

September 2020



Alabama
Commission on
the Evaluation of
Services

Suicide Prevention
Programs

Program Evaluation



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September 10, 2020

Members of the Commission,

I am pleased to transmit this report, Program Evaluation – Suicide Prevention Programs, to the commission. The program evaluation assessed the suicide prevention efforts of three state agencies – the Alabama Department of Public health, the Alabama Department of Mental Health and the Alabama State Department of Education – as they relate to (1) the state suicide prevention plan, (2) delivery within healthcare settings, and (3) delivery within schools. The evaluation officially concluded on September 2, 2020 marked by the last of three exit conferences held with the agencies.

I believe this report addresses the current status of suicide prevention efforts in our state and contains tangible recommendations for improvement. We very much appreciate the cooperation and assistance of the agencies and their staff, particularly during these disruptive times. I respectfully request that each of the agencies be given an opportunity to respond during the public presentation of the report.

Sincerely,

Marcus Morgan

Director





ACKNOWLEDGEMENTS

We would like to express our sincere gratitude for each of the organizations, agencies, and individuals for their work and dedication to suicide prevention in Alabama and the United States. We recognize the challenging work that accompanies prevention efforts. The completion of this evaluation could not have been accomplished without the timely feedback and information provided by all participants, especially in the unprecedented times of the COVID-19 pandemic.

State Agencies

Alabama Department of Mental Health "ADMH"
Alabama Department of Public Health "ADPH"
Alabama State Department of Education "ALSDE"
Alabama Department of Veteran's Affairs

Supporting States

Delaware
Florida
Illinois
Kentucky
Massachusetts
Mississippi
New Jersey
Rhode Island
Tennessee

Organizations

Alabama Suicide Prevention and Resource Coalition "ASPARC"
Suicide Prevention Network of Alabama
Alabama State University
Troy University
American Foundation for Suicide Prevention, Alabama Chapter
Hogan Health Solutions
National Action Alliance for Suicide Prevention
National Institute for Mental Health
The Pew Charitable Trusts' Results First initiative
QPR Institute
Suicide Prevention Resource Center, Education Development Center
Jennifer Claire Moore Foundation
LearnSafe
Sam Foundation
Thriveway

Individuals

Special thanks to Commissioner Kathy Sawyer for her insight into the history of suicide prevention in Alabama.



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EXECUTIVE SUMMARY

Alabama lacks critical state infrastructure to effectively collaborate and coordinate its suicide prevention activities. With only one statewide mandate to impact suicide – the Jason Flatt Act – Alabama has existing limitations that have resulted in missed opportunities, unreached at-risk populations, and unintended consequences.

Of the top 10 causes of death, only Alzheimer's has risen at a higher rate than suicide over the last 15 years. (See Table 1) From 1999 to 2018, the suicide death rate for all Alabamians has increased an average of 34.6% and as high as 85%ⁱ for some groups.

Alabama is not unique. Most states are grappling with increased suicide rates and no state has figured out a single solution to address this surging problem. While leading states have maintained their position as leading states, they are still faced with rising suicide rates. What is unique about leading states is that they have invested in prevention efforts to address their risk and protective factors. Alabama has not. Alabama has continued to rely almost exclusively on federal dollars awarded through a competitive grant process to provide public awareness campaigns and trainings designed to teach key *gatekeepers* to recognize the signs of suicidality.

The current infrastructure is best defined as autonomous. Programs are driven out of autonomous agencies and provided by autonomous community organizations or schools. While autonomy is not inherently bad, it has resulted in a fragmented and disjointed system of delivery that often does not produce reliable data or metrics to effectively manage the programs being delivered. While communities may be best suited to meet their own individual needs, they are unable to do so without the leadership of the state.

Opportunities to expand our efforts and increase our capacity have been missed. As a state that relies on grant dollars to fund programs, at least two new grant opportunities were passed on by state agencies in recent years. These opportunities would have amounted to more than twice as much funding directly available for suicide prevention.

Further hindering the state's efforts, existing information such as hospital discharge data and Patient Origin Surveys are either not produced or overly burdensome to gather. Also contributing to these deficiencies are agency data collection efforts that do not produce actionable information. This means Alabama gains little new understanding of the needs of its own population.

The state's efforts at coordination among agencies and stakeholders have lacked a strong structure, continuity, and accountability. This evaluation includes recommendations by ACES, agencies, and leading organizations and experts from around the country to generate and strengthen accountability as well as develop a more comprehensive approach to suicide prevention.

Table 1: Percent of change in national death rates among the leading causes of death from 2004 to 2018

Cause of Death	% Change ('04-18')
Suicide	29.1%
Alzheimer's disease	35.6%
Unintentional injuries	26.0%
Lung diseases	-4.3%
Kidney diseases	-11.0%
Diabetes	-14.1%
Cancer	-20.9%
Influenza and pneumonia	-26.6%
Heart disease	-26.4%
Stroke, hemorrhage, blood clots, etc.	-27.4%

SOURCE: CDC Data

ⁱ Population age group: 35 to 39



KEY FINDINGS

No single organization is responsible for coordinating the state's suicide prevention efforts, resulting in no fewer than four state agencies and multiple partners implementing a fragmented system.

Suicide prevention is a statewide problem that requires collaboration among several state agencies and community partners. Historically, that collaboration has happened on an ad hoc basis revolving around individual programs and community reactions to instances of suicide. That history has resulted in a framework where, despite some ongoing communication, no strategic collaboration is taking place.

Alabama's State Suicide Plan fails to effectively address suicide risk and protective factors.

Risk and protective factors provide areas of importance for interventions that help prevent suicide. Alabama's first published and currently drafted suicide prevention plans do not identify or address risk and protective factors that are general risk and protective factors common among most populations. While there are common risk and protective factors that should be incorporated, Alabama-specific factors also need to be developed. Understanding Alabama-specific risk and protective factors by community increases the local community's resilience to suicidal behavior and other forms of violence.¹

Alabama lacks sufficient data to not only begin identifying state specific risk and protective factors, but also targeting resources in a more efficient manner. Alabama is one of only of 2 states that does not require reporting of hospital discharge data.² Additionally, little information is collected and reviewed by ALSDE regarding suicide ideation, attempts, or threats of self-harm.

The state plans have not been developed using data and evaluations to examine changes in at-risk populations.

The state plan has not been updated regularly by examining changes in at-risk populations, reviewing new data, or analyzing evaluation findings as called for by leading organizations. Alabama's plans have largely been developed for the sole purpose of pursuing grant funding and have mostly been developed using the *National Strategy's* suicide plan template. Without evaluating the impacts of the state plan, it is difficult to develop new goals in subsequent plans that are responsive to the changing needs of Alabama's at-risk populations.

Alabama lacks a comprehensive plan that addresses the entire at-risk population.

The state plan and the activities developed under it have primarily been focused on youth ages 10-24. This means that a large contingent of the at-risk populations, 87.5%, is not included in any sort of statewide strategy to address the issue of suicide. Once these factors are addressed for the whole population, actionable strategies can be developed and deployed.

Collaboration, management, and delivery of suicide prevention activities is inefficient & ineffective due to a lack of dedicated staff.

While program specific, grant funded positions do exist, Alabama has no staff dedicated to the collaboration, management, and delivery of suicide prevention across the state. Leading states have consistently maintained internal structures that had designated leadership positions and/or staff. Equally, SPRC recommends having a dedicated leadership position and core staff required to oversee the function of a state plan.

Lack of consistent, dedicated funding has resulted in lack of capacity and collaboration, missed opportunities, and other inefficiencies that have prevented effective suicide prevention efforts.

Lack of consistent funding has contributed to missed opportunities, gaps in funding, and an inability to sustain 24-hour local crisis line services. In the last 4 years, ACES identified as much as \$4.9 million in eligible grant funding that has not been applied for by the state.



The model policy developed by ALSDE under the Jason Flatt Act does not effectively address suicide prevention or awareness.

The model policy is a clarification of state law and provides no direction for local school systems. The model policy provides no guidance to local school systems on:

- Suicide prevention and intervention activities.
- Suicide attempt response protocol.
- Notifying parents, administrators, and crisis team members of an attempt or threat of harm.
- School re-entry procedures.

Alabama's suicide prevention efforts in schools are ineffective and inefficient due to the unmandated and underregulated approach to training personnel.

The required reporting by schools to ALSDE of their compliance is an inefficient use of time and resources for both schools and ALSDE. In its present form, the collected data cannot be used to evaluate trainings or target future resources and no follow up is performed to understand why schools are unable to complete the training. Without further development and collection of data that may be used to improve the training efforts across the state, the current procedure provides little value to the state.

With no approved list of training materials, the approaches taken by schools to train certificated personnel in suicide prevention are disjointed across the state.

Under the Jason Flatt Act, ALSDE was given the authority to develop an approved list of training materials. No list was developed with the assistance of the Jason Flatt Advisory Committee in 2016 and no list has been developed in the years following. This has resulted in a lack of consistency and accountability in the trainings that are used. Some schools require their staff to complete free online trainings, while others rely on community providers or paid professionals to provide the trainings.

Insufficient use of suicide risk assessments within healthcare settings and schools prevents the effective use of interventions for at-risk individuals.

Recent findings from the National Institute of Health suggest that broad implementation of suicide risk screening and intervention is needed in emergency department settings. A new analysis of suicide risk screening tools in Alabama hospitals has some promising results, but also areas of concern. Of the hospitals that responded, only 49% acknowledge using risk screening tools in emergency departments.³

Schools, LEAs, ALSDE, and ADPH partners are increasing efforts to provide suicide prevention programs to students at varying ages and grades.

As suicides and thoughts of suicide have risen among youth over the last 10 years, more programming has been delivered to students to help address associated risks and protective factors. ADPH has even shifted programming in recent years to replace a curriculum that was less effective with older high school populations. While there is increased programming across the state, there is also greater disparity in the quality and quantity of programs and curriculums being received.

Given the limited resources available, Alabama relies on an approach to training health care professionals that may be efficient but is ineffective at impacting the much larger population.

Alabama has no requirements for medical professionals to be trained in suicide prevention. Suicide prevention training standards and minimum requirements will benefit providers and patients. Evidence shows that suicide risk assessment, treatment, and management training programs are needed to increase the level of healthcare provider confidence to assess at-risk individuals and decrease provider hesitations in addressing suicide ideations with patients.



KEY RECOMMENDATIONS

THE GOVERNOR AND LEGISLATURE SHOULD CONSIDER

- Designating a lead organization or agency to develop and publish a comprehensive and achievable suicide prevention plan, and
 - Require the State Suicide Prevention Plan to be evaluated against defined performance metrics and updated and published at least once every 5 years.
- Passing legislation requiring hospitals to report discharge data regularly to the Alabama Department of Public Health.
 - Ensure that discharge data is made available (within a reasonable amount of time) to the State Suicide Prevention Coordinator, State Suicide Prevention Plan Advisory Committee, researchers, and evaluators to target resources and develop better suicide prevention programs.
- Establishing a full-time State Suicide Prevention Coordinator to coordinate all state suicide prevention efforts.
 - Require the State Suicide Prevention Coordinator to submit a report to the Governor and the Legislature annually on the progress and performance of activities under the State Suicide Prevention Plan.
 - Provide the State Suicide Prevention Coordinator with the authority to request and receive data from all sources that may be used to target suicide prevention activities or evaluate their effectiveness.
- Identifying potential funding mechanisms that provide stability to suicide prevention efforts by:
 - Providing funding for the fulltime position of State Suicide Prevention Coordinator.
 - Providing funding for National Suicide Prevention Lifeline call centers in Alabama.
 - Requiring the State Suicide Prevention Coordinator to identify grant opportunities for suicide prevention and coordinate responses among state partners.
- Requiring the State Suicide Prevention Plan to contain actionable, measurable, and time-bound objectives by which to be evaluated.

THE DESIGNATED LEAD ORGANIZATION SHOULD

- Create or expand the State Suicide Prevention Plan Advisory Committee to:
 - Include representatives from previously unengaged organizations who serve at-risk populations.
 - Partner with the Governor's Challenge on Veteran Suicide Prevention to maximize resources and efforts.
 - Meet at least quarterly to assess strategy and implementation, identify progress and obstacles, and plan future activities under the plan.
- Work with ACES to develop performance metrics to promote continuous evaluation on the effectiveness of suicide prevention activities.
- Develop a comprehensive state plan for the entire at-risk population.
 - Consider developing both a youth and an adult suicide prevention plan to appropriately address these differing populations.
- Examine opportunities to implement standardized suicide risk assessment tools to be used by emergency responders, emergency departments, and other health care professionals.
- Identify ways and opportunities to require licensed healthcare professionals to receive training in suicide assessment, treatment, and follow-up care.



THE ALABAMA STATE DEPARTMENT OF EDUCATION SHOULD

- Report annually to the Governor, the Legislature, and the State Suicide Prevention Plan Advisory Committee on school-aged suicide ideation, attempts, and deaths by doing the following:
 - Developing a reporting protocol of school-aged suicide ideation, attempts, and deaths.
 - Conducting a regular review (at least annually) of school-aged suicide ideation, attempts, and deaths.
- Update Alabama's Model Policy for Suicide Prevention to provide guidance and protocols that are in line with recognized standards.
- Require annual reporting on the number of certificated personnel required to receive training, the number that received training, and the training program or curriculum used.
- Develop a list of approved training materials for certificated personnel to satisfy the requirements of the Jason Flatt Act.
- Identify potential locations where suicide ideation, attempts, and deaths are more frequent as locations of emphasis to provide on-site suicide prevention training within the area LEAs.
- Require school-based mental health coordinators to implement school-wide risk assessments in middle and high schools at least once annually.
- Investigate and determine the feasibility of an evidence-based or best practice statewide student curriculum to address associated risks and protective factors among school-aged children.

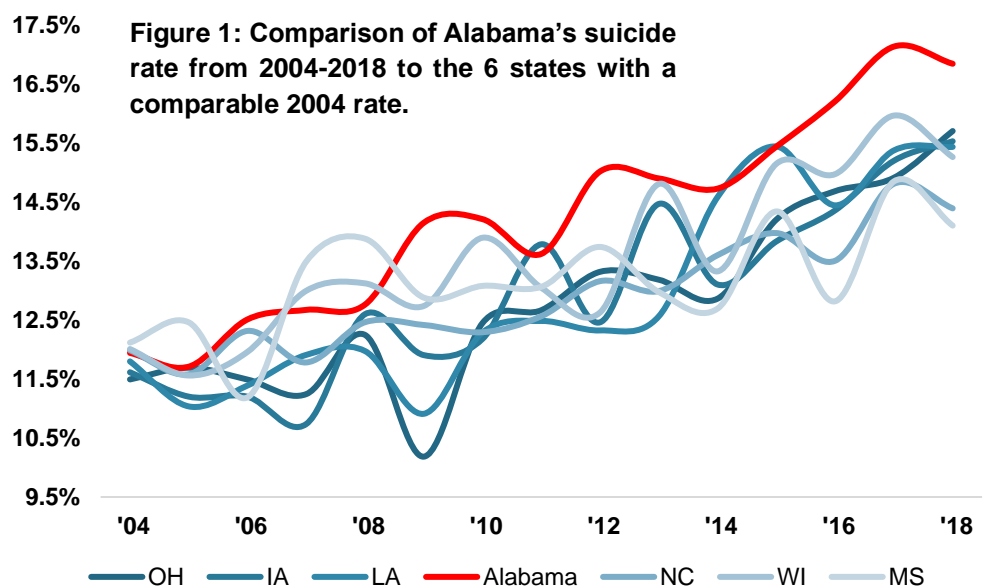


BACKGROUND

Nationally, suicide is recognized as a serious public health concern. New research shows that most suicides are related to mental health disease; with depression, substance use disorders, and psychosis being the most relevant risk factors, making it appropriate to deem it a serious mental health concern as well.⁴ Individuals experiencing acute or chronic substance use disorders have a 10-14 times greater risk of death by suicide and more than 50% of individuals who die by suicide suffer from major depression or mental health disease.^{5, 6} This is especially important because Alabama ranks 47th in the United States in mental health providers per capita.⁷ In spite of Alabama's increased awareness efforts in suicide prevention over the last several years, suicide continues to be on the rise, with the majority of suicide related deaths occurring in white, middle-aged males. Alabama has been unable to target resources towards addressing suicide attempts by demographics and location due to a lack of data. With national estimates as high as 30 attempts for every death, Alabama cannot identify suicide clusters to launch specific prevention efforts toward at-risk populations.

Suicide is a significant health outcome for Alabama because the behaviors associated have extensive impacts that are both physical and emotional, with numerous rippling effects on families, communities, resources, healthcare systems, and governments. Appropriate suicide prevention strategies can vary based on risk and protective factors of target populations as well as the social and environmental factors of their locations. With little data and few evaluations, Alabama continues to take broad approaches instead of targeted strategies to impact this rising issue. For Alabama to properly address these factors, program and impact evaluations should be regularly conducted to improve strategies and health outcomes for Alabamians.

Reporting of suicide rates continually lag about two years behind present day. Alabama's current suicide rate – from 2018 – is 16.84 per 100,000 persons. That



SOURCE: CDC Data



rate ranks 29th among the states, with the veteran suicide rate among the worst in the nation.^{ii,8} The national suicide rate was 14.78 in 2018. Though Alabama's annual state rank of suicide rate was between 24th and 30th from 2010 to 2018, Alabama's rate-of-change compared to other states is worse. This indicates that Alabama's suicide rate is growing at a faster rate than comparable states. (See **Figure 1**)

Not unlike many states, Alabama's first plan to address suicide in the state was developed in response to *The Surgeon General's Call to Action to Prevent Suicide*.⁹ Alabama convened a multi-disciplinary Suicide Task Force, which was called together by the State Health Officer and Commissioner of Mental Health. The Suicide Task Force first met in 2002 and published the state's first and only published Suicide Prevention Plan in 2004.¹⁰ Despite increasing suicide rates in Alabama, there has not been a published, actionable plan for agencies and consumers across the state since 2004, an anomaly among other states.

From the outset in 2004, establishing funding was a primary objective of the Suicide Task Force. However, between 2004 and 2012 no consistent funding could be established and the task force – currently organized as ASPARC – shifted its focus to raising awareness and seeking funding.

Funding was ultimately secured by ADPH through the GLS competitive grant in 2012 to implement the AYSPP program. The GLS grant's purpose is to support the implementation of youth suicide prevention and early intervention. To remain competitive for the GLS grant opportunities, ADPH developed, but did not publish, updated state plans in 2015 and 2019 that continued to borrow heavily from the National Strategy and were focused on the target population of the AYSPP program – youth and youth-serving organizations.

With ADPH's focus on its own program, ALSDE has implemented its own separate initiatives around suicide prevention based on legislative mandates and increased mental health needs in schools. Collaboration between AYSPP and schools happens between regional AYSPP partners and local schools, without the facilitation of ALSDE. ALSDE also works with ADMH to implement elements of SBMH, but these elements do not fall within the purview of the state suicide prevention plan. In fact, ALSDE's sole responsibility under the unpublished 2019 state plan was to incorporate a new survey question into the YRBS at no additional cost to the state.

Historically, the armed service branches and the VA have been areas of focus and proving grounds for suicide prevention efforts. The Alabama Department of Veteran Affairs exists to assist former members of the U.S. Armed Forces and their dependents in numerous capacities. Currently the department is working with the Alabama Veteran Suicide Task Force and SAMSHA's Governor's Challenge on Veteran Suicide Preventionⁱⁱⁱ to help address veteran suicide in Alabama.

For more detail on the suicide prevention efforts of these agencies see **Appendix I**.

Garrett Lee Smith Memorial Act

To address many of these needs among adolescents and young adults, Congress passed, and President Bush signed into law in October 2004, the Garrett Lee Smith Memorial Act. The act made federal funding widely available for the first time to states, tribes, and colleges across the nation to implement community-based youth and young adult suicide prevention programs. To date, ADPH has received two GLS grants:

- Cohort 7 – FY13-FY15
\$479,675 per year
- Cohort 11 – FY17-FY21
\$736,000 per year

Youth and Youth Serving Organizations

AYSPP designates youth as individuals ages 10-24. According to the CDC, child deaths under the age of 10 are not recorded as suicides.

ⁱⁱ Alabama's 2016 Veteran suicide rate was 34.1.

ⁱⁱⁱ With the goal to prevent suicide — not just among Veterans — PREVENTS seeks to change the culture surrounding mental health and suicide prevention through enhanced community integration, prioritized research activities, and implementation strategies that emphasize improved overall health and well-being.



Focus Areas

Recommendations were built around four focus areas that will address existing shortfalls and position Alabama for long-term success:

Authorize – Make changes to that leadership and staffing of suicide prevention efforts to promote better management and accountability.

Collaborate – Create an environment of partnership and strategic planning that is all encompassing of Alabama's stakeholder and populations.

Sustain – Maintain stable funding necessary to develop consistent staffing and activities.

Analyze – Collect meaningful information to allow for responsiveness and evaluation to be integral parts of suicide prevention efforts.

Table 2: 2018 rank of leading and surrounding states by suicide rate

State	Rank of Suicide Rate
New Jersey	2
New York	3
Rhode Island	4
California	7
Delaware	9
Florida	28
Georgia	18
Kentucky	31
Mississippi	15
Alabama	29

SOURCE: CDC Data

EXPLANATION OF FINDINGS

This evaluation looked primarily at the three agencies overseeing various aspects of the suicide prevention framework. While each of those agencies – ADMH, ADPH, and ALSDE – all work together in some aspects of suicide prevention, they each play unique roles in the delivery of services that lacks a strong history of collaboration.

In reaching the key findings and recommendations, ACES examined four major objectives:^{iv}

- (1) Compare and analyze state efforts to prevent suicide as they relate to the state plan.
- (2) Conduct a review of suicide prevention activities within healthcare settings in Alabama.
- (3) Conduct a review of school-based suicide prevention programs and activities in Alabama.
- (4) Analyze the relationship between suicide rates during economic recessions and unemployment duration in Alabama.

Findings and recommendations developed around four focus areas designed to directly address weaknesses and strengthen existing efforts in the state infrastructure. In order to form the basis of the findings and recommendations that follow, ACES relied on (1) established and recent research, (2) recommendations from nationally recognized organizations, and (3) the infrastructure, activities, and programs from leading and surrounding states. This report details 11 critical findings developed by ACES's analysis and presents recommendations to make improvements.

NO SINGLE ORGANIZATION IS RESPONSIBLE FOR COORDINATING THE STATE'S SUICIDE PREVENTION EFFORTS, RESULTING IN NO FEWER THAN FOUR STATE AGENCIES AND MULTIPLE PARTNERS IMPLEMENTING A FRAGMENTED SYSTEM.

Due to the limited resources available, Alabama's efforts to develop a state plan should equally develop a strategic partnership between state agencies; local community providers; and primary, secondary, and post-secondary schools which increases organizational capacity to coordinate and integrate resources between organizations. ADPH has taken the lead by initiating the development of the state plan, awareness campaigns, and coordination. However, the efforts deployed are uneven and isolated in many instances. The lack of overall coordination has left key stakeholders out of the process, which further hinders the sparse collaboration that does exist. The state's most updated unpublished plan did not have participation from many public-private stakeholders to include: Department of Senior Services, Department of Human Resources, faith based-communities, gun shop owners,

^{iv} Findings and recommendations were identified for the first three objectives. The analysis and results around the fourth objective can be found in **Appendix II**, as it did not result in an actionable recommendation.

homeless coalitions, pharmacy groups, primary care providers, law enforcement, or emergency responders.

SPRC supports the identification of a lead organization to develop and publish the state suicide prevention plan. According to SPRC, identifying and authorizing a lead division or organization that can provide centralized suicide prevention leadership will maximize coordination of efforts among all groups involved in suicide prevention and contribute to a more comprehensive approach. The lead entity could be any one of the following:

- A program within a dedicated state agency or department
- A government-appointed council or coalition
- A nonprofit agency appointed by the state
- A public-private coalition

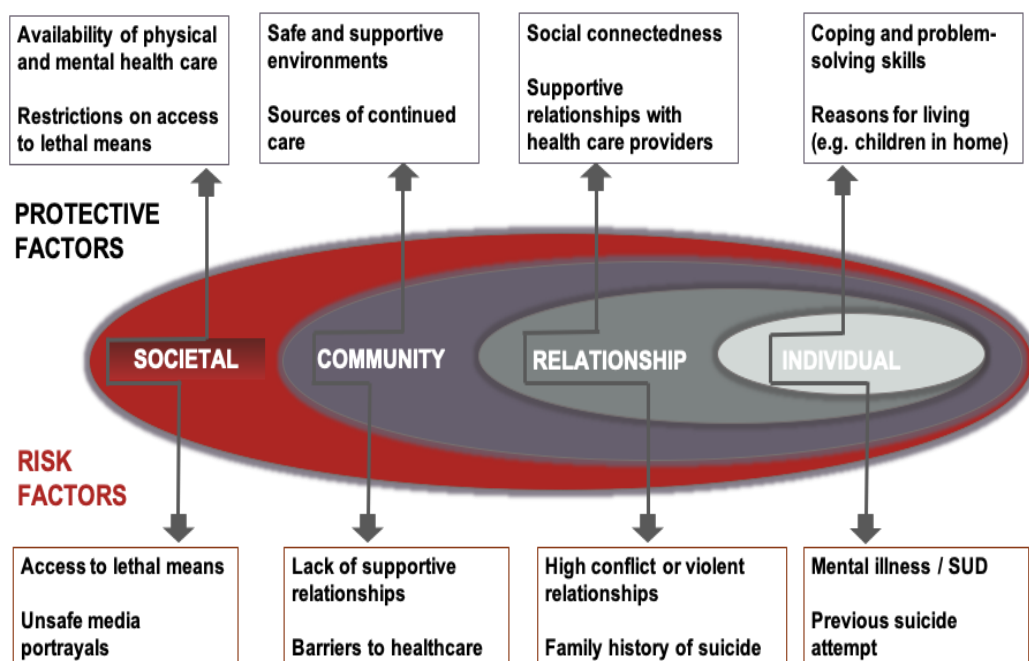
The Governor or the Legislature should formally recognize an agency or organization to lead statewide suicide prevention efforts.

ALABAMA'S STATE PLAN FAILS TO ADDRESS ASSOCIATED RISKS AND PROTECTIVE FACTORS.

Identifying and addressing suicide risk and protective factors in the state plan follows the *National Strategy's* procedure to achieve increased knowledge and direction based on the national framework and its recommendations. The *National Strategy* defines risk and protective factors associated with suicide and establishes the framework for effective suicide prevention efforts. Specifically relating to risk and protective factors, the NSSP calls for the development, implementation, and monitoring of effective programs that promote wellness and prevent suicide and related behaviors within clinical and community services. Within the NSSP, both chronic and acute suicide risk factors and protective factors are identified.

Working towards a comprehensive suicide prevention approach includes acknowledging and identifying risk and protective factors. Alabama's current, unpublished suicide prevention plan does not identify or address risk and protective factors that are common among most populations and even removed access to lethal means which is well-studied and was included in the original 2004 plan and the *National Strategy*. For more information on reducing access to lethal means, see **Appendix III**.

Risk and protective factors provide areas of importance for interventions that help prevent suicide. According to SPRC, "identifying risk and protective factors plays a critical role





“Alabama is only one of two states that does not currently require reporting of hospital discharge data.”

in several strategic planning steps". While the unpublished state plan does not identify and address the associated risk and protective factors for suicide, the current goals have the potential to expand in this area by addressing the nationally known associated risk and protective factors of suicide.

There is also potential for identifying risk factors specific to Alabama's population through collecting, analyzing, and the timely monitoring of data. In order to do so, Alabama must begin to address some unique data limitations. Alabama is one of only 2 states that does not currently require reporting of hospital discharge data. This single source of information is a vital piece to better understanding the areas and populations that are at greatest risk of suicide. However, this is only one example of the data limitations.

Data is often treated as an afterthought. Data is not integrated into the program designs or new strategies. This is best highlighted by a desire to identify new data sources being a goal of our state plan since its inception in 2004. ADPH has made strides in recent years to remedy some of these issues by building a syndromic surveillance system that could be used to better target resources; however, that data is not regularly analyzed or even accessible.

The system of agencies requesting data from each other often produces unreasonable delays. The process of multi-agency data systems means that real time access to all meaningful forms of data does not exist. No agency can deploy resources in response to suicide clusters in a timely and meaningful way. As an example, requests have been made to the State Health Planning Organization for Patient Origin Surveys since March. Those requests were met with either internal re-routing or total non-response. Once a response was finally given, more hurdles were introduced. As of the close of this evaluation – 5 months after the initial request – ACES was still unable to receive and review the records.

There are similar examples with collaboration. On one particular data set, three groups that all participated in gathering the data had some limitation of either knowledge or access to the actual data. While there are usually justifiable reasons for this disjointed system, it further highlights how difficult it is to access, analyze, and act upon data in our state. Even though some schools and school systems identify and track suicide ideation, attempts, or threats of self-harm, ALSDE does not require any reporting of suicide ideation, attempts, or threats of self-harm that could lead to another useful data set.

Alabama should begin to address these shortfalls by requiring data to be reported in a manner that is not overly burdensome, yet easily transferrable and reviewable. Until Alabama begins to collect, analyze, and monitor population specific risk and protective factors, the state can utilize national guidelines that drive evidence-based programs to address suicide prevention.

THE STATE PLANS HAVE NOT BEEN DEVELOPED USING DATA AND EVALUATION TO EXAMINE CHANGES IN THE AT RISK-POPULATION.

There are two driving forces behind updates to the Alabama State Plan for Suicide Prevention. The first is the federal competitive grant process and what those grants require from a state suicide prevention plan. The second is the National Strategy. Each time a state plan was developed or updated; the National Strategy has been



the main source for developing goals and objectives. The reason for the state updating the plan each time since 2004 has been to remain competitive for federal grants.

Alabama has had 3 state plans for suicide prevention. The first plan began being developed in 2002 and was first published in 2004. That plan remained in place until 2015, when a new plan was developed under the expiring GLS Cohort 7 grant. That plan was never published. During the first quarter of FY19, the state plan was again updated, and again unpublished. Although currently unpublished, each of the agencies and contract partners operate on the 2019 plan.

The National Strategy calls for each state to maintain a comprehensive plan that guides and coordinates suicide prevention activities. According to SPRC, plans should be updated every 3-5 years to reflect changes in the at risk-population and adapt to new data and evaluation findings which come about through evaluating each plan. Of the leading states, 4 have updated and published their state plans within the last 5 years. Two have plans that are expiring soon and two have old plans.

The historical reasons for updating the plan, means that Alabama has never evaluated its activities against its goals and objectives. Because no versions of the state plan incorporated accountability measures such as annual public reporting or evaluation components, the state plan planning committee is left to use largely the same process it did for the first state plan in 2004. If the state plan does not incorporate data into its objectives and continues to develop data through those objectives, evaluating the impacts of the plan can only be done using long term data points such as suicide rate or survey results. While these long-term data reflect the overall objectives trying to be impacted, there are numerous variables that may play a role in impacting those objectives that are not addressed in long-term data. The plan should incorporate short-term objectives, such as suicide attempts and crisis response, and routinely collect data on them in order to measure the impact of activities.

ALABAMA LACKS A COMPREHENSIVE PLAN THAT ADDRESSES THE ENTIRE AT-RISK POPULATION.

Alabama has not identified a lead organization or established the necessary staff to develop and publish a comprehensive and achievable state suicide prevention plan. The development of the state plan has been driven by ADPH to address the target population served by AYSPP and to seek grant funding for that program. This means that the state plan and the activities developed under it have primarily been focused on youth ages 10-24. As such, a large contingent of the at-risk population is not included in any sort of statewide strategy to address the issue of suicide. According to SPRC, a state plan should:

- Encompass the entire at-risk population.
- Identify risk and protective factors.
- Be measured and evaluated for success.
- Be published every 3 – 5 years using timely data to inform strategic plan.

Developing Data through Measurable Outcomes

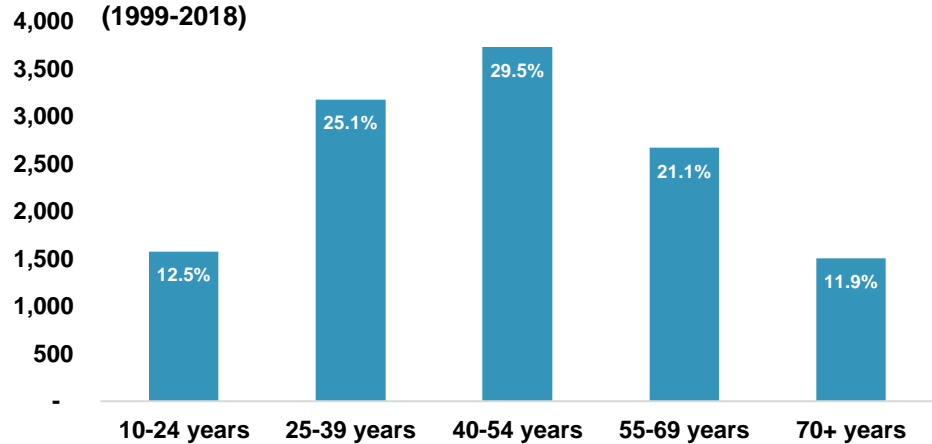
ADMH's Office of Prevention's current Strategic Plan for FY 19-22 has a measurable outcome to reduce the substance-related suicide completions by 3%. The strategic plan states that the collaboration and planning efforts of substance abuse prevention and suicide prevention has increased to establish comprehensive strategies to address associated risk and protective factors seeking to reduce the substance-related suicide completions statewide.

“Because no versions of the state plan have incorporated accountability measures such as annual public reporting or evaluation components, the planning committee for the state plan is left to use largely the same process it did for the first state plan in 2004.”



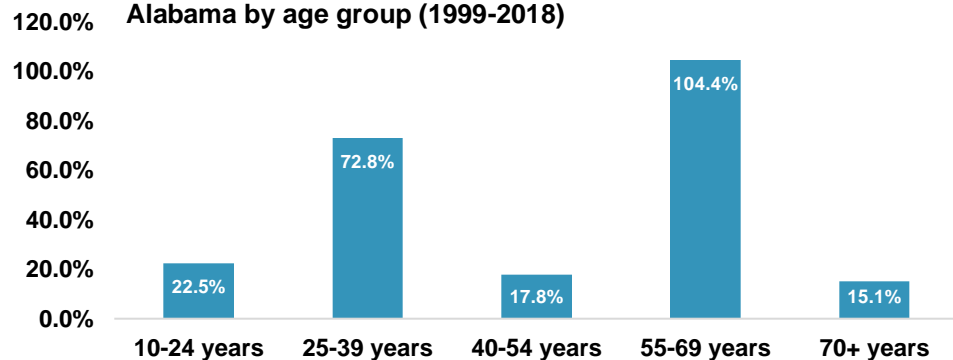
As seen in Figures 2 and 3, the youth population targeted by AYSPP – and subsequently the state plan – makes up less than 13% of the total suicides in Alabama. By not addressing the other populations, the organizations and agencies that regularly deal with these populations are also not engaged in a statewide strategy to target them. Developing a more comprehensive state plan presents the opportunity to engage a broader group of stakeholders. The designated lead organization should work to expand the State Plan Planning Committee to include these stakeholders.

Figure 2: Percent of total suicides in Alabama by age group (1999-2018)



SOURCE: CDC Data

Figure 3: Percent change in number of annual suicides in Alabama by age group (1999-2018)



SOURCE: CDC Data

Two states have specifically developed separate adult and youth suicide prevention plans to assist in reaching people of all ages while two others have only youth plans. This strategy may be relevant to Alabama's current situation. As Alabama seeks to develop a comprehensive state plan, it may become more prudent to define separate youth and adult plans. This approach has its advantages. Youth and adult populations are unique in both mindsets and ability to target. As noted, Alabama has activities targeting youth but the same cannot be said for adults. As the lead organization and planning committee look to address the adult population with a measurable and actionable state plan, it may look to those states with separate plans to determine if that approach would work best in Alabama.

COLLABORATION, MANAGEMENT, AND DELIVERY OF SUICIDE PREVENTION ACTIVITIES IS INEFFICIENT & INEFFECTIVE DUE TO A LACK OF DEDICATED STAFF.

Similar to the lack of a responsible organization, no one person is responsible for overseeing the statewide suicide prevention efforts. While it is clear that ADPH and ADMH have leadership roles, the only current full-time suicide prevention staff is the program manager for the federally funded AYSP. Further, ADPH has only been able to fully staff the AYSP program intermittently. According to ADPH, a full staff under the current Cohort 11 grant (FY17-FY21) would require a full-time program manager and at least a .5 FTE Program Evaluator. That has only been the case for 19 of the 48 months of the current grant. One reason for this is that FY16 was a gap year in grant funding where existing personnel moved to other programs. ADMH has also identified the need for an *internal* Suicide Prevention Coordinator which was filled by the department on September 1, 2020.

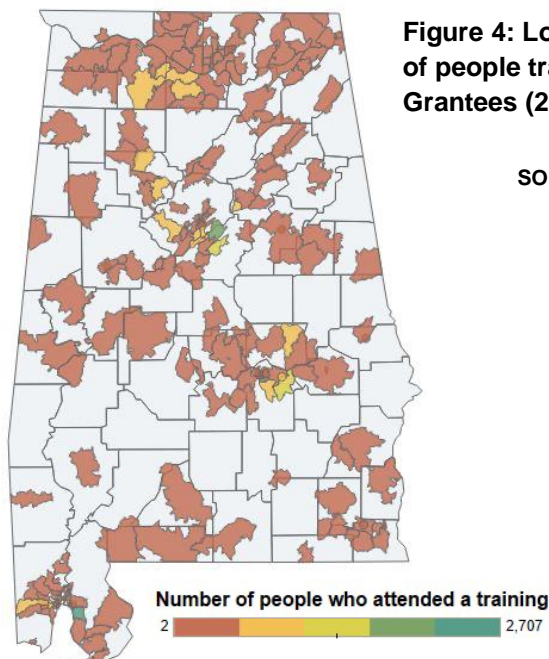


Figure 4: Location and number of people trained by AYSP Sub-Grantees (2017 to May 2020)

SOURCE: AYSP Training Data

A comprehensive approach to suicide prevention requires the time and capacity to coordinate multiple state and private organizations. Alabama has approximately 30 organizations addressing suicide prevention. The limited coordination of these organization's activities causes delays and even missed funding opportunities. Successful coordination of many organizations and efforts requires a consistent and dedicated infrastructure to sustain the investment of a data driven approach for all populations.

Lack of dedicated staff can be seen in the management of certain programs. QPR is a bedrock program under ADPH's AYSP program. It is designed to be delivered to groups of less than 35 participants except for in specific circumstances.^v After reviewing training data from FY17 through May of FY20, ACES found that QPR was

^v According to the QPR institute, one additional instructor, counselor, or mental health professional should be available for every additional 35 participants. It is possible that some of these trainees met this requirement, but ACES determined that it was not tracked to ensure fidelity.

Fidelity

ASPARC has received \$175,000 (15.8% of sub-grantee funding) from the AYSP program since FY17 to provide QPR Gatekeeper Trainings.

During the 3.5 years, ASPARC has only provided 4.5% of the total trainings. Of the 3,307 people trained by ASPARC, only 30.7% (1,015) were trained to program fidelity.

While already the most expensive provider per participant, if you only consider those 1,015 participants that were properly trained the average cost per participant is 84% higher than the next highest cost provider. (\$134.35/per participant compared to \$50.45)



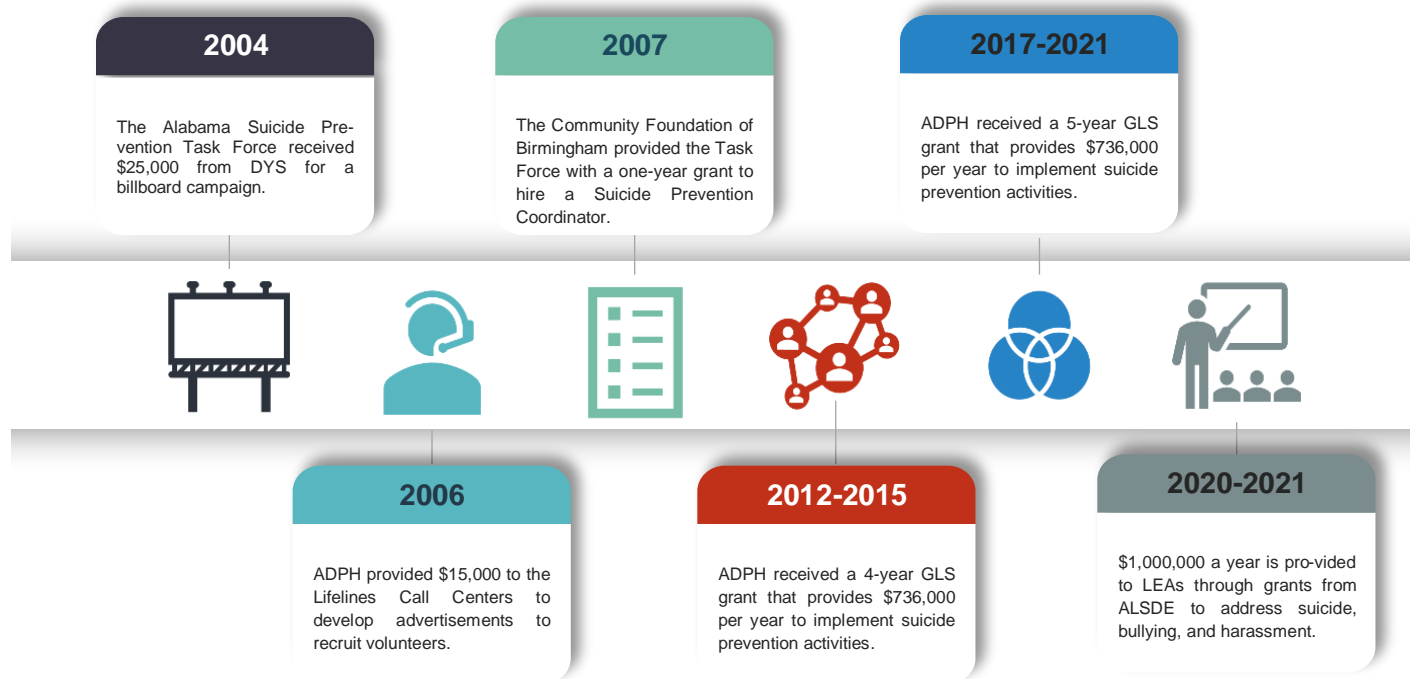
delivered to more than 35 participants for more than 11% of trainings. This means that as many as 6,254 participants of the total 17,690 were not trained to fidelity.

Many of the leading states maintain designated leadership positions or staff to manage and coordinate the activities of the state. SPRC also recommends having a dedicated leadership position and core staff required to oversee the function of a state plan. A dedicated suicide prevention coordinator works to resolve the state's data problems, takes advantages of all funding opportunities, and increases the efficiency and effectiveness of statewide efforts ensuring programs are implemented to fidelity.

LACK OF CONSISTENT, DEDICATED FUNDING HAS RESULTED IN LACK OF CAPACITY AND COLLABORATION, MISSED OPPORTUNITIES, AND OTHER INEFFICIENCIES THAT HAVE PREVENTED EFFECTIVE SUICIDE PREVENTION EFFORTS.

Alabama has never funded a statewide suicide prevention plan or program. Additionally, funding opportunities to increase capacity and efforts within the state have been missed. As a result, Alabama has been unable to meet the nationally established goals for effective programs such as call center answer rates.

Figure 5: Funding dedicated to suicide prevention efforts since 2004



SUICIDE PREVENTION LIFELINE CALL CENTERS

Alabama has three Suicide Prevention Lifeline call centers, two are available 24 hours a day and one operates during normal business hours. Alabama's most recent quarterly in-state call answer rate was 67%. The National Suicide Prevention Lifeline's in-state call answer rate goal is 90%.¹¹ Lifeline call centers with an in-state answer rate less than 90% are less effective at early intervention because the call is routed to a neighboring call center, causing longer wait times and inefficient linkages to local treatment, support, and crisis/emergency services.



Lifelines that are effectively resourced are more efficient and effective at:

- Referring a person in a mental health crisis to a trained counselor who can address their immediate needs and help connect them to ongoing care.
- Reducing health care spending with more cost-effective early intervention.
- Reducing the use of law enforcement, public health, and other safety resources.
- Meeting the growing need for crisis intervention at scale.

According to the call centers and ADPH, Alabama does not currently have the funding to increase the capacity to reach the 90% in-state call answer rate.^{vi} Although aware of this funding need, a two-year grant funding opportunity was recently missed. ADMH could not produce the required cooperative agreements necessary to apply for the opportunity. By the time ADMH notified ADPH that they would be unable to complete the application, ADPH did not have enough time to complete the application process. Even though Vibrant listed the state as eligible in the RFP, the lack of timely coordination between state agencies caused Alabama to lose out on this grant opportunity.

Increasing the in-state call answer rate to 90% would decrease the amount of calls forwarded to out-of-state call centers and increase the number of callers directed to local resources.

OTHER FUNDING OPPORTUNITIES

COMPREHENSIVE APPROACH TO SUICIDE PREVENTION

The CDC released a funding opportunity for the implementation and evaluation of a Comprehensive Approach to Suicide Prevention with funding up to \$700,000 per year for five years. Neither ADPH nor ADMH applied for this opportunity.

Upon learning that neither agency intended to apply for this grant coupled with the knowledge that Alabama could potentially be without suicide prevention funding, the SAM Foundation applied for this grant opportunity. The SAM Foundation has become one of the leading facilitators of suicide prevention training in the Northeast part of the state. They have not yet been notified if they received the grant.

IMPLEMENTATION OF THE NATIONAL STRATEGY

SAMHSA has twice released funding opportunities – 2017 and 2020 – to implement the *National Strategy* and support states and communities in advancing efforts to prevent suicide and suicide attempts among adults age 25 and older. The grants

Missed Opportunity

Vibrant, the administrator of the National Suicide Prevention Lifelines released a request for proposal for FY20-21 to assist with state capacity building through grant dollars. Alabama was one of 21 eligible states but failed to submit a proposal.

Preliminary results from states that received the grant funding have already shown positive results with increased in-state answer rates while also dealing with a higher call volume.

988 National Suicide Number

In July, the Federal Communications Commission's five leaders unanimously voted to finalize 988 as the three-digit number Americans can dial and be directed to the 24/7 national hotline.

Over the next two years, phone service providers will begin the transition process to implement the 988 number nationwide.

Also, Federal legislation is currently proposed that would direct the Federal Communications Commission to designate 9-8-8 as the universal telephone number for the purpose of the national suicide prevention. If this legislation is passed, states would have the flexibility to collect fees from phone service providers similar to 911 fees.

In calendar year 2018, Alabama collected a total \$106,276,266 from its \$1.75 per line 911 fee.

^{vi} According to Alabama Lifeline Call Centers, as much as \$875,000 would be needed to fund enough staff to raise the in-state answer rate to 90%. According to the National Suicide Prevention Lifelines, in a two-year period, Alabama would need to answer 4,375 more calls in Year 1 and 5,031 more calls in Year 2, to adjust from a current 65% in state answer rate to an 80% in state answer rate.



provided funding up to \$471,000 per year for 3 years. Neither ADPH nor ADMH applied for these opportunities.

Together, these missed opportunities amount to potentially \$4.9 million that could have enhanced Alabama's suicide prevention efforts.

THE MODEL POLICY DEVELOPED BY ALSDE UNDER THE JASON FLATT ACT DOES NOT EFFECTIVELY ADDRESS SUICIDE PREVENTION OR AWARENESS.

ALSDE's history with suicide awareness and prevention can be captured by the events and activities that took place surrounding two legislative acts, The Student Harassment Prevention Act (2009-571) and the Jason Flatt Act (2018-472). The Student Harassment Prevention Act – subsequently renamed the Jamari Terrell Williams Student Bullying Prevention Act in 2018 – dealt mostly with acts of violence, threats of violence, and harassment, but did contain two notable provisions related to suicide prevention. The first required ALSDE to develop a model policy which, at a minimum, was required to contain a procedure for reporting a threat of suicide. The second notable provision *requires* each school system to implement “standards and policies for programs in an effort to prevent student suicide.” That requirement, however, is subject to the provision of funds by the Legislature or local boards. Since 2009, there has been no direct appropriation of funds by the Legislature for such purposes.

In 2016, the Jason Flatt Act was enacted to provide further requirements of schools and ALSDE regarding suicide prevention in schools. The act amended Section 16-28B-18 which contained the requirement to implement standards and policies for programs in an effort to prevent student suicide. The act also created an advisory committee to assist ALSDE with carrying out its responsibilities under the law. One of those responsibilities was for ALSDE to develop a model policy for student suicide prevention. This model policy was supposed to assist LEAs that were required to adopt a policy for student suicide prevention under the law.

The Model Policy on Alabama's Jason Flatt Act developed by ALSDE and the advisory committee consists of three parts: (1) an introduction to the Jason Flatt Act and a statistical breakdown of the issue of suicide among youth; (2) a verbatim list of the 13 standards contained in Section 16-28B-8 (12 of which were part of the law since 2009); and (3) an expectation of students to comply with the rules of the school system.¹² This model policy was developed within the first, two-day meeting of the committee and disseminated to local Superintendents of Education prior to the next meeting of the committee. The policy has not been updated since 2016.

Requirements for model policies can be seen in several states. One such model policy from the Georgia Department of Education¹³ includes provisions for *Suicide Screening, Assessment and Referral, Crisis and Access Line information, Signs of Depression or Severe Emotional Distress, Parental Notification and Involvement*, and even protocols for both *In-School* and *Out-of-School Suicide Attempts*. The Model Policy for Suicide Awareness, Prevention, Intervention and Postvention also includes detailed action plans for *Suicide Attempt and Suicide Ideation* and *Suicide Death*. the American Foundation for Suicide Prevention also has a model policy similar to Georgia's.¹⁴ These examples and others address, at a minimum, the following:

Since 2009, there has been no direct appropriation of funds by the Legislature for suicide prevention training or programs in schools.



- Suicide prevention and intervention activities.
- Suicide attempt response protocol.
- A protocol for notifying parents, administrators, and crisis team members of an attempt or threat of harm.
- School re-entry procedures.

ALABAMA’S SUICIDE PREVENTION EFFORTS IN SCHOOLS ARE INEFFECTIVE AND INEFFICIENT DUE TO THE UNMANDATED AND UNDERREGULATED APPROACH TO TRAINING PERSONNEL.

An additional requirement under the Jason Flatt Act called for annual training for all certificated school employees in suicide awareness and prevention. Because this addition was added to the existing Student Harassment Prevention Act law, it too became subject to the provision of funds by the Legislature or local boards.

Alabama is one of 20 states to pass legislation known as “Jason Flatt Acts” that require or recommend that school personnel receive suicide prevention and awareness training. Seventeen of those states have an unfunded mandate for personnel to be trained; in many cases the training is annual. While two states, California and Wyoming, appoint an existing funding source that may be used to provide the training, no *Jason Flatt* states dedicate funding specifically to provide the training. While none of the states dedicate funding to suicide prevention training of school personnel, Alabama is the only state that made the mandatory training subject to funding being provided. This distinction has not prevented Alabama school systems from providing or requiring training, but it has limited ALSDE’s effort to regulate and evaluate the trainings.

“While none of the states dedicate funding to suicide prevention training of school personnel, Alabama is the only state that made the mandatory training subject to funding being provided.”

Additionally, the advisory committee was tasked under the Jason Flatt Act to assist ALSDE in developing rules to provide for training certificated employees. Despite the requirement for ALSDE to develop and adopt rules to provide for training, the committee did not assist the department in that process. The only rule, as it pertains to that requirement, appears to be a requirement of schools to report to ALSDE whether they completed the training each year.

The information collected is of little value to the state. No information is collected on the number of certificated employees that received training, the type of training utilized, or the cost to provide the training. No data that could be used to evaluate trainings or target future resources is collected and there is no follow-up by ALSDE for schools that did not complete the training. The result is an inefficient use of time and resources. Without meaningful information being collected and analyzed, the effort to report and collect the information would be best spent elsewhere.

WITH NO APPROVED LIST OF TRAINING MATERIALS, THE APPROACHES TAKEN BY SCHOOLS TO TRAIN CERTIFICATED PERSONNEL IN SUICIDE PREVENTION ARE FRAGMENTED ACROSS THE STATE.

ALSDE was given authority to develop a list of approved training materials for certificated employee trainings under Jason Flatt. No list was developed with the assistance of the advisory committee in 2016 and no list has been developed in the years following. The advisory committee did help ALSDE develop training material for certificated employees and produced summary resources that are available on



Cost-effective, Evidence-Based Risk Assessments

ASQ - Ask Suicide-Screening Questions is a **free** suicide-risk screening tool with **free** training resources that utilizes a short 4-part questionnaire that identifies individuals who require a more in-depth suicide assessment. The ASQ was developed for use in the medical setting and designed for screening youth ages 10-24 and validated by the National Institute of Mental Health.

C-SSRS – The Columbia-Suicide Severity Rating Scale is a **free** suicide risk screening assessment tool with **free** training that utilizes simple language to identify the full spectrum of suicidal ideation and suicidal behaviors. The C-SSRS assists in identifying the severity of the person being screened, is available for everyday use, and is tailored to be used by anyone, including varying consumers such as healthcare providers, researchers, family, first responders, military, schools, and corrections. This tool is validated by the National Suicide Prevention Lifeline.

PHQ3 and PHQ9 – Patient health questionnaires that screen for depression. The PHQ-3 inquires about the frequency of depressed mood and includes the first 2 questions of the PHQ-9. Patients who screen positive should be further evaluated with the PHQ-9 to determine whether they meet criteria for depressive disorder. Evidence shows that the PHQ-9 screening is a strong predictor of suicide.

the ALSDE website.¹⁵ Prior to the beginning of this evaluation, those resources had been updated once since the advisory committee concluded its work in 2017.

Since no funding was made available for training, the advisory committee took the initiative to develop a training that could be completed in an hour or less. Those trainings and instructions on how to do the training were made available on the ALSDE website. Still, little is known about the training that teachers receive and no record of use for the state-created training is collected or reported. With no approved list of materials, the approaches taken by schools are fragmented across the state. Free online trainings, paid professionals, and community organizations are just some of the ways that schools have attempted to provide the required trainings.

Many states allow for the training to take place within the existing in-service programs, and 11 states require the training materials to be approved by a state agency, most commonly the state's department of education. Other states allow the education departments to develop guidelines, rules, and resources or require that training plans be submitted to the department. ALSDE should develop a list of effective trainings that equip teachers with the knowledge, skills, and experience to identify if a student is at risk; and, the appropriate measures must be taken to ensure that those students identified as at risk receive appropriate care.

INSUFFICIENT USE OF SUICIDE RISK ASSESSMENTS WITHIN HEALTHCARE SETTINGS AND SCHOOLS PREVENTS THE EFFECTIVE USE OF INTERVENTIONS FOR AT-RISK INDIVIDUALS.

Early detection of suicide is important to suicide prevention. While most experts agree that suicide training and immediate action is the key to reducing suicides, it is also agreed that it is equally important to concentrate efforts in settings where reducing suicide is most likely to occur.

According to the CDC's Suicide Prevention Technical Package, current evidence suggests that identifying people at risk of suicide and the continued provision of treatment and support for these individuals can positively impact suicide and its associated risk factors. Many organizations are using risk assessment tools and screenings to identify the people at risk for suicide ideation, and SPRC recommends a process or tool that can identify people at risk for suicide as an essential component of a comprehensive suicide prevention program.

RISK ASSESSMENT IN HEALTHCARE SETTINGS

In March 2019, ADPH provided a grant to the Office of Evaluation at the University of Alabama to conduct a *Stakeholder Analysis* to better inform their efforts to update the state suicide prevention plan. While still incomplete, the preliminary results from that analysis offer some details regarding the use of risk screening and assessment tools, response protocols, and training for staff of hospitals. Of the 41 medical facilities that provided usable responses, 29 use the C-SSRS suicide risk assessment tool and an additional 10 facilities – 95% in total – use some other form of risk screening tool. However, only 49% reported using a risk screening tool within emergency departments.

Even with the high rate of risk screening tool use and written protocols for screening, nearly 40% of hospitals acknowledged that the results of their protocol are not easily



identified in documentation and the staff are not trained on follow-up, referral, or post-discharge protocols and procedures.¹⁶ Additionally, when no written protocol for referral or post visit follow-up exists, staff are not trained even if the hospitals claim to implement the activities. For more information on these important steps and programs, see **Appendix IV**.

It is widely studied and generally accepted that suicide risk screening is a cost-effective means to identify individuals at risk of choosing suicide. In light of this and the recognition that suicide continues to be among the leading causes of death in the country, The Joint Commission^{vii} and other accrediting bodies have taken steps in recent years to implement suicide prevention training and interventions. For more information on actions taken by accrediting bodies, see **Appendix V**.

While incomplete, the recent analysis of suicide risk screening tools in Alabama hospitals has some promising results about the use of suicide risk assessment tools. Because the analysis is incomplete, it is unknown (1) how and when those tools are used, (2) areas of the state that are using them, and (3) the training and protocols implemented to ensure appropriate treatment and follow-up is used. We do know that despite the need for broad implementation of suicide risk screening and intervention in emergency department settings recognized by the National Institute of Health, accrediting bodies, and other leading organizations, less than half of Alabama hospitals respondents acknowledged use of risk screening tools in emergency departments.¹⁷

In addition to risk assessment use, the *Stakeholder Analysis* also surveyed hospitals on the use of suicide prevention programs in their facilities. Of those that responded, no hospitals were using Zero Suicide – a nationally recognized framework for safer suicide care in health and behavioral health care systems – and only four acknowledge using a different program. More than 60% had never heard of Zero Suicide. ADMH has recently applied for a Zero Suicide grant from SAMSHA to deploy the Zero Suicide framework in Alabama. This is the first time Alabama has applied for a suicide-related grant beyond the GLS program.

While progress is slow, Alabama has the foundation to better identify those at risk for suicide. Based on the numbers from those facilities that responded, risk screening is being done in a large majority of Alabama hospitals. However, the lack of training, written protocols, and standardized responses means that at-risk patients do not always receive effective care. With increased standards from accrediting bodies like TJC, there is opportunity for better training and follow-up procedures to be deployed in Alabama hospitals.

Zero Suicide

The Zero Suicide framework is an organizational and systemwide commitment to safer suicide care in health and behavioral health care systems that uses three implementation elements and four clinical elements to significantly reduce suicide for those in the care of healthcare providers.ⁱ

Implementation Elements

1. Lead system-wide culture change committed to reducing suicides.
2. Train a competent, confident, and caring workforce.
3. Identify patients with suicide risk via comprehensive screenings and assessment.

Clinical Elements

1. Engage all individuals at-risk of suicide using a suicide care management plan.
2. Treat all suicidal thoughts and behaviors using evidence-based treatments.
3. Transition individuals through care with warm hand-offs and supportive contacts.
4. Improve policies and procedures through continuous quality improvement efforts.

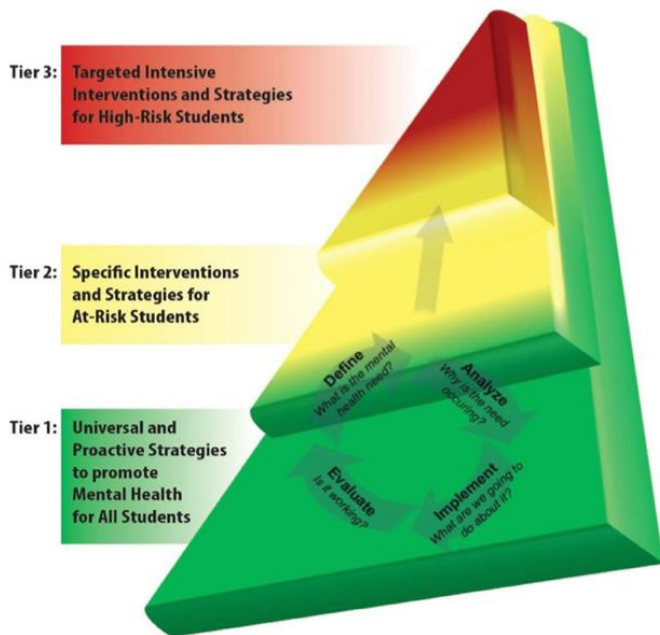
^{vii} The Joint Commission is a nonprofit tax-exempt 501(c) organization functioning as an accrediting body that develops patient safety and care standards for hospitals and other healthcare organizations.



RISK ASSESSMENT IN SCHOOLS

The three-tiered structure of school-based mental health programs in Alabama is designed to implement programs and interventions based on needs and risks to students. To date, a significant focus has been made to build out services in the top tier (**Tier 3**) through SBMH. During the 2020 Regular Session of the Legislature, funding was provided to further bolster SBMH by partnering Mental Health Coordinators with school systems. With the creation of this new position comes the opportunity to expand services, especially school-wide screenings and suicide risk assessments, to the bottom two tiers – **Tiers 1 and 2**.

An example of this approach can be found with ALSDE's Project Aware. This federally grant-funded program partners local school systems with ALSDE to implement the Ci3T model of prevention.^{viii} This evidence-based approach to creating supportive and safe learning environments is currently underway in six school systems in Alabama. The Ci3T model requires that these schools conduct school-wide universal screenings from a validated list of choices. The diversity of school systems that are currently piloting this system demonstrates that universal screenings are capable of being deployed in all schools in Alabama.



Wheeler, D. (2017). Student Support Services Project. Florida Department of Education and the University of South Florida.

SCHOOLS, LEAS, ALSDE, AND AYSPP PARTNERS ARE INCREASING THE EFFORTS TO PROVIDE SUICIDE PREVENTION PROGRAMS TO STUDENTS AT VARYING AGES AND GRADES.

In recent years, Alabama schools have begun using more programs to teach both teachers and students to identify risk factors. The diversity of these programs creates disparity across the state as some programs are only delivered to specific age groups or schools while others are designed for the entire K-12 school system.

Table 3 below shows some of the examples of programs used in schools currently. These programs are either nationally recognized or modeled after similar evidence-based programs. The table shows the disparity between programs' target audiences and current reach.

^{viii} Ci3T "Comprehensive, Integrated, Three-tiered" models of prevention assist schools in creating a comprehensive systems-oriented approach to (a) integrate efforts to support the academic, behavioral, and social competencies of all students; (b) promote collaboration and teaming between all school and community stakeholders; and (c) support educators' efficacy and well-being through data-informed professional learning, clear expectations for staff and students, and supportive, positive environments.



Table 3: Suicide prevention programs currently being delivered in Alabama schools

Program	Program Activities	Cost	# of Schools
Kognito's Friend2Friend	A 25-minute interactive, online learning activity for ages 13 – 18, that builds awareness, knowledge, and skills about mental health, suicide prevention, and aims to reduce the stigma associated with mental health.	\$25.00 per license or special pricing for districts and states needing 200 or more licenses.	20
Response	An evidence-based, high school-based suicide awareness program for students, staff, and parents. The program has a 2-hour awareness training for staff, four hours for students delivered across 4 class periods, and includes parent awareness materials.	\$425.00 for a school kit that includes the training video for staff, student curriculum, and parent awareness materials.	26
Thriveway PeerHelpers	A two-component system addressing tier 1 and tier 2 populations with an online tracking platform. Components include: <ul style="list-style-type: none"> • K-12 curriculum that covers substance use, abuse, mental health/suicide, and bullying. • Peer Helpers who are classmates, trained and supervised by professionals, that interact with other students to identify risk factors. 	Costs include: <ul style="list-style-type: none"> • Administration workshop - \$1500 • Coordinator training -\$4000 • Yearly program subscription - \$2500 Thriveway estimates an average cost of \$2800/year per school to fully implement its program.	334
LearnSafe	A computer monitoring intervention that helps faculty and staff identify students who have or may have potential behaviors and concerns, such as harming oneself or another.	Prices range from \$.39 to \$1.00 per device. The University of West Alabama, College of Education has applied for the STOP School Violence grant for the US Department of Justice to deploy the LearnSafe program to schools in the black belt region of the states in grades 7-12. Tele-mental health interventions will be deployed in coordination with the University of West Alabama.	180

Effective suicide prevention programs are essential to educating youth and preventing suicide. Depending on the program target, they can be narrowly focused or broadly implemented. As more schools are identifying a need for programs, Alabama should consider whether a statewide curriculum is a more efficient and effective option.



GIVEN THE LIMITED RESOURCES AVAILABLE, ALABAMA RELIES ON AN APPROACH TO TRAINING HEALTH CARE PROFESSIONALS THAT MAY BE EFFICIENT BUT IS INEFFECTIVE AT IMPACTING THE MUCH LARGER POPULATION.

As many as half of suicide patients received healthcare services and 24% received mental healthcare services in the month prior to their death.¹⁸

Highlighting the need for healthcare professionals to be trained in suicide prevention, the American Medical Association's 2018 Annual Meeting called for the engagement of organizations to facilitate the development of educational resources and training related to suicide risk of patients, medical students, residents/fellows, practicing physicians, and other health care professionals. The amended policy encourages the development of curricula and training for physicians that has a focus on suicide risk assessment, prevention, and lethal means counseling.¹⁹ These strategies and goals are supported by studies that confirm people that choose suicide have high rates and patterns of healthcare utilization in the year before suicide death.²⁰

That policy change falls in line with the *National Strategy* efforts to improve suicide prevention in healthcare settings. To begin making improvement, the goal to "promote suicide prevention as a core component of healthcare services" was included in the 2012 update.²¹

Despite the comorbidity of mental health disorders and suicide, many health professionals do not typically receive routine training in suicide assessment, treatment, or risk management. Mental health professionals regularly encounter individuals who are at risk of suicide. This lack of knowledge and training impacts their ability to provide comprehensive care for at-risk patients.²² Primary care providers also regularly encounter those same patients as well as many more that do not have a known diagnosed mental health condition but are still at risk.²³ In fact, primary care providers are more than twice as likely to encounter a patient at risk of suicide in the month prior to choosing suicide.²⁴ According to the American Academy of Family Physicians, "[s]creening for suicide risk and access to lethal means, even in apparently asymptomatic patients, is a critically important part of the family physician's role in reducing mortality and morbidity from mental illness."²⁵

Despite these encouragements and evidence for a competent workforce and the National Strategy recommendations being in place for 7 years²⁶, there still exists limited priority for state mandates or standards to guide healthcare providers in suicide prevention assessment, training, and follow-up. A recent survey of states showed that only 10 states required mental and behavioral healthcare professionals to complete training for identifying individuals at risk of suicide and for creating preventative action. Only three of these states, Nevada, Washington and West Virginia, include other types of healthcare providers, such as nurses and physicians. In Indiana, only emergency medical technicians are required to have suicide prevention training.²⁷ See **Table 4** for more information on the required trainings in these states.



Table 4: List of states that require healthcare professionals to receive training in suicide prevention

State	Required to Receive Training	Amount of Training
Kentucky	Social workers, therapists, counselors, and psychologists.	Requires 3-6 hours of training every 6 years.
Nevada	Psychiatrists, psychologists, therapists, clinical professional counselors, social workers, and detoxification technicians.	A condition to the renewal of their licenses or certificates.
New Hampshire	Pastoral psychotherapists, social workers, clinical mental health counselors, and therapists.	3 hours for biennial license renewal.
Utah	Therapists, social workers, and counselors.	2 hours as a condition of licensure.
Washington	(a) Certified or licensed advisers, counselors, chemical dependency professionals, marriage and family therapists, mental health counselors, occupational therapy practitioners, psychologists, advanced social workers, independent clinical social workers, and social worker associates. (b) Licensed chiropractors, naturopaths, nurses, nurse practitioners, physicians, physician assistants, physical therapists, physical therapist assistants.	(a) 3-6 hours of training at least once every 6 years. (b) 3-6 hours (one-time training)
West Virginia	RPNs, nurse practitioners, psychologists, social workers, and professional counselors.	2 hours for each reporting period for continuing education requirements.
Tennessee	Social workers, marriage and family therapists, counselors, psychologists, occupational therapists, and staff directly working in the field of mental health and substance abuse.	2 hours every 2 years
California	Psychologists.	6 hours at the point of licensure, renewal, or reinstatement.
Indiana	Emergency Medical Technicians	Complete a research-based training program concerning suicide assessment, treatment, and management that is: (1) demonstrated to be an effective or promising program; and (2) recommended by the Indiana Suicide Prevention Network Advisory Council.

Alabama has no requirements for medical professionals to be trained in suicide prevention. However, ADMH has worked collaboratively with ADPH and ASPARC to provide some trainings to their mental health therapists and staff in the 19 community mental health centers across the state. Since August of 2018, ASPARC has provided QPR trainings to nearly 400 hundred individuals in 13 mental health facilities throughout the state. Additionally, ADMH has reported to date at least 1,031 individuals trained in MHFA since 2016 through the community mental health centers across the state.²⁸

Alabama has made strides in recent years to increase the number of mental health professionals that have received some form of suicide prevention training. Like many states across the U.S., Alabama is working to raise awareness of the need for and availability of these trainings. Only a small percentage of states have taken legislative action to require suicide prevention training among mental health professionals and even fewer require other health professionals.



CONCLUSION

Alabama has seen a steady increase in suicide death rates among all age groups under 70 years old, most drastically in the 35-39 (13.16 rate increase) and 30-34 (9.44 rate increase) age groups over the last 20 years.²⁹ To better address this increase, changes to the current infrastructure should be considered.

THE GOVERNOR AND LEGISLATURE SHOULD CONSIDER

- Designating a lead organization or agency to develop and publish a comprehensive and achievable suicide prevention plan and require the state plan to be evaluated against defined performance metrics, updated, and published at least once every 5 years.
- Establishing and funding a full-time State Suicide Prevention Coordinator to coordinate all state suicide prevention efforts and report to the Governor and the Legislature annually on the progress and performance of activities under the state plan. The State Suicide Prevention Coordinator should also be required to identify grant opportunities for suicide prevention and coordinate responses among state partners
- Passing legislation requiring hospitals to report discharge data regularly to the Alabama Department of Public Health and ensure that data is made available (within a reasonable amount of time) to the State Suicide Prevention Coordinator, State Suicide Prevention Plan Advisory Committee, researchers, and evaluators to target resources and develop better suicide prevention programs.
- Identifying potential state funding mechanisms that provide stability to suicide prevention efforts by providing funding for National Suicide Prevention Lifeline call centers in Alabama.

THE DESIGNATED LEAD ORGANIZATION SHOULD

- Organize the State Suicide Prevention Plan Advisory Committee to include representatives from previously unengaged organizations who regularly engage at-risk populations, including the Governor's Challenge on Veteran Suicide Prevention.
- Together with the Advisory Committee, develop a comprehensive state plan for the entire at-risk population and meet at least quarterly to assess strategy and implementation, identify progress and obstacles, and plan future activities under the plan.
- Identify ways and opportunities to 1) increase the use of standardized suicide risk assessment tools in health care settings and schools and 2) require licensed healthcare professionals to receive training in suicide assessment, treatment, and follow-up care.

THE ALABAMA DEPARTMENT OF EDUCATION SHOULD

- Regularly review and report annually to the Governor, the Legislature, and the State Suicide Prevention Plan Advisory Committee on school aged suicide ideation, attempts, and deaths.
- Require annual reporting on the training of certificated personnel and identify target areas where suicide ideation, attempts, and deaths are more frequent to provide on-site suicide prevention training within the area LEAs.
- Investigate and determine the feasibility of an evidence-based or best practice statewide student curriculum to address associated risks and protective factors among school-aged children.



APPENDIX I: SUICIDE PREVENTION EFFORTS IN ALABAMA

ALABAMA DEPARTMENT OF PUBLIC HEALTH

With the inception of the first federal funds for suicide prevention, ADPH developed AYSPP to implement the activities proposed under the grant. As the only dedicated funds for AYSPP, efforts have focused on the planning and implementation of the grant activities. The purpose of the AYSPP is to develop and implement statewide youth suicide prevention and early intervention strategies that will include collaboration among schools, educational institutions, juvenile justice systems, foster care systems, substance abuse and mental health programs, and other child and youth-supporting organizations. Those activities have primarily consisted of awareness activities centered around a media campaign and gatekeeper trainings.

ADPH's Just Talk about It campaign was created in the early years of the AYSPP program and has seen regular updates to stay relevant to today's youth. The campaign's evolution has added other messages such as Know the Signs and Suicide-Proofing Your Home. These messages have been distributed throughout the state, including digital and social media platforms.

The gatekeeper trainings are offered through community partners that receive annual mini grants. ADPH partners with ASPARC, institutions of higher education, social workers, and five crisis centers located throughout the state to reach its target population. The design of this multifaceted approach is to allow for multiple exposure and intervention methods and more community engagement for Alabama's youth population. Since the award of the 2017 GLS grant, ADPH has trained about 43,740 participants in various programs and locations.

ADPH has continued efforts since 2016 to pilot a Referral Network System (RNS) in various locations and settings throughout the state. The RNS is designed to provide training, risk assessment, referral, and follow-up procedures and tracking in a single system. That system can provide data in real time to health care providers, ADPH suicide prevention staff, and evaluators to not only ensure appropriate identification, referral, and care of those at-risk of choosing suicide; but also allowing for dedicated staff to implement suicide cluster and crisis response plans. To date, ADPH has been able to partner with two institutions to implement the system which has resulted in 178 screenings since 2018.

RNS is a unique opportunity for Alabama. The development and implementation of a program that both identifies those at risk and provides for treatment and follow-up is a necessary tool to help reduce suicides in Alabama. RNS is further unique in that it collects and stores uniform data that could be used by program managers and evaluators to target resources and assess program effectiveness of those resources.

Historically, there are only federal grant dollars to support ADPH's suicide prevention efforts. Current funding consists of \$736,000 per year (FY17-FY21) awarded by SAMHSA. This funding is not on a set schedule commonly found in many grants. SAMHSA does not allow an organization to reapply for GLS funding until the organization is in the last year of its current funding cycle. While ADPH does plan to reapply for the GLS grant if an opportunity is made available, ADPH does not know if an opportunity will be available in Spring 2021. This leaves the prospect that another gap in funding could occur, as it did in 2016.



ALABAMA STATE DEPARTMENT OF EDUCATION

Under ALSDE, the number of programs which may directly or indirectly address suicide prevention and risk and protective factors is numerous. Flexible funding options such as at-risk funds, SBMH, safe school initiatives, bullying prevention grants, and recent COVID ESSER funds are available through various grants and applications. Because these funding mechanisms rarely carry with them detailed reporting, it is difficult to measure the levels that state and federal dollars are spent on suicide prevention within schools. Despite these irregular records, it is clear that many schools have instituted programs and interventions to address suicide.

Through the years, ALSDE's history with suicide awareness and prevention can be captured by the events and activities that took place surrounding two legislative acts, The Student Harassment Prevention Act (2009-571) and the Jason Flatt Act (2018-472). While the Student Harassment Prevention Act covered some aspects of suicide prevention, the largest efforts from the department came in response to the Jason Flatt Act. While these acts directly impacted suicide prevention efforts, the last decade has also seen an increase in mental and behavioral health services through SBMH.

Under SBMH, there have been concerted efforts to expand access to master's level mental health therapists to all LEAs across the state and the creation of the new Mental Health Coordinator position will provide further opportunities to identify students that are at risk and provide the appropriate follow-up services. ALSDE has also provided YMHFA training opportunities to teachers and administrators at their Mega Conference the past 2 summers.^{ix}

Mental Health First Aid

Mental Health First Aid (MHFA) is a skills-based 8-hour training course that teaches participants about mental health and substance-use issues. Participants learn how to apply the Mental Health First Aid action plan in a variety of situations, including suicidal thoughts and behaviors. MHFA has a youth and teen program. The youth training is primarily focused on participants that work with youth and can use to help ages 12-18. MHFA teen teaches high school students about common mental health challenges and what to do to support their personal mental health and how to respond to a friend that is struggling. The initial cost of a MHFA certification is about \$2200. Once an instructor certification has been obtained, the instructor can reproduce the training at no cost. Participants must use the workbook at a cost of \$18.95 per participant.

ALABAMA DEPARTMENT OF MENTAL HEALTH

ADMH partners with ALSDE to provide school-based mental health services in schools since 2010. The goal of the collaboration between ADMH and ALSDE is to partner community mental health centers with LEAs to ensure that children enrolled in local school systems have access to mental health prevention, early intervention, and treatment services. This is achieved by integrating mental health services with public schools and increasing the use of evidence-based practices.³⁰ Currently, 21 of the 72 school systems participating in SBMH are funded through state funds. Three more systems are funded through ALSDE's Project Aware grant.

ADMH serves as both the Single State Authority for the Substance Abuse Prevention and Treatment Block Grant,

as well as the State Mental Health Authority for the Community Mental Health Services Block Grant. Approximately 10% of its prevention funds come from state dollars. ADMH serves as an active participant in suicide prevention activities and partners with ADPH to address population needs as it relates to suicide prevention. ADMH has also been working to provide MHFA trainings to community health providers since 2016. Recently, ADMH applied for SAMHSA's grant to implement Zero Suicide in Health Systems. The notice of award has not been released to date and this grant only allows for suicide prevention strategies in healthcare systems. [State map of SBMH school systems]

^{ix} While planned for 2020, the Mega Conference was ultimately cancelled due to the Covid-19 pandemic.



ALABAMA DEPARTMENT OF VETERANS AFFAIRS

The Alabama Department of Veteran Affairs exists to assist former members of the U.S. Armed Forces and their dependents in numerous capacities. The department provides services that complement those of the U.S. Department of Veterans Affairs and works to implement many of those strategies,³¹ including the recently developed PREVENTS White House initiative.^{32, x} Additionally, the Alabama Veteran Suicide Task Force was formed in 2019 to create an integrated approach to reducing veteran suicide. To do so, the task force examined the causes of Alabama Veteran suicides and will determine ways to reduce the veteran suicide rate. The Veteran Suicide Task Force has since merged with the Governor's Challenge on Veteran Suicide Prevention^{xi} to strengthen its work and purpose. Examples of these efforts are the monthly town hall meetings, collaboration with teams from other states, dialing in best practices, advertising, and training. It is notable that due to COVID-19, the face-to-face town halls have been suspended. While there are Alabama-specific initiatives underway, this examination focused on programs and activities that are primarily led by state agencies and their partners.

Historically, the armed service branches and the VA have been areas of focus and proving grounds for suicide prevention efforts. Notably, the U.S. Veterans Affairs new universal risk screening for suicidal intent has been standardized and has been utilized on 900,000 veterans since 2018.

Governor's Challenge

The United States Department of Veterans Affairs partnered with SAMHSA for the Governor's Challenge, an effort that focuses on preventing suicide in service men, women, veterans, and their families. There are 27 partnering states participating in the challenge, including Alabama.

Alabama is one of 27 states taking part in the challenge and are working to implement state-wide suicide prevention best practices for SMVF, using a public health approach.



^x The President's Roadmap to Empower Veterans and End a National Tragedy of Suicide (PREVENTS) takes a holistic public health approach to suicide prevention.

^{xi} With the goal to prevent suicide — not just among Veterans — PREVENTS seeks to change the culture surrounding mental health and suicide prevention through enhanced community integration, prioritized research activities, and implementation strategies that emphasize improved overall health and well-being.



APPENDIX II: SUICIDE RATES AND UNEMPLOYMENT

OBJECTIVE 4: THE RELATIONSHIP BETWEEN SUICIDE RATES DURING ECONOMIC RECESSIONS AND UNEMPLOYMENT DURATION IN ALABAMA

There is a well-studied link between suicide and recessions.³³ Particularly the links between job loss and economic stress.³⁴ However, most of these studies have looked at either national data or data compiled from multiple states; and were largely done prior to the Great Recession of 2008-2009.

ACES sought to identify trends in Alabama using publicly available economic and unemployment data from 1999-2018 compared to the suicides in Alabama during that same time frame. While Alabama did experience an increase in suicides during the Great Recession as expected, the 31% rise in suicide rates since 2008 despite record low numbers of unemployment made identifying any factors from economic and unemployment data as associated risks inconclusive. Because the analysis was limited to monthly, statewide data; ACES contacted researchers with Loyola University Chicago and the University of Connecticut to discuss further methods of analysis. The coordination with those researchers – who have previously studied similar correlations – provided similar conclusions from work looking at national level data.

The drastic increase in suicides over the last 20 years is a nationwide problem. ACES has examined or interviewed 16 leading and surrounding states that are all currently trying to better understand the causes for this increase and meet the need for more prevention and intervention activities. The increased rates, in the midst of a prolonged period of economic improvement, point to the amplified need to collect and study data from across a broad spectrum of sources to help target our state's limited resources at those individuals who are at risk of choosing suicide.



APPENDIX III: ACCESS TO LETHAL MEANS

One of the *National Strategy's* goals is to "promote efforts to reduce access to lethal means of suicide among individuals with identified suicide risk." Understanding which individuals are at risk for access to lethal means (medicine, firearms, bridges without barriers, poison) can help assist in targeted approaches to reduce suicide attempts and completions. The *National Strategy* has three objectives to address access to lethal means:

1. Encourage providers who interact with individuals at risk for suicide to routinely assess for access to lethal means. (Objective 6.1)
2. Partner with firearm dealers and gun owners to incorporate suicide awareness as a basic tenet of firearm safety and responsible firearm ownership. (Objective 6.2.)
3. Develop and implement new safety technologies (e.g., bridge barriers, lockboxes) to reduce access to lethal means. (Objective 6.3.)

In 2020, The Action Alliance created and released a report titled *Lethal Means & Suicide Prevention: A Guide for Community and Industry Leaders*³⁵ that details the potential for impacting the *National Strategy's* goal for reducing access to lethal at-risk individuals. Recommendations for firearms, ligatures, and poison are included:

- **Firearms:** Interventions that promote safe storage, such as gun locks and safes; equipping firearm retailers and range owners with the skills to identify individuals who may be at risk for suicide; and asking loved ones to temporarily hold firearms during a time of crisis.
- **Ligatures:** Reducing access to ligatures, especially within hospitals, jails/prisons, and detention facilities is key to reducing suicide by suffocation. Ligatures can include bed linens, belts, ropes, and scarves. Interventions that promote safe environments through environmental screening, in settings such as hospitals and prisons can assist in reducing the available means for suicide attempts in institutions.
- **Poison:** Interventions that promote the reduction of access to poison both prescription and non-prescription medications such as drug return programs and reducing the carbon monoxide content of car exhaust and household gas assists in the reduction of suicide deaths by poison.

Lethal means access can be identified by utilizing a suicide risk assessment tool or other program that identifies people at risk for suicide and their access to lethal means. Most programs include working with the individual and their friends and family on reducing access to lethal means, especially in times of crisis. Counseling on Access to Lethal Means (CALM) is an evidence-based program supported by many leading organizations such as SPRC as an effective intervention to assist in working with people at risk for suicide by boosting the confidence of knowing how and what to ask suicidal people.



APPENDIX IV: IMPORTANT STEPS & PROGRAMS BEYOND IDENTIFICATION

Identifying the signs of suicide and risk screening are only the first step in the continuum of care for at-risk individuals. Written, formalized protocols and equivalent staff training on how to respond to an individual identified as at risk is a necessary second step to quality care. A thorough analysis of the *Stakeholder Analysis* would be required to better understand how hospitals are addressing this area. That analysis should include an assessment of hospital efforts to implement the following steps and programs:

- **Referral** –After the identification of suicide risk has been made, an immediate (same-day) referral to a mental health professional who has access to an inpatient psychiatric facility or to an emergency department is important for more in depth assessment, treatment, and management for the individual. Healthcare providers should know the following local resources for facility referral options: outpatient, inpatient, mental health centers, crisis center, hospitals, suicide help lines, local psychiatrists/therapists, and should the need arise, transportation resources³⁶.
- **Safety Plan Intervention** – Safety plans are developed and used to help individuals at risk of suicide to prevent and/or manage suicidal crises. It is written as a collaboration between healthcare provider and patient with a defined set of coping strategies and resources.
- **Follow-up** – According to the Suicide Prevention Lifeline, “follow-up care supports the transition of individuals who are in suicidal crisi[s]”³⁷. Data shows that follow up is an impactful and cost-effective method of suicide prevention and can be as easy as making a phone call, sending a text message, or sending a letter/postcard.
- **Postvention** – Postvention is the response in the aftermath of a suicide to enable the healing of individuals from the grief and distress of suicide loss, ease other negative effects of exposure to suicide, and prevent suicide among people who are at high risk after exposure to suicide. Effective postvention requires forethought and plan development before the occurrence of a suicide.³⁸ The Suicide Prevention Resource Center supports the use of NAMI’s Connect program developed in New Hampshire that helps organizations effectively respond to suicide death in an effort to avoid more suicides and promote healing for survivors of suicide loss, since the shockwave of suicide reaches beyond immediate family and friends, well into the community.³⁹



APPENDIX V: ACCREDITING BODIES ON SUICIDE PREVENTION TRAINING

THE JOINT COMMISSION

In 2019, The Joint Commission re-evaluated its National Safety Patient Goals to reflect the current status of suicide. The accrediting body implemented the following requirements:⁴⁰

1. Environmental Risk Assessment that identifies features in the physical environment that could be used to attempt suicide with specific directives for psychiatric hospitals and nonpsychiatric units in general hospitals.
2. Screen all patients for suicidal ideation being evaluated or treated for behavioral health issues as their primary reason for seeking care.
3. Use an evidence-based process to conduct suicide assessment of patients who have screened positive for suicidal ideation.
4. Document patients' overall level of risk for suicide and the plan to alleviate the risk for suicide.
5. Follow written policies and procedures for counseling and follow-up care at discharge for patients identified at risk for suicide, which includes training and competence assessment of staff who care for patients at risk for suicide.
6. Follow written policies and procedures for counseling and follow up care at discharge.
7. Monitor implementation and effectiveness of policies and procedures for screening, assessment, and management of patients at risk for suicide and take action as needed to improve compliance.ⁱ

The seven new and revised elements of performance are applicable to all Joint Commission accredited hospitals and behavioral health care organizations. These new requirements, effective July 1, 2019, are designed to improve the quality and safety of care for those who are being treated for behavioral health conditions and those who are identified as high risk for suicide.⁴¹ Important to meeting the National Patient Safety Goals is the requirement of following written policies and procedures addressing the care of patients identified as at risk for suicide. According to the Joint Commission, policies and procedures should include the following for both behavioral healthcare settings and hospital accreditation programs:⁴²

- Training and competence assessment of staff who care for patients at risk for suicide
- Guidelines for reassessment
- Monitoring patients who are at high risk for suicide

COMMISSION ON ACCREDITATION OF REHABILITATION FACILITIES

The Commission on Accreditation of Rehabilitation Facilities (CARF) CARF is an independent, non-profit accrediting organization that sets standards in health and human services. CARF currently accredits more than 60,000 programs and services at over 28,000 international locations. CARF's 2019 assessment standard requires programs accredited under CARF's Behavioral Health and Opioid Treatment Program Standards Manuals to conduct suicide risk screening for all persons served ages 12 and older. The new standard calls for a standardized tool be used that is normal for the population served. Example tools include the C-SSRS, SAFE-T screener, and ASQ. CARF supports and encourages organizations to be certain that suicide is a component of fundamental training for all personnel, providing them with the knowledge and framework to competently and confidently take action, regardless of their role within the organization.⁴³



AGENCY RESPONSE: ALABAMA STATE DEPARTMENT OF EDUCATION



STATE OF ALABAMA
DEPARTMENT OF EDUCATION



Eric G. Mackey, Ed.D.
State Superintendent of Education

Alabama
State Board
of Education

September 10, 2020

Governor Kay Ivey
President

Alabama Commission on the Evaluation of Services
11 South Union Street, Suite 207
Montgomery, AL 36130

Jackie Zeigler
District I
Vice President

Dear Commission:

Tracie West
District II

I would like to thank the staff at the Alabama State Department of Education (ALSDE) and all those who participated in this suicide prevention evaluation. The commission's team was professional and a pleasure to work with. The time, energy, and expertise devoted to this project has been exceptional. I sincerely appreciate the opportunity to review and provide a response to the observations noted by the ACES evaluation team.

Stephanie Bell
District III

Attached is a summary to the specific recommendations.

Yvette M. Richardson, Ed.D.
District IV
President Pro Tem

Please do not hesitate to contact me with questions or concerns.

Tommie T. Stewart, Ph.D.
District V

Sincerely,

Cynthia McCarty, Ph.D.
District VI

Eric G. Mackey
State Superintendent of Education

Jeff Newman
District VII

EGM:LAK

Wayne Reynolds, Ed.D.
District VIII

Attachment

Eric G. Mackey, Ed.D.
Secretary and
Executive Officer

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Summary

Comprehensive suicide prevention planning informs all adults in schools and communities about how to intervene with a young person exhibiting warning signs for suicide. There is a place for everyone in suicide prevention. The Alabama State Department of Education (ALSDE) strives to provide resources and support to help inform and support local education agencies and schools in the development of their suicide prevention plans, and ALSDE is committed to continuing to be a part of our state's comprehensive efforts!

While the evaluation report offers an overview and inspection of Alabama's overall suicide prevention efforts, we cannot help but acknowledge ALSDE is generally identified as having a larger responsibility than any other state agency. This unwarranted classification appears to only be linked to a single state law—the Jason Flatt Act.

In 2007, the Jason Flatt Act was first passed in Tennessee and became the nation's most inclusive and mandatory youth suicide awareness and prevention legislation pertaining to teacher's in-service Training. It required all educators in the state to complete 2 hours of youth suicide awareness and prevention training each year to be able to be licensed to teach in Tennessee. This was soon followed by Louisiana and California in 2008 (California is mandated to be offered – with no individual teacher requirement). In the years following, 20 states, including Alabama, have now passed a version of the Jason Flatt Act suicide prevention requirements.¹

In all 20 states, the Jason Flatt Acts are targeted to youth suicide prevention efforts and are supported by State Departments of Education. The Jason Flatt foundation is dedicated to the prevention of the "Silent Epidemic" of youth suicide but recognizes "a state can pass this important life-saving/life-changing legislation **without** a fiscal note."²

In Alabama, portions of the Jason Flatt appear as part of the Jamari Terrell Williams Student Bullying Prevention Act (which was formerly known as the Student Harassment Prevention Act). Through a history of amendments, Chapter 28B of Title 16, *Code of Alabama*, has consistently required the Department to develop model policies with varying components. The resulting model policies that remain in place are the Student Bullying Prevention Model Policy and the Jason Flatt Suicide Prevention Policy.

¹ Summary of state laws as provided by <https://jasonfoundation.com/about-us/jason-flatt-act/>.

² Id.



Responses to Specific Recommendations

1. Report annually to the Governor, the Legislature, and the State Suicide Prevention Plan Advisory Committee on school-aged suicide ideation, attempts, and deaths by doing the following:

- Developing reporting and tracking protocols of school-aged suicide ideation, attempts, and deaths.
- Conducting a regular review (at least annually) of school-aged suicide ideation, attempts, and deaths.

Alabama does not have a statewide early warning system tracker. The ALSDE is currently exploring the LEA needs and will be compiling LEA risk-assessment data in consultation with ADMH to make continuing recommendations for the state's overall school-based mental health plan. The ALSDE consistently contends schools should not be the official reporter of any suicide attempts or deaths as school reports are not a credible source of suicide deaths health privacy regulations. Police departments could generate an incident offense report but that would not be comprehensive as all attempts are not reported (2,286 total attempts in Alabama – all ages – as of September 2020). Perhaps the state could work with the Medical Association to create a database similar to the prescription drug monitoring program where medical professionals could enter in the data and then create a report that does not compromise a patient's information.

2. Update Alabama's Model Policy for Suicide Prevention to provide guidance and protocols that are in line with recognized standards.

Considering the historical changes of the chapter containing portions of the Jason Flatt Act, ALSDE will consider merging the bullying prevention and suicide prevention model policies to consolidate its guidance and protocols and work with non-profits around the state to promote messaging.

3. Require annual reporting on the number of certificated personnel required to receive training, the number that received training, and the training program or curriculum used.

The ALSDE already requires annual reporting of the number of certificated personnel that receive training. The training program used by individual districts can be identified in annual reporting.

4. Develop a list of approved training materials for certificated personnel to satisfy the requirements of the Jason Flatt Act.

The ALSDE, in compliance with the Jason Flatt Act, worked with the Alabama Suicide Prevention Advisory Committee to publish the "ALABAMA SUICIDE PREVENTION RESOURCES FOR SCHOOL FACULTY AND STAFF." This resource provides a list of vetted training materials. Moreover, ALSDE and the committee even developed its own training resource for school personnel which has been available since 2017.

5. Identify potential locations where suicide ideation, attempts, and deaths are more frequent as locations of emphasis to provide on-site suicide prevention training within the area LEAs.

Alabama does not have a statewide early warning system tracker. The ALSDE is currently exploring the LEA needs and will be compiling LEA risk-assessment data in consultation with ADMH to make continuing recommendations for the state's overall school-based mental health plan. The appropriate agency to track potential locations for suicided ideation, attempts, and deaths is probably a law enforcement agency; the prevalence of suicide during the school day/on school property is essentially zero and schools often do not have direct information for off campus incidents. Suicide attempts are often not reported to police, so that information might be best collected by ADMH or a private group like the Alabama Hospital Association.

6. Require school-based mental health coordinators to implement school-wide risk assessments in middle and high schools at least once annually.

This is currently being required as part of the School-Based Mental Health Service Coordinator Grant program. In FY21, 103 districts will receive a \$40,000 grant. As part of their participation, ALSDE is requiring each district to comply with the following: "On or before the last day of the 2021 fiscal year, and as requested thereafter, complete and submit to the ALSDE/ADMH the results of a needs assessment and resource map for the schools under the jurisdiction of the board. The results of the needs assessment shall document the status of mental health for the entire school system and allow the local board of education to engage in a quality improvement process to improve the provision of mental health resources to students within the school system."

7. Investigate and determine the feasibility of an evidence-based or best practice statewide student curriculum to address associated risks and protective factors among school-aged children.

ALSDE is currently doing this through the following:

- a. **Southeastern Mental Health Technology Transfer Grant.**

Program outcomes include using data to develop a customized report summarizing school mental health in the state. Completion of this profile will allow participants to learn about the school mental health landscape and innovations in other states. Grant partners include Emory University, ALSDE, ADMH, Children's Trust Fund, Alabama Network of Family Services; United Ways of Alabama (211 Systems), Florence City Schools, and Monroe County Schools.

- b. **Project A.W.A.R.E. Grant.**

Project A.W.A.R.E. (Advancing Wellness and Resiliency in Education) is a program designed to build or expand the capacity of State Educational Agencies in partnership with State Mental Health Agencies (SMHAs) overseeing school-aged youth and local education agencies (LEAs). Program goals are to increase awareness of mental health issues among school aged youth, provide Ci3T training for school personnel and other adults who interact with school-aged youth to detect and respond to mental health issues, and connect school-aged youth who may have behavioral issues and their families to needed services. Grant partners include the following: Comprehensive Integrated Three-Tiered Model of Services (Ci3T) team—Dr. Robin Ennis and Mrs. Sara Cole Fleming; ALSDE; Conecuh County; Homewood City; Jackson County; Alabaster City; Chambers County; Cherokee County; Coosa County; Fort Payne City; Marshall County; Tarrant City; Washington County.



c. School-Based Mental Health Collaboration between Alabama Department of Mental Health (ADMH) and Alabama State Department of Education (ALSDE).

The existing School-Based Mental Health Services Collaboration with the ALSDE and the ADMH is designed to ensure all students have access to high-quality mental health prevention and treatment services.



AGENCY RESPONSE: ALABAMA DEPARTMENT OF MENTAL HEALTH

The following response from Commissioner Lynn T. Beshear was submitted via email:

The Pillars of the Alabama Department of Mental Health represent the goal of Relevancy through Relationships supported by innovative and crucial programs, grounded by a strong foundation. Prevention is the first pillar. ADMH implements strategies to reduce risk factors and increase protective factors to promote the health and well-being of the individuals we serve. Fostering collaborative partnerships is vital to successful planning and implementation efforts to address the needs of individuals, families and communities. Through continuous coordinated efforts with existing stakeholders, along with the opportunity to expand the collaborative, ADMH will further its mission to *Serve, Empower, Support*.

Again, thank you for this opportunity; we look forward to the continued coordinated efforts to address suicide prevention needs within our communities.

Lynn T. Beshear
Commissioner
Alabama Department of Mental Health
Office: 334-242-3640

Serve · Empower · Support



Promoting the health and well-being of Alabamians with mental illness, developmental disabilities and substance use disorders.



ACRONYMS AND DEFINITIONS

AYSPP – The Alabama Youth Suicide Prevention Program

CALM – Counseling on Access to Lethal Means is an intervention program that focuses on how to reduce access to suicide methods.

CARF – Commission on Accreditation of Rehabilitation Facilities is an accrediting organization that sets standards of care for health and human services programs and facilities.

CDC – Center for Disease Control

Ci3T – Comprehensive, Integrated, Three- tiered (model of prevention)

C-SSRS – Columbia Suicide Severity Rating Scale is a free suicide risk assessment tool used to assist in identifying an individual in need of help.

ESSER – Elementary and Secondary School Emergency Relief Fund are relief funds through the CARES Act.

Gatekeeper – Someone in a position to recognize a crisis and the warning signs that someone may be contemplating suicide.

LEAs – Local Education Agency

MHFA and YMHA – Mental Health First Aid (youth and adult) is a gatekeeper intervention that teaches participants about mental health and substance-use issues for many populations including, but not limited to, youth and adults.

NAMI – National Alliance on Mental Health

NIH – National Institute of Health

NSSP – National Strategy for Suicide Prevention

Protective factors – characteristics that make it less likely that individuals will consider, attempt, or die by suicide.

QPR – Question, Persuade, Refer is a gatekeeper intervention that teaches participants the warning signs of a suicide crisis and how to respond.

Risk factors – characteristics that make it most likely that an individual will consider, attempt or die by suicide.

RNS – Referral Network System for behavioral health providers to follow-up with patients after discharge from an emergency department or inpatient unit after a non-fatal suicide attempt to ensure continuity of care.

SAFE-T – The Suicide Assessment Five-step Evaluation and Triage portable card that guides mental health professionals in the clinical setting through five steps which address the patient's level of suicide risk and suggests appropriate interventions.

SAMHSA – Substance Abuse and Mental Health Services Administration

SBMH – School Based Mental Health



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