Juneau Suicide Prevention Coalition
www.juneausuicideprevention.org
www.juneaumentalhealth.org

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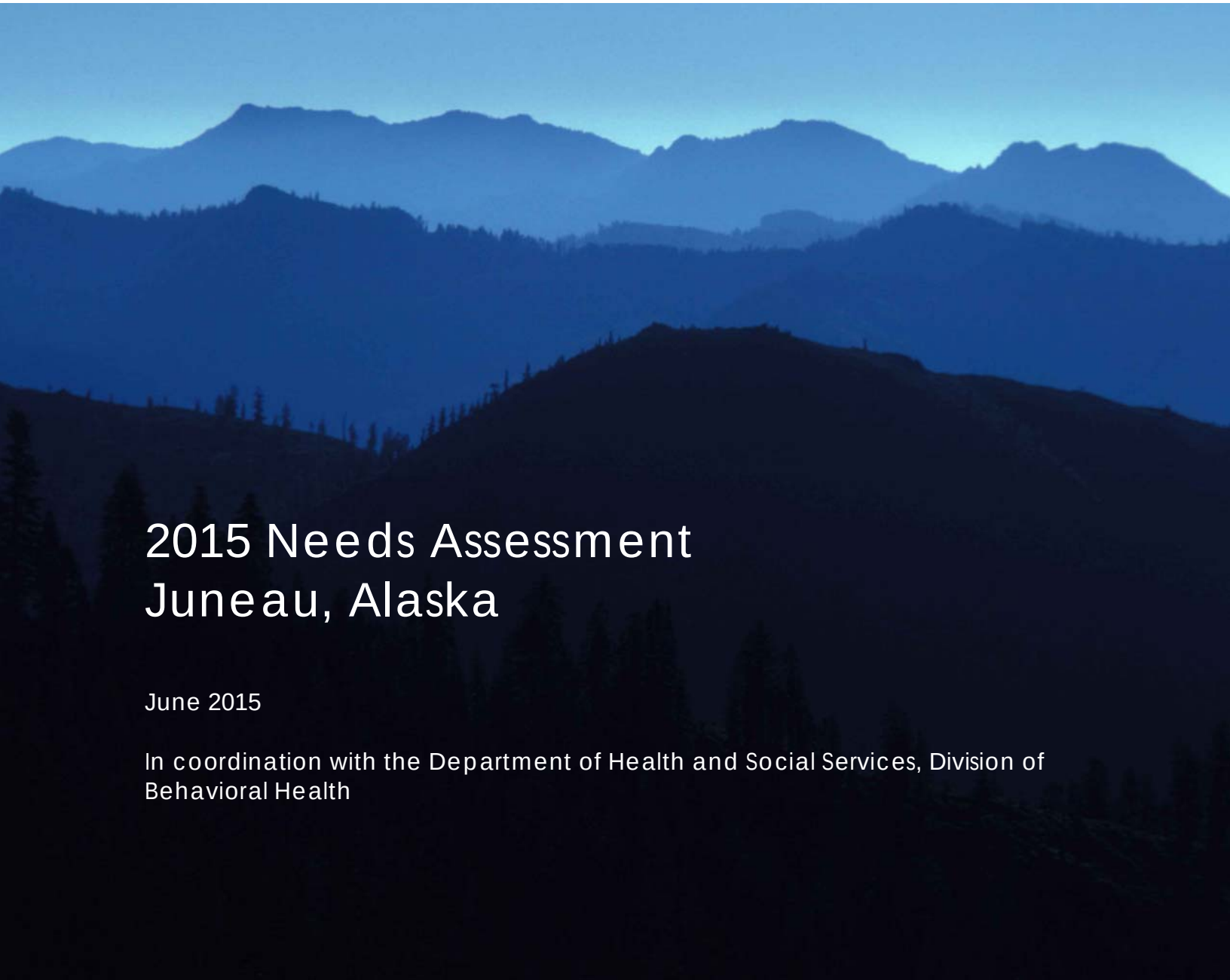

2015 Needs Assessment
Juneau, Alaska

June 2015

In coordination with the Department of Health and Social Services, Division of Behavioral Health

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I. Introduction

A. Purpose of the Community Assessment

The purpose of the community assessment is to determine the underlying causes of suicide in Juneau, and to provide the foundation for a realistic and sustainable plan to reduce suicides by addressing the relationship between these underlying factors and suicide. The key participants in this effort are the volunteer and agency members of the Juneau Suicide Prevention Coalition that has been providing services and community action since 2008.

B. Concerns That Brought Local Stakeholders to the Table

On March 30, 2008, this article appeared in *the Juneau Empire*, "The quiet tragedy: Teen suicide in Juneau." The lead sentences told a disturbing story that framed the change in the Juneau community's approach to suicide prevention:

"Four teens took their own lives in Juneau since early fall, and eight young adults have committed suicide in the past year and a half… The tragedy is striking Juneau families and few people want to talk about it... Talking about it is a start, they said… The number of deaths was determined during a series of meetings last fall, including psychologists, pastors, police, counselors and others who informally listed recent suicide deaths in Juneau… Records don't provide a complete picture of the number of deaths by suicide because police aren't always involved, or an overdose or accident might not be confirmed as a suicide. Police data, however, indicates suicide deaths have increased in Juneau in the past year….Ninety-five suicide attempts of all ages were confirmed in 2007, compared to 76 in 2006, according to the police department. Seven suicides were confirmed in 2007, compared to four the year before."

C. How the Juneau Suicide Prevention Coalition Was Formed

In response to this increased number of suicides, concerned citizens, parents, and agency members began meeting in 2008 to determine ways to significantly reduce suicides. Brendan Kiernan, a Juneau School District Psychologist, established a community-wide group consisting of representatives from local agencies and concerned Juneau residents. This group became known as the Juneau Community Suicide Prevention Task Force and later changed its name to the Juneau Suicide Prevention Coalition to reflect the continuing nature of our commitment and efforts.

The Coalition, through the Juneau School District, applied for a grant from the State of Alaska Department of Health and Social Services, Division of Behavioral Health to fund implementation of a suicide prevention curriculum known as "Signs of Suicide" (SOS) at all district high schools. Recognizing the need to ensure a continuum of services to people of all ages identified as at risk, as well as the importance of community-wide communication to address the problem of suicide in a comprehensive way, the Coalition developed and implemented several other program and service activities to address suicide in our community. These activities are described more fully in *Section III. "What community gaps, assets, and/or weaknesses should be considered?" page 50.*

D. A Picture of Juneau

To many residents, as well as many people across the state, Juneau appears to be a relatively well-educated, affluent, and well-served community with fewer social problems than most. In reality, factors including Juneau's isolation, shifting population demographics, job market characteristics, current economic conditions, declining student enrollment, cultural characteristics, and the high cost of living present great challenges to the Juneau community. These factors are summarized below; additional information regarding community characteristics is included in the *Appendix, page 69.*

- **Isolation:** Juneau is isolated and has a relatively small population compared to many cities in the U.S. Due to Juneau's rugged topography, the community developed along the shoreline with some population concentrations. These features make it more difficult and expensive to provide public services and infrastructure. Juneau's small population, location, and topography currently limits its range of social and economic opportunities compared to a larger more centralized community, or one with nearby communities.
- **Shifting Population Demographics**: Juneau's overall population has been relatively static, while its K-12 student population is declining. Juneau's senior population (over 55) is the fastest growing segment. Juneau has a relatively transient population that turns over every 10 to 12 years. This is approximately two and a half times faster than the average in the U.S. Additionally, Juneau has a growing number of non-resident workers engaged in fishing, tourism, and mining. These population characteristics present challenges to our educational, economic and service delivery systems.
- **Job Market Characteristics:** On the plus side, Juneau is not likely to experience major economic disruptions, despite slow projected economic growth. Also, Juneau has relatively low unemployment and a relatively high average household annual income. On the negative side, Juneau is losing higher paying jobs and gaining lower paying jobs, including more seasonal jobs. Presumably, the loss of higher paying jobs will also result in lower average education of workers. Additionally, Juneau has also significantly increased the number of non-resident workers primarily in tourism, seafood processing, and mining. This impacts not only the economy, but the social fabric of the community. Also troubling is the recent and anticipated loss of public and private sector jobs due to budgetary and economic conditions. These losses impact public infrastructure and services, most notably K-12 education.
- **Current Economic Conditions:** Declining state revenue, relatively flat local sales and property tax, declining average wages, and growing non-resident employment all contribute to continuing losses in local revenue. These losses result in increasing reductions of government funded services and schools. This trend appears like it will extend well into the future.
- **Declining Student Enrollment:** The Juneau School District (JSD) had 4,720 students as of August 22, 2014, a decrease of 118 students from the previous year. The JSD has seen a continual decline in student population from 2005 to 2014 of about 1% on an annual compounded basis. No student increase is forecasted through 2017. The JSD has had significant revenue shortfalls and projects continued shortfalls in future years. By protecting teachers and the classroom to the extent possible, the JSD will likely continue

to make deeper cuts in ancillary services, including counseling and support services that may also be critical to future student success.

- **Cultural Characteristics:** Juneau has a fairly diverse population. While 30% of the general population is non-Caucasian, the Juneau School District reports that 46% of its student population is non-Caucasian, with students speaking 27 languages at home, and 23% of the students on the "Free and Reduced Lunch" list, the basic measure of poverty for the District. Minority populations often face unique challenges in Juneau. Considering culture and ethnicity is critical in developing programs and services that address the needs of all community members.
- **High Cost of Living:** Although Juneau has a relatively high per capita income, this is offset by a very high cost of living. The average cost of a home in Juneau is over $377,000 and the average apartment rental cost is over $1,100 per month. Juneau also has a serious housing shortage, especially affordable rental housing. The housing shortage, including subsidized housing, puts an additional squeeze on lower income households. Juneau is estimated to have approximately 600 homeless persons (Juneau Economic Development Council, "Juneau Housing Needs Assessment," November, 2012.)

II. Methods

The Juneau Suicide Prevention Coalition used a variety of methods to gather and analyze data and other information for the various aspects of the community needs assessment. The structure and process that we used to conduct the needs assessment and the components of the community needs assessment are described below.

A. Structure and Process

The Juneau Suicide Prevention Coalition (JSPC) appointed an Assessment Committee (AC) to oversee the completion of the community needs assessment and to prepare a report of the work, process, and findings. Members of the Assessment Committee included the following:

- Alice Rarig: Contract researcher; Coalition member
- Kevin Ritchie: Contractor for readiness assessment and assessment report writer; Coalition member
- Julie Neyhart: Contractor for readiness assessment; Coalition member
- Sam Trivette: Survivor; Coalition member
- Jennifer Carson: Catholic Community Service; Coalition member
- Gus Marx: Juneau Youth Services; Fiscal Agent/Coalition member
- Hilary Young: Juneau Youth Services; Fiscal Agent/Coalition member
- Walter Majoros: Juneau Youth Services; Fiscal Agent/Coalition member

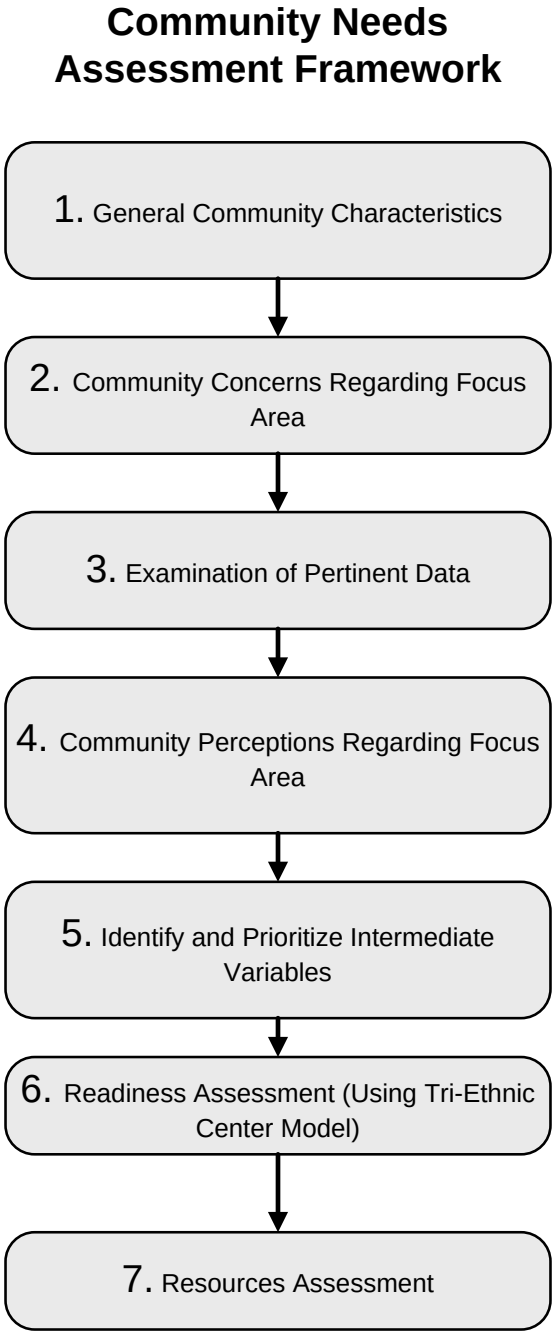
The process used by the Assessment Committee and the Coalition to oversee and complete the needs assessment included the following:

- Assessment Committee (AC) Meetings: The AC met weekly for several months to scope the assessment process, make assignments and review draft work products.
- Work Assignments: Individual AC members were assigned and reported on their review of research materials, local information, and literature.
- Contracts for Professional Services: JYS as the Coalition's fiscal agent issued and managed contracts for: data review and analysis; completion of the readiness assessment; interview transcriptions; and assessment report writing.
- Full Coalition Involvement: The full Coalition Stakeholder Committee met monthly to provide input to and review progress of the different components and phases of the needs assessment.

B. Components of the Needs Assessment

The Assessment Committee followed the steps in the Community Needs Assessment Framework provided by the Division of Behavioral Health. The Committee developed and implemented plans for quantitative data assessment (use of secondary sources) and qualitative data

assessment, and collection of survey data (primary data collected by the project) for quantitative and qualitative assessment. An overview chart and a summary of our approach for each of the steps in the community needs assessment framework are presented below:



1. General Community Characteristics: Our first step was to review characteristics of the community defined as City and Borough of Juneau. We reviewed information from several documents and sources including the U.S. Census, the Juneau Economic Development Council and the Department of Labor.

2. Community Concerns Regarding Focus Area: For this step, our main information sources included: a review of the Coalition's history and development, minutes from Coalition meetings, Coalition website information, local newspaper articles and Coalition members' input.

3. Examination of Pertinent Data: For this step, we examined what is known about behavioral health in Juneau, with a primary focus on suicide, but with attention also to the issues of mental health and substance abuse. The data sources reviewed and reported on are listed in the table below.

Table II-1. Data Sources	
A. Secondary Data Sources	
Major Sources	
1. YRBS	Juneau School District
2. BRFSS	AKDHSS Div. of Public Health
3. Other Sources	School Climate Survey
	Alaska's Violent Death Reporting System
	Alaska Trauma Registry
	Alaska Bureau of Vital Statistics
	U.S. Census
	National Survey on Drug Use and Health (NSDUH)—national and state data
	United Way Community Indicators Report (2010)
	Adverse Childhood Experience (ACE) Study
	Juneau Healthy Indicators Report (2013)
	Juneau and Southeast Alaska Economic Indicators Report (2013)
	EPI Bulletins
	Careline calls from Juneau
	Coalition data (website hits)
	DOL (population, unemployment/employment)
	Healthy Alaskans 2020 Study
B. Primary Data Sources	
1. Community Survey	
2. Behavioral Health Provider Survey	
3. Primary Care Provider Survey	
4. Key informant interviews	

The above list was developed with the input of, and reviewed by, staff from the Division of Behavioral Health.

The opportunity to do an in-depth analysis of existing data sets included both the Youth Risk Behavior Survey and Behavioral Risk Factor Surveillance System survey data. We looked at the Juneau community's data in contrast to statewide, which resulted in an extensive analytical project. One key factor in this accomplishment was the engagement of the Juneau School District which made available the "school climate" survey results and direct access to the YRBS master local data set. The focus of the YRBS and BRFSS data analysis was to look at variables thought to be indicators of causes, or intermediate variables, which increase the risk of suicide. The specifics of the methodology for these analyses are described in *Section III*.

The background of several members of the Assessment Committee benefitted this analysis: Alice Rarig, MPH, PhD., a retired senior health planner from the state Department of Health and Social Services, had the skills and knowledge to handle the data set securely and to accomplish appropriate statistical analyses. Julie Neyhart, with experience in the state Office of Children's Services and in NAMI Juneau, reviewed literature on children's emotional health. Kevin Ritchie, former Juneau City Manager and volunteer with several community organizations, reviewed many local economic development and other community assessment reports, and also did a broad literature review of state and national suicide-related data, and prevention strategy reports and guidelines. JYS staff, with their experience in community outreach and behavioral health, played a major role in designing and implementing the community survey, behavioral health provider survey, and primary care provider survey. Other members of the Assessment Committee brought knowledge as community members, survivors, and agency representatives and completed "assignments" for review of materials to ensure that the Committee's work was well distributed.

4. Community Perceptions Regarding Focus Area: For this step, we developed a survey to determine the community's perceptions concerning the issue of suicide. The survey was posted online and the site was published in the *Juneau Empire* hard copy and website. In addition, the survey was administered and completed at a variety of community meetings and gatherings. We received and reviewed 266 separate survey responses, which represents close to 1% of the overall Juneau community. We had excellent representation in the survey responses across several variables included age, gender, race and income level.

   We also developed and implemented similar surveys for two specialty groups—behavioral health providers and primary care providers. The links for these surveys were sent to these providers so that they could be completed electronically. We received seven (7) responses for the behavioral health surveys and also seven (7) responses from primary care providers. While these numbers may appear low, they primarily include agency and clinic responses, as opposed to individual practitioner responses. We therefore believe they are representative of their respective sectors.

5. Identify and Prioritize Intermediate Variables: A planning meeting of our Coalition Stakeholder Committee was held December 17, 2014 to review all of the data

(quantitative data and analysis, and community survey results) and to refine the specific issues to be addressed, including reaching agreement on the primary issue to be addressed by the grant project. Based on the information presented, the Coalition gave its strong endorsement to focus on "traumatic experiences" as the primary intermediate variable that is directly correlated with increased suicide risk.

6. Readiness Assessment: Key leaders were identified for eight (8) different sectors of the community. We followed all the required steps in the Tri-Ethnic Center Community Readiness guide. Two members of the Assessment Committee interviewed the key informants and recorded the interviews. The transcribed interviews were independently reviewed by the two Committee members. The responses were then scored across the five (5) assessment domains, and average and composite scores were determined.

7. Resources Assessment**:** Information from multiple sources was used to complete this step in the assessment process. These sources included key informant responses from the readiness assessment; information from key informant interviews and other sources from the preliminary needs assessment for our original FY15 grant application; SWOT analysis information from a Coalition planning meeting; and information provided by individual Coalition members pertaining to their areas of expertise.

III. Key Findings

A. What is known about the behavioral health focus area?

Background and Summary

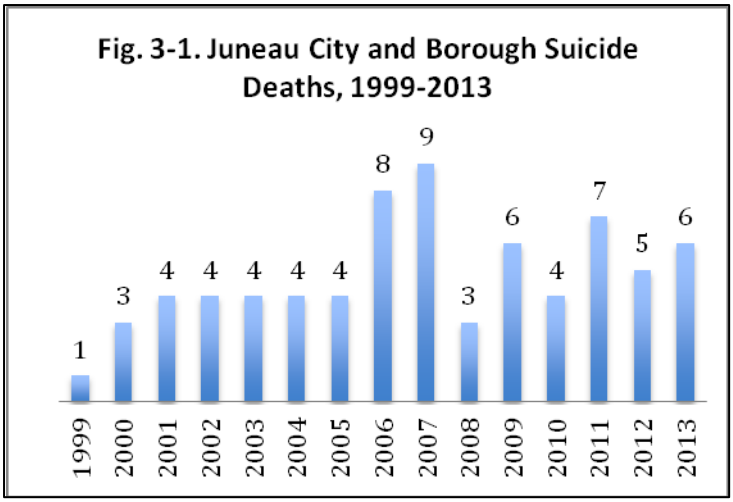
This section provides summary facts about suicide in Juneau, in comparison to Alaska. Because they are closely related to suicide, we also provide information about mental health problems and alcohol/drug abuse. In addition, we provide information about mortality (completed suicides) and morbidity (suicide attempts). Finally, we provide information from the Healthy Alaskans 2020 report regarding leading health indicators related to suicide prevention. A summary of our findings for this section of the needs assessment is presented below:

- Comparison of Juneau to the State: The overview of data on suicide, mental health and substance abuse in Juneau and in the state confirmed that Juneau's population has similar rates and patterns of suicide, alcohol use, depression, and signs of emotional distress as the state population, despite being relatively affluent and having higher employment rates than much of the state.
- Ages of Completed Suicides: Seniors ages 65 and older have the highest rate of suicide in Juneau (26.5 per 100,000), followed closely by the 18-44 younger adult population (23.54 per 100,000).
- Alaska Natives: Alaska Natives are at higher risk for suicide than the non-Native population, with the statewide rate for Alaska Natives more than twice the statewide average. Local data from the Youth Risk Behavior Study confirms that a higher percent of Native Alaskan youth experience suicidal thoughts, plans and attempts than non-Native youth.
- Characteristics of Completed Suicides: Mental health problems, substance abuse, and interpersonal problems were the primary characteristics associated with completed suicides in Alaska.
- Suicide Means: Firearms were the leading method used for suicide in Alaska followed by strangulation/suffocation and poisoning.
- Suicide Attempts: Suicide attempts are second only to falls as a reason for injury related hospitalizations in Southeast Alaska.
- Health Indicators: The Healthy Alaskans 2020 Plan has identified suicide reduction as one of its leading health indicators, along with other issues related to suicide including child abuse, sexual assault, mental health and substance abuse.
- Factors Influencing Suicide: Our preliminary research and data analysis indicated a correlation between trauma, behavioral health problems and suicide. To better understand the interrelationship of these factors, we conducted a more in depth analysis of these factors in *Section III, page 22* of the report.

Facts about Behavioral Health Problems in Juneau

Suicide

Juneau has had 56 suicides by residents in the past ten years (2004-2013),[1] a crude suicide rate of about 18 per 100,000, with the age adjusted rate similar to the state's rate of 23.0 – about twice the nation's suicide rate. The counts for low population areas (including Juneau) are small, so age-specific rates are not appropriate to use. But statewide in Alaska, the age specific rate for 15-24 year olds has been higher than other age groups. In most other states, older adults and seniors have the highest rates.[2] For broader age groups, Juneau's age specific rates are high for 15-44 year olds and for 65 and over (*See Table 3-1 on page 13*).



Nearly one fourth of high school students in Juneau (24%, about the same as the statewide rate of 23%) report that they have thought seriously about committing suicide in the past year or planned or attempted suicide (Youth Risk Behavior Survey—YRBS), and about 4% of adults report thoughts of suicide in the past year (Behavioral Risk Factor Surveillance System – BRFSS). This needs assessment includes extensive analysis of the characteristics and risks of survey respondents, comparing those with and without suicide thoughts, plans and attempts.

Mental Health Problems

Although the YRBS does not have questions specifically about depression, 29% of Juneau students (28% statewide) said they "felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities during the past 12 months." Alaska Native/American Indian youth in Juneau and in the state were more likely than other youth to report feeling sad. In the analysis beginning on *page 34,* we look at the relationship of mental/emotional distress to suicide ideation and attempts. We also look at inter-relationships of suicidal thoughts/plans/attempts, mental/emotional stress, substance use and other risky behaviors and characteristics of youth and adults in Juneau.

Adult survey results from the Behavioral Risk Factor Surveillance System (BRFSS) indicate that Juneau adults report more mean days of poor mental health than the state average (3.5 in last 30 days, compared with 3.2 statewide). Juneau adults are slightly more likely to report poor sleep 14 days or more in the last month (31%) and frequent mental distress (11%). On each of these

[1] Advance copy of table for update of the Alaska Health Care Data Book, Section II (Tables 2.630 and 2.640) from Alaska Bureau of Vital Statistics, Brice Murray. 12/3/2014. http://dhss.alaska.gov/dph/HealthPlanning/Pages/publications/healthcare/default.aspx

[2] http://ibis.dhss.alaska.gov/indicator/complete_profile/Suic1524.html

measures, Alaska Natives[3] in Juneau have higher rates of mental distress. Ten percent (10%) of the Alaska adult population reports having current moderate to severe depression, and another 17% report mild depression.

Current Alcohol Use
Survey data shows that Juneau adults are more likely to be current users of alcohol than Alaska adults in general (60% compared with 57%, not a statistically significant difference), with 64% of whites and 52% of Alaska Natives reporting use. Binge drinking is also slightly higher – 22% for Juneau compared with 17% for the state adults. 27% of Alaska Native adults in Juneau report binge drinking, although "heavy drinking" is similar for Alaska Natives and Caucasians (both around 7%). (Source: BRFSS)

One-third of Juneau youth and Alaska youth also report current alcohol use (defined as one or more drinks of alcohol in past 30 days) on the YRBS survey.

Other Substance Use
45% of Juneau youth report "ever using" marijuana, cocaine, solvents, heroin and other illicit substances, a slightly smaller portion than the 50% statewide. Also, 24% of Juneau youth report using marijuana or a prescribed drug without a prescription within the past 30 days. Statewide use is slightly higher at 26%.

National Survey of Drug Use and Health (NSDUH) data suggest that Alaska 18-25 year olds' use of marijuana and other illicit drugs are both about 25%, but that the level drops to about 10% for both types of substance use for those 25 and over.[4]

Mortality

Overview
Alaska has the second highest suicide rate in the nation, with a rate that remains nearly double the national rate: 23.0 per 100,000 compared with 12.5 U.S. deaths per 100,000 in 2012. While suicide ranks as the tenth leading cause of death for the Unites States, it is the 6th leading cause of death for Alaska, and ranks usually 4th or 5th for the City and Borough of Juneau. The age adjusted rate for Juneau has most years been slightly lower than the statewide average, but the rate is still nearly double the U.S. rate. Suicide has been the leading cause of death for Alaskans 15 – 44, and the rate for Alaska Natives is more than double the state average. The suicide rate for males is more than three times the rate for females in Alaska (33.7/100,000 vs. 9.1/100,000 in 2009-2013, CDC WONDER).

[3] In this report, we use Alaska Native to mean either Alaska Native or American Indian.
[4] State of Alaska Epidemiologic Profile on Substance Use, Abuse and Dependence: "Consumption and Consequence Update 2013," www.epi.hss.state.ak.us/injury/sa/SubstanceAbuseEpiProfile_2013.pdf, contains selected NSDUH data as well as data from many other state and federal sources.

Juneau experienced a spike in suicides in 2006 and 2007 which aroused community concern as noted above, with the Juneau Suicide Prevention Task Force (now "Coalition") forming to organize community discussion and action (*see Figure 3-1 on page 11*). As indicated in *Table 3-1* below, young adults (18-44) account for most local suicides, although the percentage is higher for those 65 and over.

Table 3-1. Suicide Deaths By Residence - Juneau - and Age Group (2004-2013)

Age Group	Count	Population 2010	Crude Rate
<18	4	7292	5.49
18-44	27	11472	23.54
45-64	18	9876	18.23
65+	7	2635	26.57
Total	56	31275	17.91

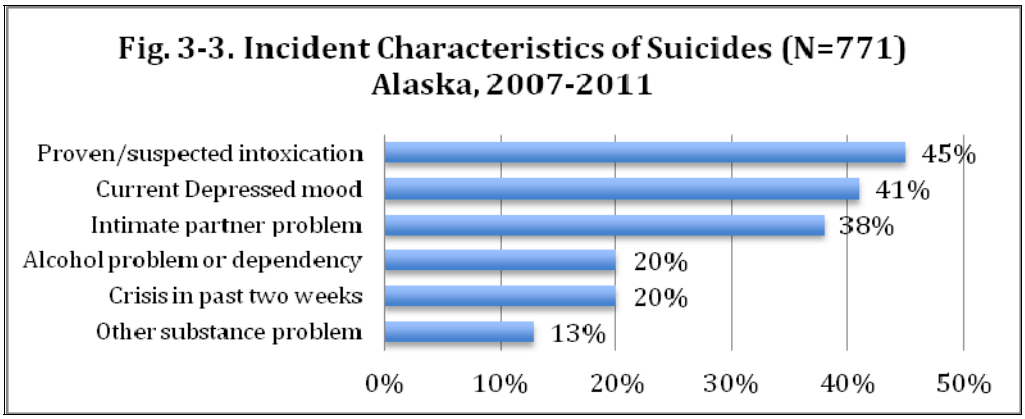
EPI and AKVDRS Data

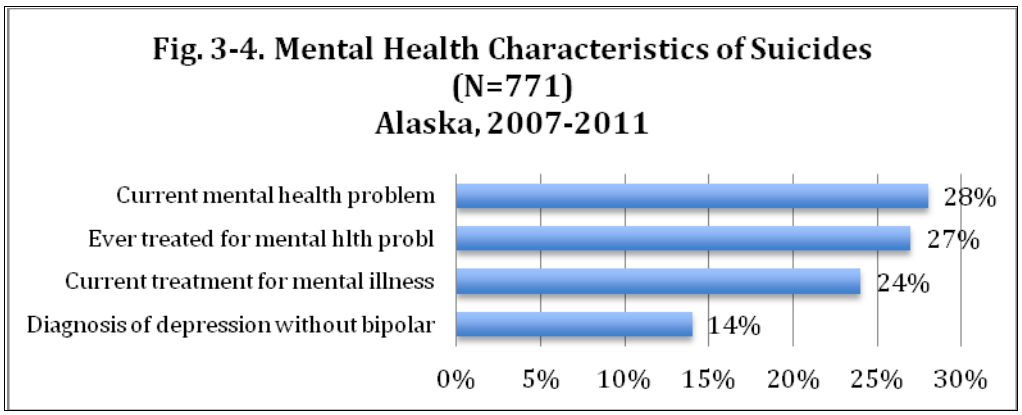
Two valuable resources about suicide in the state are the Epidemiology Bulletins "Characteristics of Suicide among Alaska Native and Alaska Non-Native People, 2003-2008,"[5] and the Alaska Violent Death Reporting System (AKVDRS) Suicide Update – Alaska 2007-2011.[6] The AKVDRS provides additional data fields for violent deaths, allowing for more in-depth reporting about methods of suicide, location, and other characteristics.

The Epidemiology Bulletin (2012) states: "Historically, the majority of suicides in Alaska have occurred as a result of a gunshot wound, followed by poisoning and suffocation. Mental health issues were commonly noted for suicide decedents. A personal history of relationship issues, breakups, or previous attempts, and a family history of suicide have been found to be significant risk factors associated with suicidal behavior. In addition, a history of substance abuse, most commonly alcohol, has been associated with suicidal behavior." See *Figures 3.3 and 3.4* below for the behavioral health characteristics of Alaskan suicides.

[5] Craig, J & Hull-Jilly, D., Characteristics of Suicide among Alaska Native and Non-Native People, 2003-2008, State of Alaska Epidemiology Bulletin Vol. 15, Number 1, July 30, 2012, http://www.epi.alaska.gov/bulletins/docs/rr2012_01.pdf

[6] AKVDRS Suicide Update – Alaska 2007-2011, Epi Bulletin 2013 Number 3, January 14, 2013, http://www.epi.hss.state.ak.us/bulletins/docs/b2013_03.pdf. Note: AKVDRS is the Alaska Violent Death Reporting System which assembles records on violent deaths from Medical Examiner, State Trooper records and other sources.





Source for Figures 3-3and 3-4 AKVDRS Suicide in Alaska Update 2013 Epi Bulletin

The Epidemiology Bulletin on characteristics of suicides (July 20, 2012) reports that of the cases tested, just over half tested positive for alcohol. A fifth of toxicology results were positive for marijuana, and other drugs were found in 10% or more cases.

Means of Suicide

An Alaska Epidemiology Bulletin[7] reports on "means" of suicide deaths (2007-2011). Firearms were the most common method used by suicide decedents. The report notes that efforts to reduce access to firearms among young people, and gun safety efforts, may have reduced the prevalence of firearms use, and perhaps of completed suicides. The report also shows that most suicides (3/4) occur in a house or apartment. Gunshot injury was the most common cause of death (males: 427/617, 69%; females: 71/154, 46%), followed by hanging/strangulation/ suffocation (males: 139/617, 23%; females: 42/154, 27%), and poisoning (males: 30/617, 5%; females: 33/154, 21%). These characteristics of completed suicides can be considered in thinking about strategies to intervene to prevent these deaths.

[7] AKVDRS Suicide Update – Alaska 2007-2011, Epi Bulletin 2013 Number 3, January 14, 2013, http://www.epi.hss.state.ak.us/bulletins/docs/b2013_03.pdf. Note: AKVDRS is the Alaska Violent Death Reporting System which assembles records on violent deaths from Medical Examiner, State Trooper records and other sources.

Morbidity (Suicide Attempts)

The Alaska Trauma Registry shows that suicide attempts are second only to falls as a reason for injury related hospitalizations in Southeast Alaska (also true statewide).

Statewide, suicide attempts are the most common reason for non-fatal injury related hospitalization for 15-34 year olds. It is the second most common reason for such hospitalizations for 35-54 year olds, dropping to the third most common cause after falls and motor vehicle accidents for 55 – 84 year olds.

Table 3-2. **Injury Hospitalizations by Leading Cause and Age Group**, Alaska Trauma Registry 2007-2011 (Source: Alaska Trauma Registry)

Injury Hospitalizations by Leading Cause and Age Group													
Rank	<1	1-4	5-9	10-14	15-19	20-24	25-34	35-44	45-54	55-64	65-74	75-84	85+
1	Falls 84	Falls 259	Falls 213	Falls 210	Suicide 556	Suicide 486	Suicide 632	Falls 709	Falls 1162	Falls 1310	Falls 1039	Falls 1173	Falls 856
2	As-sault 33	Poison 133	Bicycle 58	ATV 101	Falls 220 MV Traffic 220	Assault 297	Falls 507	Suicide 486	Suicide 380	MV Traffic 191	MV Traffic 110	MV Traffic 68	MV Traffic 15
3	Burn 22	Burn 48	Falls from play-ground 53	Suicide 97	Assault 147	MV Traffic 267	Assault 430	Assault 320	MV Traffic 271	Suicide 133	Suicide 29	Suicide 16	Acc. Struck 10

Healthy Alaskans 2020 Leading Health Indicators Related to Suicide Prevention

Healthy Alaskans 2020 (HA2020) is a framework of 25 health priorities or indicators for Alaska. "To reduce the rate of deaths due to suicide" is Leading Health Indicator #7. Eight other indicators are directly related to suicide risk, including mental health, child maltreatment, sexual assault, social support for adolescents, and substance use. Thus suicide prevention, trauma and behavioral health are central themes for the statewide objectives and strategies for improving health in Alaska over this decade.

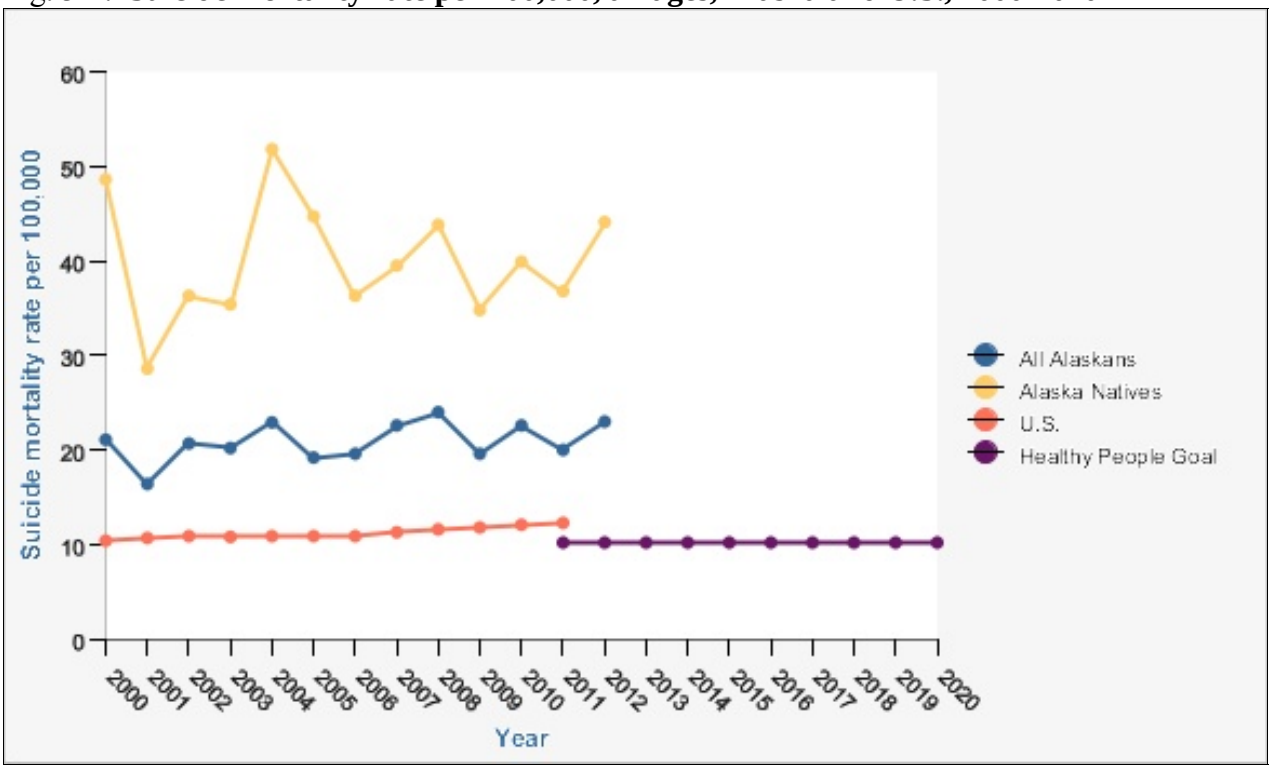
The HA2020 description regarding suicide includes: "Alaska's suicide rates continued to be the highest among males, young adults, American Indian/Alaska Native people, and persons living in the rural regions of the state. Mental illness and other life stressors are highly associated with suicide."

Each suicide can be seen as a sentinel event which is likely the culmination of conditions and events that may include traumatic experiences, mental health or emotional problems, illness, and

interpersonal problems. Substance use and abuse may be contributing factors and may be indicators of increasing risk of suicide and of other outcomes like family or community violence or "accidental" injury. Suicide prevention efforts draw attention to primary prevention as well as intervention once risks exist, and follow-up after attempts and completed suicides to address the impact on families and communities.

As indicated in *Figure 3-2* below, one key feature of the HA2020 measures is tracking of Alaska Native data as well as statewide data. Suicide among Alaska Natives has remained double the all-Alaskans rate.

Fig. 3-2. **Suicide mortality rate per 100,000, all ages, Alaska and U.S., 2000-2020**



Source: http://ibis.dhss.alaska.gov/indicator/view/SuicDth.HA.html Healthy Alaskans 2020 website. Factors Impacting Suicide

Our preliminary research and data analysis indicated that suicide is not an isolated event that occurs in a vacuum. The data and research indicated a correlation between trauma, risky behaviors, mental/emotional distress, and suicide. To better understand the factors that most influence suicidal thoughts and actions, we decided it was essential to conduct a more in-depth analysis exploring the interrelationship between trauma, behavioral health and suicide. This analysis is presented in *Section III, page 22* of the report.

B. What are the perceptions of residents about the behavioral health focus area in the community?

Summary and Conclusions

Suicide prevention is a key issue at all levels of the Juneau community: the general public; behavioral health agencies; primary care providers; and community leaders. First, both the Healthy Alaskans 2020 Health Assessment (2013) and the United Way Community Indicators (2009) illustrate the high level of community concern regarding suicide prevention in Juneau. Second, the Juneau Suicide Prevention Coalition surveys show:

- Importance of Suicide as an Issue: 84.6% of Juneau public respondents rank the importance of the issue of suicide as a 4 or 5 on a scale of 1 to 5 (and 100% of behavioral health agencies and primary care providers).
- Importance of Suicide Prevention Efforts: 85.3% of Juneau public respondents rank the importance of having "dedicated efforts and services to help prevent suicide" as a 4 or 5 on a scale of 1 to 5 (and 100% of behavioral health agencies and primary care providers).
- Knowledge about Behavioral Health Risk Factors: Respondents in all three surveys were knowledgeable about the strong correlation between the following factors and suicide: depression/poor mental health; alcohol/drugs; and disconnection/isolation (83.5% for the public; 91.7% for behavioral health agencies; 95.27% for primary care providers).
- Knowledge about Trauma Risk Factors: Respondents in all three surveys were less knowledgeable about the relationship between traumatic events and suicide. Three contributing factors in the survey relate to trauma—trauma when young; violence/sexual assault, and bullying. The ratings of importance for these three contributing factors were significantly lower than the ratings for depression/poor mental health; alcohol/drugs; and disconnection/isolation (63.9% for the general public; 58.3% for behavioral health agencies; 68.23% for primary care providers).
- Behavioral Health and Primary Care Differences:
    - Knowledge Level: Behavioral health agencies were more knowledgeable about suicide/suicide prevention, with 100% of the behavioral health providers stating they were very knowledgeable compared to 42.9% for primary care providers.
    - Client/Patient Estimates: There was also a significant difference between behavioral health providers and primary care providers regarding their estimates of clients/patients with current or past suicide ideation/attempts. For behavioral health agencies, the average was 71.4% while the average for primary care providers was 3.1%. While some difference would be expected due to differences in populations, we believe much of the difference is due to the low percent of primary care providers who indicated that they screened routinely for current suicide risk (28.6%) and past attempts (42.9%).
- Primary Care Providers Regarding Trauma History: The medical community also does not appear to recognize the full extent of traumatic events (domestic violence/sexual and behavioral problems) as current or past issues for their clients. For example, the primary

care providers on average stated that 5.6% of their clients experienced domestic violence in the past or currently. This stands in stark contrast with the rating for behavioral health providers (71.4%) and a 2010 University of Alaska, Anchorage study which found that 47% of Juneau women had experienced domestic violence in their lifetimes.

The combined survey results indicate that there is a strong community desire to more effectively address suicide prevention. Additionally, the overall community recognizes many of the key contributing factors regarding suicide, but lags behind in recognizing the impact of traumatic experiences (early childhood trauma, violence/sexual assault, bullying) on suicide risk. Finally the medical community appears to need education on the extent that suicide ideation attempts, trauma and behavioral health problems impact the lives of their patients.

Overview

Our Needs Assessment Committee looked at two existing state and local reports, as well as three surveys developed specifically by our Coalition, to assess the perceptions of local residents regarding the issue of suicide. For existing reports, we reviewed:

- Healthy Alaskan 2020 Health Assessment
- 2009 Juneau Community Indicators Reports

Both reports underscore suicide as a high priority issue for Juneau.

In addition, our Coalition developed and administered three local surveys: a general community survey, a behavioral health provider survey, and a primary care provider survey. These surveys include some questions that are common to all three surveys, and some questions that apply to only one or two of the surveys. These surveys were excellent tools to assess the community's knowledge and beliefs regarding suicide and related factors, including strategies to prevent suicide.

We have provided below a summary of key points from the Healthy Alaskans 2020 and Juneau Community Indicators reports; in addition, we have provided more detailed information regarding the responses to the three Coalition-developed surveys.

Healthy Alaskans 2020 Health Assessment: Understanding the Health of Alaskans

(June 2013) **http://hss.state.ak.us/ha2020/**

There were two Alaska statewide surveys for the Healthy Alaskans 2020 Health Assessment and responses were analyzed by region. The result that is most relevant to this planning effort is the second survey that asked respondents to identify specific health measures, or indicators, most meaningful to themselves and their communities. The specific health indicator most frequently selected statewide and in Southeast Alaska (72% of Southeast Alaska respondents selected it) was "Rate of death due to suicide."

The next indicator prioritized for Southeast Alaska was, "Percentage of high school students who felt so sad or hopeless every day for 2 weeks or more in a row that they stopped doing some usual activities, in the past 12 months." (64% of Southeast Alaska respondents selected it).

Both indicators, selected from a broad range of health indicators, demonstrate that Southeast Alaskan residents see suicide and youth emotional distress as areas we need to address to have a healthy community. Southeast Alaska showed a somewhat deeper concern for suicide than the statewide average, with 72% choosing suicide reduction as the key indicator compared to 67% statewide.

For Juneau – United Way of Southeast Alaska – United Way Community Indicators, 2010

The purpose of the Community Indicators Study was to determine: "What indicators say the most about the community as a whole over time?" The project sought to identify a concise set of indicators that reflect broad public priorities. The goal was a blending of long-term and shorter-term perspectives that address both the following questions:

- What indicators say the most about the community as a whole over time?
- What indicators do we need in order to track the issues we know are community priorities now?

In this study "suicide" was selected as one of 15 overall indicators to represent the wellbeing of the Juneau community, and one of six (6) leading indicators in the "health" category.

Juneau Suicide Prevention Coalition Surveys – General Public, Behavioral Health Agencies, and Primary Care (Medical) Providers

Who was surveyed?

For the three Coalition surveys combined, close to 1% of the Juneau population filled out a survey on a voluntary basis (280 total responses). The response methods for the general community surveys included: online responses to general advertising; and in-person responses with members of community organizations like the Rotary Clubs, and community meetings. We believe that those completing the survey were somewhat more representative of those active in community issues. For the behavioral health and primary care surveys, we emailed the survey link to the provider agencies and clinics.

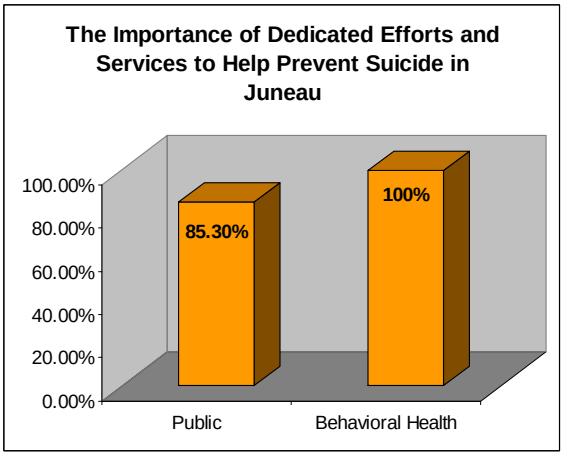
The demographic data indicates that the responses were highly representative of the race and age levels in Juneau, but more weighted toward females, and those with higher incomes. As noted earlier, the behavioral health provider survey was completed by seven (7) agencies and the primary care provider survey was completed by seven (7) respondents. The survey questions and responses for the three survey groups are included in the *Appendix, page 82.*

Analysis

Community Readiness

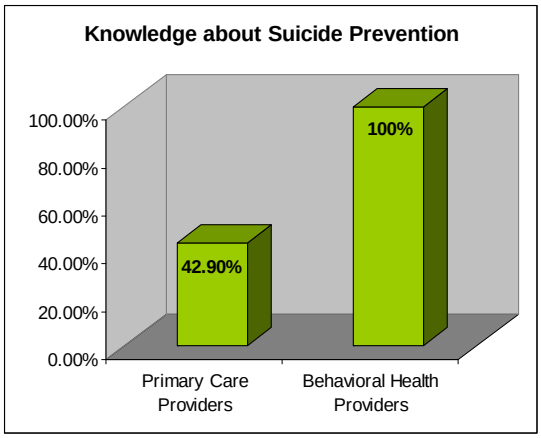
Two questions asked about the importance of the issue of suicide/suicide prevention in Juneau.

Of the general public surveyed, 84.6% ranked it a 4 or 5 (out of 5), and 94.3% ranked it either a 3, 4 or 5, indicating suicide as a very high community priority. The importance of having "dedicated efforts and services to help prevent suicide in Juneau" received nearly the same responses (85.3% and 95.6%). In addition, 100% of the behavioral health agencies and primary care providers scored both questions at either a 4 or 5. These responses indicate a very high community readiness to take action on the broad subject of suicide prevention.

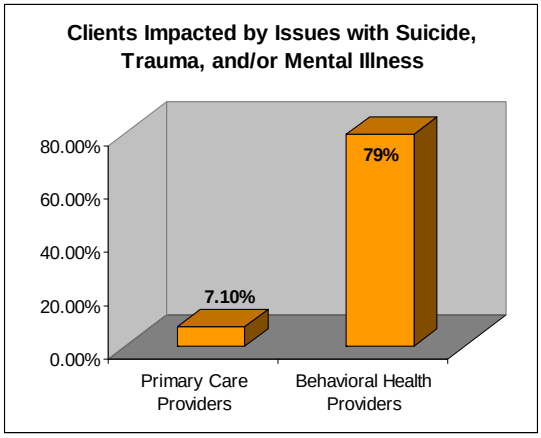


Community and Provider Knowledge

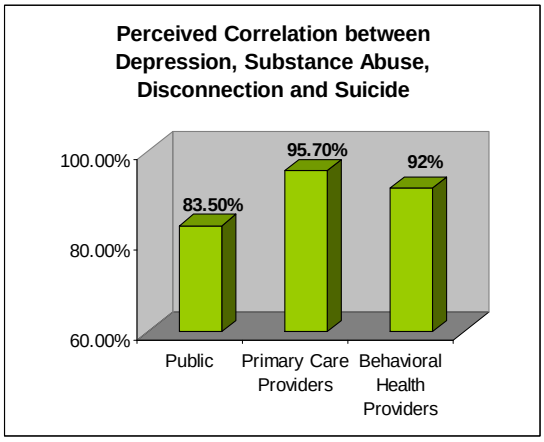
Only approximately one third of general public respondents felt they could identify the signs of suicide well, but nearly two thirds felt that they would know where to turn for help if someone was suicidal. Assuming that these respondents are representative of general public in Juneau, a need for additional broad discussion and training regarding suicide prevention in Juneau is indicated.



Primary care and behavioral health providers differed in their responses to their knowledge about suicide. Whereas, 100% of the behavioral health providers believed their agencies were very knowledgeable about suicide/suicide prevention (4 or 5 rating), only 42.9% of the primary care providers reported that level of knowledge.



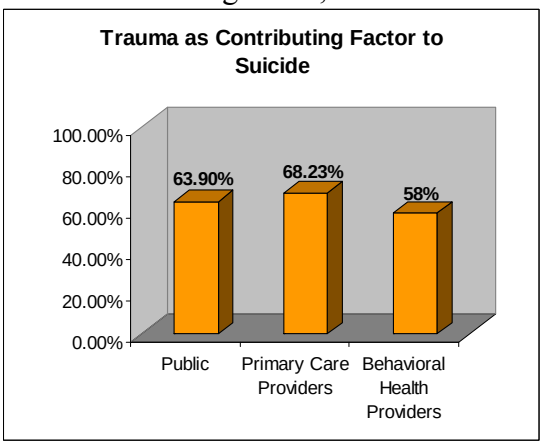
Behavioral health and primary care providers also differed significantly in their perception of the percent of their current or past clients who had issues with suicide ideation/attempts and other conditions that are often linked with suicide risk (71.4% for behavioral health providers, versus 3.1% for primary care providers). In addition to suicide, both groups of providers were asked what percent of their clients had past or current issues with mental illness, substance abuse, co-occurring mental health/substance abuse issues, domestic violence/sexual assault (victim and offender), and childhood trauma. In every case, primary-care providers stated that a significantly lower percent of their clients were impacted by these issues. The



overall difference between the two groups is startling; behavioral health providers estimated that 79.3% of the clients on average had issues with suicide, trauma and behavioral health, while only 7.1% of primary care providers believed their clients had current or past concerns with these issues.

Contributing Factors, Protective Factors and Interventions

The vast majority of respondents for all three surveys believe there is a strong correlation between suicide and depression/mental health issues, substance abuse, and disconnection/social isolation. In aggregate, these three issues were estimated to have a very high relationship with suicide in Juneau (83.5% for the public; 91.7% for behavioral health agencies; 95.3% for primary care providers).

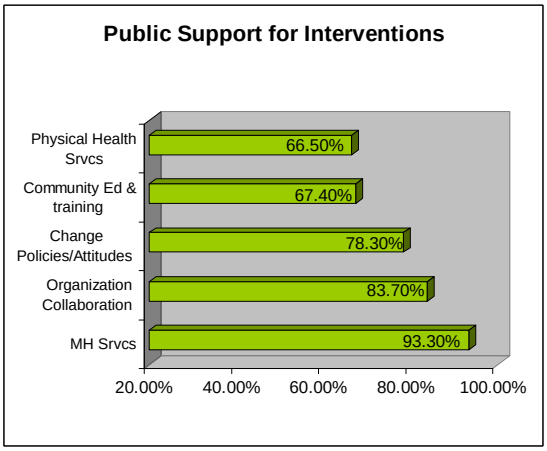


In contrast, respondent for all three surveys recognized a significantly lower correlation with childhood trauma, violence/sexual assault and bullying as contributing factors with suicide. Collectively these issues received the following ratings of importance (63.9% for the general public; 58.3% for behavioral health agencies; 68.2% for primary care providers).

The "protective factors" that were identified as most likely to reduce suicide risk included friendships/positive relationships, involvement in productive activities, and religious/spiritual connection. This was true for the general community, behavioral health providers, and primary care providers.

A broad approach of interventions was strongly supported by the three survey groups. Support for the interventions below, depending on the type of intervention and survey group, ranged from 64% to 100%:

- Mental health services (combined rating of 93.3%)
- Collaboration between organizations (combined rating of 83.7%)
- Change community policies/attitudes (combined rating of 78.3%)
- Community education and training (combined rating of 67.4%)
- P*h*ysical health services (combined rating of 66.5%)



C. What behavioral health priority was identified in your community?

Introduction

To identify the intermediate variables having the greatest impact on suicide risk in Juneau, the Coalition's Needs Assessment Committee adopted the following strategies:

a. Reviewing data that had been assembled for the original FY 15 grant application;

b. Doing a further literature review including review of data reports regarding the Juneau community and schools, as well as statewide and national data; and

c. Selecting data sets to analyze for characteristics of youth and adults reporting suicidal ideation, depression, behaviors that signaled potential self-harm, and exposure to violence, abuse, illness, poverty, and other adverse circumstances.

The first step was to identify relevant intermediate variables. A team effort emerged to go over the list of potential data sources (primary and secondary) including local, regional, state, and national sources, and to review the literature on factors associated with increased risk of suicide, to identify promising variables and sources of data for measuring and demonstrating "need" in our community. Each member of the Needs Assessment Committee reviewed one or more reports and/or descriptions of data sets and results available to date, and reported back to the Committee for discussion at our weekly work sessions. This process resulted in the Needs Assessment Committee identifying which potential data sources could be used for new analysis (YRBS and BRFSS, School Climate Survey, Alaska Trauma Registry for reasons for hospitalization, and vital statistics). Reports and access to data sets were then requested.

Members of the Committee spoke with Juneau School District staff about the "school climate" surveys and the YRBS, and obtained approval to use both data sets. The School Climate Survey data, however, would require requesting and paying for further analysis if more was needed than the already published results. The Committee decided the published results were sufficient for review. YRBS data could be analyzed more effectively to identify characteristics of the respondents over multiple survey years, so the decision was made to acquire and analyze the YRBS data.

With Committee member Alice Rarig contracted to undertake the in-depth data analysis, we did bi-variate analysis of over fifty of the approximately 120 YRBS variables to quantify the differences in these measures for students with and without suicide ideation, planning or attempt, and for students who did/did not report signs of serious emotional distress (feeling alone or sad). To the extent possible we also requested analyses of BRFSS data for adults to parallel the assessment of students, although the details of specific factors had to vary with the differences in surveys.

The results of the survey analyses revealed new insights into the specific kinds of risk and protective factors associated with the groupings (suicidal risk or not, and with or without emotional/mental health problems). The Committee members and several additional Coalition members participated in reviewing and discussing the implications of the findings. The data suggested that adverse experiences in childhood including sexual abuse, exposure to violence or physical abuse, emotional abuse whether in the home or at school (bullying, for example), and

other adverse circumstances (from BRFSS we saw the significance of poverty, unemployment, chronic disease, low educational attainment, and lack of stable couple relationship) were much more prevalent in the groups showing risk of suicide. Having a mental health problem or severe emotional distress was also more prevalent in the high suicide risk groups. "Risky behaviors" such as alcohol and drug abuse were also more prevalent in the at-risk groups for suicidal thinking or action, but the differences were less strong than the adverse childhood experiences.

Summary

In this section, we looked at the interrelationship between various forms of trauma, risky behavior (including substance abuse), indicators of mental/emotional distress, and suicide. Our primary data sources were the Youth Risk Behavior Survey (YRBS) and the Behavior Risk Factor Surveillance System (BRFSS). We were able to review Juneau-specific data for both sources. We also explored protective factors that have potential to mitigate suicide risk.

Taken as a whole, our research and data analysis indicates that traumatic experiences, especially those experienced in childhood, are strongly predictive of suicidal thoughts, plans, and attempts. As a result, our Coalition has chosen to focus on trauma experienced in childhood and adolescence and its relationship to suicide risk, as our priority area.

Noted suicide researcher T. Joiner draws a close connection between the successful completion of suicide and early trauma. Joiner believes that two simultaneous conditions must exist for an individual to go beyond suicide ideation to a state where suicide completion is likely. First is a feeling of "perceived burdensomeness and a sense of low belongingness or social alienation." Second, the individual who goes beyond ideation and achieves suicide must also have, "the acquired ability for lethal self-injury." Joiner notes:

> "….The capability for suicide is acquired largely through repeated exposure to painful or fearsome experiences. This results in …. a higher tolerance for pain and a sense of fearlessness in the face of death. Acquired capability is viewed as a continuous construct…. such that more painful and provocative experiences will confer greater capacity for suicide." (Thomas Joiner, PhD, "The Interpersonal-Psychological Theory of Suicidal Behavior: Current Empirical Status," American Psychological Association, Science Briefs, June 2009)

Risky behaviors such as drinking, drug use, and smoking were also found to be correlated with increased suicide risk. The data also indicated that serious mental emotional disorders and distress are associated with higher suicide risk, both independently and in conjunction with childhood trauma, and adult experience of interpersonal violence, including sexual assault and domestic violence.

A summary of our findings in this section includes the following:

- Adverse Experiences for Youth: A review of YRBS data for Juneau from 2003 to 2013 indicated that youth who had suicide thoughts, plans and attempts were much more likely to have experienced trauma than the non-suicide group. The suicide risk group was nearly double or more than double for the following adverse experiences: being bullied at school

(39% vs. 17.8%); being electronically bullied (36% vs. 17%); being hit by an intimate partner (21% vs. 10%); sex before the age of 13 (13% vs. 7%); and forced sexual intercourse (21% vs. 8%). Please see *Figure 3.10, page 31).*

- Adverse Experiences for Adults: Data from the Alaska Behavior Risk Factor Surveillance System (BRFSS) survey now includes information on adverse childhood experiences (ACEs) for these adults. We were able to compare Juneau responses with Alaska data, and data from other states. In a five state comparison, Alaska ranked first in childhood sexual abuse and second in childhood physical and emotional abuse. The data also indicates that Juneau adults report experiencing more ACEs than the state average. The national ACE Study shows a strong correlation between childhood ACEs and future physical and mental health problems, including suicide attempts.
- Increased Risk for Alaska Natives: YRBS data indicate a higher rate of suicide thoughts, plans and attempts for Native youth than non-Native youth in Juneau (32% vs. 26%); BRFSS data indicates a higher rate of suicide thoughts for Alaska Native adults than non-Natives (4.7% vs. 4.0%). In a multi-year BRFSS analysis (2006-2102), Alaska Native adults in Juneau ranked two to three times higher than Caucasians for the following factors: witnessing domestic violence, being sexually abused, and being hurt by an intimate partner (in the past five years and ever).
- Emotional Distress/Poor Mental Health: The Juneau YRBS data indicated that the suicide risk group of students (thoughts, plans and attempts) had a significantly higher level of emotional distress than the non-suicide group in several areas: sadness (63.6% versus 18.1%); engaging in fights (37% vs. 21.8%); feeling alone (42.3% vs. 24.7%); having no adult to talk to (20.3% vs. 11.5%); and carrying a weapon (30.5% vs. 17.0%). For adults, BRFSS data indicated that 10% of Caucasians and 15% Alaska Natives in Juneau experienced frequent mental distress.
- Risky Behaviors: The YRBS data showed a much higher level of risky behavior for the suicide risk group than the non-suicide risk group in several categories including the following: current smoking (30.5% vs. 15.0%); current drinking (47.8% vs. 31.4%); current marijuana use (33.4% vs. 21.0%); and multiple sex partners (15.4% vs. 10.0%). For adults, the BRFSS data for Juneau indicates that about 60% of Juneau adults are current drinkers, and about 20% binge drink.
- Protective Factors: For youth, the Juneau YRBS data indicated that there were several protective factors for both the suicide and non-suicide group. The protective factors that showed the biggest difference for the non-suicide risk group over the suicide risk group included the following: connectedness to the community (54% vs.36%); team sports (57% vs. 47%); 3 or more adults to talk to (49% vs. 40%; and parents to talk to daily about school (47% vs. 38%). Community connectedness seems to be the strongest youth protective factor, with about 80% of the non-suicide group "strongly agreeing" with the statement: "In the community, I feel like I matter to people," versus only 20% for the suicide-risk group. For adults, the protective factors that most corresponded to less depression and suicide thoughts included: moderate to high income; at least a high school education; employment; and being in a current couple relationship.

Background on Survey Data Sources

Two surveys – one of youth in the schools, one of adults in households – provide much insight into the population's characteristics and adverse experiences such as child abuse and unwanted sexual activity, as well as risky behaviors such as smoking, drinking, and drug use, and healthy activities (physical activity and nutrition, etc.). The Youth Risk Behavior Survey (YRBS) for Alaska youth in high school (grades 9-12) has been conducted every two years for more than two decades, and the Behavioral Risk Factor Surveillance System (BRFSS) survey of adults has been conducted annually for even longer.

The Juneau Suicide Prevention Coalition (JSPC) asked the Juneau School District (JSD) for approval to request access to and use of the local YRBS survey results. Use of the "local" file permits analysis of all the local school responses. In Juneau this includes the alternative high school (Yaakoosge Daakahidi High School) as well as Juneau Douglas High School and Thunder Mountain High School.

The Juneau School District approved our use of the local data set for our community assessment process. The Alaska Division of Public Health, Section of Chronic Disease Prevention and Health Promotion provided the master data set to our research analyst Alice Rarig, PhD. The master data set encompasses the entire Alaska composite data set for high school students, enabling comparison of Juneau responses to all statewide responses. (Other individual school districts are not compared since that would require their approval.)

Use of the data set enabled us to do comparative analyses of youth experiencing suicide thoughts, plans or attempts with those not reporting such distress, and to look at the correlation between various contributing factors, with assessment of Juneau in comparison to the state as a whole. We have used six survey years of data to obtain a robust number for Juneau respondents (about 3900).[8]

Similarly, for the BRFSS data, although we did not have access to the original data set, we were able to request data runs by the Alaska Division of Public Health staff for Juneau and statewide, including some analysis by race, to address questions about intermediate factors that may affect behavioral health outcomes and suicide risk.

The data are presented in sequence, for youth and for adults as data are available, on the following topics:

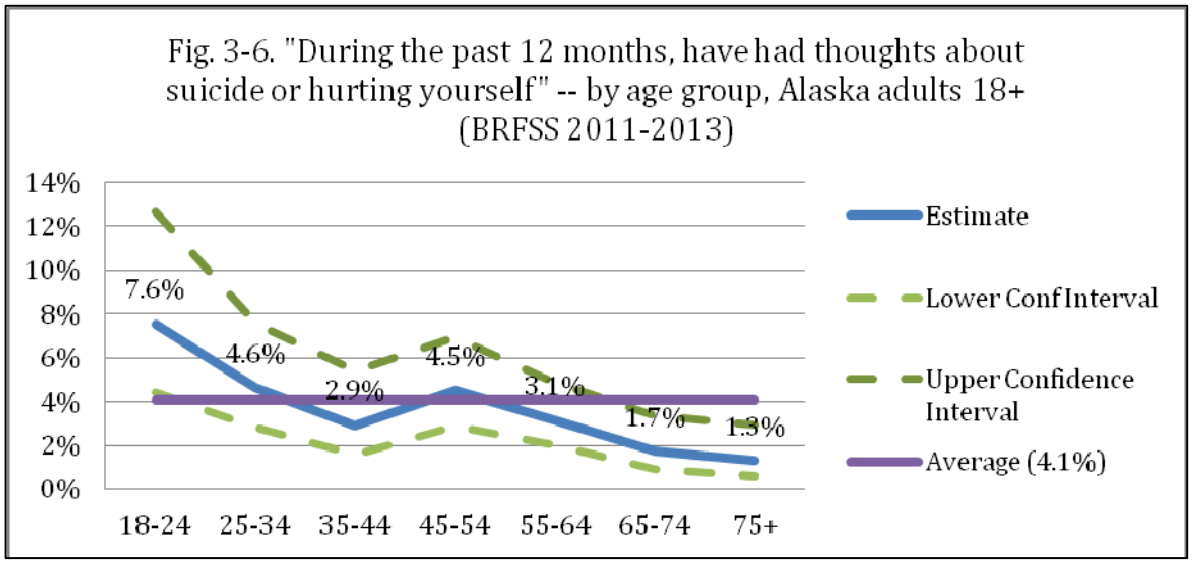
- Prevalence data
- Adverse experiences: adults
- Adverse experiences: youth
- Mental and emotional distress: youth and adults
- Risky behavior: youth and adults
- Protective factors: youth and adults

[8] The YRBS does not include youth who have left school.

Prevalence Data

The Behavioral Risk Factor Surveillance System (BRFSS) survey administered in 2011 and 2013 included a question about "thoughts of suicide or hurting yourself during the past 12 months." About 4.1% of respondents said they had had such thoughts. This is too small a group of respondents to see statistically significant differences by age, sex, race and other characteristics. The Alaska Trauma Registry (ATR) indicates that about 640 hospitalizations per year in Alaska are related to a suicide attempt, which would suggest that fewer than 3% of those adults who think about suicide or self-harm attempt it, and according to the mortality data, fewer than 1% of adults who think about suicide each year actually complete it.

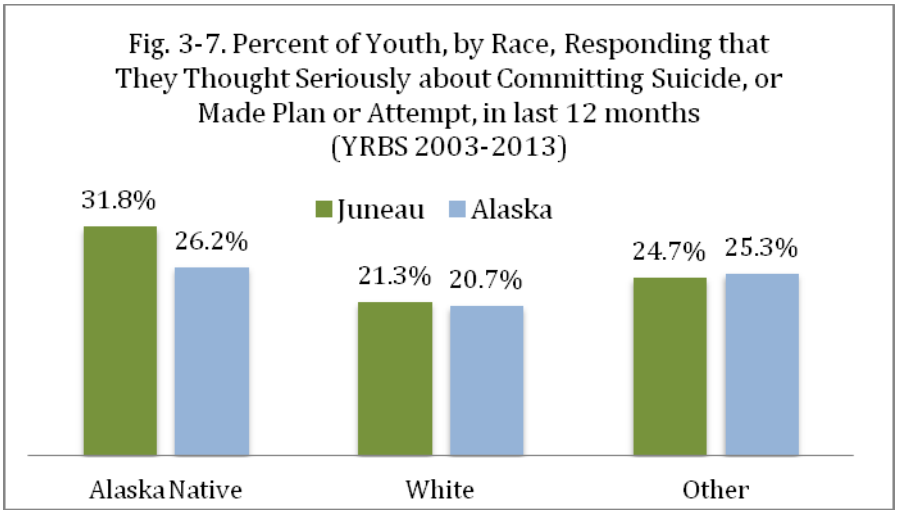
Although the BRFSS summary of suicidal thinking showed low rates for Alaskans 65 years old and over *(Figure 3-6)*, these would be responses from elders in their own homes rather than in institutions or the hospital, so the BRFSS has a bias toward healthier senior citizens. There is essentially a data gap at present for population-based mental health status measures for seniors



because of the difficulty of sampling the population regardless of housing and health status. The BRFSS results suggest that young adults 18-24 years old are more likely than older Alaskans to have thought about suicide or self-harm, consistent with both Alaska Trauma Registry and death data about actual attempts and suicides. Although the 7.6% estimate for 18-24 year olds thinking about suicide or self-harm is higher than for older groups, it is well below the rate (23%) for high school youth from the YRBS (Youth Risk Behavior Survey).

In the 2011-2013 BRFSS survey results, the rate for Alaska Natives reporting thoughts of suicide was somewhat higher than for non-Native adults (4.7 vs. 4.0), but the sample size is too small to confirm that there is a statistically significant difference. In contrast, we know that the suicide death rate for Alaska Natives and American Indians statewide is double the statewide rate for all Alaskans – about 46 per 100,000 compared with 23 per 100,000. For 18-25 year olds, the Alaska

Native suicide rate (103.0 per 100,000) is triple the "all Alaskans" rate of 34.1 per 100,000. [9]



In the statewide YRBS, Alaska Native youth who said that they had seriously thought about suicide, or actually made a plan or an attempt, represented 26% of the American Indian/Alaska Native (AI/AN) youth responding to the survey; the overall rate was 24%. In Juneau, the Alaska Native rate is higher than for the state as a whole with nearly 32% of Native youth reporting these thoughts and actions *(Figure 3-7)*.

Adverse Childhood Experiences: Adults

The 2013 BRFSS survey included a module of questions about "Adverse Childhood Experiences" or "ACEs." Selected data are provided below showing the association of such experiences to poorer physical and mental health in adulthood, and showing that Alaskan adults reported higher levels of abuse – emotional, physical and sexual – than the average of five other states doing the same study. There is a strong association of higher ACEs scores with inadequate sleep, frequent mental distress, and being unable to work. *Table 3-3* below lists the ACEs questions that were included in the 2013 BRFSS survey, along with a comparison of Juneau and state responses.

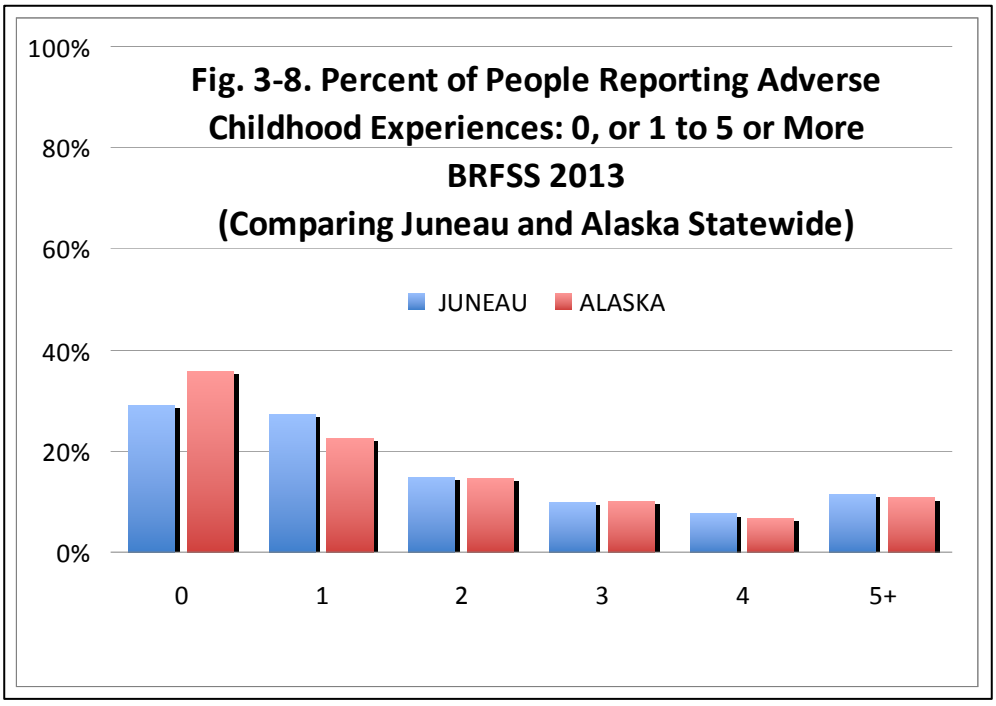
Table 3-3. Juneau Suicide Study: Adverse Childhood Experiences: 2013

	Alaska	Juneau
Before age 18, were your patents separated or divorced?	31.70%	27.10%
Before age 18, did you live with anyone who was depressed, mentally ill or suicidal?	21.90%	20.70%
Before age 18, did you live with anyone who served time or was sentenced to prison or jail?	11.50%	9.30%
Before age 18, did a parent or adult in home ever hit, beat, kick, or physically hurt you?	19.10%	19.10%
Before age 18, did parent or adults in the home ever swear at you, insult you or put you down twice or more?	31.00%	38.20%
Before age 18, did your parents or adults in home ever slap, hit, kick, punch or beat each other up?	18.70%	15.50%

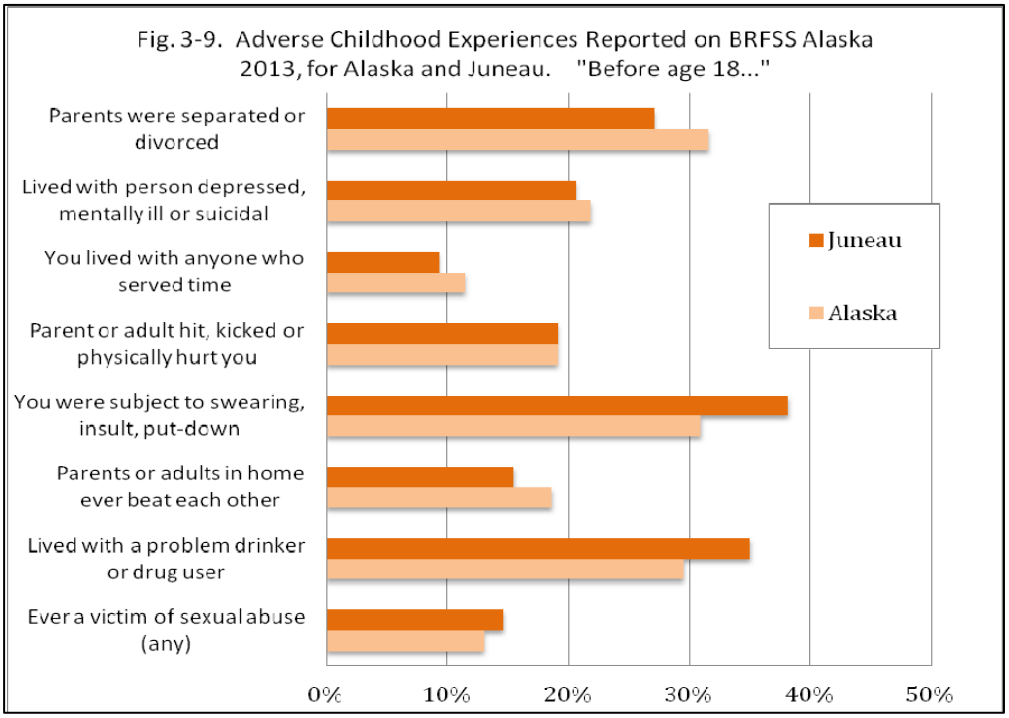
[9] http://ibis.dhss.alaska.gov/indicator/complete_profile/Suic1524.html

	Alaska	Juneau
Before age 18, did you live with anyone who was a problem drinker or used illegal drugs or abused prescription medications? (ANY)	29.60%	35.10%
Before age 18, did you live anyone who was a problem drinker or alcoholic?	29.00%	31.00%
Before age 18, did you live with anyone who used illegal street drugs or abused prescription medications?	14.50%	15.80%
Before age 18, were you ever a victim of sexual abuse? (ANY)	13.10%	14.60%
Before age18, did anyone at least 5 years older ever try to make you touch them sexually?	9.60%	9.60%
Before age 18, did anyone at least 5 years older force you to have sex?	6.20%	6.60%
Before age 18, did anyone at least 5 years older ever touch you sexually?	12.60%	16.30%

Summing up the number of adverse childhood experiences (grouped into eight categories) results in the following data *(Figure 3-8)* for Alaska and Juneau, showing Juneau adults report more "ACEs" than the average statewide:



A graphical summary *(Figure 3-9)* of the specific ACEs questions tabulated for 2013 suggests that Juneau residents are more likely than state adult residents overall to have been subject to insult and put-downs in their childhood, to have lived with a problem drinker or drug user, and to have been a victim of sexual abuse.



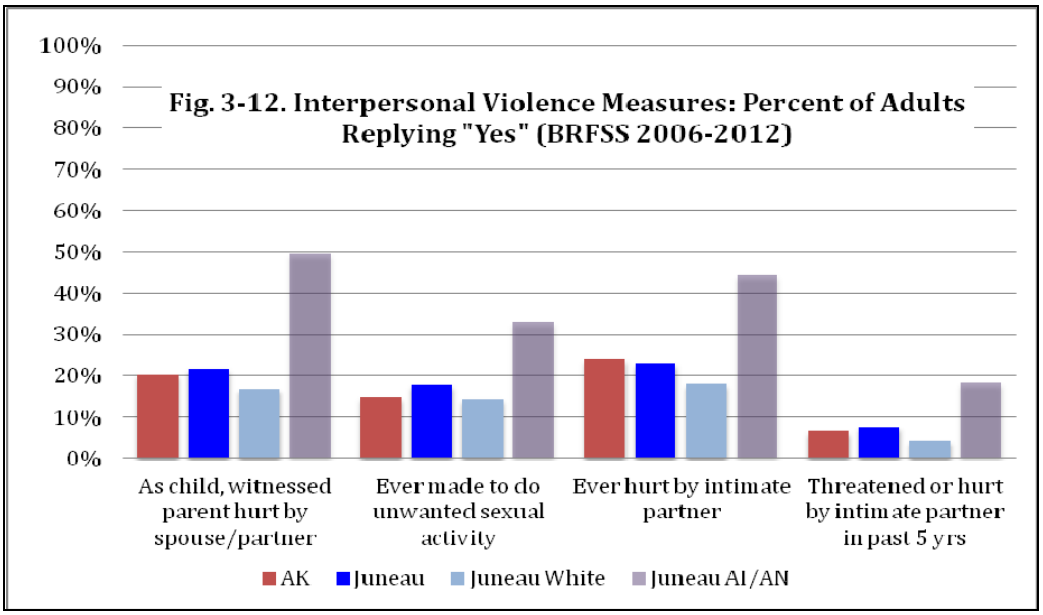
A comparison of ACEs with five other states *(Table 3-4)* shows that Alaska stands out as having the highest level of sexual abuse (14.8%) among the six states. Levels of emotional abuse (31.0%) and physical abuse (19.1) are second respectively to Washington state and New Mexico.

Table 3-4. **Alaska and Five Other States' Adult Responses about Childhood Experience of Abuse**

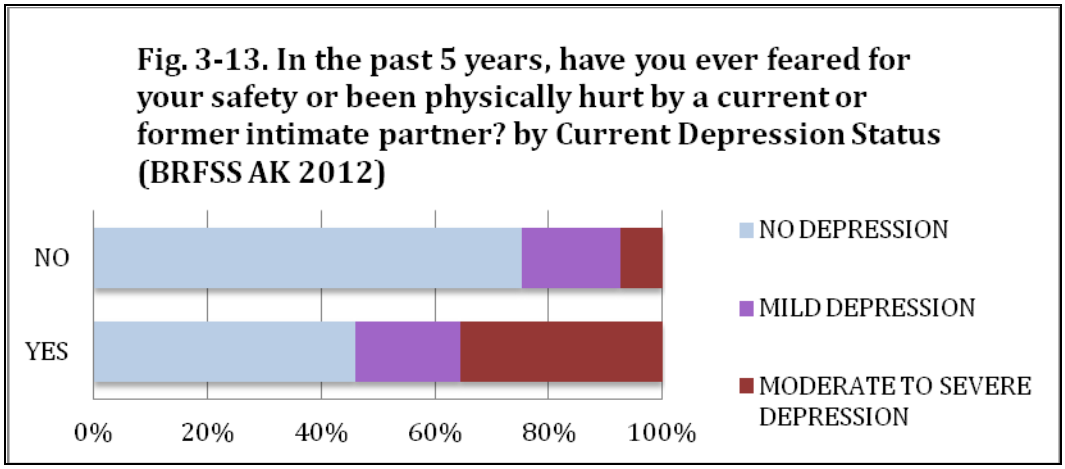
Adverse Childhood Experience	Alaska	Arkansas	Louisiana	New Mexico	Tennessee	Washington
Abuse	%	%	%	%	%	%
Emotional	31.0	24.3	21.1	28.1	19.2	34.9
Physical	19.1	14.1	10.5	19.5	12.9	18.1
Sexual	14.8	10.9	9.9	12.9	12.7	13.5
Source: Alaska data from the 2013 Alaska BRFSS, Alaska Department of Health and Social Services, Division of Public Health, Section of Chronic Disease Prevention and Health Promotion.						
Source: Five state Study data from Centers for Disease Control and Prevention, Adverse Childhood experiences Reported by Adults—Five States, 2009. http://www.ncbi.nlm.nih.gov/pubmed/21160456.						

BRFSS Alaska data for adults on one of the ACE questions – witnessing a parent hurt by a spouse or partner – is available for multiple years. There have also been routine questions on other personal traumatic experiences including unwanted sexual activity, ever hurt by an intimate partner, and threatened or hurt by an intimate partner in the last five years. For the current needs

assessment project, data have been analyzed for Juneau compared with the state, and for the two major race groups in Juneau – white and Alaska Native/American Indian (AI/AN). The reported prevalence of these kinds of violence or witnessing of domestic violence shows that Alaska Native/American Indian adults are more than twice as likely as whites to have had such experiences *(Figure 3-12)*.



The links between depression in adulthood and witnessing violence as a child, and/or experiencing or fearing interpersonal violence with an intimate partner are evident in the BRFSS data which show that adults who experienced or witnessed domestic violence are more likely to experience current depression. The strongest correlation is between current depression and the recent experience of physical abuse or fear of it *(Figure 3-13)*.



A recent Washington State ACE Study report summarizes some of the insights gained so far regarding the impact of ACEs on adults:

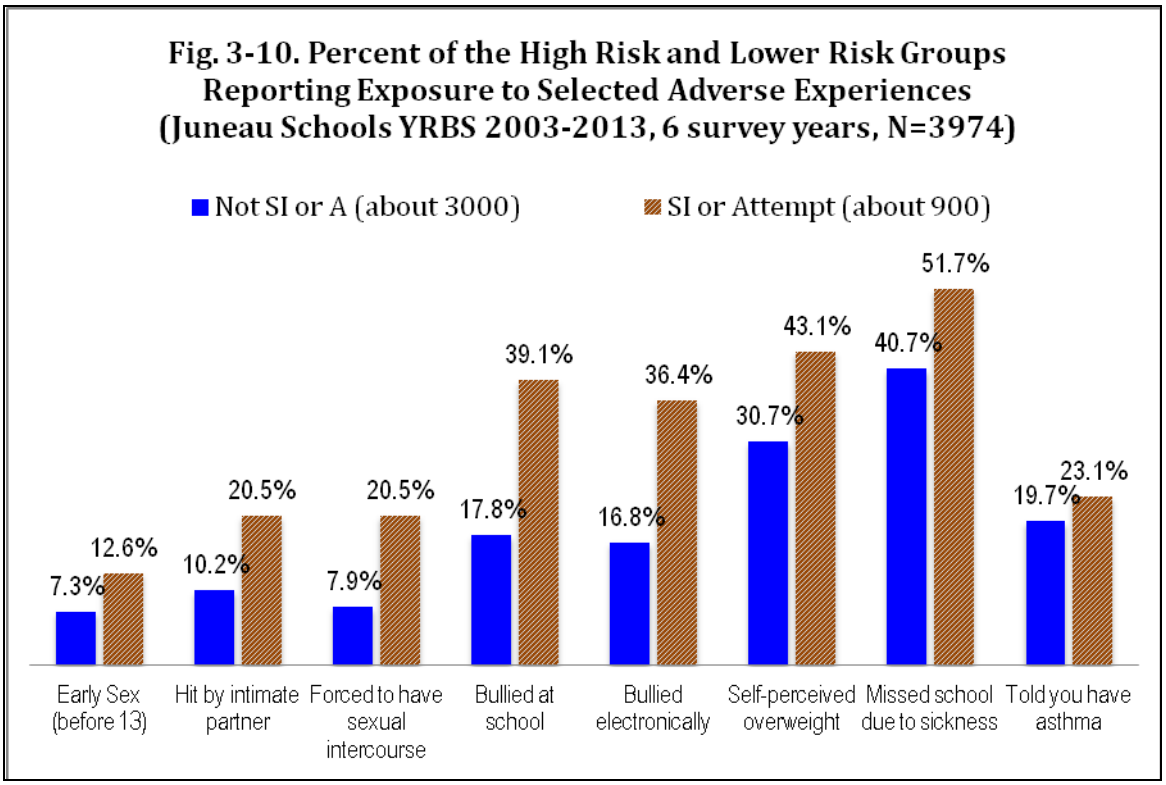
"The key concept underlying the ACE study is that stressful or traumatic childhood experiences such as abuse, neglect, witnessing domestic violence, or growing up with alcohol or other substance abuse, mental illness, parental discord, or crime in the home…are a common pathway to social emotional and cognitive impairments that lead to increased risk of unhealthy behaviors, risk of violence or re-victimization, disease, disability and premature mortality. We now know from breakthroughs in neurobiology that ACEs disrupt neurodevelopment and can have lasting effects on brain structure and function – the biologic pathways that likely explain the strength of the findings from the ACE Study."[10]

Adverse Experiences: Youth

We have YRBS data for youth for some questions that are similar to the BRFSS questions about adverse childhood experiences. With the YRBS we were also able to compare the youth who reported serious thoughts or planning for suicide *("SI or Attempt")* with those who did not *("Not SI or A")*, to see if those expressing higher risk also have been exposed to more "adverse experiences." A number of the questions in the YRBS represent adverse experiences of teenagers that increase likelihood of their being in the high suicide risk group, as shown in *Figure 3-10* below. Research literature suggests that such adverse experiences are also strongly associated with poorer mental health in adulthood.[11]

[10] Anda, Robert F. and Brown, David W., Adverse Childhood Experiences and Population Health in Washington: The Face of a Chronic Public Health Disaster, 2010, prepared for the Washington State Family Policy Council.
http://robertandamd.files.wordpress.com/2012/01/aces-in-washington-2009-brfss-final-report-7-7-2010.pdf

[11] e.g.: Edwards, VJ et al, Relationship Between Multiple Forms of Childhood Maltreatment and Adult Mental Health in Community Respondents: Results From the Adverse Childhood Experiences Study. AJP vol. 160, Issue 8, August 2003. Pp 1453-1460.
http://ajp.psychiatryonline.org/doi/full/10.1176/appi.ajp.160.8.1453



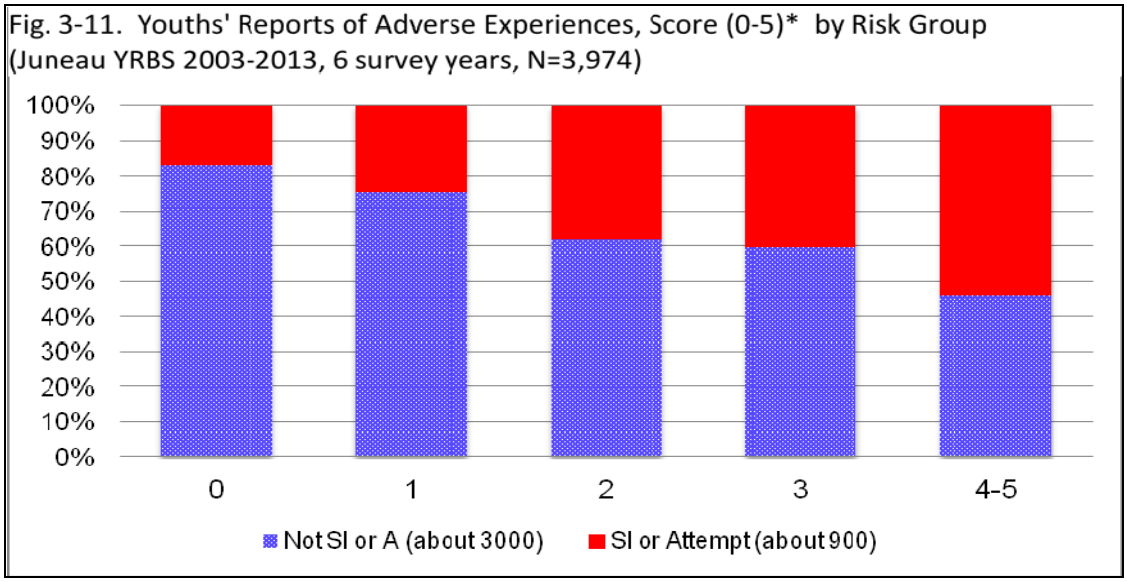
As indicated in *Figure 3.10*, being bullied at school and being electronically bullied are both reported by more than a third of the suicide risk group. The reports of being bullied by the non-suicide risk group are also high (18% and 17%) and might be considered evidence of a risk that could escalate to physical or mental health problems.

Although the YRBS does not ask about earlier history of physical abuse by parent or other adult in the home, YRBS does ask about interpersonal violence – "Have you ever been hit by an intimate partner?" – which was answered "yes" by 20% of the high suicide risk group, and 10 percent of the lower risk group (those not reporting suicide ideation or attempt).

Sexual intercourse before age 13, and forced sexual intercourse were also much more prevalent among the suicide risk group than the non-suicide risk group. Note that in the reports from adults in BRFSS results we observed that 15% of Juneau adults reported having been victims of sexual abuse before age 18. Seven percent said they had been forced before age 18 to have sex by someone at least five years older than they were.

Measures of several physical health problems also show an elevated suicide risk. The suicide risk group was more likely than the non-suicide risk group to report they have had sickness that caused them to miss one or more days of school in the past month. Chronic illness – only asthma and diabetes are specifically asked about in the YRBS – appears to affect about 16% of the non-suicide group and about 19% of the suicide risk group. Perception of being overweight is an issue for one in three respondents in Juneau – and it is more prevalent in the suicide risk group. These physical health issues thus appear to be indicators that could be used as part of screening or risk assessment.

Giving one point each for five adverse (or traumatic) experiences – early sex, ever hit by intimate partner, forced sex, missed school due to sickness, and ever told you have asthma[12] – we see that the more adverse experiences, the higher the likelihood of the respondent being in the suicide risk group.



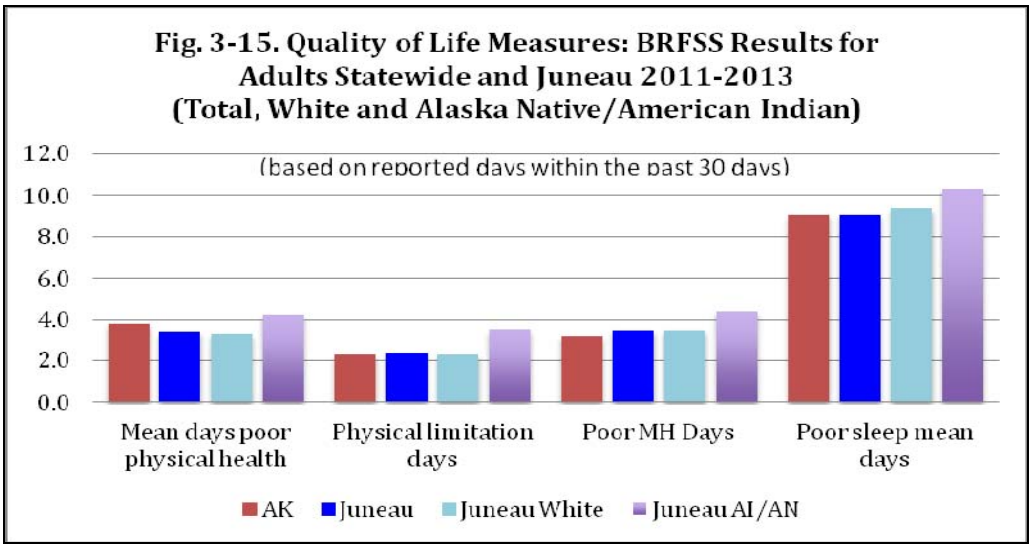
*Score counts 1 for each kind of experience: early (before age 13) sexual intercourse, ever hit by intimate partner, ever forced to have sex, self-perceived overweight, missed school due to illness, ever told by doctor you have asthma. Questions about bullying were not available for all years.

Mental and Emotional Distress

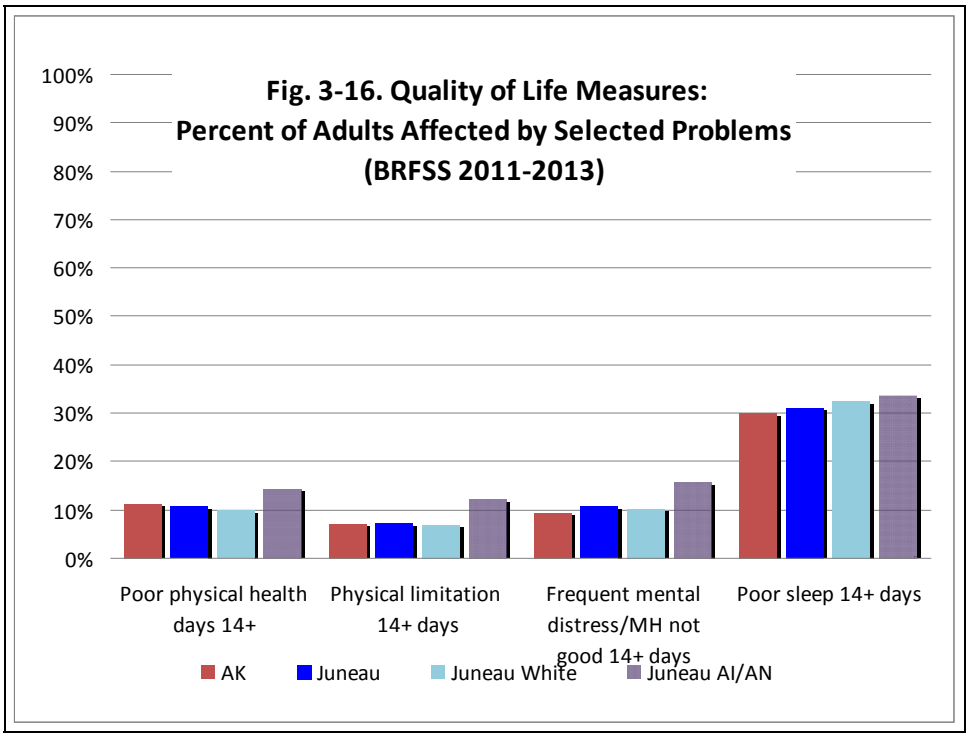
Mental and Emotional Distress for Adults

The BRFSS Survey includes physical and mental health measures that are indicative of behavioral health issues. The measures that are available every year on behavioral health status include number of poor mental health days, nights of poor sleep, as well as poor physical health days. "Mean days" are calculated from the responses regarding "how many" days did you have poor physical or mental health. The question about poor sleep indicates that Alaskans (same for Juneau residents) had about nine days in the past month with poor sleep – nearly one day (or night) out of three. About 30% of adults report having 14 days or more of nights of poor sleep in the past month. Although the questions regarding depression (current depression, or "ever having been told they had a depressive disorder") and about anxiety are not asked annually, BRFSS does have annual data about days of poor physical and mental health and poor sleep, which can be examined by race and by region, as shown in *Figure 3-15* for Juneau compared with the state of Alaska.

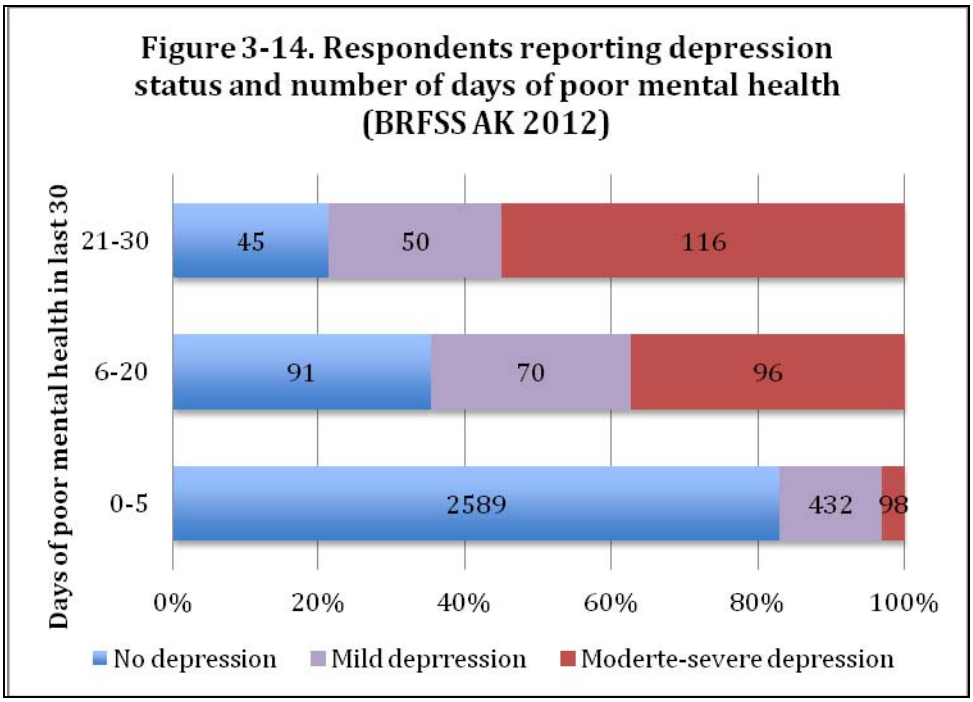
[12] Bullying on school grounds and electronic bullying were available for just two and one survey years respectively.



The question about "poor mental health days" is used as indicator of frequent mental distress. This is another variable that indicates Alaska Native/American Indian residents of Juneau are at higher risk, with about 15% of AI/AN adults reporting poor mental health days, in contrast to about 10% of white Juneau residents *(Figure 3-16).*



BRFSS data from 2012 substantiates the correlation between poor mental health days and depression. As indicated in *Figure 3-14* below, those with mild or more severe depression were more likely to report more days of poor mental health than those without depression.



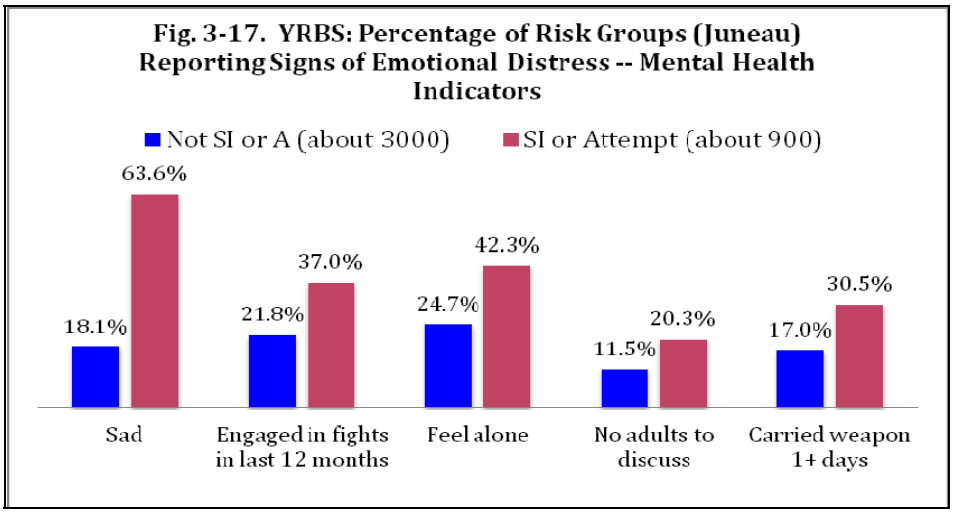
In addition, information from the Alaska Violent Death Reporting System (AKVDRS) substantiates mental health issues as a risk factor for Alaska suicides. In a study of 771 suicides for the period of 2007-2001, the following correlations were found: 28% involved current mental health problems; 27% had been treated for mental health problems; 24% were currently being treated for a mental illness; and 14% had a depression diagnosis.

Mental and Emotional Distress for Youth

For youth, the YRBS provides several measures of emotional distress, as well as reports of being involved in fighting on school grounds and a number of risky behaviors which may be "flags" of behavioral health problems. [13] *Figure 3-17* below shows that nearly two-thirds of the suicide risk group also said that within the past twelve months they had felt so sad that they stopped doing their usual activities, compared with less than one-fifth of the lower risk group. At 42%, the suicide risk group was almost twice as likely as the low risk group to have said they "feel alone in my life." They were also more likely to have engaged in fights in the last twelve months, and to have carried a weapon at school on at least one day of the past 30. They were also more likely to report that they did not have an adult other than a parent from whom they would feel comfortable seeking help (20% compared with 12%).

[13] Cerel J[1], Roberts TA. Suicidal behavior in the family and adolescent risk behavior. J Adolesc Health. 2005 Apr;36(4):352.e9-16.

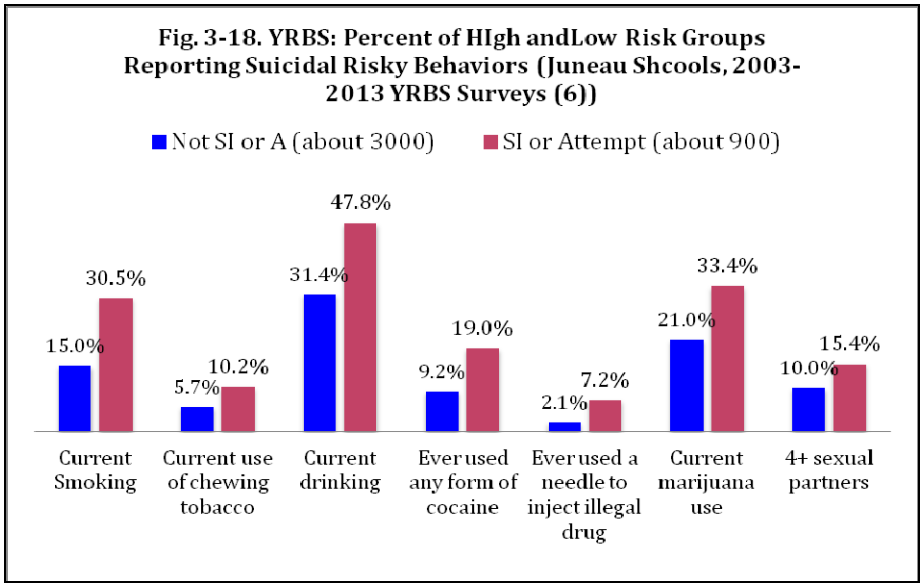
Fig. 3-17. YRBS: Percentage of Risk Groups (Juneau) Reporting Signs of Emotional Distress—Mental Health Indicators



Risky Behaviors

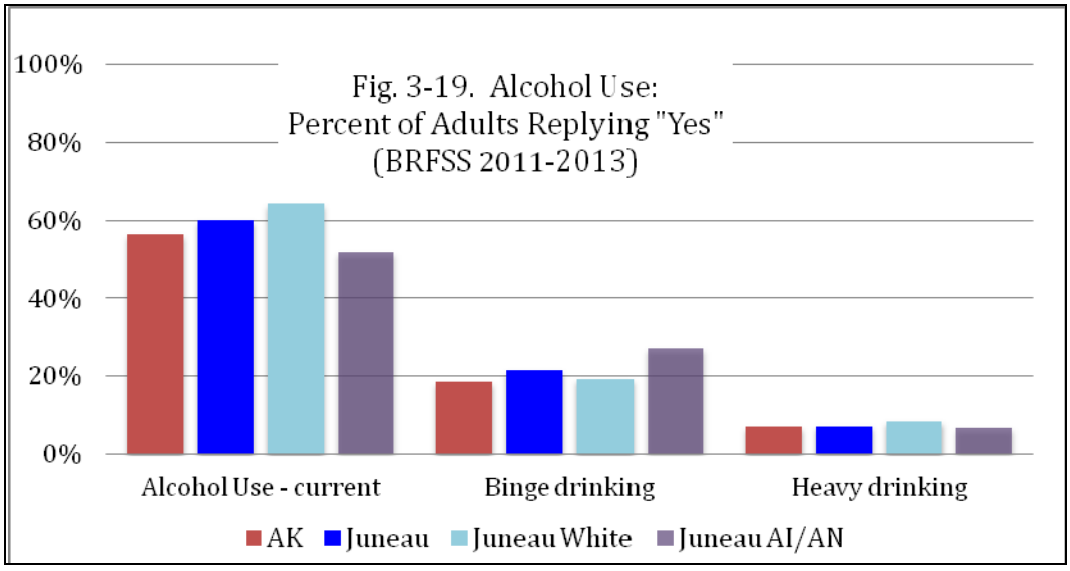
Youth who have expressed suicidal thoughts, planning or attempts also report significantly greater prevalence of risky behaviors such as smoking, drinking and use of illegal drugs. Having had four or more sexual partners is also more likely in the suicide risk group. For this needs assessment, the selected variables represent major factors that might be independent of one another, rather than redundant or closely correlated measures.

Juneau youth in the suicide risk group were twice as likely as youth in the non-suicide risk group to smoke (30 percent vs. 15 percent), or ever to have used cocaine (19% vs. 9%), and half again as likely to be using alcohol (48% vs. 31%) and/or marijuana (33% vs. 21%) *(Figure 3-18).*



Researchers have found strong correlations of substance use and other risky behaviors with suicide and ideation in adolescents[14] but more recent analyses are looking at ACEs and mental health conditions as underlying causes, with risk-taking behaviors being intermediate factors that may either correlate with or contribute further to outcomes such as mental illness or suicide.

For adults, BRFSS Survey data in *Figure 3-19* below shows that current alcohol use (any in the last month) is reported by 60% of Juneau adults (higher for Caucasians than for Alaska Natives). Binge drinking is reported by over 20% of Juneau adults. In contrast to general alcohol use, the binge drinking rate is higher for Alaska Natives than for Caucasians.



Information from the Alaska Violent Death Reporting System (AKVDRS) substantiates alcohol and substance use as a risk factor for Alaska suicides. The following correlations were found for completed suicides: 45% involved proven or suspected intoxication; 20% had a history of alcohol problems or dependency; and 13% had a history of other substance abuse problems.

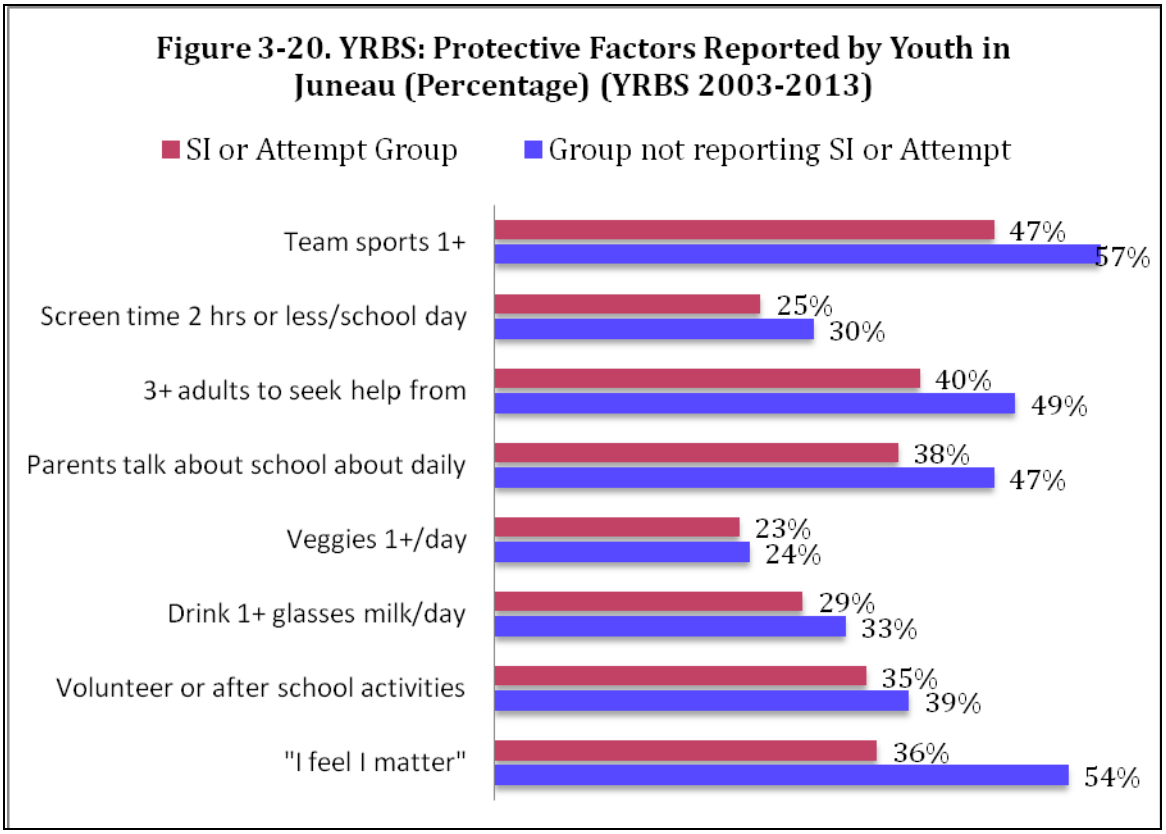
Protective Factors

YRBS provides data on several dimensions of "resilience" such as feelings of connectedness to the community, family engagement, after-school activity including participation in team sports, physical activity and nutrition. BRFSS has questions about nutrition and physical activity. Some questions can be looked at from the point of view of asset measurement rather than risk measurement, for example, low levels of "screen time" (hours of television and video games on school days) can be seen as an asset rather than assessing high levels of screen time as a "risk factor."

[14] e.g., King RA, Schwab-Stone M, Flisher AJ, Greenwald S, Kramer RA, Goodman SH, Lahey BB, Shaffer D, Gould MS. Psychosocial and risk behavior correlates of youth suicide attempts and suicidal ideation. J Am Acad Child Adolesc Psychiatry. 2001 Jul;40(7):837-46. Also Robert Anda et al re WA state, ACEs study, op cit.

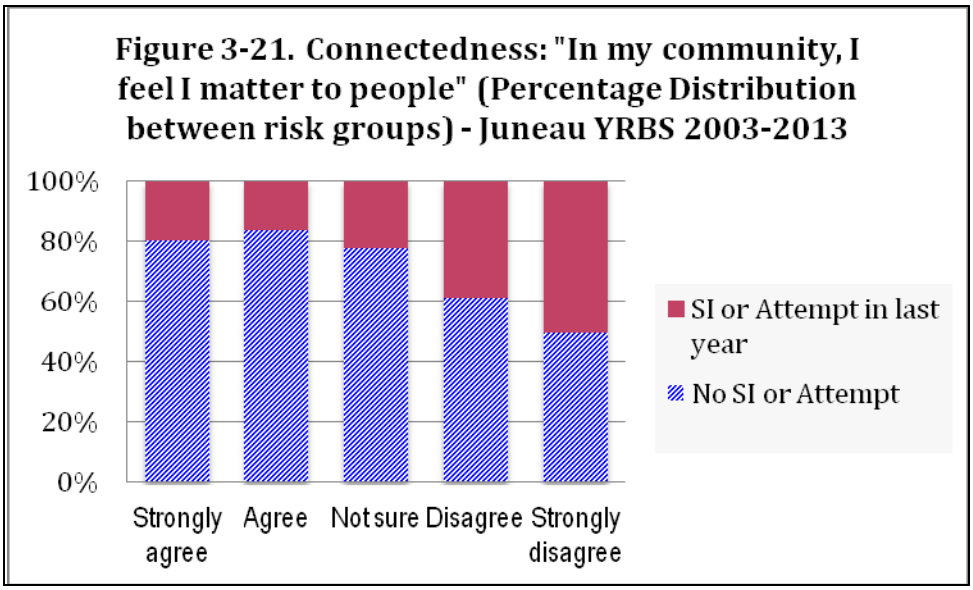
Neither YRBS nor BRFSS have direct information regarding some protective factors that have been found in more in-depth studies of ACEs, which appear to be important "intermediate factors." Strong emotional support in a family or community may help trauma-affected children and adults be more resilient. Some studies have sought to measure "maternal warmth" and a supportive family environment which appear to reduce the impact of early childhood sexual and physical abuse, thus reducing risk of behavioral health problems and risk of suicide for people who experienced childhood trauma. [15]

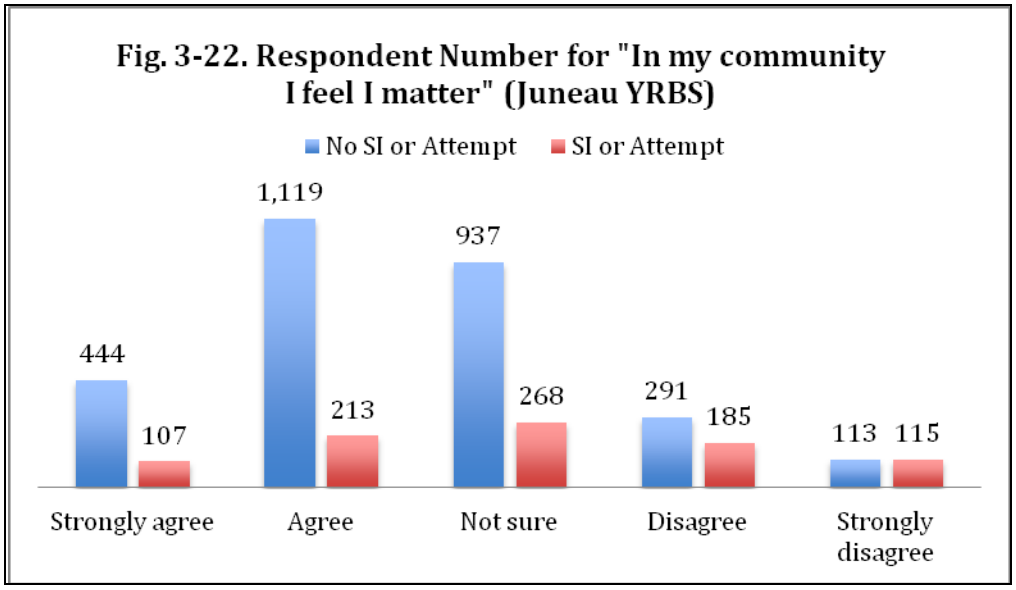
As shown in *Figure 3-20*, YRBS responses suggest that connectedness to the community (feeling that one matters in the community), participating in sports, and having both parents and other adults available for talking about school and for help, are more prevalent for the non-suicide risk group of youth.



As shown in *Figure 3-21* below, the suicide risk group accounts for 50 percent of the youth who strongly disagreed with the statement that "in the community, I feel like I matter to people," and accounts for only about twenty percent of those who agreed or strongly agreed with the statement. In *Figure 3-22*, the actual numbers may be small for the "strongly disagree" category, but the difference in distribution from strongly agree to strongly disagree is very evident.

[15] Connor JJ[1], Rueter MA. Parent-child relationships as systems of support or risk for adolescent suicidality. J Fam Psychol. 2006 Mar;20(1):143-55.





For adults, protective factors correlated with less depression and no report of suicidal thoughts include: moderate to high income, education at least high school, employment, and being in a couple relationship. In this project, exercise and nutrition have not yet been examined but are expected to be protective.

Connectedness[16] has been discussed in the literature, including studies with attention to effectiveness of interventions to strengthen support systems for youth after a suicide attempt.

[16] King, Cheryl A. and Merchant, Christopher R., "Social and Interpersonal Factors Relating to Adolescent Suicidality: A Review of the Literature." *Archives of Suicide Research,* 12: 181-196.

Although the YRBS data examined so far by this project do not show a strong protective effect of good nutrition, more analysis of nutrition and physical activity as well as additional measures of engagement in school based or community activities could be undertaken as the Juneau Suicide Prevention Coalition considers strategies to reduce suicides and to improve emotional and physical health of youth in Juneau. Enhancing quality of life for students in the present, encouraging their success, and preparing them for successful and healthy adulthood – including living, working and parenting without abuse – are implicit goals of the project.

Other Data Sources

Several data sources besides YRBS and BRFSS have been referenced in the discussion above, namely the Bureau of Vital Statistics for mortality data, the Alaska Trauma Registry regarding hospitalizations for injuries and poisonings, and the Bulletins of the Section of Epidemiology, Alaska Division of Public Health, which report on the Alaska Violent Death Reporting System data. The Adverse Childhood Experiences studies ongoing through Centers for Disease Control and Prevention, Kaiser Foundation and various state health departments and universities have also been noted in the discussion above. The Alaska Department of Health and Social Services is using the ACEs "module" for the BRFSS survey in 2014 and 2015 so there will be a more robust data set (in combination with the 2013 data) for analysis in future.

Census and Alaska Department of Labor demographic data about Juneau have been included in *Section I* of the report. Several Juneau-based studies such as the Juneau Healthy Indicators Report, the United Way Community Indicators Report, Juneau and Southeast Alaska Economic Indicators Report have also been cited in other sections of the report.

The Juneau School Climate Survey was reviewed in depth. While repeated measures from that survey could help with evaluation of impact of policy changes or programmatic interventions, as needs assessment documentation the results seemed to some extent redundant of the YRBS data, so we chose to focus on the more in-depth YRBS data which we could also analyze using the master data set.

D. What factors encourage/discourage the behavioral health priority area in your community?

There are several factors that either encourage or discourage our community's ability to effectively address the relationship between trauma and suicide risk. These factors are described below.

Encouraging (Aggravating) Factors

Tradition of Silence and Tolerance
One of the biggest challenges in addressing the causal link between traumatic experiences and suicide risk is the history of silence and tolerance regarding both trauma and suicide. There is a longstanding social norm that "what happens in the family stays in the family." There is a reluctance of family members to come forward if they have been the victims of family violence or sexual abuse. Similarly, with child sexual abuse situations where the father figure is the offender, the non-offending parent often sides with the offending parent to disbelieve the assaults, leading to further silence. In addition, our society has often chosen to respect family privacy to the point where serious abuse situations go unrecognized. All of these factors combine to create a veil of invisibility regarding traumatic abuse that occurs within the family.

There is a similar history of silence regarding suicide, and in some ways this is a more challenging issue with suicide than with trauma. With traumatic experiences such as family violence or sexual assault, a crime has been committed, creating a duty or obligation to report the events. There is no law against suicide, however, and there is no crime that is committed against another person. We need to respect the desires of the grieving family members to decide how much, if any, information is shared regarding a suicide. There have been several deaths in Juneau in recent years that seemed like they might be suicide, but the family was not willing to acknowledge suicide as the cause of death. The unfortunate consequence of silence regarding suicide is that the community underestimates the scope of the problem due to underreporting. In addition, when suicide is not identified, the family may not receive the type of support that would assist in surviving a suicide of someone they love.

Interrelationship of Behavioral Health Conditions
Another factor that challenges efforts to prevent trauma-based suicide is the strong interrelationship between mental health, substance abuse, violence and suicide. For example we saw a high percentage of both youth and adults who had co-occurring mental health and substance use disorders (63% for adults—JAMHI data; 39% for youth—JYS data). Similarly, we saw a high percentage of suicide ideation and self-harm incidents for youth and adults with mental health and substance use disorders (68 suicide ideation/self-harm incidents for JYS clients in FY 13; 32% of JAMHI clients report suicide ideation). Finally, we saw a high percent of suicide attempts/completions involving substance abuse (22% of Juneau Police responses to suicidal subjects involved alcohol; over 50% of Alaska suicide autopsies from 2003-2008 involved alcohol).

Our review of YRBS and BRFSS data also indicate the interrelationship of trauma and other behavioral health conditions. Our analysis of Juneau-specific data indicates that trauma in combination with risky behaviors (alcohol/tobacco/drug abuse; risky sexual behavior), and emotional distress (sadness/depression, violence, isolation, weapon misuse), present a much greater risk for suicide than just trauma alone. The implication here is that trauma cannot be addressed in isolation to reduce suicide risk; integrated strategies that identify the relationship between trauma, risky behavior and emotional distress will be the most effective.

Separation of Prevention Efforts

While there is a growing recognition of the relationship between childhood trauma and future mental health and physical health problems, the prevention efforts in these two areas are largely separate and non-integrated. There has been a strong domestic violence and sexual assault advocacy movement since the 1970's and more recently, a growing suicide prevention effort at the local, state and national levels. Despite the strength of their individual prevention efforts, the violence prevention and suicide prevention movements have not developed the level of collaboration necessary to create a unified prevention plan. This is true at the national, statewide and local levels.

At the local level we have a Violence Prevention Coalition and our Suicide Prevention Coalition. Although there are some stakeholders who participate in both coalitions, our two coalitions have not yet worked to explore our areas of common interest, so that we can develop a more broad-based prevention platform. The one area where we developed a common prevention strategy is with Sources of Strength in the Juneau high schools, which we have provided since 2012. We have coordinated with AWARE to ensure that the Sources of Strength activities in the high schools address both violence prevention and suicide prevention.

Stigma and Stereotypes

Stigma and stereotypes also challenge efforts to address the relationship between trauma and suicide. In the area of violence prevention, victims of trauma are often not believed when they come forward to acknowledge their experiences. For example, victims of rape are often not believed, or are seen as somehow causing the assault that they have experienced. This social norm is so common that it has a name—"blaming the victim." In addition, victims of trauma such as rape are often re-victimized when they go through criminal justice proceedings, due to such issues as the public nature of criminal trials and needing to continually re-tell their stories.

There are similar challenges with suicide. There are many myths and stereotypes surrounding suicide including: that suicide is rare; that suicides can't be prevented; that people who verbalize suicide intent are only seeking attention; that all suicidal persons are mentally ill; and that if you ask someone if they are suicidal, you may be putting the idea into their heads. These myths and stereotypes trivialize and spread misinformation about suicide, and inhibit the type of open dialogue necessary to ensure effective suicide prevention strategies at the community level.

Intergenerational Trauma

Another factor that challenges trauma-based suicide prevention is the intergenerational nature of trauma. With domestic violence and sexual assault for example, research indicates that children who have experienced or witnessed violence in the home are more likely to become perpetrators

and victims of violence than those who do not have these experiences. Similarly, trauma victims often have difficulties in demonstrating positive parenting due to the impact of the traumatic events that they have experienced as children.

Intergenerational or "historical trauma" of Alaska Natives requires unique consideration. Native leaders note that the generational trauma experienced by Alaska Natives is more pronounced than for the general community because their cultural framework was not respected historically and they were forced to be acculturated into the dominant Caucasian culture. To effectively address suicide prevention with Alaska Natives requires us to respectfully address cultural trauma in addition to adverse personal experiences.

Discouraging (Mitigating) Factors

Increasing Base of Research

There is a growing body of research that links trauma and increased risk for future physical and behavioral health problems. The most famous research in this area is the ACE Study conducted by the Centers for Disease Control. The study includes physical examinations and interviews with over 17,000 adults regarding their experience of abuse, neglect and family dysfunction. The study found that approximately 20% of the survey group had experienced three or more of these "adverse childhood experiences." The study also found that the more adverse childhood experiences, the greater the risk for serious physical and behavioral health problems. Regarding behavioral health risks, increased ACEs resulted in increased risks in the areas of domestic violence, alcoholism and alcohol abuse, illicit drug use, depression and suicide attempts.

While the ACE Study and related research hold great promise for future prevention and intervention strategies, this is an area where practice is lagging behind research. Overall knowledge of the impact of ACEs on suicide risk and other behavioral health problems in uneven and limited. Behavioral health organizations are becoming increasingly knowledgeable in this area, and many are adopting evidenced-based programs and services to provide trauma-informed assessment and care. Knowledge in other professional sectors and the general community regarding the impact of ACEs is still very limited.

Increasing Community Knowledge Regarding Individual Issues

Increasing community knowledge is a precursor for reducing the impact of trauma on suicide. While there is limited knowledge currently about the link between trauma and suicide, there is increasing community knowledge regarding trauma and suicide as standalone issues. Through past and current prevention efforts the community has become more educated on the individual issues of domestic violence, sexual assault, child abuse, mental illness, substance abuse and suicide. This places our community in a state of readiness to receive education and training on the interrelationship between traumatic experiences, risky behavior, emotional/mental distress and suicide. This can be achieved locally through greater collaboration between violence prevention, behavioral health prevention and suicide prevention efforts.

Treatment Services
One of the strongest ways to disrupt the link between adverse experiences and suicide is to ensure that services are in place to address the risky behaviors and mental/emotional distress experienced by victims of trauma. We are fortunate to have a relatively robust system of treatment services in Juneau to address mental health and substance abuse conditions for youth and adults. For both youth and adults, Juneau providers offer a full continuum of care including emergency services, outpatient/school-based services and residential programs. In addition, local behavioral health services are provided across the age spectrum, to children as young as three years old up to and including senior citizens. We have a good track record of being able to meet behavioral health needs locally, with very few youth and adults needing to leave the community to receive specialty behavioral health care.

Local behavioral health organizations have received significant training in trauma-informed assessment and service provision, and as noted earlier, are adopting practices to recognize and address trauma for both youth and adults. Several of the organizations that provide behavioral health services (Juneau Youth Services, JAMHI, Bartlett Hospital, and Catholic Community Service) are current members of our Coalition.

Collaboration
Not only are services available locally to address behavioral health conditions that are linked with trauma and suicide; there is also a high level of community and interagency collaboration to address these issues. There is a strong spirit of collaboration among local organizations serving clients with behavioral health needs.

In addition to the Juneau Suicide Prevention Coalition, other coalition efforts include: the Juneau Behavioral Health Providers Group; the Teen Health Center; the Prison Re-Entry Coalition; the Domestic Violence Prevention Coalition; the tobacco-free Behavioral Health Work Group; the Juneau Homeless Coalition; and the Clean Air Coalition. These coalitions help to ensure that community behavioral health issues are addressed in a more comprehensive manner.

There are also numerous interagency agreements to ensure coordinated services among behavioral health and other community organizations. For example, the local Affiliated Agreement for Integrated Primary Care and Behavioral Health Services includes 12 separate community organizations. A future challenge for our Coalition will be to help ensure that multiple prevention and treatment collaboration efforts are steering in a common direction and are integrated to the greatest extent possible.

Policy Changes
There are several examples of positive policy changes at the statewide and local levels to address suicide, trauma and behavioral health as individual issues. At the statewide level, the passing of SB 137 in 2012 to require suicide prevention training for school personnel is an example of a positive public policy change. Similarly, the Alaska legislature is considering joining other states by adopting Erin's Law, which would require school districts to provide age-appropriate child sexual abuse prevention curricula, and educational training for school personnel and parents.

There have also been many policy changes within individual agencies in Juneau to identify and provide additional support to clients who are at risk for suicide. For example, over three years ago Juneau Youth Services developed a risk screening process to screen clients for risk of suicide or harm to others. All direct care staff are trained in this screening process, and youth who screen at moderate or high risk levels receive clinical support to address their immediate safety needs. Other behavioral health agencies have implemented similar screening processes.

While the examples above indicate a willingness to change policies at the state and local level relating to childhood trauma and suicide, there is a need to explore and develop more policies that address the interrelationship of trauma and suicide. This will help establish a greater recognition of the impact of trauma on youth and adults, and also help ensure that trauma survivors are better identified and receive the support services they need to have healthy and productive lives.

Shifting Community Values and Norms

As stated earlier, there is a historical culture of silence and tolerance surrounding trauma and suicide. At the same time, there is significant evidence of shifting societal values and norms in this area. One of the best examples of this current shift is in the area of date rape on college campuses. There are many examples throughout the country of colleges that are being challenged regarding their lack of proactive policies to prevent sexual assault, to respond appropriately once an assault has occurred, and to prevent future experiences of trauma.

Similarly there is a greater willingness in Juneau and throughout the state and country to reframe trauma and suicide from strictly personal or family issues, to issues that affect the fabric of our community. Our community is beginning to understand the magnitude of these issues, our collective responsibility to address the issues, and our need to reduce their occurrence. To create deeper social change regarding values and norms, we need to help the community better understand the causal relationship between trauma, behavioral health conditions and suicide.

E. Is the community ready to make change?

Methods

In conducting the readiness assessment, our Coalition followed all the steps in the Tri-Ethnic Center's "Community Readiness for Community Change" model. These steps, along with our analysis of the information gained from the assessment, are presented below.

Interview Framework

Each interview began with a brief explanation of the kinds of trauma impacting suicide that were identified by the data analysis. Each respondent was given a one page chart listing the types of traumatic experiences that increase suicide risk, as indicated by the research and data analysis component of our needs assessment. Each respondent was informed that the focus of the interview was on "the impact of traumatic experiences on suicide risk."

Selecting Key Respondents

The Coalition's Needs Assessment Committee determined the sectors and specific sector representatives that would give a balanced picture of the community's perceptions of our focus area. The following eight sectors and representatives were chosen:

- Youth Leader
- Primary Care Provider
- Alaska Native Leader
- Business Leader
- Spiritual Leader
- Law Enforcement Lieutenant
- Behavioral Health Provider
- School Principal

The Key Respondents selected for interview were chosen based on their affiliations and their ability to represent the perspective of their community sector. Three of the eight Key Respondents are also members of the Juneau Suicide Prevention Coalition.

Interviews

Kevin Ritchie, former Juneau City/Borough Manager, and Julie Neyhart, former State Social Worker, were chosen to interview Key Respondents and oversee the readiness assessment process. Julie and Kevin each interviewed four Key Respondents. The Assessment Committee decided the interviews should be conducted in person due to the personal nature and length of the interviews, as well as the added difficulty of recording interviews telephonically. The interviewers were aware of the need to avoid any verbal or visual cues to the Key Respondents.

Summary - Analysis of Community Readiness in Juneau

Overall, we believe the Community Readiness Assessment indicates that the community of Juneau is poised to take collective action on addressing the relationship between traumatic experiences and suicide risk. The interview responses indicate that the community has an extremely high interest in reducing suicide in any way that is shown to be effective, and there is untapped support for efforts to reduce suicide by focusing more on the traumatic experiences that increase suicide risk.

Collective evaluation of the interviews indicate that the missing key ingredients are:

- Clearly drawing the connection (presenting data and information to the public and leadership) between traumatic experiences and elevated suicide risk, and
- Tapping the underlying community passion to reduce suicides.

The interviews indicate that once the connection between trauma and suicide is drawn convincingly, and effective strategies are proposed, there will be sufficient support for additional sustainable community action.

As highlighted in many of the interviews, addressing the issue of suicide, as well as traumatic experiences, is hindered by the stigma related to open discussion in families, in the general community, and to some extent, within the service community itself. One effective catalyst for community action discussed by several Key Respondents is multiple or high profile suicides. To be successful, the prevention efforts must rise to this level of public knowledge and concern, hopefully, without the catalyst of additional high profile suicides.

Scoring

Scoring was done on five dimensions as shown in the chart below. The two interviewers read each interview transcript, scored each of the interviews independently, and then met to reconcile differences in scores. Each scoring difference was debated using interview statements and how they matched with the Anchored Rating Scales.

Summary of Consensus Rating against Anchored Rating Scales for Each Dimension
(Interviewees are listed as #1 - #8)

Dimensions	#1	#2	#3	#4	#5	#6	#7	#8	Average
Knowledge of Efforts	4.0	3.0	3.5	3.5	4.0	3.0	3.5	5.0	3.7
Leadership	4.5	4.0	4.0	5.0	5.0	5.0	4.5	5.0	4.6
Community Climate	4.0	4.0	4.0	4.0	5.0	5.5	3.5	5.0	4.4
Knowledge of Issue	4.0	4.0	3.0	4.0	5.5	6.0	4.0	4.0	4.3
Resources	3.0	4.0	5.0	5.0	4.0	5.0	4.5	5.5	4.5
Average CR Score									4.3

DIMENSION	READINESS LEVEL	READINESS STAGE
Knowledge of Efforts	3.6	Vague Awareness/Preplanning
Leadership	4.7	Preparation
Community	4.4	Preplanning/Preparation
Knowledge of Issue	4.3	Preplanning/Preparation
Resources	4.9	Preparation
Overall Score	4.3	Preplanning/Preparation

The readiness level and readiness stage for each dimension are discussed below. The Readiness Stages include: No Awareness; Denial Resistance; Vague Awareness; Preplanning; Preparation; Initiation; Stabilization; Confirmation/Expansion and Community Ownership.

Overall Community Readiness Score

The Average Community Readiness score of 4.3 falls between the Readiness Stages of Stage 4 (Preplanning) and Stage 5 (Preparation) according to the scoring guide. However, after comparing Juneau's readiness to the description of the Stages, Juneau appears to be either at Stage 5 (Preparation), or even toward Stage 6 (Initiation) of the Community Readiness model.

We believe that the score of 4.3 understates community readiness because while there is an extremely high level of passion throughout Juneau to reduce suicide in any way that is effective, this community passion has not been fully tapped for action. We believe that respondents answered accurately, but sometimes responded differently to the current priority of the issue versus the potential priority of the issue, and this could not be reflected well in the rating scale. We believe the community of Juneau's readiness is reflected in the statements below which include the general community feeling that "This is our responsibility and we will do whatever it takes." This sentiment was strongly reflected in many of the interviews.

In reviewing the interview responses, dimension scores and descriptions of readiness levels, we made the following observations regarding Juneau's readiness to address the relationship between trauma and suicide:

- General Community Awareness: Community members are well aware of the local and statewide incidences of both suicide and traumatic experiences, especially suicide, bullying and domestic violence.
- Relationship Between Trauma and Suicide: Most community members could see a connection between trauma and suicide, and were generally aware of efforts in both areas. At the same time, they had little specific information about the effectiveness of local efforts, and very little specific information on the connection between the two issues.
- Ownership of the Issue: On the general issue of suicide, there is a feeling in the community and leadership that "This is our responsibility and we will do whatever it

takes." However, this energy has not been sufficiently tapped to support additional efforts.

- Resources: Key respondents identified some resources (financial, volunteer, and collaborative) that can be used for further efforts to address the relationship between traumatic experiences and suicide risk.

Analysis of the Anchored Rating Scales for Scoring Each Dimension

Community Knowledge of Current Efforts

An average score of 3.7 indicates that some to most residents have heard about local efforts, but may not know much about them. The people touched by suicides and traumatic experiences are far more aware of these issues.

The youth respondent said, "I think it depends on knowing and having an experience….I didn't know any idea about any of these programs until….meeting people and hearing about the programs…."

Regarding the Juneau Native community, the Alaska Native leader stated, "I am also glad to see that the tribes have….stepped forward in the child abuse area with their clients. I don't think they necessarily do it to prevent suicide because that is one of the fallacies of the tribe is they don't seem to connect to suicide."

Regarding basic understanding the behavioral health respondent stated, "I think people's hearts are in the right place, and I think they support this work (trauma and suicide reduction). I just think they don't fully understand the role of traumatic experiences that might contribute to some persons taking their lives."

Leadership (includes elected and appointed leaders and influential community members)

An average score of 4.6 indicates that elected officials and influential community members acknowledge that the impact of trauma on suicide risk is a concern in the community and that some are actively supportive of continuing or improving current efforts.

The youth respondent summed it up with, "I think they (leadership) support it. They just don't address it much."

The business respondent stated, "They (leadership) are not opposed to any positive action to take care of this (suicide). I don't think anybody, a rational person would do that and I don't think anybody that sitting in our leadership is in that position. I mean, they are not (saying)…not my problem'."

The law enforcement respondent stated, "Yes, I believe there is support for it. I cannot imagine any leader in Juneau saying …' I don't think we should put energy into trauma causing suicide'."

Community Climate

The average score of 4.4 is between complacent support and an attitude that "We are concerned and we want to do something." The difficulty in rating this dimension is that the current climate

is more passive due to a lower level of community suicides. But in the recent past there has been an extremely high level of community energy around suicide reduction, and a growing or at least maintenance-level concern around traumatic experiences. The concern level rises when suicides and traumatic experiences (e.g., child sexual abuse) increase and/or are publicized in the media.

The law enforcement respondent summed it up, "Juneau has experienced….eight suicides in a year…and at that point it was everyone's top priority."

Community Knowledge about the Issue
The average score of 4.3 indicates that the community has somewhere between limited and basic knowledge about the relation of traumatic experiences and suicide. While there are a significant number of professionals and volunteers who are very knowledgeable, the community as a whole has a fairly low level of knowledge.

The school respondent stated, "I think there are pockets of people who are working hard to help prevent future incidents of suicide and self-harm, and I think we don't always talk to each other."

Specifically related to the lack of discussion regarding the connection between suicide and trauma, the law enforcement respondent summed it up, "The community has probable cause to believe that trauma is associated with suicidal thoughts."

Resources Related to the Issue (people, money, time, space, etc.)
The average score of 4.5 indicates that some resources have been identified. The score is likely somewhat low due to the significant fiscal challenges occurring at the national, state, and community level. However, the long term strength of the Coalition and the local passion for reducing suicide gave some respondents a somewhat brighter outlook for both financial and program support.

For example:
The primary care respondent stated, "I think leadership would utilize more resources to try to find solutions to this problem."

The Alaska Native leader respondent stated, "Well, this Juneau Coalition is so well knit that I think even if we had no money, we would meet and try to do everything that we could to maintain it…." In regard to the tribe he stated, "I've got a lot of confidence in the new President and I think he needs to be able to just hear our presentation…."

The law enforcement respondent stated, "This specific issue and all of its correlating spider web connected issues to it of trauma leading to suicide has gotten less and less funding as we have moved along, so I believe that our funding has been inconsistent within people's knowledge of the problem."

The business respondent stated, "You are going to have to come to them first of all and prove that this particular method is going to reduce it, right, and if you can do that, then they will (say), oh okay, we will bank roll that one…"

F. What community strengths, gaps, assets, and/or weaknesses should be considered?

We have significant strengths and assets to draw upon to develop and implement a strategic plan that addresses trauma as a major contributing factor for suicide in our community. Similarly, we also have gaps and challenges that need to be addressed. The information for this section comes from multiples sources including key informant interviews from our preliminary and comprehensive community needs assessment, a review of research information and data; and our seven years of experience in providing and evaluating suicide prevention services.

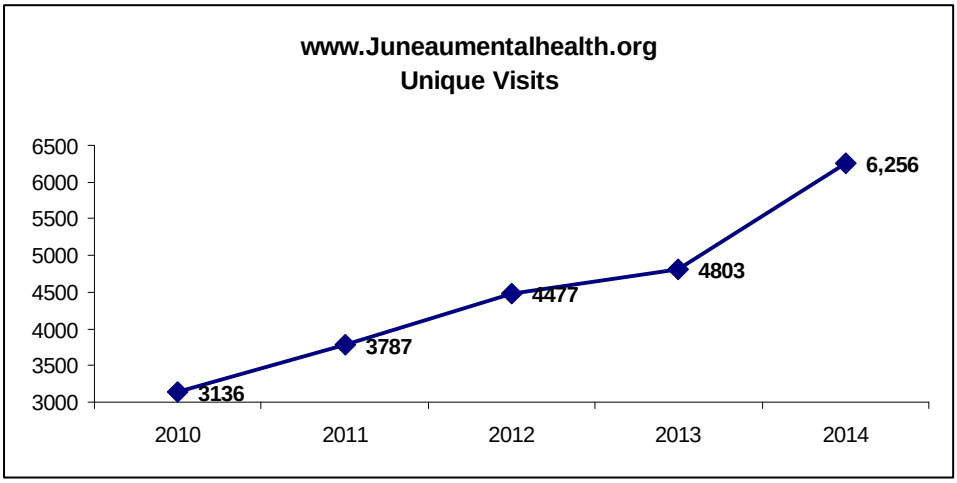
Strengths/Assets

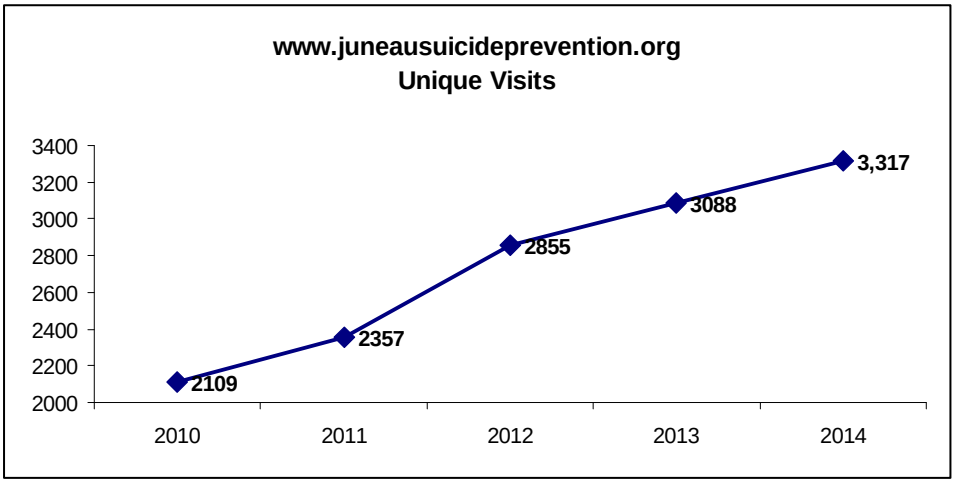
Past and Current JSPC Prevention Efforts
The Juneau Suicide Prevention Coalition was formed seven years ago. We are a mature coalition and have been providing a broad array of community-based activities since our inception. A summary of these activities is presented below:

- Signs of Suicide: We have provided the evidence-based "Signs of Suicide" curriculum in the Juneau School District since 2008. The program teaches students how to identify symptoms of depression and suicide risk in themselves and others, and how to seek help to address these issues. Risk screenings and referrals for counseling have also been provided. The program has been offered to all incoming high school students. In addition, booster sessions have been provided to high school sophomores, juniors and seniors.

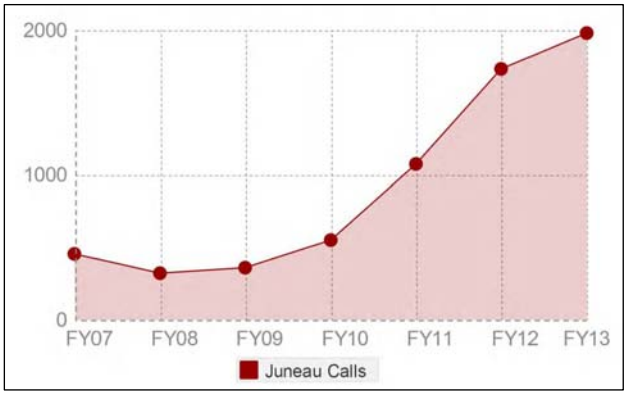
- Sources of Strength: We have added Sources of Strength to our school efforts. This evidence-based suicide prevention and health promotion program empowers youth as peer leaders, with the guidance of adult advisors, to change unhealthy norms in the school environment. The peer leaders use positive messaging to promote healthy actions and behavior as a means to prevent negative behaviors such as suicide, interpersonal violence, bullying, and substance use. Sources of Strength focuses on positive social messaging in multiple domains including mental health, family support, positive friends, mentors, healthy activities, generosity, spirituality, and medical access. We have implemented Sources of Strength in all three Juneau high schools. Approximately 195 peer leaders and 20 adult advisors have been trained in the program.

- Websites: We developed and continue to maintain two separate websites to address suicide: www.juneausuicideprevention.org/ and www.juneaumentalhealth.org. These two websites provide the public with important information on warning signs and risk factors for suicide, as well as information on how to access resources for a current emergency and resources to address a variety of mental health and substance abuse concerns. As demonstrated below by the rising number of hits on these two websites, the community is increasingly identifying and utilizing resources that are highlighted on these sites.





- Advertising: We have advertised our websites and the statewide Careline crisis intervention number in several ways including: signs on city buses, banners in high school gyms, the Treadwell hockey rink board, advertisements in event booklets for sports, arts and other activities, coffee lid seals, and various items such as pens, sports bags, and hats. As an indicator of our success in this area, we have included a graph which shows the number of Careline calls from Juneau from 2007 through 2013. From FY 10 through FY 13, the number of Juneau Careline calls increased by 300%.



- Other Public Awareness Materials and Activities: We have provided a host of other public awareness materials including: brochures for youth, families, seniors and at-risk populations; newspaper and special event advertising; and wallet cards with warning signs and resource information. Distribution of these materials to the community is an ongoing effort. We have also engaged in outreach to students and faculty at the University of Alaska, Southeast.

- Public Awareness/Advertising Activities in Other Southeast AK Communities: Under previous grants, we purchased movie on-screen advertising for the Alaska Careline number and our two websites for showing in other Southeast communities. We have also purchased advertisements, including Careline and website information in the Capital City Weekly, which is distributed in Southeast Alaska communities.

- Suicide Prevention Training: Over time we have provided a variety of suicide prevention trainings to diverse audiences in Juneau and a few other Southeast communities, including a training called "Understanding Suicide: Building intervention Skills" developed by our Coalition using a video lecture by an internationally recognized suicide-prevention authority, Dr. Bob Baugher. Most recently we have promoted and provided Gatekeeper training to targeted audiences in Juneau. On February 9-10, 2015 eleven community members, including six (6) current Coalition members, received training to become certified Gatekeeper trainers. In addition, we held a recent Gatekeeper training that was attended by approximately 100 youth and adult community members.

- Postvention: We have provided several resources to families and community members who have lost someone they care about through suicide, or some other form of sudden loss. We have distributed books and brochures in the community to assist with this grieving and healing process. We also have a Postvention Response Team available to provide resources and support to families and community members who have lost a loved one to suicide.

Juneau Violence Prevention Coalition (JVPC) Efforts

As noted earlier, to provide effective community prevention services that address the relationship between trauma and suicide, it is important that we be more aware of local violence prevention activities. We are fortunate to have a very strong Violence Prevention Coalition in Juneau focusing on the following four areas:

- Pathway 1: Men and boys will take a leadership role in creating an environment of mutual respect between men and women.

- Pathway 2: Youth will become leaders in the community promoting respectful relationships.

- Pathway 3: Girls will have the skills to recognize and have healthy relationships.

- Pathway 4: Policies and systems will adopt practices conducive to promoting healthy relationships and intimate partner/sexual violence prevention programs.

The diverse activities and strong community presence of both the Juneau Suicide Prevention Coalition (JSPC) and the Juneau Violence Prevention Coalition provide a very strong foundation on which to develop a common prevention platform to mitigate the impact of trauma on suicide risk.

Broad-based Stakeholder/Interagency Involvement
One of the greatest strengths for the JSPC is our broad-based community involvement. We currently have 13 separate organizations representing multiple sectors of the community participating in our Coalition efforts. In addition, we have several active Coalition volunteers who are not representing agencies or organizations. The following community sectors and organizations participate in Coalition activities, including the current community needs assessment:

- Tribal agencies: Alaska Native Brotherhood
- Parents: Survivors of suicide
- Law enforcement: Juneau Police Department
- Children's behavioral health: Juneau Youth Services
- Adult behavioral health: JAMHI; Bartlett Hospital
- Faith community: Juneau Cooperative Church Council
- Secondary education: Juneau School District
- Postsecondary education: University of Alaska Southeast
- Mental health advocacy/volunteers: NAMI Juneau
- Health care: Juneau Public Health Center
- Social services for children, families and seniors: Salvation Army, Catholic Community Service

Similarly, the Juneau Violence Prevention Coalition also has broad-based participation from the following sectors and organizations in its prevention efforts:

- Non-profit organizations
- Faith community/religious organizations
- State government representatives
- Juneau School District
- Alaska Association of School Boards
- Public health representatives
- Alaska Native tribal partners

The broad-based community involvement in each Coalition, along with the fact that some representatives and organizations serve on both Coalitions, will help ensure that community strategies to address the trauma-suicide relationship are integrated and comprehensive.

Gaps/Challenges

Other Sector Involvement

While the Juneau Suicide Prevention Coalition, as noted above, has broad-based community involvement, there are several sectors that we have identified that are either unrepresented or underrepresented in our current prevention efforts. It is important that we increase our collaboration with the following groups to maximize the effectiveness of our Coalition efforts to help break the link between trauma and suicide.

- Alaska Native Community: While we have had individual Native leaders on our Coalition since its inception, we have struggled more in engaging Native health and social service organizations in an ongoing manner. Due to the high level of importance of increased collaboration in this area, we address "Collaboration with the Alaska Native Community" as a separate challenge below.
- Medical Community: Primary care practitioners play a key role in identifying youth and adults who have experienced trauma and/or are at risk for suicide. Yet less than 29% of surveyed primary care providers routinely screen patients for current suicide risk, and less than 43% routinely screen for past suicide attempts.
- Business Community: Historically, the business community has not been adequately represented on our Coalition, or in its associated activities. We made recent headway in this area when Coalition members provided Gatekeeper training to the three local Rotary chapters. A stronger partnership with the business community is needed to ensure greater community ownership for our prevention efforts.
- Domestic Violence/Sexual Assault: We have had only sporadic involvement of violence prevention representatives on our Coalition. Increased involvement and collaboration will be needed in the future to develop coordinated strategies to prevent trauma-based suicide.

At-Risk Populations

There are certain subgroups that are at a greater risk for trauma-related suicide in our community. It is important that targeted strategies be developed to address the unique needs and characteristics of these at-risk groups:

- Alaska Natives: With a statewide suicide rate that is three times the national average, and double the rate for whites in our state, more tailored Coalition efforts should be focused on the needs of Alaska Natives. See discussion below regarding "Collaboration with the Alaska Native Community."
- College-age Young Adults: The highest rate of suicide by age group in Alaska is for adults ages 20-29. These young adults are at risk for: traumatic experiences such as date rape/violence; risky behavior with alcohol, drugs and sex; and emotional distress such as depression and isolation. These factors combine to create increased suicide risk.
- Veterans: As a group, veterans experience a high level of post-traumatic stress, behavior health disorders, and suicide. We do not have any current Coalition activities that are focused specifically on the unique needs of veterans.

- Senior Citizens: Although the overall number is small, senior citizens 65 and over accounted for the highest percent of suicide deaths in Juneau from 2004 to 2013 (27%). In addition, as noted in the *Introduction* section of this report, seniors represent the fastest growing sector of the Juneau population.

Collaboration with the Alaska Native Community

While the need for more collaboration with the Alaska Native community is apparent, there are challenges to achieving greater collaboration in this area. First, due to the sovereign status of Alaska tribes, there are often different laws, funding, services and governing structures for Alaska Natives. Alaska Natives must live within the dual frameworks of their Native culture and the dominant Caucasian culture. In addition, forced acculturation has created a certain level of distrust and reluctance for Alaska Native organizations and leaders to engage in broader community-wide planning and prevention efforts.

An event in February 2015 exemplifies the type of model that is needed for greater collaboration to address the trauma experienced by Alaska Natives. The Central Council of Tlingit and Haida Indian Tribes of Alaska (Central Council) hosted a two-and-a-half-day training and coordination event ("Mending the Sacred Hoop") to develop a coordinated response to domestic violence victims in the community. Our Coalition and several other community organizations participated in the event. By participating in local efforts that are Native-led, we strengthen our collaborative relationships and develop prevention strategies that are culturally-based and responsive to the unique needs of Alaska Natives.

Policy Development Challenges

As noted under the *Discouraging (Mitigating) Factors* section of the report, there have been statewide and local policies that have been developed to address trauma, behavioral health and suicide as individual issues. At the same time, there are gaps and challenges related to developing policies that will effectively address the interrelationship of trauma, behavioral health issues and suicide risk.

One of the gaps that we identified in our community assessment is the lack of consistent policies among primary care providers to screen youth and adults for current suicide risk and past suicide attempts. Similarly, many other local organizations lack policies or practices to help identify persons who have experienced trauma and/or have elevated suicide risk.

The Juneau School District, while it has protocols to address youth who are actively suicidal, has impediments in identifying youth who are at risk for suicide. In the earlier years of our Coalition, we surveyed high school students regarding depression and suicide risk and provided follow-up support. We learned later that a personal survey requires prior parental consent. The positive parental consent process, while well intended, has the unintended consequence of inhibiting the identification of at-risk students. The positive consent process also significantly lowers the student response rate on the YRBS; a lower response rate means a less accurate picture of students' experience with trauma, risky behavior, emotional distress and suicide risk, as well as less accuracy in measuring changes over time.

IV. Synthesis

Our community needs assessment includes multiple stages of research and analysis. Highlights from each of these stages are presented below. The assessment, taken as a whole, provides an excellent framework from which to develop a strategic plan to address the relationship between traumatic experiences and suicide.

Community Characteristics

Although Juneau is a relatively well-educated, affluent community, there are several community characteristics that need to be taken into consideration when developing and implementing suicide prevention services. These characteristics are summarized below:

- Isolation: Juneau's small population, land-locked location and topography limit its range of social and economic opportunities compared to a larger, more centralized community.
- Shifting Population Demographics: Although the overall population is stable, the children and youth population is declining and the senior population is increasing rapidly. In addition the population is much more transient than the average U.S. community.
- Jobs/Economy: Juneau has historically had a stable job market with relatively low unemployment. On the other hand there are several current trends that represent challenges including: a reduction in higher paying jobs and increase in lower paying jobs; an increase in non-resident workers; and losses in public sector employment and local services due to the current economic downturn.
- Declining Student Enrollment: The Juneau School District has seen a significant student population decline in recent years, with no increase forecasted through 2017. This has led to severe budget reductions, including the elimination of many personnel and support programs and services.
- Cultural Characteristics: 30% of the Juneau population is non-Caucasian, and 11.7% are Alaska Native; considering culture and ethnicity is critical in developing programs and services that address the needs of all community members.
- High Cost of Living: It is very expensive to live in Juneau. Juneau has a significant housing shortage, and the average cost of a single family home is over $377,000, and average rental is over $1,100 per month. There is a severe shortage of lower cost apartments. As a result, Juneau has approximately 600 homeless persons, which represents 2% of the overall population.

Key Findings

What Is Known about the Behavioral Health Focus Area

We began by conducting a general review of data and research pertaining to Juneau and Alaska. We also reviewed local and statewide data pertaining to substance abuse and mental health. Some of key findings for this stage of our assessment included the following:

- Comparison of Juneau to the State: The overview of data on suicide, mental health and substance abuse in Juneau and in the state confirmed that Juneau's population has similar rates and patterns of suicide, alcohol use, depression, and signs of emotional distress as the state population, despite being relatively affluent and having higher employment rates than much of the state.
- Ages of Completed Suicides: Seniors ages 65 and older have the highest rate of suicide in Juneau (26.5 per 100,000), followed closely by the 18-44 younger adult population (23.54 per 100,000).
- Alaska Natives: Alaska Natives are at higher risk for suicide than the non-Native population, with the statewide rate for Alaska Natives more than twice the statewide average.
- Characteristics of Completed Suicides: Mental health problems, substance abuse, and interpersonal problems were the primary characteristics associated with completed suicides in Alaska.
- Suicide Means and Attempts: Firearms were the leading method used for suicide in Alaska followed by strangulation/suffocation and poisoning. Suicide attempts are second only to falls as a reason for injury-related hospitalizations in Southeast Alaska.
- Factors Influencing Suicide: Our preliminary research and data analysis indicated a correlation between trauma/violence, behavioral health problems and suicide. To better understand the interrelationship of these factors, we conducted a more in-depth analysis of these factors, primarily through the Youth Risk Behavior Survey (YRBS) and the Behavior Risk Factor Surveillance System (BRFSS) survey.

Community Perceptions Regarding the Focus Area

We used written surveys to assess the community's perceptions regarding suicide. Surveys were conducted with the general public, behavioral health agencies and primary care providers. The following themes and data emerged from the surveys:

- Priority Area of Concern: All three survey groups rated suicide/suicide prevention as a very high priority issue to address in our community.
- Priority Area for Action: All three groups strongly believed that it was important to have dedicated efforts to prevent suicide in our community.
- Relationship between Suicide and Behavioral Health: Respondents in all three surveys recognized the following factors as being strongly correlated with suicide: depression/ poor mental health; alcohol/drugs; and disconnection/isolation. The average correlation rating for the three groups on these issues was 90.2%
- Relationship between Suicide and Trauma: Respondents for all three groups identified a significantly lower correlation between suicide and the following traumatic experiences: childhood trauma; violence/sexual assault; and bullying. The average correlation rating for the three groups on these issues was 63.5%

- Behavioral Health versus Primary Care Providers: There was a startling difference in the perceptions of the two provider groups regarding the percent of their clients who currently or previously experienced a variety of issues relating to suicide, behavioral health and trauma. Behavioral health providers estimated that 79.3% of their clients experienced these issues on average, compared with 7.1% of primary care providers. Due to differences in populations served, we would expect some difference here but not a difference of this magnitude.
- Suicide Screening: Of the primary care respondents, only 28.6% routinely screen for current suicide risk; and 42.9% routinely screen for past suicide attempts.

What Behavioral Health Priority Area Was Identified

Using YRBS and BRFSS/ACEs data for Juneau and the state, we examined the relationship between suicide and childhood trauma, other traumatic experiences such as interpersonal violence, risky behavior such as substance abuse, and mental/emotional distress. With the YRBS, we were able to divide the youth into two groups: those who had suicide thoughts, plans, or attempts and those who did not. This allowed us to compare the suicide risk group and non-suicide risk group in relationship to a number of risk and protective factors. We also reviewed protective factors that reduce the risk of suicide for youth and adults.

Our research and data analysis indicate that traumatic experiences, especially those experienced in childhood, are strongly predictive of an elevated risk of suicide.

The primary findings from this analysis included the following:

- Impact of Trauma: There is a strong correlation between trauma and suicide risk. Collectively the YRBS and BRFSS/ACEs data demonstrate that a significant number of youth and adults in Juneau have experienced trauma in various forms. More importantly, the data shows that youth and adults in Juneau who have experienced trauma are at an elevated risk for suicide, as well as other mental health and physical health problems. As a result, our Coalition has chosen to focus on trauma experienced in childhood and adolescence, and its relationship to suicide risk, as our priority area.
- Risky Behavior: Similarly there is a strong correlation between risky behavior and suicide. Youth in the suicide risk group were more likely to smoke, drink, take other drugs, and have risky sex. In addition, intoxication and a history of alcohol/drug abuse have been strongly linked with completed suicides in Alaska.
- Mental/Emotional Distress: Youth in the suicide risk group were more likely to feel sad, feel alone, engage in fights, not have adults to talk to, and carry weapons to school. In addition, 10% of Caucasians and 15% of Alaska Natives in Juneau experience frequent mental distress. State data indicates that current mental health problems and a history of mental illness and other mental health problems are strongly linked to completed suicides in Alaska.

Data Synthesis and Prioritization of Intermediate Variables

In reviewing the relationship between childhood trauma (ACEs), risky behavior, mental/ emotional distress and suicide, our Coalition identified childhood trauma as the priority

intermediate variable to address in our future suicide prevention efforts. There were several reasons for our selection of ACEs as our priority focus area.

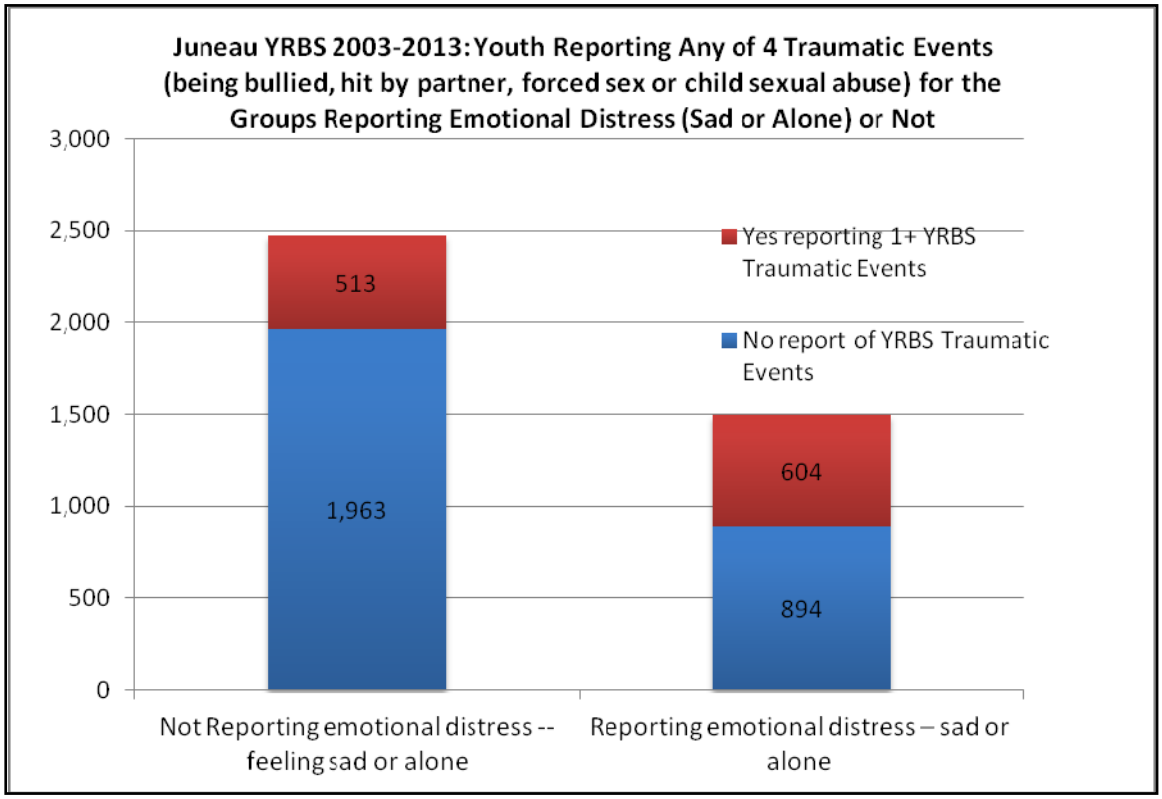
- Research Findings: The original ACE study, which included 17,000 participants, and subsequent studies have identified adverse childhood experiences such as emotional/physical/sexual abuse, emotional/physical neglect, and various forms of household dysfunction as being highly predictive of future physical and behavioral health problems, including suicide attempts. ACEs therefore appear to be the key factors underlying suicide risk. ACEs research demonstrates that adverse childhood experiences lead to risky behaviors and mental/emotional distress, which in turn result in elevated suicide risk. Stated differently, the research suggests that ACEs are a root cause of increased suicide risk, whereas risky behavior and mental/emotional stress are contributing factors often correlated with ACEs.
- Coalition Data Analysis: Our Coalition analysis of YRBS and BRFSS data substantiate the strength of ACEs as predictors of emotional distress and suicide risk. Our analysis of nearly 4,000 YRBS responses from 2003-2013 indicated the youth who had suicide thoughts, plans or attempts had the following higher rate of ACEs:
    - A 73% higher rate of early sex (before age 13).
    - A 101% higher rate of being hit by an intimate partner.
    - A 159% higher rate of forced sexual intercourse.
    - A 120% higher rate of being bullied at school.
    - A 117% higher rate of being bullied electronically.

  Our YRBS data analysis also indicated a strong correlation between ACEs and emotional/mental distress (sad or alone) for Juneau youth:

Table A

Traumatic Events (bullied, forced sex, sex before age 13, hit by partner)	Not reporting emotional distress -- feeling sad or alone	Reporting emotional distress – sad or alone	Total
No	1,963	894	2,857
%	69%	31%	100%
Yes	513	604	1,117
%	46%	54%	100%

Figure A



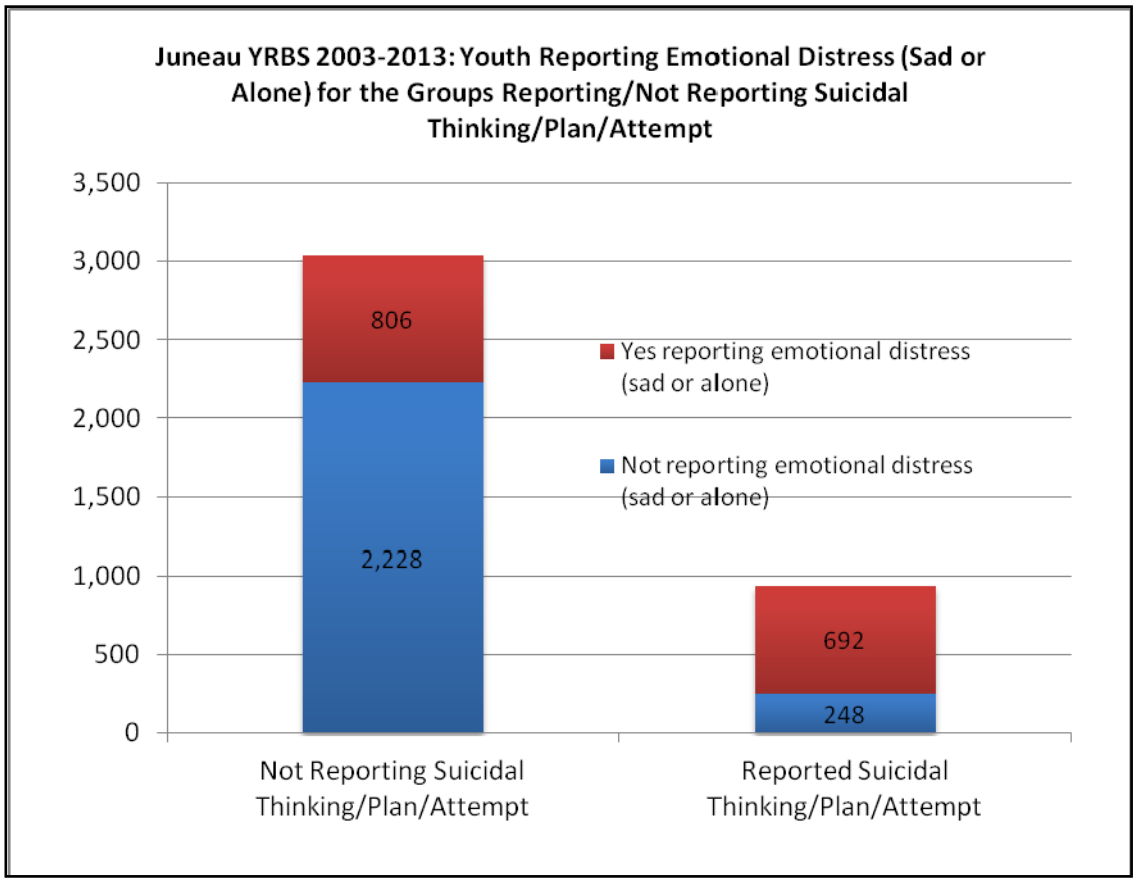
Youth who experienced one or more ACEs were at a significantly higher risk of mental/emotional distress, as measured by feeling alone or sad. It is important to note that more than half (604, or 54%) of those who reported one or more ACEs in the YRBS also reported serious mental/emotional distress (feeling sad or alone). This suggests the strong relationship between ACEs and mental health problems which is also noted in the ACEs research literature.

Our data analysis also indicated that once youth experience emotional/mental distress—largely through their exposure to ACEs—they also experience an elevated suicide risk.

Table B

Emotional Distress - - "Sad" (2+ weeks) or "I feel alone in my community"	Not Suicidal	Suicidal Thinking/ Plan/Attempt	Total
No	2,228	248	2,476
%	90%	10%	100%
Yes	806	692	1,498
%	54%	46%	100%

Figure B

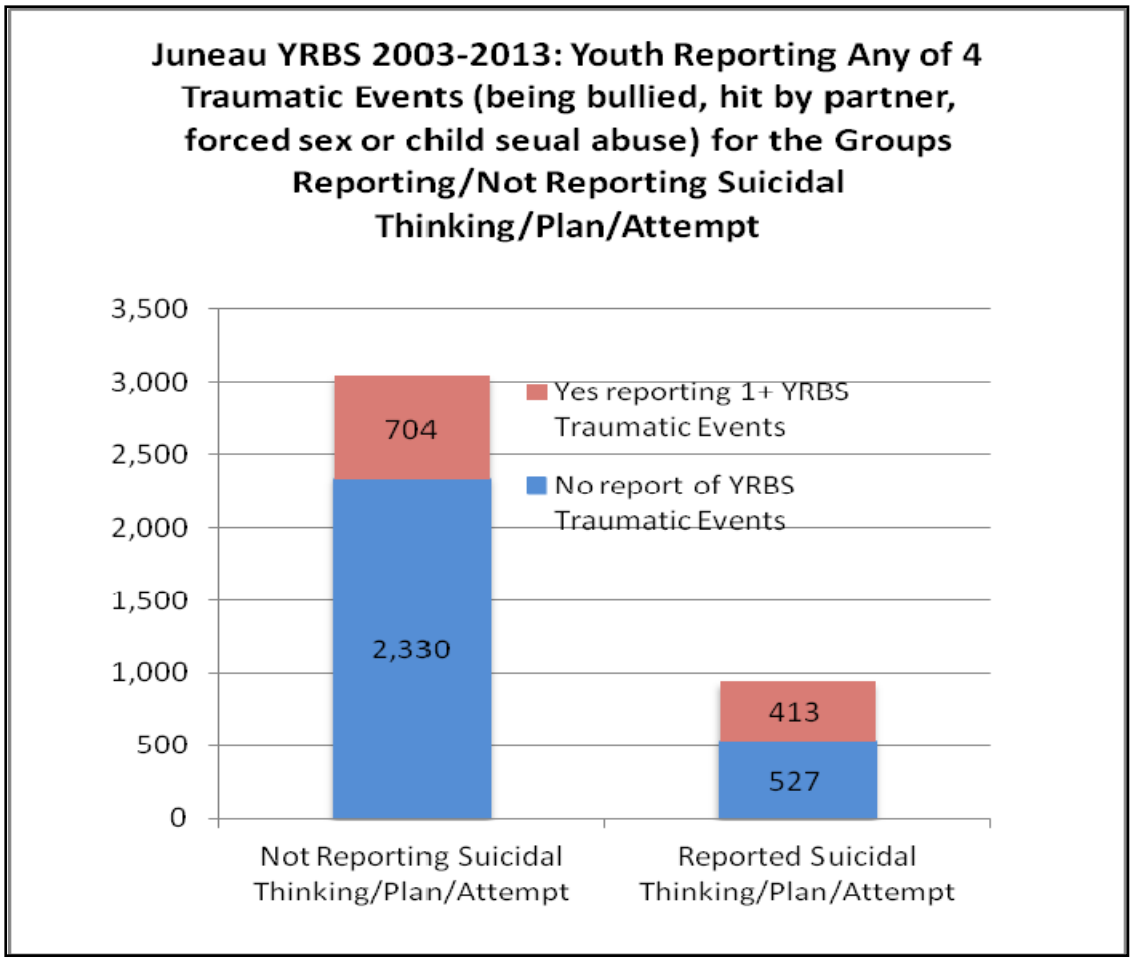


It is significant to note that almost half (46%) of the youth who reporting feeling sad or alone also reported suicide thoughts, plans and attempts, indicating the strong correlation between mental/emotional distress and suicide risk. The chart and table below show YRBS results regarding the relationship between ACEs and suicide risk for Juneau youth.

Table C

Traumatic Events (bullied, forced sex, sex before age 13, hit by partner)	Not Suicidal	Suicidal Thinking/ Plan/Attempt	Total
No	2330	527	2,857
%	82%	18%	100%
Yes	704	413	1,117
%	63%	37%	100%

Figure C



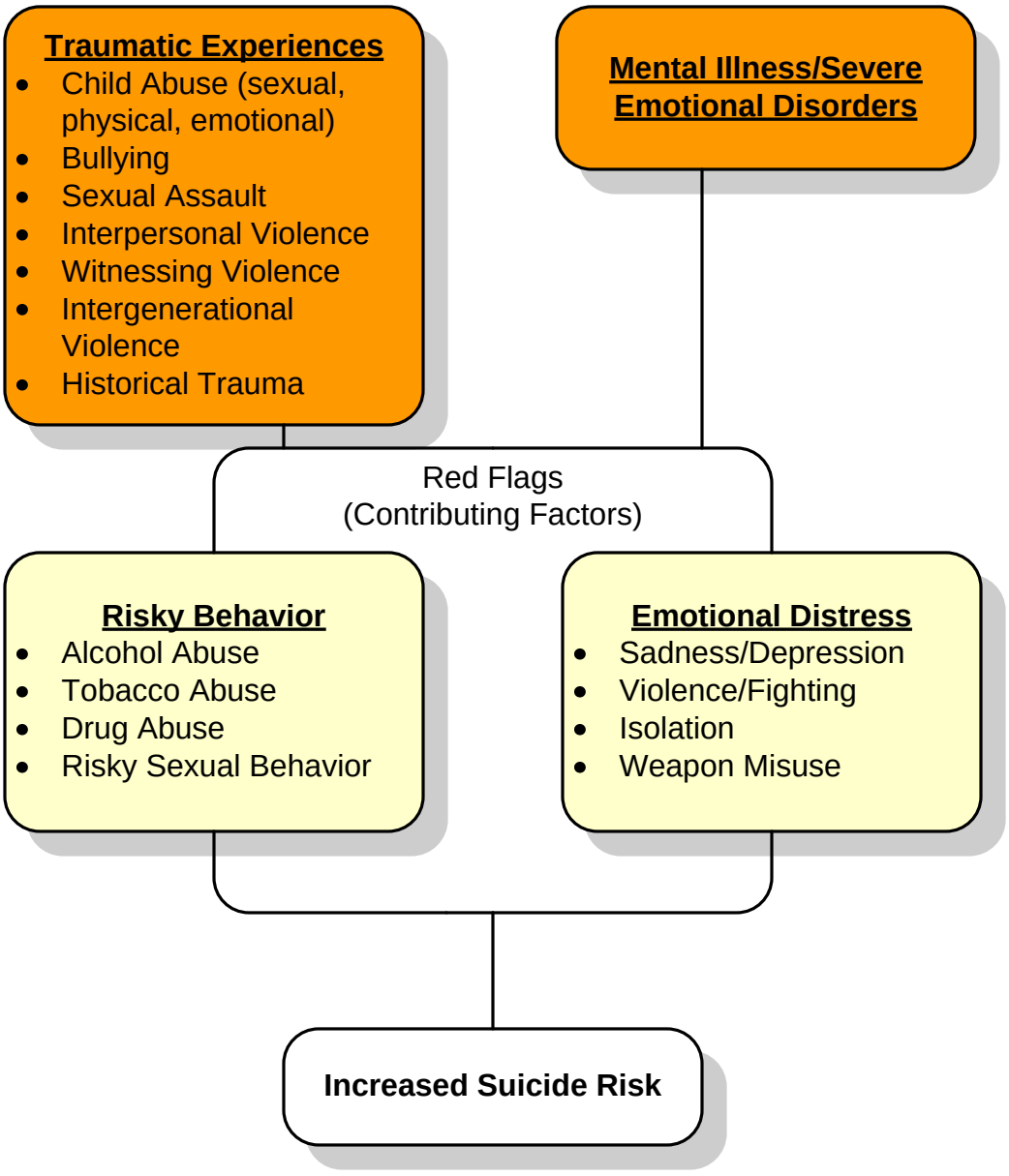
As indicated above, youth who reported any ACEs were twice as likely as those not reporting them to be in the suicide risk group (37% versus 18%).

In summary, our YRBS data analysis indicates a strong interrelationship of factors, beginning with ACEs, in combination with mental emotional/distress, that result in elevated suicide risk. Over a quarter (28%) of Juneau youth reported one or more ACEs, and of those who did experience such trauma, 54% reported emotional distress, and 37% reported suicidal risk (thoughts, plans or attempts). The correlations were much lower for youth who did not report any ACEs: less than a third (31%) reported emotional distress (sad or alone), and less than a fifth (18%) reported suicide risk.

Our analysis of Alaska BRFSS data supports the causal link between ACES, mental/ emotional distress and suicide. BRFSS data for 2013 indicated that, depending on the type of adverse childhood experience, between 6.6% to 38.2% of Juneau adults experienced various forms of ACEs. In a five-state ACES study of adults, Alaska ranked highest for child sexual abuse, and second for physical and emotional abuse. In addition, approximately 10% of Caucasian residents and 15% of Alaska Natives in Juneau reported frequent mental distress. Finally, according to the Alaska Violent Death Reporting System, 28% of Alaskans who committed suicide between 2007-2011 had current mental health problems.

The interrelationship described above between traumatic experiences, risky behavior and emotional distress can also be depicted graphically, as indicated on the following page.

Factors Increasing Suicide Risk Indicated by Our Needs Assessment



In addition, our research and data analysis indicated the following:

- Increased Risk for Alaska Natives: Local YRBS data confirms that a higher percent of Native Alaskan youth experience suicidal thoughts, plans and attempts than non-Native youth (32% vs. 26%). Similarly, local BRFSS data indicates Alaska Native adults in

Juneau ranked two to three times higher than Caucasians for witnessing domestic violence, having been sexually abused, and being hurt by an intimate partner; as noted earlier, these factors are linked to increased suicide risk.

- Protective Factors: Community connectedness seems to be the strongest youth protective factor, with about 80% of the non-suicide group strongly agreeing with the statement "in the community, I feel like a matter to people," versus only 20% for the suicide risk group. Team sports and adults/parents to talk to were also identified as protective factors for youth. For adults, the protective factors that most corresponded to less depression and suicide thoughts included: moderate to high income; at least a high school education; employment; and being in a current couple relationship.

Target Population

The target population that we have chosen, as informed by our data analysis, is youth and young adults ages 15-30. Three different sets of data—mortality rates, hospitalization data, and survey data on suicidal ideation and planning—all indicate the disproportionate suicide risk for youth and young adults.

Alaska Trauma Registry data indicates that suicide attempts are the leading cause of hospitalization in Alaska for youth and young adults, ages 15-34. In addition, Vital Statistics data for Juneau shows that young adults (18-44) accounted for the most local suicides in the period from 2004-2013 (27 suicides or a rate of 23.54 per 100,000). Data on suicide deaths in Juneau showed that the18-44 year old age group and seniors 65 and over experienced higher mortality rates than middle aged adults in Juneau. The high suicide rate for youth and young adults in Juneau is consistent with statewide data, where suicide in the leading cause of death for Alaskans ages 15-44.

YRBS data for 3,900 youth surveyed during the period of 2003-2013 substantiates the significant suicide risk for high school-aged youth in Juneau. During this time period, 23% of surveyed youth responded positively for one or more of the following risk categories: suicide ideation; suicide plans; and suicide attempts.

Although our full Coalition did not specify an exact target population age range at its prioritization meeting, several Coalition members express their greatest concern was for youth who have experienced ACEs, such as child sexual abuse and intergenerational/cultural trauma. Our Needs Assessment Committee has determined, consistent with the Coalition discussion, that the data indicate that youth and young adults ages15-30 are the most appropriate target population for our future prevention efforts.

Measuring the impact of prevention efforts should be feasible for this age group for both sexes and potentially by major race grouping, using hospitalization data, vital statistics, and potentially YRBS biennial survey data or other pre-post surveys of cohorts who are afforded prevention programs. "Universal" prevention strategies are anticipated to have impacts on all ages, especially if reducing family violence and the culture of silence are addressed, but for planning and evaluation, the youth and young adult populations will be the focus. Looking forward to evaluating impact of prevention efforts, the Coalition expects to request data reports based on the target age group, with sex and race breakdown where feasible.

Full Coalition Involvement in Data Analysis and Prioritization
The full Coalition was involved on an ongoing basis in the data analysis and prioritization process. In the fall of 2014, the full Coalition established the Needs Assessment Committee to complete research and data analysis to determine the intermediate variables that had the greatest impact on suicide risk and completed suicides in Juneau. The Needs Assessment Committee was given a two-month timeframe to complete its analysis and provide information to the full Coalition for discussion and prioritization of intermediate variables.

The iterative process of examining the relationships of risk and protective factors for youth and for adults using the two major surveys (YRBS and BRFSS) led the Needs Assessment Committee to compile the results for presentation to the full Coalition for a "prioritization" exercise in mid-December. The Committee summary tracked the topics of characteristics (age, sex, race), exposure to adverse experiences, risky behaviors, serious emotional distress, and protective factors, summarizing what we learned from the data for youth and for adults.

The Coalition meeting to review the work of the Assessment Committee and prioritize intermediate variables took place on December 17, 2014. The meeting was attended by 19 Coalition members representing the following community sectors: survivors; Alaska Native community; law enforcement; faith community; children's behavioral health; adult behavioral health; education; public health; social services; and the business community.

At the December 17 meeting, the Coalition was given a detailed presentation by the Assessment Committee of the process, methods, and key findings of the work. The key presentation on intermediate variables, supported by PowerPoint slides and handouts, was given by our contract professional researcher, Alice Rarig.

Kevin Ritchie facilitated the group prioritization process of intermediate variables including adverse childhood experiences, risky behaviors (such as substance abuse) and mental/emotional distress. After the research and findings were presented, the Coalition members asked questions to solidify their understanding of the information and help formulate priorities. Several Coalition members made statements about the impact of early trauma and the stigma surrounding meaningful community dialogue regarding childhood trauma. A consensus emerged regarding the importance of addressing adverse childhood experiences (ACEs) as the key intermediate variable impacting suicide in our community. Particular concern was expressed for addressing child sexual abuse, domestic violence and intergeneration/cultural trauma.

After a full and open discussion of the research and findings by the Coalition members, the facilitator asked each Coalition member in turn around the table to give a summary statement of their individual priority for the Coalition. Most of the summary statements spoke strongly in support of ACEs as the key variable that the Coalition should be addressing, while acknowledging that a broad approach is widely recognized as critical for effective suicide prevention.

The Needs Assessment Committee provided updates regarding the data analysis and needs assessment report at the January and February 2015 full Coalition meetings. The March 18, 2015

Coalition meeting was devoted almost entirely to reviewing the final needs assessment report being submitted to the Division of Behavioral Health. The Coalition applauded and fully endorsed the final report, including the recognition of ACEs as the primary intermediate variable affecting suicide risk in Juneau.

Encouraging (Aggravating) Factors

There are a number of factors that exacerbate trauma-related suicides and challenge our ability to develop effective strategies in this area. These challenges include the following:

- Culture of Silence and Tolerance: There is a tradition of silence and tolerance surrounding both trauma and suicide. The social norm of respecting a family's privacy often results in our community turning a blind eye to many instances of domestic violence and sexual assault. Similarly there is reluctance for many families to publicly acknowledge a death of a loved one as suicide, which results in the public underestimating the extent of suicide in our community.
- Interrelationship of Behavioral Health Conditions: Our research and data analysis substantiates that suicide does not occur in a vacuum. There is strong relationship between mental health, substance abuse, violence/trauma and suicide. Our analysis indicates that trauma, in combination with risky behavior and emotional distress, present a much greater risk for suicide than just trauma alone.
- Separation of Prevention Efforts: While there is a growing recognition of the relationship between trauma and future mental health and physical problems (including suicide), the prevention efforts in these two areas are largely separate and non-integrated. We see this dynamic locally with the Juneau Suicide Prevention Coalition and the Juneau Violence Prevention Coalition. These two coalitions, both of which are doing excellent work in their own right, have not yet worked together to develop a more unified community prevention platform.
- Stigma and Stereotypes: Stigma and stereotypes challenge efforts to address the relationship between trauma and suicide. Victims of trauma, especially domestic violence and sexual assault are often blamed for the abuse that they experience. Similarly, there are many myths and stereotypes surrounding suicide such as: suicide/suicide attempts are rare; all suicidal persons are mentally ill; and that people who verbalize suicide intent are just seeking attention. The myths, stereotypes and stigma surrounding trauma and suicide perpetuate misinformation and inhibit meaningful community dialogue on these issues.
- Intergenerational Trauma: The intergenerational nature of trauma presents another challenge to trauma-based suicide prevention efforts. Children who have witnessed or experienced domestic violence and sexual assault have an elevated risk to become victims or perpetrators themselves. The "historical trauma" of Alaska Natives requires unique consideration. To effectively address suicide prevention with Alaska Natives requires us to respectfully address cultural trauma in addition to adverse personal experiences.

Discouraging (Mitigating) Factors
Despite the factors that challenge or impede prevention efforts to address the relationship between trauma and suicide, there are several strengths and assets that we can build upon to make progress in this area. These factors are described below.

- Increasing Body of Research: The ACE Study and related research have clearly demonstrated that the experience of childhood trauma significantly increases the risk for physical and mental health problems later in life, including suicide risk. The ACE study also indicates that the more adverse childhood experiences, the greater the risk for serious physical and behavior health problems. While this body of research is compelling, the information is not yet well known with the general public and is mostly limited to behavior health and other professionals who work directly with childhood trauma victims.
- Increasing Community Knowledge about Individual Issues: While there is currently limited community knowledge about the relationship between trauma and suicide risk, there is increasing community knowledge about trauma and suicide as standalone issues. There are significant current prevention efforts in our community addressing issues such as child abuse, domestic violence, sexual assault, mental illness, substance abuse and suicide. The next logical step is for the community to be educated on the relationship between traumatic experiences, risky behaviors, mental/emotional distress and suicide.
- Treatment Services: We are fortunate to have a relatively robust system of behavioral health services in Juneau to address the needs of trauma victims. For both youth and adults, we have a full continuum of emergency, outpatient/school-based, and residential services. We are able to meet most behavioral health needs locally, with very few youth and adults needing to leave the community to receive specialty behavioral health services. In addition, local behavioral health providers have received significant training in trauma informed assessment and care, and are adopting practices to address trauma more effectively within their organizations.
- Collaboration: There is high level of collaboration in Juneau in the areas of behavioral health and violence prevention. There are multiple coalitions addressing facets of the chain between trauma, risky behaviors, behavioral health conditions and suicide. The challenge now is to ensure that prevention efforts are more integrated and more directly address the relationship between trauma and suicide.
- Policy Changes: There are several examples of positive policy changes at the statewide and local level to address suicide, trauma and behavioral health as individual issues. Examples include state-required training for school personnel in suicide prevention and suicide risk screening protocols in local behavioral health organizations. To help prevent traumatic experiences, and to ensure that trauma victims are identified and receive the support services they need, it is important to develop policies that more directly address the relationship between trauma and suicide.
- Shifting Community Values and Norms: There is significant evidence of shifting societal norms and values regarding the culture of silence surrounding trauma and suicide, as demonstrated by growing efforts in areas such as domestic violence/sexual assault prevention and suicide prevention. There is a greater willingness in Juneau and

throughout the country to reframe trauma and suicide from strictly family or personal issues, to issues that affect our whole community.

Community Readiness

The community readiness assessment that we conducted indicates that the Juneau community is poised to take collective action to address the relationship between traumatic experiences and suicide. The community leaders we interviewed believe that the community has a very high interest in reducing suicides in any way that is shown to be effective.

The leaders perceive the community members as being relatively aware of problems in such areas suicide, domestic violence and bullying. They also believe that the community members can vaguely identify a connection between trauma and suicide and are generally aware of prevention efforts in each of these areas individually. At the same time they perceive the community as having very little knowledge about the specific relationship between traumatic experiences and suicide. This is consistent with our community survey findings, which demonstrated that community members are less knowledgeable about the relationships between trauma and suicide, than they are about the relationship between behavioral health problems and suicide.

The overall average community readiness score was 4.3, which falls between the preplanning and preparation stages of readiness in the Tri-Ethnic Center model. We believe that this rating underestimates the state of readiness to address the relationship between trauma and suicide. The leaders who were interviewed believe there is a high level of knowledge and passion within the community concerning suicide prevention. At the same time, the community needs to be better educated to harness that passion to address trauma-based suicide.

The leaders who were interviewed were also confident that sufficient resources could be harnessed to effectively address the relationship between trauma and suicide. The respondents believed that once community leaders, professionals and the general public more fully understand the impact of trauma, they will be willing to devote significant financial, volunteer and collaborative resources to support prevention efforts in this area.

Strengths/Assets

We are fortunate to have significant strengths and assets to draw upon to implement a strategic plan that addresses trauma as a major contributing factor for suicide in our community. These factors are summarized below:

- Past and Current (JSPC) Prevention Efforts: The Juneau Suicide Prevention Coalition was formed several years ago and has been a statewide leader in providing a broad array of community-based services to combat suicide. The activities include: two evidence-based suicide prevention programs in the Juneau schools (Signs of Suicide and Sources of Strength); websites focusing on suicide prevention and behavioral health resources; a wide range of advertising and public awareness activities; a variety of suicide prevention training activities; and postvention support to those who are impacted by suicide and other forms of sudden loss. These activities give us an experience base and infrastructure to incorporate a more intensive focus on trauma-based suicide.

- Juneau Violence Prevention Coalition (JVPC) Efforts: The Juneau Violence Prevention Coalition has been effective in addressing trauma in the form of interpersonal violence and sexual assault. The JVPC has focused its efforts in the following areas: having boys and men be leaders in violence prevention; helping youth become leaders in promoting respectful relationships; helping girls develop skills to develop healthy relationships; and impacting policies to promote healthy relationships and violence prevention strategies. There is a need to draw upon the collective resources and expertise of the JSPC and JVPC to develop comprehensive and integrated strategies to address the relationship between trauma and suicide.
- Broad-based Stakeholder/Interagency Involvement: The other major strength that our coalition has that will help us move forward to more effectively address trauma-based suicide is our broad-based stakeholder and interagency involvement. Core members of our coalition represent the following sectors: suicide survivors; the faith community; tribal/Native representation; children's and adult behavioral health; secondary education; health/public health; post-secondary education; social services; and law enforcement. The representatives from these sectors are often leaders within their organizations, and many Coalition members participate on a volunteer basis. This broad-based involvement will ensure that the strategies we develop to address trauma-based suicide reflect the perspective and involvement of diverse elements of our community.

Gaps/Challenges

Despite the strengths and assets noted above, there are also gaps and challenges that we must address to ensure our success in implementing strategies to prevent trauma-based suicides. These challenges are summarized below:

- Other Sector Involvement: While we have board-based participation in our Coalition, there are certain sectors of the community that are unrepresented or underrepresented in our prevention efforts. These sectors include the Alaska Native community; medical providers; the business community; and the domestic violence/sexual assault community. We need to build a stronger bridge with these sectors to more effectively break the causal chain between traumatic experiences and suicide.
- At-Risk Populations: Similarly, there are certain populations at an elevated risk for suicide that could benefit from increased resources and support to alleviate trauma-based suicide. These high-risk groups include young adults, Alaska Natives, veterans and senior citizens. Depending on the specific focus of our strategic plan, we will need to develop more targeted strategies to more effectively address the needs of these high risk populations.
- Collaboration with the Alaska Native Community: Due to the sovereign status of Alaska tribes, there are often different laws, funding, services and governing structures for Alaska Natives, who must live within the dual frameworks of their Native culture and the dominant Caucasian culture. In addition, forced acculturation and discrimination often result in reluctance of Native leaders and organizations to engage in collaborative prevention efforts. We must develop strategies to overcome these barriers to develop broader and more inclusive communitywide changes.

- Policy Development Issues: One policy gap that we identified is the lack of consistent policies to screen youth and adults for trauma history and suicide risk. Another barrier we identified is the positive parental consent process that is required for students to participate in the Youth Behavior Risk Survey; this process results is a substantial portion of the student population not participating in the survey. Addressing policy gaps and challenges needs to be a key component of a strategic plan which focuses on the relationship between trauma and suicide.

Appendix

A. Summary and Analysis—A Picture of Juneau

A Picture of Juneau: Detailed Information

Location, Climate, and Geography

Juneau is located in a rainforest approximately in the middle of the Alaska Panhandle. Juneau is not accessible by road. Primary access to the city is by airplane, and ferry or barge. The closest road link is Haines, approximately a 4.5 hour ferry ride. Juneau is 900 air miles north of Seattle and 600 air miles southeast of Anchorage.

Juneau has a relatively mild marine climate. Winters are moist and long, but relatively mild compared to most Alaskan communities due to the marine influence. The rest of the year is just moist. Precipitation falls on an average 230 days per year, averaging 62.27 inches at the airport (1981–2010), but ranging from 55 to 92 inches, depending on location within the community. While below the Arctic Circle, on the winter solstice (Dec. 21) there are only 6.5 hours of light, with an offsetting increase in light on the summer solstice.

The City and Borough of Juneau has a total area of 3,255 square miles. Of that, 2,716.7 square miles are land and 538.3 square miles are water. However, extensive ice fields and mountainous topography make the buildable portion of its massive land area relatively small. In fact, Juneau has developed linearly along the coastlines with larger population consolidations in the three primary areas: downtown Juneau, Lemon Creek, and the Mendenhall Valley. This linear development makes the provision of public infrastructure (e.g. water, sewer, power) and public services (e.g. schools, social services, police, fire, etc.) much more expensive and difficult.

The isolated location virtually eliminates the option to travel to attractions and events (e.g., from sports to culture). And despite a number of active programs, the size of the community significantly limits the social, cultural, sports, and other opportunities that can be sustained in Juneau.

Population Demographics (U.S. Census)

As of the 2010 census, the City and Borough had a population of 31,275. In July 2013, the population estimate from the U.S. Census Bureau was 32,660, making it technically the second most populous city in Alaska. (Surpassing the City of Fairbanks with a 2013 US census population estimate of 32,324; however, the entire combined 2013 City of Fairbanks and Fairbanks North Star Borough population estimate is 100,436).

Per the 2010 census, there were 12,187 households, and 7,742 families residing in the city/borough. There were 13,055 housing units.

Of the households:

- 36.7% had children under the age of 18 living with them
- 51.2% were married couples living together
- 10.5% had a female householder with no husband present
- 33.8% were non-families
- 24.4% of all households were made up of individuals
- 4.3% had someone living alone who was 65 years of age or older
- The average household size was 2.6
- The average family size was 3.1

The age distribution of Juneau was as follows:

- 27.4% of the population was under the age of 18
- 8.1% were from 18 to 24
- 32.8% were from 25 to 44
- 25.7% were from 45 to 64, and
- 6.1% were 65 years of age or older
- The median age was 35 years.

Income:

- The median income for a household in the city/borough was $62,034.
- The median income for a family was $70,284.
- Males had a median income of $46,744 versus $33,168 for females.
- The per capita income for the city/borough was $26,719.
- 6.0% of the population and 3.7% of families were below the poverty line, including 6.7% of those under the age of 18 and 3.9% of those 65 and older.

Juneau's Cost of Living

Several studies are conducted periodically to determine the living costs of Juneau compared to other communities around the United States. Juneau's isolation, smaller economy, challenging terrain and climate all contribute to raise transportation and livings costs, generally making Juneau a more expensive place to live than most other U.S. cities, as well as other communities on the road system in Alaska.

In 2011, Juneau had the highest cost of living overall of selected Alaska communities (Anchorage, Fairbanks, Kodiak, and Juneau) according to the Council for Community and Economic Research's ACCRA quarterly cost of living survey. This survey produces a cost-of-living index by comparing the prices of about 120 goods and services in 318 communities across the country.

Increasing Senior Population

While Juneau's population is aging quickly, a look at recent projections of growth rates by age group reveals an interesting prediction. The Alaska Department of Labor (ADOL) has projected the number of Juneau residents entering retirement age through 2035. These projections are

based primarily on analysis of the past and present birth and death rates between 2000 and 2010, and the migration to and from Juneau by age group. ADOL projects the number of Juneau residents aged 65 to 69 years will peak around 2020, but begin to decline after that.

The proportion of those 55 and older in Juneau increased from 10% in 1990 to over 23% in 2011. By 2025 those 55 and older are projected to make up almost one third (32%) of the local population.

Migration and Resident Transiency

Migration is a large component of Juneau's culture and demographic trends. On average between 2000 and 2011, 8.3% of our year-end population moved to Juneau, and 8.8% of that population moved away from Juneau. Although some residents stay for long periods of time, and some move more frequently, this movement results in a net change in number of residents enough to equal Juneau's population every 11 to 12 years. The recent national rate of population "turnover" is far lower than that of Juneau. The national population has around a 3.9% migration per year, for a population turnover about every 25.6 years. For Alaska as a whole, the migration rate is slightly higher than for Juneau (just over 9% between 2009 and 2010), for a turnover about every 11 years.

Educational Attainment

Juneau citizens have a relatively high level of education, most likely due to the employment structure in Juneau. Per the U.S. Census 2013 estimate:

	Juneau	Alaska	All U.S.
High School Graduate or greater	95.5%	91.6%	86.00%
BA or greater	36.7%	27.5%	28.8%

Local Municipal Government

The City and Borough of Juneau (CBJ) is the capital city of Alaska. The City and Borough is a consolidated "city/county" local government governed by a nine-member municipal Mayor and Assembly. It has been the capital of Alaska since 1906, when the government of the then-District of Alaska was moved from Sitka as dictated by the U.S. Congress in 1900. The municipality unified on July 1, 1970, when the city of Juneau merged with the city of Douglas and the surrounding Greater Juneau Borough to form the current home rule municipality.

As with many Alaskan municipalities, the CBJ provides an extensive breadth of public infrastructure and services, including an airport, hospital, ski area, ice skating rinks, harbors, along with traditional municipal public services. Schools are also funded in partnership with the State. Under state law, the CBJ has far broader taxing powers that most communities in the lower 48 states and Hawaii. The CBJ has virtually full authority over property and sales taxes in addition to other broad tax authority.

CBJ Provision of municipal health and social services
The City and Borough indirectly provides some health and social services:

- Bartlett Regional Hospital: Bartlett Regional Hospital has a 12-bed mental health unit and the Rainforest Recovery Center for substance abuse and other addiction disorders; Bartlett also provides outpatient psychiatric services.
- The local government does not generally provide other direct social services but provides some funding through social services block grants and youth services block grants. For FY16:

Social Services Block Grants	$878,900
Juneau Youth Services	$39,600
JAMHI	$410,400
AYEC-Hearts	$90,200
Youth Activity Grants	$332,500
Juneau Afterschool Coalition	$47,500

City and Borough of Juneau revenue shortfalls
The CBJ has an adopted FY15 and "approved" FY16 Biennial Operating Budget. In the first year of each two-year budget, the Assembly adopts the first year's budget (FY15) and approves, in concept, the second year's budget (FY16).

In order to balance the FY15 Budget, CBJ took the following actions:

- Made $3 million in budget reductions (operating budget $2 million and capital budget $1 million)
- Used $2.7 million of available fund balance.
- Raised fees by $300,000.
- Decreased School Funding: State "foundation funding" has decreased $200,000 (resulting from combination of increase in base rate and decline in number of students), and local CBJ funding also decreased $200,000.

The significant reductions resulted in eliminating 12.04 positions, making it harder to maintain an acceptable level of customer service in all areas. In balancing the FY15 budget, emphasis was placed on working towards a "sustainable" level of general government expenditures. To meet the projected deficit, the proposed FY16 budget includes the use of $1.65 million from the Budget Reserve.

According to the City Manager, "As we look forward to balancing the FY16 budget we will need to take a hard look at what services and programs can be eliminated and where revenues can be raised. Juneau is a strong and diverse community, where the citizens have come to expect responsive municipal services delivered in an efficient manner. Our property assessments and sales tax revenues are stable and our population is stable."

Local Tribal Government

The Central Council of the Tlingit and Haida Indian Tribes of Alaska (CCTHITA) is the tribal government representing approximately 30,000 Tlingit and Haida Indians worldwide. The Council is a sovereign entity and has a government-to-government relationship with the United States. The Council has its headquarters in Juneau (www.ccthita.org).

The Tribal Assembly of the Central Council is composed of delegates from the Communities of Tlingit and Haida Indian Tribes. The governing body of the Central Council is comprised of the Tribal Assembly of delegates and the Executive Council. The governing body of the Central Council possesses sovereign and plenary power to legislate for and to govern, conduct, and manage the affairs and property of the Tribe.

CCTHITA provides a broad range of social, public safety, and judicial services and programs.

Juneau Schools

The Juneau School District (JSD) has 4,720 public school students. It is the fifth largest district in the State of Alaska.

Declining Student Enrollment

4,720 students were enrolled in the Juneau School District as of August 22, 2014, a decrease of 2.4 percent (118 students) from the previous year.

Nearly half the decrease came in the middle school grades (-58 students), while 30 percent was due to declines in elementary schools (-36 students) and 20 percent occurred at the high school level (-24 students).

The Juneau School District has seen a continual decline in student population for the ten-year period from 2005 to 2014 of about 1 percent on an annual compounded basis. Erickson & Associates, economic consultants for the Juneau School District, released a forecast projecting flat enrollment totals through 2017, with little change in any of the grade categories.

Comparison of Student Ethnicity vs. the Total Juneau Population

Enrollment by Ethnicity	Students*	2013 General Population**
Total	+/- 4,700	32,660
White	54%	70.3%
Alaska Native/American Indian	23%	11.7%
Asian/Nat Hawaiian/Pac Islander	10%	7.1%
Multi-Ethnic	7%	9.4%
Hispanic	5%	6.2%
Black	1%	1.5%
Enrollment by Gender		
Female	48%	48.9%
Male	52%	51.1%

Student Statistics*

English Language Learners	7%
Number of Languages Spoken	27%
Free & Reduced-Price Students	23%
Special Education	16%
Extended Learning	5%

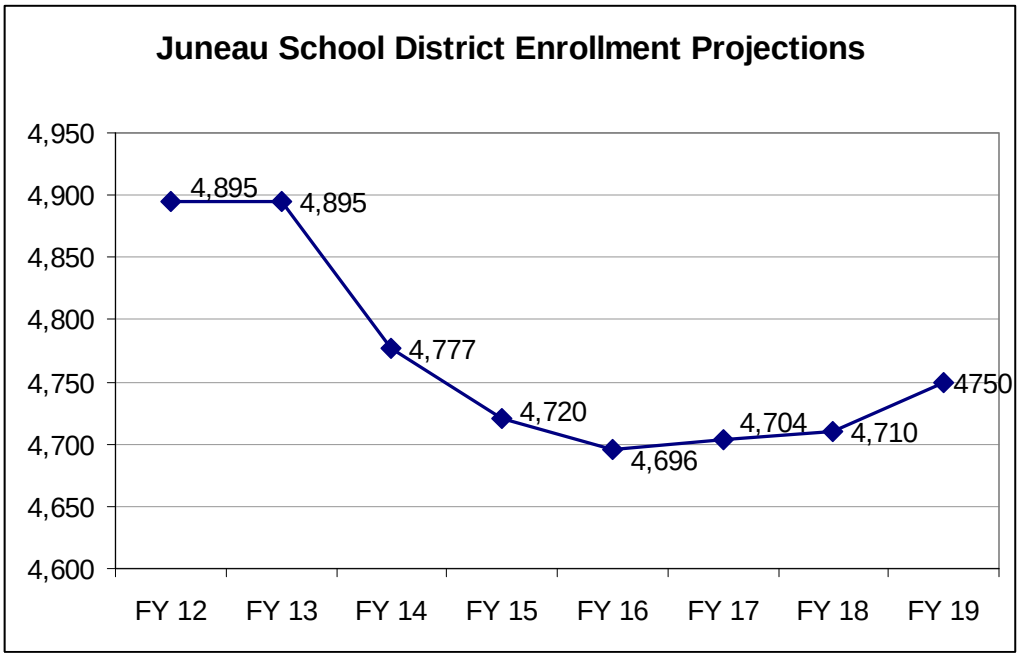
*Juneau School District

** U.S. Census

Quick Notes for FY 2015

Projected Enrollment	4,790.00
Total Teachers (FTE)	354.95
Total Employees (FTE)	661.51

JSD Enrollment Projections



Juneau School District Budget

JSD has annual budget of approximately $90 million ($75 million operating fund, $14 million special revenue funds, $1 million activity funds).

Of the operating budget, 63% comes from the State of Alaska, 35% from the City and Borough of Juneau and 2% from other sources.

Ninety percent of the budget is spent on personnel.

Seventy-seven percent of the budget is spent on instruction.

Primary and secondary schools
Juneau is served by the Juneau School District and includes the following schools:

Gastineau Elementary School
Harborview Elementary School
Riverbend Elementary School
Mendenhall River Elementary School
Glacier Valley Elementary School
Auke Bay Elementary School
Juneau Community Charter School
Dzantik'i Heeni Middle School
Floyd Dryden Middle School
Juneau-Douglas High School
Thunder Mountain High School
Yaa̲koosgé Daakahídi Alternative High School
HomeBRIDGE (homeschooling program)
Montessori Borealis School (grades 1-8)

In addition, the following private schools also serve Juneau:

- (Glacier) Valley Baptist Academy
- Faith Community School
- Thunder Mountain Learning Center (Formerly Thunder Mountain Academy)
- Juneau Seventh-day Adventist Christian School
- Juneau Montessori School

Excerpts from the JSD 2015 budget document Executive Summary:

> **JSD budget cuts:** During the previous three budgets…the District made reductions totaling $11.7 million to programs, reduced approximately 100 jobs and slashed central office support in an effort to avoid cuts to the classroom. We believe we have done our best - within the resources available - to protect the classroom while supporting the continued professional development for our teachers.
>
> This (FY15) budget contains painful reductions in the form of reduced spending, increased class sizes and further loss of important positions. We have already begun reducing expenditures this year in an effort to reduce the impact for next year. This budget includes reductions in areas we attempted to protect in the last several years. We wish we could continue to protect them, but believe our current challenge makes the reductions necessary.
>
> **Our (JSD) Future Budgets**
> Future revenues are not expected to keep pace with escalating costs.
>
> **Student Success:** Using our grade K - 10 MAPS data, which reflects previous national standards, we can see that many of our students are doing well - over

60% meeting that standard. But nearly 40% of our students are not meeting grade level expectations in reading and math - both key skills for their future success.

Over the past few years, our district has made a number of changes intended to graduate students ready to succeed beyond high school. From structural changes like smaller high schools to program changes like AVID and CARES, we have seen evidence that these supports help and the graduation rate has increased to 79%. That's great progress, but it leaves over 20% still not graduating within four years.

In addition to their academic success, many of our students are engaged in the arts, trade related experiences, and extracurricular activities. We have a broad array of electives and student activities available to students that create opportunities for learning, increase engagement and promote leadership development. Two-thirds of our high school students are actively involved in organized activities.

About (JSD) our Graduation Rate
The District's vision statement is based on every student graduating. The federal government standardized how to calculate this figure a few years ago; so in FY 2013 79% of the class of 2013 graduated in four years of high school. This was an improvement over the class of 2012 where 71% of the students graduated in four years. The District is focusing its efforts on improving this rate. The class of 2015 will have more stringent credit requirements, including more total credits, more math and more science credits.

University of Alaska Southeast

The University of Alaska Southeast is located within the Auke Bay community right along Auke Lake. The Juneau-Douglas Community College, founded in 1956, and the Southeastern Senior College, established in 1972, were merged in 1980, forming the University of Alaska, Juneau. The University was restructured as the University of Alaska Southeast to include the Ketchikan and Sitka campuses. The university offers degrees in both undergraduate and graduate studies. The University of Alaska Southeast is known for its research in regards to the Tongass National Forest and the Juneau Icefield. According to the University of Alaska Southeast Spring 2014 Closing Enrollment Report, the Juneau Campus had 2,449 students. (Enrollment has declined annually from 3,279 in 2011).

Juneau Housing

Juneau's Housing Market
Juneau has an effective lending market with local and online participants offering a range of mortgage options at historically low rates. This is offset by high cost of living and high real estate prices, fueled by low supply rather than unsustainable market appreciation. Based on data from the Juneau Multiple Listing Service as of January 2015, Juneau's 2014 average sales price

for single-family homes reached $377,161, surpassing the previous high of $373,717 in 2013. For this analysis, a single-family home is defined as a single-family detached dwelling.

Despite Alaska having many of the favorable characteristics of a healthy housing market, the number of new housing units in Juneau has not kept pace with local demand. Low income residents are being pushed out of affordable rentals by median and above median income households.

In 2011, Juneau's population is estimated to have grown by over 400 households. The number of households with incomes over $100,000 renting rather than owning their homes increased over 90% between 2000 and 2010, far outpacing growth of the rental market overall.

Rental Housing Needs

In Juneau, there are 1,790 cost-burdened renter households paying more than 30% of their household income for rent, with 1,585 of these earning less than $50,000. Using a variety of methods for calculating the current shortage of rental housing units, the Juneau Economic Development Council (JEDC) estimates Juneau needed 170-230 new rental housing units to reach 5% vacancy. According to the Alaska Department of Labor "Rental Costs and Vacancy Rates, 2014," Juneau's current vacancy rate is 3.4%, with an average monthly rental cost of $1.117. About 441 rentals priced under $700/month are needed to cover the income rent gap for low and very low-income households, many of whom are already eligible for subsidized housing or vouchers, which are already fully allocated. The need for smaller one- and two-person rentals in Downtown Juneau is high and exacerbated by the recent displacement of over 40 households due to fire-related evacuation from the Gastineau Apartments in November 2012.

Further study is needed to determine the need for additional senior housing units. Though that population is growing and existing senior housing is full, the number of households requiring supportive services has not been quantified. Similarly, the need for dormitory or other styles of housing for seasonal non-resident workers requires further analysis to determine whether and how new housing of this type could be economical.

Owner Housing Needs

The effective age and functional obsolescence of Juneau's housing stock, the slow pace of new home construction and long-term unmet demand all indicate Juneau needs 513-517 new single-family homes to achieve a 5% vacancy rate. (According to the US Census 2009-2103 American Community Survey, the estimated 2013 homeowner vacancy rate is 0.6%.) Based on annualizing year-to-date sales volume and the supply of properties listed for sale, Juneau only has a 3.1-months inventory of single-family and duplex properties available for buyers. Another 113 single-family homes and duplexes would increase the inventory of likely owner-occupied properties to a six-month supply, which like the 5% rental vacancy rate, is generally enough to provide homebuyers an appropriate range of property styles, conditions, prices and locations from which to choose and, more importantly, some leverage with respect to sellers.

If we focus just on meeting the needs of cost burdened households within the range of 80%-120% of Juneau's 2010 median household income, JEDC estimates there were 1,183 households residing in homes they could not comfortably afford in 2010.

Key Juneau Housing Indicators – Conclusions from the Juneau Economic Development Council Housing Assessment:

- Juneau needs 441 additional rental units priced at $700 or below.
- 359 more Juneau households are eligible for public housing and 395 more Juneau households are eligible for housing subsidy vouchers than exist in Juneau.
- 1,585 low and moderate-income renter households pay more than 30% of their income for housing.
- 24.7% of Juneau's renter households live in subsidized housing (based on the 2010 US Census American Community Survey—ACS) estimate.
- 562 homeless individuals were estimated to live in Juneau in 2011.

Juneau Economy and Employment

Economic and Employment Picture of Juneau (information from the Juneau Economic Development Council)

On the plus side, Juneau is not likely to experience major economic disruptions. Also, Juneau has relatively low unemployment and a relatively high average household annual income.

On the negative side, Juneau is losing higher paying jobs and gaining lower paying jobs, including more seasonal jobs. Presumably, the loss of higher paying jobs will also result in lower average education of workers. Additionally, Juneau has also significantly increased the number of non-resident workers primarily in tourism, seafood processing, and mining. This impacts not only the economy, but the social fabric of the community. Also troubling is the significant loss of local government employees, including municipal services, schools, and tribal. These losses impact public infrastructure and services, most notably, K-12 education.

Juneau is likely to have slow economic and job growth in the future
After three years of net job growth led by the private sector, both the government and private sectors of Juneau lost jobs in 2013. While total private sector employment declined by less than 1% (-41 jobs), the government sector employment dropped by almost 3% (-200 jobs). Job losses were led by local government, where job count decreased by 4.7% (-101 jobs), declining for the third year in a row. Civilian employment with the federal government, also down for the third year in a row, had a net loss of 68 jobs, a significant 8.2% decline. Looking ahead, the key influences on the employment outlook will be slow population growth and continued rebound in cruise tourism, which will be the driving force for a small expansion in the service sector. The JEDC anticipates private sector employment increasing in the area of 0.8% to about 11,400 jobs by 2017. The government sector employment will remain stagnant at about 7,100 jobs.

Juneau Jobs by Sector
While the single largest employer in Juneau continues to be the state government, the private sector in Juneau employs more total residents (10,991) than the state, federal, and local

government combined (7,095). Juneau's private sector is predominately service-providing, with 9,165 jobs in the service sector compared to 1,827 in the goods-producing sector. Retail trade (1,985 jobs), leisure and hospitality (1,618 jobs), and transportation and warehousing (1,049 jobs) are the largest private employers, together accounting for about 42% of all private sector jobs. In 2013, the leisure and hospitality sector led in job expansion with an increase of 57 jobs, followed by retail trade (+34). Local and tribal government (-101) had the most job losses, followed by federal civilian employment.

A net gain or loss of jobs must be looked at in the context of expansion or contraction in total industry earnings to determine the economic impact for Juneau. In this context, the industry sectors of leisure and hospitality, retail trade, membership organizations, construction, manufacturing, and professional, scientific and technical services experienced expansion, as both employment and total wages increased in 2013.

The sectors of health care, natural resources and mining, state government, transportation and warehousing, and social services had a loss of jobs, but a gain in total payroll, indicating that while lower paying part-time or full-time jobs were reduced, there was no net impact on Juneau's economy.

The federal civilian government sector's loss of 68 jobs represents significant industry contraction with economic consequences for Juneau, as the 8.2% reduction in the workforce was coupled with a 7.5% reduction in the total payroll. The local and tribal sector also saw contraction with just under 5% reduction in jobs, and a 1% reduction in total sector earnings.

State Government Employment
In 2013, State employment lost a net of 31 jobs in Juneau, nearly reversing the 32 jobs gained in 2012. From a ten-year perspective, the number of state jobs in Juneau has returned to within two percent of the number of jobs in 2004. However, while Juneau has struggled to retain jobs, the percent of state jobs is now over 12% higher in Anchorage and nearly 5% higher in Fairbanks.

Federal Government Employment
An annual average of 761 people are employed in civilian federal jobs in Juneau. The average wage of these federal employees is approximately $87,500, making it one of the highest paying sectors in Juneau, second only to natural resources and mining. Thirteen federal government agencies have a local presence, but only 5 have more than 10 employees. Since 2004, Juneau has suffered a loss of 193 federal positions, which is a 20% reduction in the federal workforce. In comparison, Anchorage and Fairbanks have both experienced only a 10% reduction in federal jobs.

Local and Tribal Government Employment
Local and tribal government reported a third year of substantial loss of jobs, reducing employee count by 101 (5% of all local and tribal government) between 2012 and 2013. Despite this, the average annual wage increased 4 percent from $51,193 to $53,160 from 2012.

Looking at a ten-year perspective, Juneau now employs almost 6% fewer local government employees than in 2004, despite a 6% increase in population. Anchorage has returned to 2004 employment levels, while Fairbanks has 4% more jobs in local government than in 2004.

Non-resident Employment has significantly increased

In 2012, approximately 30% of the workforce in Juneau (a total of about 6,400 workers) did not live in the city full time. This is an increase of 7% since 2010, when 23% of the workforce did not live in Juneau. Among nonresidents, 40% are residents of Alaska outside of Juneau while 60% are residents of another state. The majority of Juneau's non-local workforce consists of non-Alaskans working in the private sector (3,400). The manufacturing sector, which includes seafood processing, has traditionally had a high nonresident seasonal workforce. About 73% of processing workers in the Juneau workforce are nonresident, according to ADOLWD (Alaska Department of Labor, Division of Workforce Development). Mining is another local industry that has a high percent of full-time, out-of-state workers, estimated at 28% by the industry.

Juneau has low unemployment

In the past 5 years the unemployment rate in Juneau has been consistently lower than the rest of the region, state, and country. As of July 2014, the unemployment rate in Juneau was 4.4%, compared to the U.S. average of 6.5%. In addition, the regional average (5.3%) has substantially improved over the state average (6.5%). Juneau, the state, and the rest of the United States, all appear to be on a steady decline in unemployment since 2010, and Juneau has almost reached its pre-recession level of 4.3%.

Juneau has a relatively high per capita personal income

Total personal income, defined as total gross income from all sources, increased from $1.7 billion to $1.8 billion in Juneau between 2011 and 2012, a 2.2% increase after adjusting for inflation. Since 2009 the per capita personal income has been growing faster than inflation, which means that Juneau is gaining spending power. Juneau continues to have a higher per capita income than the State and the U.S. According to the US Census, American Community Survey 2009-2013:

	Juneau	**Alaska**	**US**
Per Capita 2013 Money Income	$37,558	$32,651	$28,155
Median Household Income	$81,490	$70,760	$53,046
Persons below Poverty Level	6.2%	9.9%	14.5%

Average annual wages by sector

In 2013, the average annual wage in the government sector, for all state, federal, local, and tribal employment was $59,357. The average annual wage in the private sector was $41,880. Overall wages increased almost 4% for private sector employees and just over 3% for the public sector compared to 2012. When adjusted for inflation, the increase is closer to 2% for private sector and 1.5% for government sector employees.

Juneau is losing higher paying jobs and gaining lower paying jobs

A look at job gains and losses when compared to sector wages shows a more nuanced picture. It shows that Juneau has lost jobs in its highest paying sectors while gaining jobs in the lowest paying sectors.

Notable industry changes between 2012 and 2013 include:

- Natural Resources and Mining, Juneau's highest paying sector, decreased employment by 4% (-31 jobs) but experienced a 5% jump in average monthly wage. The Natural Resource industry continues to be the highest paying industry on average, with wages over two times the average private sector wage.
- Federal civilian employment, Juneau's second highest paying sector, decreased employment by 8.2% (-68 jobs) with no change in average monthly wage.
- Hospitality and leisure, much of which is involved in the tourism industry, grew 4% with 57 new jobs, and went up 2% in average wages, although it remains the lowest paid industry on average. However, since many of the jobs and workers in this industry are seasonal, it is likely that the average wage is slightly skewed.

B. What are the perceptions of residents about the behavioral health focus area in the community?

Summary of Three Community Survey Responses

Community (General Public)	n = 266
Mental Health Agency	n = 7
Primary Care Provider (Medical)	n = 7

Questions Specific to the General Community Survey

- Age – General public survey responses
  - 20 and under 22.3%
  - 21-45 25.0%
  - 46-60 27.3%
  - 61 and over 25.4%

- Gender – General Public survey responses - Male 34.4%, Female 65.6%R

- Race – General public survey responses

Survey Responses

	Survey Participants	Juneau (US Census)
◦ Am Ind/Ak Native	12.1%	11.7%
◦ White	82.2%	70.3%
◦ Black	0.4%	1.5%
◦ Asian/Pac	5.3%	7.1%
◦ Hispanic/other	N/A	15.6%

(Note: survey did not have a Hispanic or other option – Presumably many responded "White")

Income - General Public Survey – Under $75,000 – 54%; Over $75,000 – 46%

How often do people (Complete – Attempt – Think About) suicides in Juneau?

General Public Survey Responses:

	Complete	Attempt	Think About
Almost Never	7.8%	2.7%	1.5%
Occasionally	58.4%	29.2%	19.6%
Fairly Often	30.4%	51.0%	42.7%
Very Often	3.5%	17.1%	36.2%

Questions Common to the Community and Agency/Provider Surveys:
How much does each of these factors contribute to the problem of suicide in Juneau? (1=very little to 5=very much) (Ranked in order highest to lowest – X% represents all responding with a 4 or 5 ranking)

	Community	BH Agency	Primary Care
1. Depression/Poor MH	92.5%	100%	100%
2. Alcohol/drugs	84.4%	100%	100%
3. Disconnection/isolation	73.6%	75.0%	85.8%
4. Trauma when young	65.0%	75.0%	66.7%
5. Violence/sexual assault	64.9%	50.0%	71.4%
6. Bullying	61.9%	50.0%	66.6%
7. Access to weapons	47.5%	25.0%	69.5%
8. Poor health	46.9%	0.0%	71.4%
9. Poverty	37.1%	0.0%	80.0%
10. Young consensual sex	20.5%	0.0%	33.4%

How much do these personal factors help prevent the problem of suicide in our community? (1=very little to 5=very much) (Ranked in order highest to lowest – X% represents all responding with a 4 or 5 ranking)

Protective Factors	Community	BH Agency	Primary Care
1. Friendships/positive relations	87.8%	100%	100%
2. Involve in productive activities	79.1%	100%	85.7%
3. Religious/spiritual connection	63.0%	75.0%	85.7%
4. Economic stability	52.5%	25.0%	42.9%

How much does each of these interventions or actions help prevent suicide in our community? (1=very little to 5=very much) (Ranked in order highest to lowest – X% represents all responding with a 4 or 5 ranking)

Effective interventions (respond 4+5 out of 5)	Community	BH Agency	Primary Care
Mental Health Services	79.8%	100%	100%
Community education and training	68.9%	50.0%	83.3%
Collaboration between orgs	67.8%	100%	83.3%
Physical health services	63.9%	50.0%	85.7%
Change community policies/attitudes	63.6%	100%	71.4%
Limit weapon access	27.8%	0%	40.0%

How confident are you in your ability to recognize the signs and symptoms of suicide?
(1=very little to 5=very much) (X% represents all responding with a 4 or 5 ranking)

Community	34.0%
Primary Care	57.2%
Behavioral Health	Not Asked

Would you know where to go for help if you or someone you care about were feeling suicidal? (1=very little to 5=very much) (X% represents all responding with a 4 or 5 ranking)

Community	59.5%
Primary Care	71.4%
Behavioral Health	Not Asked

How important is the issue of suicide/suicide prevention in Juneau?
(1=very little to 5=very much) (X% represents all responding with a 4 or 5 ranking)

Community	84.6%
Primary Care	100%
Behavioral Health	100%

Community	94.3%	(X% represents all responding with a 3, 4, or 5 ranking)
Primary Care	100%	
Behavioral Health	100%	

How important is it to have dedicated efforts and services to help prevent suicide in Juneau? (1=very little to 5=very much) (X% represents all responding with a 4 or 5 ranking)

Community	85.3%
Primary Care	100%
Agency	100%

Community	95.6%	(X% represents all responding with a 3, 4, or 5 ranking)
Primary Care	100%	
Agency	100%	

Questions for Behavioral Health Providers and Primary Care Providers Only
Number of clients served on an annual basis:

Behavioral Health Agencies	Total = 1,614
Primary Care Providers	Total = 20,000+

Age Status of Clients Served: Includes both youth and adults; most primary care providers serve youth and adults equally. Most behavioral health agencies serve adults or youth primarily, while a few (about 20%) serve both youth and adults.

"Your estimate of the percent of clients with current or past:"

	BH Agency	Primary Care
Mental Illness/serious mental health issues	85.7%	18.7%
Substance abuse issues	100%	9.3%
Suicide ideation/attempts	71.4%	3.1%
Co-occurring mental health/substance abuse issues	100%	7.0%
Domestic Violence (victim)	71.4%	5.6%
Sexual abuse (victim)	71.4%	5.1%
Domestic violence (offender)	71.4%	0.9%
Sexual assault (offender)	71.4%	0.6%
Traumatic experiences in childhood	71.4%	13.7%

How knowledgeable is your agency about suicide/suicide prevention?

1 Very Little					5 Very Much
	1	2	3	4	5
BH Agency	0%	0%	0%	50.0.7%	50.0%
Primary Care	0%	14.3%	42.9%	28.6%	14.3%

How knowledgeable is the Juneau community about suicide/suicide prevention?

1 Very Little					5 Very Much
	1	2	3	4	5
BH Agency	0%	0%	100%	0%	0%
Primary Care	0%	16.7%	66.7%	16.7%	0%

Questions for Primary Care Providers Only

Do you screen every patient for current suicide risk?

Yes 28.6%
No 71.4%

Do you screen every patient for past suicide attempts?

Yes 42.9%
No 57.1%