevention effort, and possibly bringing in outside experts.

AFSP and SPRC explain the underlying principles for school-based postvention:

Be Consistent. Schools should treat all student deaths in the same way. Having one approach for a student who dies of cancer and another for a student who dies by suicide reinforces the stigma that surrounds suicide. It can also cause pain and confusion for the family of the student who has died by suicide.

Be Careful. Schools should also be aware that adolescents are vulnerable to suicide contagion. Responses to student suicides must not inadvertently glamorize or romanticize the student or his/her death.

Educate. While the privacy of the student who died by suicide and his/her family should be respected, schools should include in their postvention efforts an educational component that teaches students about the role of depression and mental illness in suicide. Incorporating training on SafeTalk or other suicide intervention models is a way of building student resilience against suicide contagion.

⁹ Excerpted from the *After a Suicide: A Toolkit for Schools*, SPRC (2011)
<http://www.afsp.org/files/Surviving/toolkit.pdf>

Follow Through. Ensuring that support and treatment services are available to students who may be at risk of depression or self-harm after the loss of a friend to suicide is key to school-based postvention efforts. If these services are beyond the capacity and/or expertise of the school staff, it is important that the school bring in community behavioral health professionals and others to address the needs of the students.

Teachers and school staff also have a role in community wide postvention efforts. Coordinating crisis response with community partners (mental health providers, spiritual leaders, youth organizations, etc.) allows schools to better support students and parents struggling with a loss to suicide. Schools can supplement postvention and crisis response from community service providers by providing safe and appropriate opportunities for students to express emotions and identify personal strategies for managing them.

After a student suicide, schools are often asked by family and friends to memorialize the person in a large event. It can be challenging for schools to find a comfortable balance between compassion for grieving students and preserving the school's primary purpose of education. In the case of suicide, schools must also consider how to appropriately memorialize the student who has died without risking suicide contagion among surviving students who may themselves be at risk. This is why it is so important that schools strive to treat all deaths in the same way.

Resources

Alaska Department of Education and Early Development

www.eed.state.ad.us

Alaska Association of School Boards

<http://aasb.org>

Centers for Disease Control and Prevention (CDC)

Recommendations for a community plan for the prevention and containment of suicide contagion, online at:

www.cdc.gov/mmwr/preview/mmwrhtml/00001755.htm.

Articles and Research

Kerr M.M., Brent D.A., McKain B., McCommons P.S.A guide for a school's response in the aftermath of sudden death.4th edition.(2003)

www.starcenter.pitt.edu/files/document/Postvention.pdf.

Faith Based Communities and Clergy

Communities of faith can offer a focus on healing when a suicide occurs because faith often plays such an important and vital role in many communities. Communities of faith play a particularly important role in many Alaska communities because of the fellowship provided in isolated villages and towns. When a suicide occurs, the immediate families, friends and the community as a whole will need a central place to come together to grieve, heal, and understand.

Close friends and immediate family are at a much greater risk of harming themselves after the suicide of a loved one.¹⁰ There remains a stigma associated with suicide that can cause shame, guilt and embarrassment for the family and friends of someone who commits suicide. That can, in turn, make the grieving process more difficult. Because of this, clergy members and leaders of communities of faith should address the issue of suicide with “sensitivity, compassion, grace and love.”¹¹

Beliefs about suicide vary according to different traditions of faith. Communities of faith will handle a death by suicide in different ways. The different cultures of Alaska have also developed unique ways of coping with a loss to their community by suicide. While these differences exist, all survivors of a loss to suicide need compassion and understanding during a very difficult time.

Only the person that took his or her own life could ever explain the reasons why he or she chose to commit suicide. Some people believe that a person commits suicide because of a “moral weakness” or a character flaw, but research has shown this is not true. The National Institute of Medical Health has reported that 90 percent of suicides are believed to be committed by people experiencing a mental illness that creates psychological pain they could not escape.¹² These people - often experiencing depression, bi-polar disorder, schizophrenia or other diagnosable mental illnesses – may not have believed there was an option for help and so decided to ease their psychological pain through suicide.

It is important for members of the clergy and religious leaders to remember that the family, friends and community experiencing a loss to suicide may be dealing with psychological burdens similar to those of the person who died, and those burdens can be made heavier by a loved one’s suicide. It can be difficult to determine who in a

10 Centers for Disease Control and Prevention

11 Suicide Prevention Resource Center. (2004). After a suicide: Recommendations for religious services and other public memorial observances. Newton, MA: Education Development Center, Inc.

12 National Institute of Mental Health. (2003) In harm’s way: Suicide in America (Rev.).

community may be feeling this extra burden during the grieving process, so it is important to be careful and compassionate in the emotional, psychological, and spiritual support offered after a suicide.

Get the Facts. It is important to provide accurate information about suicide. Rumors, speculation and false information can cause great harm to a community in the aftermath of a suicide. Encourage congregants and community members not to gossip about the incident.

Offer Help. Communities of faith can be a place of great comfort for grieving people. Spiritual guidance can be very important to survivors of a loss to suicide and leadership from leaders in the community of faith can help reduce the chances of additional suicide (or suicide contagion).

Suggest Help. No single person or organization can solve the issue of suicide contagion. If someone is in need of help beyond the scope of the community of faith and/or its leaders, help the person in need of help make contact with mental health professionals – or, at the very least, Careline (1-877-266-4357).

Support Survivors. If your community of faith provides space for different types of support groups, such as Alcoholics Anonymous, think about offering a similar opportunity to support groups for people who have survived a loss to suicide or who have survived a suicide attempt. You could also encourage your members to start a survivors support group, or help advertise an existing community group for survivors.

Be Part of the Team. Many communities throughout Alaska have created suicide prevention task forces/coalitions to help promote suicide prevention, intervention and postvention. Clergy members and religious leaders have been an important part of many of those groups. Join a local or regional task force/coalition, or, if there is not a suicide prevention group to join, work with other local leaders to create a task force, coalition or working group.

Spread the Word. As a central meeting place for many people in a community, communities of faith are a great place to share information. Newsletters, worship programs, bulletins, etc. all provide an opportunity to share information about resources for survivors of a loss to suicide. Create a brochure or a poster about suicide prevention resources or counseling available through local pastoral resources and the community mental health providers. Provide posters or information that includes the Alaska Careline or the national crisis intervention telephone numbers (create your own or call the Statewide Suicide Prevention Council at 907-465-6518 for materials).

Remain Available. Grieving the death of a loved one by suicide will be different for every survivor of a loss to suicide. Some will experience immediate grief, while others

will need some time to express their feelings and heal from the pain. Everyone deals with grief differently and at their own pace. This is true for the recovery process for people who have survived an attempt to commit suicide. Some will find stability and recover quickly, while others will struggle to find it. Recognize that support from the community of faith and its leaders may be needed long after the loss or attempt. When counseling a congregant or family, offer to be available in the future should the person need support or help.

Check In. Survivors of a loss to suicide may feel isolated after their loved one's suicide. Survivors of an attempt to commit suicide may feel the same way, due to stigma or feelings of shame or being judged. People may feel uncomfortable talking to a survivor because of the stigma associated with suicide. Check in from time to time with the survivor to see how he or she is doing. Knowing someone cares can go a long way to reducing the risk of suicide among survivors of a suicide loss or attempt by helping someone feel like a valued part of a community.

Lend a Hand. Losing someone to suicide can create more than just an emotional void. Whether it is a spouse, parent, sibling or child that commits suicide, there will be a physical void left as well. The survivor or survivors of that loss may need help with simple tasks like chopping wood, picking up kids from school, cooking dinner or helping with homework. Lending a hand — and encouraging the members of your congregation to lend a hand — with basic chores can help provide much needed time and space for a survivor to grieve and heal.

Provide a Service: A memorial service is difficult to plan for anyone who has passed away, but services for people who have committed suicide can be particularly difficult. Issues such as the particular traditions of faith regarding suicide, social stigma associated with suicide, unanswered questions, and heightened risk of suicide by survivors of the loss are all things to be considered in planning the service. Assisting the family and friends with the details of a memorial service or funeral can help ease a tremendous burden on survivors of a loss to suicide.

Consider Appropriate Public Memorials. It is natural for people to want to honor their friends or loved ones when they die, particularly when the person dies at a young age. However, grand memorials can glamorize the suicide and actually encourage other people who feel lost, ignored, depressed and alone to choose to commit suicide as a way to acknowledged by the community.¹³ Permanent fixtures such as statues, crosses, park benches, etc. and naming buildings such as youth centers or basketball courts

13 There have been cases in the past where people or communities have created public memorials to honor someone who died by suicide that people believe contributed to other suicides, according to the Centers for Disease Control and Prevention.

after the person who died by suicide are therefore discouraged by professionals, because it could be perceived by vulnerable youth as a glorification of the person's suicidal act. Memorial events such as concerts, basketball tournaments, poetry jams or other public performances should be avoided (or carefully designed), because they could inadvertently increase risk of suicide in vulnerable youth, particularly those that feel a lack of attention and want something done in their honor. Encourage constructive ways to honor the person's life and promote healing. For example, encourage the youth group of your community of faith to get involved in suicide prevention events or organize their own. Offer your place of worship as a space for friends and family to hold a fundraiser for local suicide prevention efforts. Encourage congregational events that focus on the importance of living a long, healthy, productive, honorable, and fulfilling life to honor the person who died.

Funeral Directors/Memorial Officers

Like leaders of communities of faith, the people responsible for arranging burial, funeral services and memorials have a role in postvention efforts. Not only do these individuals have a direct relationship with the survivors of the loss to suicide, but they also have a chance to provide information and comfort to the wide community as it seeks to heal after the suicide. It is important that funerals or memorials services “foster an atmosphere that will help survivors understand, heal, and move forward in as healthy a manner as possible.”¹⁴ Accurate information and responsible communication after a suicide are very important, because that information has the potential to increase or decrease the risk of additional suicides among those affected by the loss.¹⁵

The Suicide Prevention Resource Center recommends eight areas to consider when planning a funeral or memorial service:

- Comfort the Grieving
- Help Survivors Deal with Feelings of Guilt
- Help Survivors Face Feelings of Anger
- Address Stigma
- Use Appropriate Language
- Prevent Imitation and Modeling
- Consider the Special Needs of Youth
- Consider Appropriate Public Memorials

Comfort the Grieving. A death by suicide will lead to many questions from survivors and great emotional pain. Suicides are often sudden and unexpected, with a high percentage in Alaska by young people, so the pain and sorrow is often great. Survivors of a loss to suicide need close friends and family to comfort them, particularly in the immediate days following a suicide. Survivors often seek support and comfort from their faith communities during this time. By acknowledging these things as part of the memorial, you help people understand better what the survivors of the loss are experiencing and how they can support them in their grief.

Help Survivors Deal with Feelings of Guilt. Family and close friends of someone who has committed suicide often feel guilty for not recognizing any signs of suicide risk in their loved one, or for not acting on the signs, or for not believing that the person would actually go through with it. There is often an exaggerated sense of responsibility for not

14 Suicide Prevention Resource Center. (2004). After a suicide: Recommendations for religious services and other public memorial observances. Newton, MA: Education Development Center, Inc.

15 Centers for Disease Control and Prevention.

being able to help when it mattered most. Some survivors of a loss to suicide may feel as if the death is somehow their fault. Blame is not a word that should be associated with suicide. A memorial service can help the family, friends and community understand that it is not their fault. People will want answers, but few will be immediately available, so it is important to help them better understand suicide and offer them support, including spiritual and emotional, while they are grieving.

Help Survivors Face Feelings of Anger. Anger is considered by many mental health professionals to be a normal part of the grieving process.¹⁶ Anger can take on a variety of forms. Survivors may find themselves angry at others (such as psychologists, law enforcement, teachers, family members, significant others, etc.) for not helping prevent the suicide. They might also feel angry at themselves for not doing enough to help prevent the suicide. Survivors often find themselves angry at the person who died — angry for committing suicide, for causing grief or shame, or for leaving them alone. Acknowledging these feelings of anger, and showing support for survivors of a loss at a funeral is important. It can help community members understand why a survivor of a loss to suicide is angry and reinforce that feelings of anger do not negate the love felt for the person who died.

Address Stigma. Stigma remains a hurdle in suicide prevention, intervention and postvention in Alaska. There are still people and communities that feel uncomfortable talking about suicide, and when they do, there are often myths and untruths perpetuated. Stigma can be one of the greatest barriers to healing from a loss by suicide. It is important to face stigma directly at a memorial service. For instance, dispelling the myths that suicide is caused by moral weakness or character flaws will help open the hearts of the community to supporting the survivors. If the deceased was suffering from a mental illness, it may be helpful to address that (carefully) at the memorial service. This can help people understand the relationship between suicide and mental illness and encourage others to seek help if needed (some people in attendance could be dealing with their own depression in silence, so your words could help them find help). Just as stigma about suicide and mental illness are found in our communities, they are present in families — so be mindful that families may not want this information included in the memorial. While it is important to respect their wishes, you can use this as an opportunity to educate them about the increased risk of suicide experienced by survivors of a loss to suicide, how suicide contagion affects our towns and villages, and how they could be of help to others feeling the same pain and distress their loved one felt.

¹⁶ Suicide Prevention Resource Center. (2004). After a suicide: Recommendations for religious services and other public memorial observances. Newton, MA: Education Development Center, Inc.

Use Appropriate Language. Words used at a memorial service can have a lasting impression on those in attendance. Positive messaging can help prevent suicide contagion, while negative messaging could increase the risk of contagion. People chosen to give eulogies should choose their words carefully, because some phrases can have negative connotations that some may perceive as disrespectful of the deceased. For example, “successful suicide” seems a harmless phrase, but many experts feel it can convey to a vulnerable individual that they too can be considered by their peers or community as “successful” if they commit suicide.¹⁷ It can be difficult to find the correct words when talking about suicide, particularly at a memorial service, so it is best to always try to be respectful, sensitive and kind to the deceased and those in attendance. Offer to help those speaking at the memorial to find positive and loving words to share at the memorial (which also provides a chance to comfort them in their grief and help them deal with any feelings of guilt or anger).

Prevent Imitation and Modeling. Since suicide contagion is such a great concern after a suicide, it is important to communicate at a memorial service in a way that will reduce the possibility of others imitating the suicide behavior of the deceased. Experts believe it is never appropriate to discuss how someone took their life in detail, or to focus on the means of suicide, because it may cause emotionally vulnerable people to mull over those details in their minds.¹⁸ The goal of a memorial service is to remember the **life** of the person who died, not to glamorize his or her death. Memorial service organizers and speakers should be careful not to imply that a suicide was noble, “cool” or appropriate. Encourage them to focus on the good things the person accomplished in life, such as if her or she was a good basketball player, hunter, grandchild, sibling, etc. Unlike services for people who died for other reasons, funerals and memorials for individuals who die by suicide should avoid the standard words of comfort like “finding a better place,” “being at peace,” or “following God’s plan.” Suggesting that suicide is a means of finding peace or heaven could be heard by emotionally vulnerable people as a way of easing pain and distress. Encourage a memorial service that empowers the community to prevent future deaths by suicide by highlighting the prevention resources available and ways to support each other in times of crisis.

Consider the Special Needs of Youth. During a memorial service related to suicide, particularly one for a young person, the youth should be addressed very directly about the scope of suicide and the pain it leaves behind in a community. Young people are the most vulnerable to imitating a friend's or loved one's suicide. Positive coping skills, such as seeking help from a teacher, counselor, coach or trusted adult in the community,

¹⁷ American Association of Suicidology, www.reportingonsuicide.org.

¹⁸ Suicide Prevention Resource Center. (2004). After a suicide: Recommendations for religious services and other public memorial observances. Newton, MA: Education Development Center, Inc.

should be encouraged. Leaders of a service should be very direct about the dangers of using drugs and alcohol to numb or escape the pain related to a loss to suicide. Alcohol is a depressant and can lead to poor decision making and dangerous behavior, particularly while someone is grieving. Youth should be given positive reinforcement and told about their very important place in the community, now and in the future. Stress the importance of youth looking out for each other after a suicide. Young people will often be more open with their peers, so it is important that they watch for any warning signs their friends and family members might exhibit. It is also important for memorial service leaders to emphasize to youth that it is okay to ask for and receive help when hurting. Provide youth (and adults) at the memorial with the name and contact information for Careline. Ask them to identify a trusted adult or official to alert if they feel suicidal or think someone they know is in crisis. Offer a small discussion group on suicide for youth after the memorial or funeral (with a mental health professional to facilitate) to give them a place to discuss their feelings, to learn where they can get help in crisis, and to learn how to watch over their peers.

Consider Appropriate Public Memorials. It is natural for people to want to honor their friends or loved ones when they die, particularly when the person dies at a young age. However, grand memorials can glamorize the suicide and actually encourage other people who feel lost, ignored, depressed and alone to choose to commit suicide as a way to be acknowledged by the community.¹⁹ Memorial events such as concerts, basketball tournaments, poetry jams or other public performances should be avoided (or carefully designed), because they could inadvertently increase risk of suicide in vulnerable youth, particularly those that feel a lack of attention and want something done in their honor. Encourage constructive ways to honor the person's life and promote healing.

¹⁹ There have been cases in the past where people or communities have created public memorials to honor someone who died by suicide that people believe contributed to other suicides, according to the Centers for Disease Control and Prevention.

APPENDIX A

Crisis Hotlines

Alaska Careline

While many people have suicidal thoughts or feelings at some point in their lives, nearly all suicidal people suffer from conditions that will pass with time and with help. Careline provides crisis intervention for individuals considering suicide, or experiencing crisis, isolation, or depression. Careline supports survivors of suicide through ongoing support, crisis intervention, education, and referral. Careline offers:

- Free, immediate and confidential help, 24-hours per day, 365 days per year.
- Treats callers with respect.
- Listens without judging.
- Helps callers discover their own solutions and offers support along the way.
- Provides intervention to those who are considering suicide.
- Provides information to those who are concerned about someone else.
- Assist those who are not receiving the mental health care they need.

Call toll-free statewide at **877-266-HELP (4357)** or **800-273-8255**.

Check out our Chat feature: www.CarelineAlaska.com or New Text Option: 907-2LISTEN

Careline Crisis Intervention

726 26th Avenue
Fairbanks, Alaska 99701
(907) 452-2771 . (Fax) 457-2442

SEARHC Helpline

1-877-294-0074

A service from SouthEast Alaska Regional Health Corporation for personal or family crisis matters

- Available 24 hours a day – 7 days a week
- You talk to a real counselor
- It's Confidential,
- Effective and Compassionate
- For Southeast Alaska Residents

APPENDIX B

Safe and Effective Messaging for Suicide Prevention

This document offers evidence-based recommendations for creating safe and effective messages to raise public awareness that suicide is a serious and preventable public health problem. The following list of “Do’s” and “Don’ts” should be used to assess the appropriateness and safety of message content in suicide awareness campaigns. Recommendations are based upon the best available knowledge about messaging.^{1,2,3} They apply not only to awareness campaigns, such as those conducted through Public Service Announcements (PSAs), but to most types of educational and training efforts intended for the general public.

These recommendations address message content, but not the equally important aspects of planning, developing, testing, and disseminating messages. While engaged in these processes, one should seek to tailor messages to address the specific needs and help-seeking patterns of the target audience. For example, since youth are likely to seek help for emotional problems from the Internet, a public awareness campaign for youth might include Internet-based resources.⁴ References for resources that address planning and disseminating messages can be found in SPRC’s Online Library (<http://library.sprc.org/>) under “Awareness and Social Marketing”.

The Do’s—Practices that may be helpful in public awareness campaigns:

- **Do emphasize help-seeking and provide information on finding help.** When recommending mental health treatment, provide concrete steps for finding help. Inform people that help is available through the National Suicide Prevention Lifeline (1-800-273-TALK [8255]) and through established local service providers and crisis centers.
- **Do emphasize prevention.** Reinforce the fact that there are preventative actions individuals can take if they are having thoughts of suicide or know others who are or might be. Emphasize that suicides are preventable and should be prevented to the extent possible.⁵
- **Do list the warning signs, as well as risk and protective factors of suicide.** Teach people how to tell if they or someone they know may be thinking of harming themselves. Include lists of warning signs, such as those developed through a consensus process led by the [American Association of Suicidology \(AAS\)](#).⁶ Messages should also identify protective factors that reduce the likelihood of suicide and risk factors that heighten risk of suicide. Risk and protective factors are listed on pages 35-36 of the [National Strategy for Suicide Prevention](#).
- **Do highlight effective treatments for underlying mental health problems.** Over 90 percent of those who die by suicide suffer from a significant psychiatric illness, substance abuse disorder or both at the time of their death.⁷⁻⁸ The impact of mental illness and substance abuse as risk factors for suicide can be reduced by access to effective treatments and strengthened social support in an understanding community.⁹

The Don'ts—Practices that may be problematic in public awareness campaigns:

- **Don't glorify or romanticize suicide or people who have died by suicide.** Vulnerable people, especially young people, may identify with the attention and sympathy garnered by someone who has died by suicide.¹⁰ They should not be held up as role models.
- **Don't normalize suicide by presenting it as a common event.** Although significant numbers of people attempt suicide, it is important not to present the data in a way that makes suicide seem common, normal or acceptable. Most people do not seriously consider suicide an option; therefore, suicidal ideation is not normal. Most individuals, and most youth, who seriously

Cont

Safe and Effective Messaging for Suicide Prevention

- consider suicide do not overtly act on those thoughts, but find more constructive ways to resolve them. Presenting suicide as common may unintentionally remove a protective bias against suicide in a community.¹¹
- **Don't present suicide as an inexplicable act or explain it as a result of stress only.** Presenting suicide as the inexplicable act of an otherwise healthy or high-achieving person may encourage identification with the victim.¹² Additionally, it misses the opportunity to inform audiences of both the complexity and preventability of suicide. The same applies to any explanation of suicide as the understandable response to an individual's stressful situation or to an individual's membership in a group encountering discrimination. Oversimplification of suicide in any of these ways can mislead people to believe that it is a normal response to fairly common life circumstances.¹³
- **Don't focus on personal details of people who have died by suicide.** Vulnerable individuals may identify with the personal details of someone who died by suicide, leading them to consider ending their lives in the same way.¹⁴
- **Don't present overly detailed descriptions of suicide victims or methods of suicide.** Research shows that pictures or detailed descriptions of how or where a person died by suicide can be a factor in vulnerable individuals imitating the act. Clinicians believe the danger is even greater if there is a detailed description of the method.¹⁵

Acknowledgment

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APPENDIX C

Indian Health Service Emergency Response Model

The Indian Health Service (IHS) has designed an emergency response model for helping American Indian and Alaska Native communities when tragedy strikes. Communities work through the IHS to access support from the U.S. Public Health Service (USPHS). This support consists of teams of two or more USPHS mental health providers who offer emergency mental health and community outreach services. The teams work in 2-week rotations for up to 90 days of emergency response. The goal is to help the community reduce the impact of the immediate crisis and to stabilize members so that they can begin to develop long-term solutions (i.e., planning, prevention, and implementation plans).

This is the process for requesting and accessing this help:

1. The community makes a request for help to the IHS area office through the IHS service unit, tribal health program, or urban Indian clinic.
2. The IHS Area Director submits the request to IHS Headquarters (HQ) and the Division of Behavioral Health director, who notifies the appropriate IHS HQ staff.
3. The IHS Division of Behavioral Health and Emergency Services (ES) staff members respond to the affected community and conduct a rapid needs assessment. While on site, HQ staff members meet with the IHS area office, tribal health program, urban Indian clinic, IHS Chief Executive Officer, the tribal council, and other tribal programs as requested.
4. Depending on the rapid needs assessment and the expressed needs of the community, the IHS ES Director can forward the request for emergency assistance to the USPHS Office of Force Readiness and Deployment for action.

Contact Information

Alaska Area Native Health Service
4141 Ambassador Drive, Suite 300
Anchorage, AK 99508.5928
Telephone: 907.729.3686
FAX: 907.729.3689

APPENDIX D

Alaska Division of Behavioral Health, Protocol & Procedure for Local Behavioral Health Emergencies Requiring State Assistance

The State of Alaska provides for the coordination of behavioral health disaster response services through the Department of Social Services, Division of Behavioral Health (DBH). The *State of Alaska Behavioral Health Emergency Response Plan, 2005* addresses the policies, scope, operations, roles, responsibilities, and authorities that form the foundation of behavioral health response to disasters and major emergencies. The Plan states that the Division relies upon local community mental health centers (CMHC) to provide the initial behavioral health response to any local emergency or disaster.

The Plan also outlines how DBH will support a CMHC if local resources are overwhelmed by any disaster event. During a state or federally declared disaster, DBH will coordinate "...the identification, location, procurement, mobilization and deployment of additional behavioral health resources" through the State Emergency Coordination Center and local emergency operations center structures.

Alaskan communities may experience incidents which create a need for emergency behavioral health response but which do not require the implementation of disaster response protocols addressed in the Plan. Most of these incidents can be addressed adequately by local or regional behavioral health resources. However, there are incidents which may either overwhelm the capability of local resources, or compromise these resources to the extent that they are unable to respond adequately to the present need. The Plan does not adequately address the protocols or procedural details for how DBH would support CMHCs in these incidents. This document sets forth the protocol and procedure for the DBH response to such local emergencies which require state assistance but which do not qualify as state or federal declared disasters.

PROCEDURES

General

An event that affects a single community or local area but which does not qualify as a state (or federally) declared disaster may still require a substantial commitment of CMHC and / or other local behavioral health resources. It may temporarily reduce the CMHC capability to respond to other emergencies. CMHC will still attempt to provide behavioral health emergency response services with assistance provided through Mutual Aid Agreements. The costs associated with these efforts are assumed under the normal operating budget of the CMHC.

CMHCs are obligated to contact the state regarding local emergency response for the following situations: report to DBH any missing, injured or deceased consumers; and, if the event generates significant media coverage, provide regular updates or briefings to DBH upon request.

If a community event or local emergency which requires behavioral health response results in the compromise of CMHC resources, the CMHC may request state assistance directly from DBH through the regional coordinator or other assigned DBH staff. In making such a request the CMHC will present to the DBH Regional Coordinator a written or oral factual and detailed account of the incident to include:

1. time, date, place and event description
2. number and description of victims
3. description of target populations requiring services
4. any action taken by CMHC
5. other organizations involved in response
6. an explanation of why local resources are compromised
7. description of needed services or resources
8. an estimate of the scope of work involved including timeline
9. name and contact information of CMHC Representative

Upon DBH acceptance and agreement of the request, the CMHC will:

- Provide initial coordination of deployed resources including:
 1. arrangements for lodging
 2. arrangements for ground transportation and food as necessary
 3. initial debriefing of incident
 4. description of community; maps; liaison as indicated
 5. arrangements for initial meetings
 6. contact information for other response groups
- Maintain record of expenses incurred for response efforts, and by deployed resources (see Allowable Expenses)
- Provide regular updates to DBH representative as indicated
- Provide verbal or written summary report to DBH representative at conclusion of response
- Reimburse deployed resources for all documented expenses
- Submit a modified budget at next quarterly report to DBH reflecting additional costs associated with emergency response and referencing the event in the narrative

Upon receipt of a CMHC request for assistance the DBH Regional Coordinator will act as the 'incident response coordinator' for DBH and is responsible for the following tasks:

- Document facts and details of the incident
- Assess the need for additional State supported behavioral health resources
- Notify Treatment & Recovery Manager (T&RM) of incident, and seek approval of CMHC request
- Confirm source of Emergency Funds
- Provide regular information update and debriefing to T&RM
- Directly, and / or in coordination with the DBH Designated Behavioral Health Disaster Coordinator, identify, locate, procure, mobilize and deploy appropriate behavioral health emergency response resources to the affected community
- Debrief deployed resources regarding the incident, the request for services, specifics about the affected community, CMHC information, expense reporting, etc.
- Arrange for all deployed behavioral health emergency response resources to coordinate response efforts through the local or regional CMHC
- Coordinate with local or regional CMHC to:
 1. arrange for lodging, food and other needs for deployed resources as necessary
 2. provide accounting and reporting of all expenses incurred for response and by deployed resources
 3. submit modified grant budget reflecting all final response costs to Regional Coordinator for approval and reimbursement
- Follow up with CMHC and / or deployed resources regarding assessment of need beyond initial response
- Maintain final record of incident response
- Update Regional Emergency Funds utilization record
- Forward CMHC modified grant budget to Treatment & Recovery Manager for review, and / or assistance with approval and reimbursement

When contacted by a Regional Coordinator regarding a request for State assistance the Treatment & Recovery Manager will perform the following tasks:

- Review documented facts and details of the incident
- Notify Division of Behavioral Health Director of incident, and seek approval of request as necessary
- Provide regular information update and debriefing for Division Director
- Notify FMS Administrative Manager of incident response

- Assist Regional Coordinator with source and approval of alternative emergency funds as indicated or requested
- Assist with identification, location, procurement, mobilization and deployment efforts for behavioral health emergency response resources as indicated or requested by Regional Coordinator
- Coordinate with Division of Behavioral Health Director and Senior Staff to appoint Designated Behavioral Health Disaster Coordinator if necessary, and if such position does not already exist
- Review CMHC modified grant budget, and assist Regional Coordinator with approval process as indicated
- Debrief DBH Director of final resolution of incident response as indicated or requested
- Forward CMHC modified grant budget to FMS Manager for action as indicated

When contacted by a Regional Coordinator, or Treatment & Recovery Manager, or as appointed by a Section Manager or the DBH Director, the Designated Behavioral Health Disaster Coordinator will in response to a CMHC request for State assistance perform the following tasks directly, or in coordination with the Regional Coordinator:

- Act as primary incident response coordinator;
- Perform all the tasks noted under responsibilities for DBH Regional Coordinator

Documentation Requirements

The Regional Coordinator or designated 'incident response coordinator' is responsible for maintaining a permanent record of any DBH incident response activity provided to local communities through the local or regional CMHC. Initial and final reports respectively should contain the following information:

- Date & time of contact, and name and contact information of person requesting assistance
- Facts and details of precipitating incident
- Rationale for CMHC request for State assistance
- Needs Assessment
- Any agreements, implied or expressed, between Regional Coordinator and CMHC
- Brief outline for initial plan of response
- Names and contact information of all parties associated with response effort
- Notation, or copies of update communications with DBH, CMHC and other resources
- Indication of resolution of incident response
- Copy of CMHC expense report / modified grant budget (final report)

The report may consist of handwritten notes, emails, letters, FAX, expense report, and copy of amended grant budget. Reports should be kept in a permanent file titled: Critical Incident Response, (name of CMHC), (Month, Year).

Confidentiality of consumer information shall be maintained by all DBH personnel according to all existing DBH policies, procedures and observed laws and regulations. Identifying consumer information shall be withheld from deployed behavioral health emergency response resources until such time as they arrive in the affected community and make contact with the local CMHC. Exceptions to this policy will be considered under the following conditions:

1. The identification of victims, victim families, or others associated with the incident will have a significant impact upon the choice of emergency response personnel, or the details involved in response planning
2. Behavioral Health emergency response providers need to know the identity of victims, victim families, or others associated with the incident in order to make informed decisions affecting professional boundaries, and / or ethical issues

Behavioral Health Emergency Response Resources

DBH personnel involved with the response to a CMHC request for assistance with a behavioral health emergency may draw from a number of resources. These include any of the following:

- CMHC staff from other regionally-based centers
- CMHC staff from centers located outside the region
- Approved CISM Teams consisting of personnel from within region
- Approved CISM Teams consisting of specific specialists located elsewhere in the state
- Volunteer American Red Cross Licensed behavioral health professionals
- DBH staff

All emergency response providers should make their own personal travel arrangements. Providers may also be required to bring sleeping bags, or other personal gear. Lodging, food, and other needs will be arranged by the local CMHC or their representative(s). All expenses (see Allowable Expenses below) incurred by emergency response providers should be submitted to the local CMHC, or representative(s) for reimbursement.

All emergency response providers deployed by DBH will coordinate all response efforts through the local or regional CMHC or representative(s).

Allowable Expenses

The following is an approved list of expenses eligible for reimbursement incurred by emergency response providers participating in behavioral health emergency response efforts directed by DBH and local CMHC:

- Air fare
- Ground transportation
- Per Diem (food allowance)
- Lodging expenses
- Photocopying
- Maximum \$200 per day Honorarium for [self-employed] independent behavioral health contractors (as approved by DBH Director)

All expenses incurred by emergency response providers must be documented by receipt, and should be submitted to the local CMHC or representative(s) for reimbursement.

APPENDIX E

RECOMMENDATIONS FOR REPORTING ON SUICIDE

Developed in collaboration with: American Association of Suicidology, American Foundation for Suicide Prevention, Annenberg Public Policy Center, Associated Press Managing Editors, Canterbury Suicide Project - University of Otago, Christchurch, New Zealand, Columbia University Department of Psychiatry, ConnectSafely.org, Emotion Technology, International Association for Suicide Prevention Task Force on Media and Suicide, Medical University of Vienna, National Alliance on Mental Illness, National Institute of Mental Health, National Press Photographers Association, New York State Psychiatric Institute, Substance Abuse and Mental Health Services Administration, Suicide Awareness Voices of Education, Suicide Prevention Resource Center, The Centers for Disease Control and Prevention (CDC) and UCLA School of Public Health, Community Health Sciences.



IMPORTANT POINTS FOR COVERING SUICIDE

- More than 50 research studies worldwide have found that certain types of news coverage can increase the likelihood of suicide in vulnerable individuals. The magnitude of the increase is related to the amount, duration and prominence of coverage.
- Risk of additional suicides increases when the story explicitly describes the suicide method, uses dramatic/graphic headlines or images, and repeated/extensive coverage sensationalizes or glamorizes a death.
- Covering suicide carefully, even briefly, can change public misperceptions and correct myths, which can encourage those who are vulnerable or at risk to seek help.

Suicide is a public health issue. Media and online coverage of suicide should be informed by using best practices. Some suicide deaths may be newsworthy. However, the way media cover suicide can influence behavior negatively by contributing to contagion or positively by encouraging help-seeking.

⋮ **Suicide Contagion or “Copycat Suicide”**
⋮ occurs when one or more suicides
⋮ are reported in a way that contributes
⋮ to another suicide.
⋮

References and additional information can be found at: www.ReportingOnSuicide.org.

INSTEAD OF THIS:



- Big or sensationalistic headlines, or prominent placement (e.g., “Kurt Cobain Used Shotgun to Commit Suicide”).
- Including photos/videos of the location or method of death, grieving family, friends, memorials or funerals.
- Describing recent suicides as an “epidemic,” “skyrocketing,” or other strong terms.
- Describing a suicide as inexplicable or “without warning.”
- “John Doe left a suicide note saying...”.
- Investigating and reporting on suicide similar to reporting on crimes.
- Quoting/interviewing police or first responders about the causes of suicide.
- Referring to suicide as “successful,” “unsuccessful” or a “failed attempt.”

DO THIS:



- Inform the audience without sensationalizing the suicide and minimize prominence (e.g., “Kurt Cobain Dead at 27”).
- Use school/work or family photo; include hotline logo or local crisis phone numbers.
- Carefully investigate the most recent CDC data and use non-sensational words like “rise” or “higher.”
- Most, but not all, people who die by suicide exhibit warning signs. Include the “Warning Signs” and “What to Do” sidebar (from p. 2) in your article if possible.
- “A note from the deceased was found and is being reviewed by the medical examiner.”
- Report on suicide as a public health issue.
- Seek advice from suicide prevention experts.
- Describe as “died by suicide” or “completed” or “killed him/herself.”



AVOID MISINFORMATION AND OFFER HOPE

- Suicide is complex. There are almost always multiple causes, including psychiatric illnesses, that may not have been recognized or treated. However, these illnesses are treatable.
- Refer to research findings that mental disorders and/or substance abuse have been found in 90% of people who have died by suicide.
- Avoid reporting that death by suicide was preceded by a single event, such as a recent job loss, divorce or bad grades. Reporting like this leaves the public with an overly simplistic and misleading understanding of suicide.
- Consider quoting a suicide prevention expert on causes and treatments. Avoid putting expert opinions in a sensationalistic context.
- Use your story to inform readers about the causes of suicide, its warning signs, trends in rates and recent treatment advances.
- Add statement(s) about the many treatment options available, stories of those who overcame a suicidal crisis and resources for help.
- Include up-to-date local/national resources where readers/viewers can find treatment, information and advice that promotes help-seeking.



SUGGESTIONS FOR ONLINE MEDIA, MESSAGE BOARDS, BLOGGERS & CITIZEN JOURNALISTS

- Bloggers, citizen journalists and public commentators can help reduce risk of contagion with posts or links to treatment services, warning signs and suicide hotlines.
- Include stories of hope and recovery, information on how to overcome suicidal thinking and increase coping skills.
- The potential for online reports, photos/videos and stories to go viral makes it vital that online coverage of suicide follow site or industry safety recommendations.
- Social networking sites often become memorials to the deceased and should be monitored for hurtful comments and for statements that others are considering suicide. Message board guidelines, policies and procedures could support removal of inappropriate and/or insensitive posts.

MORE INFORMATION AND RESOURCES AT:

www.ReportingOnSuicide.org



WARNING SIGNS OF SUICIDE

- Talking about wanting to die
- Looking for a way to kill oneself
- Talking about feeling hopeless or having no purpose
- Talking about feeling trapped or in unbearable pain
- Talking about being a burden to others
- Increasing the use of alcohol or drugs
- Acting anxious, agitated or recklessly
- Sleeping too little or too much
- Withdrawing or feeling isolated
- Showing rage or talking about seeking revenge
- Displaying extreme mood swings

The more of these signs a person shows, the greater the risk. Warning signs are associated with suicide but may not be what causes a suicide.



WHAT TO DO

If someone you know exhibits warning signs of suicide:

- Do not leave the person alone
- Remove any firearms, alcohol, drugs or sharp objects that could be used in a suicide attempt
- Call the U.S. National Suicide Prevention Lifeline at 800-273-TALK (8255)
- Take the person to an emergency room or seek help from a medical or mental health professional

THE NATIONAL SUICIDE PREVENTION LIFELINE 800-273-TALK (8255)

A free, 24/7 service that can provide suicidal persons or those around them with support, information and local resources.

