September 7 – 13, 2015

National Suicide Prevention Week Information & Media Kit

“Preventing Suicide: Reaching Out and Saving Lives”
Sponsored by

American Association of Suicidology
5221 Wisconsin Avenue, N.W.
Washington, D.C. 20015
Phone: (202) 237-2280
Fax: (202) 237-2282
www.suicidology.org
info@suicidology.org
American Association of Suicidology
National Suicide Prevention Week
September 7 – 13, 2015

Table of Contents
Part A. Introduction
   Suicide Prevention: Everyone’s Business
   Suicide Prevention Ribbon
   National Suicide Prevention Day & World Suicide Prevention Week

Part B. Media and Awareness Materials
   General Guidelines
   Timeline
   Tips for Governor’s or Mayor’s Proclamation
   Sample Governor’s or Mayor’s Proclamation
   Tips for a Press Release
   Sample Press Release
   Tips for a Public Service Announcement
   Sample Public Service Announcement (20 Seconds)
   Sample Public Service Announcement (30 Seconds)
   Sample Public Service Announcement (45 Seconds)
   Tips for an Op-Ed
   Sample Op-Eds
   Tips for a Flyer
   Sample Flyer
   Publicity Ideas
   Media Guidelines
   Recommendations for Reporting on Suicide

Part C. Suicide Fact Sheets
   2013 USA Official Final Data
   2013 USA State Suicide Rates and Ranking Among the Elderly and Young
   2013 USA State Suicide Rates and Rankings by Gender
   2013 Health Regions and Suicide Rates
   Understanding and Helping the Suicidal Person
   Warning Signs of Suicide
   Facts about Suicide and Depression
   Survivors of Suicide Fact Sheet
   Helping Survivors of Suicide: What Can You Do?
   Surviving suicidal thinking: How we all can help

Part D. American Association of Suicidology
   General Information
   Membership Information
   Additional Resources
   AAS Online Store
Part A. Introduction
Who Can Participate in National Suicide Prevention Week?

Suicide prevention is everyone’s business and anyone can participate in National Suicide Prevention Week. Here are some examples of organizations and institutions that might be involved with this national event:

**Schools and Colleges**

**Community Mental Health Centers**

**Hospitals**

**Private Treatment Facilities**

**Churches**

**Corporations and Businesses**

Aside from organizations and institutions, survivors of suicide loss, people who’ve been suicidal, loved ones and anyone involved in suicide prevention.

**How can they help?**

High schools, colleges and universities can create their own activities for National Suicide Prevention Week. These locations are ideal to promote public awareness of the goals of suicide prevention, educate the public about the prevalence of suicide, as well as involve young adults in prevention activities.

Community mental health centers, hospitals, private treatment facilities and churches have a wide range of access to members of the community and are therefore in an ideal position to host National Suicide Prevention Week in their locality.

Corporations and businesses can participate not only by hosting events for National Suicide Prevention Week, but by sponsoring local or state events and providing services or materials. This collaboration between businesses and the community shows a willingness to work together towards the important cause of suicide awareness and prevention.

**How can you help?**

If you are an individual interested in becoming involved in National Suicide Prevention Week or with other activities related to suicide prevention, please contact your statewide suicide prevention coalition or your local mental health provider. Contact AAS with all other questions.
Suicide Prevention Ribbon

The purple and turquoise Suicide Prevention Ribbon symbolizes suicide awareness and prevention.

The idea of using purple and turquoise stems from conversations between Sandy Martin, founder of the Lifekeeper Quilts, and Michelle Linn-Gust, Past-President of AAS. Ms. Martin pointed out that every cause had a colored ribbon except suicide prevention. Because many causes already have a color, the decision was made to go with two. Purple and turquoise are both healing colors. The color combination stands for survivors of suicide and suicide itself. The ribbon serves as a reminder that suicide is an issue we need to talk about.

The Suicide Prevention Ribbon’s first appearance was at the AAS Annual Conference in Santa Fe in 2003, and has been used in various conferences and suicide events since.

Along with the purple and turquoise ribbons, purple and turquoise wristbands are also available to show support for anyone whose life has been touched by suicide. Please go to http://www.suicidology.org/store/ to order ribbons, wristbands, or other support materials.
National Suicide Prevention Week
&
World Suicide Prevention Day

The International Association for Suicide Prevention (IASP), in collaboration with the World Health Organization (WHO) and the World Federation for Mental Health, is hosting World Suicide Prevention Day on September 10th, 2015. This year’s theme is “Preventing Suicide: Reaching Out and Saving Lives,” and will focus on raising awareness that suicide is a major preventable cause of premature death on a global level. Governments need to develop policy frameworks for national suicide prevention strategies. At the local level, policy statements and research outcomes need to be translated into prevention programs and activities in communities.

The International Association for Suicide Prevention (IASP) was founded in Vienna, Austria in 1960 as a working fellowship of researchers, clinicians, practitioners, volunteers and organizations of many kinds. IASP wishes to contribute to suicide prevention through the resources of its members and in collaboration with other major organizations in the field of prevention. AAS is proud to be a member and supporter of IASP (http://www.iasp.info).

The World Health Organization (WHO) is a United Nations health agency founded in April 1948. Its primary objective is to help all people attain highest possible level of health (physical, mental and social well-being). This organization carries out this objective through advocacy, education, research medical and technological development as well as the implementation of health standards and norms (http://www.who.int/en/).

The World Federation for Mental Health’s mission is to promote the highest possible level of mental health in all aspects (biological, medical, educational and social) for all people and nations. Their goals are to heighten public awareness, promote mental health, prevent mental disorders and improve the care and treatment of those with mental disorders (http://www.wfhm.com).

Suicide as an International Problem

Suicide is an international problem and a major public health concern. Suicide claims approximately 1 million lives worldwide each year, resulting in one suicide every 40 seconds. There is an estimated 10 to 20 suicide attempts per each completed suicide, resulting in several million suicide attempts each year. Suicide and suicidal behavior affects individuals of all ages, genders, races and religions across the planet. Suicide affects more men than women in all countries but China.

Risk factors remain essentially the same from country to country. Mental illness, substance abuse, previous suicide attempts, hopelessness, access to lethal means, recent loss of loved ones, unemployment and vulnerability to self-harm are just few examples of risk factors.

Protective factors are also the same in all corners of the world. High self-esteem, social connectedness, problem-solving skills, supportive family and friends are all examples of factors that buffer against suicide and suicidal behaviors.

World Suicide Prevention Day represents a call for action and involvement by all governments and organizations worldwide to contribute to the cause of suicide awareness and prevention through activities, events, conferences and campaigns in their country. By collaborating together in this endeavor, we can indeed save lives.
Part B. Media and Awareness Materials
American Association of Suicidology

National Suicide Prevention Week
September 7 – 13, 2015

General Guidelines

This section includes sample materials as well as suggestions and tips for communicating with the media, including a proclamation, a press release, a public services announcement (PSA), an op-ed and a flyer. Also included is a suggested timeline, publicity ideas and media guidelines. The document, Recommendations for Media Reporting on Suicide is incorporated into this kit and can be found at www.reportingonsuicide.org.

General Tips

The content of your media materials should reflect your targeted audience. For example, if your targeted audience is teenagers, statistics will not hold their attention. Instead, focus their attention on breaking the stigma surrounding reaching out for help or receiving mental health treatment for mental healthcare. Assume the reader is new to the topic; explain terminology and concepts. Keep in mind that you are trying to reach the general public regarding your opinions and issues.

Use plain language. Be brief, clear and to the point.

There should always be a positive angle included in your message. For example, despite the high rate of suicide in male youths, you can relay information about the effectiveness of treatment and the preventability of suicide.

There should always be information included about where to go to get help (1-800-273-TALK (8255), contact information for local crisis centers, etc.).

Remember:
The PURPOSE of contact and communication with the media is to get the word out.
The GOAL you want to portray is that by working together through awareness, promotion and education, we can reduce the incidence of suicides and prevent individuals from becoming suicidal.
As you embark on engaging the media to promote your organization for National Suicide Prevention Week, consider the following timeline to guide your efforts:

<table>
<thead>
<tr>
<th>Week of 8/10</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEDIA LIST: Develop or update your database of local journalists, TV and reporters who cover health, science, lifestyle or features, or who have covered suicide or mental health issues in the past. Identify how many radio and television outlets you will reach out to in each category – newspaper, radio and television.</td>
<td></td>
</tr>
<tr>
<td>REAL STORIES: Identify local people who have experienced suicide or suicidal thinking and who would be willing to go “on record” with the media to tell their story in an attempt to help others. Have these sources available for the media to talk to on an as-requested basis.</td>
<td></td>
</tr>
<tr>
<td>PSAs: Contact newspapers, radio or television stations to determine their interest in running public service announcements. Work with a local audio-visual technician to create or modify PSAs for dissemination in August and the first weeks of September.</td>
<td></td>
</tr>
<tr>
<td>SPEAKING ENGAGEMENTS: Contact local organizations to schedule speaking engagements by their staff to occur during Suicide Prevention Week.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Week of 8/17</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACTIVITIES: Finalize any open house, visitors’ day, events, training sessions or other special activity associated with Suicide Prevention Week. Create promotional materials for your activities.</td>
<td></td>
</tr>
<tr>
<td>PRESS RELEASE: Draft a press release and highlight your organization. Add local statistics regarding suicide in your state, county or region of the country.</td>
<td></td>
</tr>
<tr>
<td>LEGISTLATIVE OUTREACH: Begin a dialogue with your mayor’s and governor’s offices to pitch the idea of a signed proclamation noting Suicide Prevention Week.</td>
<td></td>
</tr>
<tr>
<td>OP-ED: Prepare and finalize an op-ed for dissemination to print media the following week.</td>
<td></td>
</tr>
</tbody>
</table>
Instructions:
The goal of a proclamation is to promote your activities to the general public. Add your organization’s information in the allotted areas.

Change the items to suit your community’s needs, or the specific theme of your event, should it differ. For example, include statistics or facts from your state or to suit your demographic criteria. For recent statistics, please consult the WISQARS database run by the National Center for Injury Prevention and Control (NCIPC) (www.cdc.gov/injury/wisqars/).

Public officials willing to sign your proclamation increase attention to your efforts. Typically, the Governor or Mayor signs the proclamation. Try to find a public official who already has some interest in the issue of suicide prevention.

Make the signing a public event. Organize a press conference for the occasion. Send copies of the proclamation to newspapers and health reporters in your metropolitan area, and publicize it on your website.
Sample Proclamation

Governor’s (or Mayor’s) Proclamation

Draft for Consideration by Suicide Prevention Subcommittee
For submission to Governor Sam Brownback
Reply please with suggestions by noon Thursday 7/23/2015

Governor’s Proclamation for Suicide Prevention Week of September 7-13, 2015

WHEREAS, in the United States, one person dies by suicide every 12.8 minutes, with 41,149 deaths by suicide in our country during 2013;

WHEREAS, in our country, suicide is the 2nd leading cause of death for 15-24 year olds, and is the 10th leading cause of death for people of all ages;

WHEREAS, each person’s death by suicide intimately affects at least six other people, with over 200,000 newly bereaved each year;

WHEREAS, in 2013, 425 Kansans died by suicide, and several thousand friends and family members were changed forever by losing those people;

WHEREAS, many of those people who died never received effective behavioral health services, for many reasons including the difficulty of accessing services by healthcare providers trained in best practices to reduce suicide risk, the stigma of using behavioral health treatment and the stigma associated with losing a loved one to suicide;

WHEREAS, the Suicide Prevention Subcommittee of the Governor’s Behavioral Health Services Planning Council, which is comprised of representatives of behavioral health organizations, state agencies, military/veterans organizations, educational institutions, and the community at large, who are dedicated to reducing the frequency of suicide attempts and deaths, and the pain for those affected by suicide deaths, through research projects, educational programs, intervention services, and bereavement services urges that all Kansans:

1. Recognize suicide as a significant public health problem in Kansas and declare suicide prevention a statewide priority;

2. Support the development of accessible behavioral health services for all 105 counties of our state, implementing national best practices in reducing suicide risk for people of all ages and backgrounds

3. Acknowledge that no single suicide prevention effort will be sufficient or appropriate for all populations or communities; and

4. Encourage initiatives based on the goals and activities contained in the National Strategy for Suicide Prevention, Zero Suicide of the National Action Alliance for Suicide Prevention, and The Way Forward by the Action Alliance’s suicide attempt survivor task force.

WHEREAS, far too many Kansans die by suicide each year, and most of these deaths are preventable;

THEREFORE IT BE RESOLVED that, I, Sam Brownback, Governor of Kansas, do hereby designate September 7th through 13th, 2014, as “Suicide Prevention Week” in the state of Kansas and urge Kansans to learn how they can help because Suicide Prevention Is Everyone’s Business.
Helpful Hints:
The purpose of a press release is to convey information to the media. It serves as the first contact between you and the media.

Use your organization’s letterhead. Your press release should not surpass two pages (type “more” or “over” at the bottom right for any subsequent pages).

Be precise and direct. Use plain language and explain any terms. This is an information sheet; no opinions, no fluff.

Your audience is journalists, and their audience is the general public. You want to peak the journalist’s interest into writing an article or contacting you for an interview.

If you have a program of events already established, include a copy with the press release.

Send your press release to newspapers or radio stations that are most likely to use it. Check out different papers to determine which ones print articles and advertisements with similar topics.

There are three ways to disseminate a press release: mail, fax or e-mail. If you are not sure which one to use, call the newspaper or the journalist in question and ask them for their preferred method of communication.

Develop or update your database of local journalists. Include television and radio reporters who regularly cover health, science, lifestyle or features or who have covered suicide or mental health issues in the past. If you are not sure who to write to, check your local library; they generally have a listing of media contacts.

You can send your press release to more than one media outlet; for example, you can send the same press release to many different local newspapers. However, it is generally not recommended to send the same media piece to newspaper/radio stations in the same ‘market’. For example, do not send the same press release to two national newspapers or radio stations.

Content:
At the top left hand corner, the words “for immediate release” appear in bold, capital letters.

If you have an eye-catching headline, insert it in bold and centered. If not, insert the words “notification to the press” in bold, capital letters.

Your contact information should follow and include:

Name*
Title
Organization name
Address
Phone and fax numbers
E-mail address

*The name of your contact person will be the person most knowledgeable concerning the event in question
Then proceed to the big five questions: who, what, when, where, and why. Order the information by importance. Also, include specific information relevant to your community or state, as well as national statistics.

Emphasize new points (first time event, new activity, special appearance). If your event has an angle, use it. The media likes innovative and unique ideas.

You can either display the information in a statement format (see Sample Press Release) or in a text format (no longer than two pages double spaced).

Include a Letter:
With your press release, include a letter (on agency letterhead) explaining who you are and why you are promoting your events. Include your contact information (address, phone numbers, fax and email address) in case reporters wish to follow-up on your information.

If you have volunteers who are willing to share their personal stories, mention such a possibility in your letter. Oftentimes, the media will include real life stories; it personalizes the article.

If the event you are trying to promote is time sensitive, include such information in the letter. For example, “This article was written partially in light of the upcoming National Suicide Prevention Week from September 7th to 13th.” This will help the editor determine when to put it to print.
Sample Press Release (on your company’s letterhead)

FOR IMMEDIATE PRESS RELEASE

CONTACT:
[Your Contact Person’s Name]
[Your Organization’s Name]
[Your Organization’s Address]
[Your Telephone Number]

NOTIFICATION TO THE PRESS

WHAT: Suicide Prevention Week for 2015 is set for September 7th through 13th. [Your state] ranks [rank] in the nation in its rate of suicide deaths.

Suicide is the 10th leading cause of death in the United States with one suicide occurring on average every 12.8 minutes.

Suicide is the 2nd leading cause of death among 15 to 24-year-olds.

The elderly make up 14.1% of the population, but comprise 17.5% of all suicides.

Approximately 1,028,725 American attempt suicide each year.

It is estimated that five million living Americans have attempted to kill themselves.

Every year in the United States, more than 21,100 men and women kill themselves with a gun; two-thirds more than the number who use a gun to kill another person.

An estimated 4.8 million Americans are survivors of suicide of a friend, family member, or loved one.

[Your staff person] is available to discuss these and other facts surrounding suicide.

WHO: Suicide specialist, [your contact person], [position at your agency], is an expert in the areas of suicide assessment and intervention. [Include other information about the person’s skills, expertise, and services available at your agency].

WHEN: National Suicide Prevention Week, September 7th through 13th. This year’s theme is “Preventing Suicide: Reaching Out and Saving Lives.”

HOW: To arrange an interview or for future information, please contact [your contact person] at [phone number].

AMERICAN ASSOCIATION OF SUICIDIOLOGY
American Association of Suicidology

National Suicide Prevention Week
September 7 – 13, 2015

Public Service Announcement

Tips:
Try to find a public figure to read the Public Service Announcement (PSA) or a prominent figure in the area of suicide prevention. Perhaps there is already an advocate for suicide awareness and prevention in your community.

PSAs can be done for radio, television or the print media. The three samples that follow are radio PSAs.

The goal of a PSA is to raise awareness and to educate people on a specific issue.

PSAs are generally developed for one of three reasons: to prevent a behavior, to stop a behavior and/or to encourage the adoption of a new behavior.

Include your complete contact information with your submission. Also, mention the timeframe for the announcements. For example, you may want a radio station to broadcast your PSA starting one month prior to September 10th or have a newspaper print your PSA every day during the week of September 7th.
Sample PSA

Public Service Announcement
Suicide Prevention (20 Seconds)

Did you know that, in the United States, more people die by suicide (50% more!) each year than by homicide?

Experts believe that most suicidal individuals do not want to die. They just want to end the pain they are experiencing.

When suicidal intent or risk is detected early, lives can be saved.

September 7th through September 13th is National Suicide Prevention Week. Please join [your organization] in supporting suicide prevention. Together we can reduce the number of lives shaken by a needless and tragic death.
Sample PSA

Public Service Announcement
Suicide Prevention (30 Seconds)

Did you know that, in the United States, one person completes suicide every 13 minutes? Or that it’s estimated the more than 5 million people in the United States have been directly affected by a suicide?

Experts believe that most suicidal individuals do not want to die. They just want to end the pain they are experiencing.

Experts also know that suicidal crises tend to be brief. When suicidal behaviors are detected early, lives can be saved.

September 7th through September 13th is National Suicide Prevention Week. Please join [your organization] in supporting suicide prevention. Together we can reduce the number of lives shaken by a needless and tragic death.
Sample PSA

Public Service Announcement
Suicide Prevention (45 Seconds)

Did you know that, in the United States, one person completes suicide every 13 minutes? Or it’s estimated that more than 5 million people in the United States have been directly affected by a suicide? Or that 50% of all persons who die by suicide use a firearm, kept in the home allegedly for safety, to kill themselves?

Experts believe that most suicidal individuals do not want to die. They just want to end the pain they are experiencing.

Experts also know that suicidal crises tend to be brief. When suicidal behaviors are detected early, lives can be saved. There are services available in our community for the assessment and treatment of suicidal behaviors and their underlying causes.

September 7th through September 13th is National Suicide Prevention Week. This year’s theme is “Preventing Suicide: Reaching out and Saving Lives.” Please join [your agency] in supporting suicide prevention. Together we can reduce the number of lives shaken by a needless and tragic death.
American Association of Suicidology
National Suicide Prevention Week
September 7 – 13, 2015

Op-Ed

Getting Ready:
An op-ed is short for opinion-editorial. Some are written by journalists and some are submitted by the general public.

An op-ed is a journalism tool used by the general public to express an opinion or share ideas about a timely and specific issue. The goal of an op-ed is to get people interested in your issue in the hopes that they might become involved in your cause.

It is always a good idea to contact the newspaper you are aiming for in advance. Call or email the editor of the op-ed section, introduce yourself and pitch your idea for an op-ed. Be receptive to any advice; this person is an expert on op-eds.

You can send a submission to more than one newspaper, but not in the same ‘market.’ That is, do not send the same article to two national newspapers. It is however acceptable to submit your article to several local newspapers that circulate in different areas.

Send your submission at least ten to fourteen days before you would like it to appear in the media.

Ask your organization if you can sign the article on behalf of your organization. This will add credibility and strength to your message.

Writing the Article:
Assume the reader is new to this topic; explain any terminology and concepts. Keep in mind that you are trying to reach the general public regarding your opinions and issues.

Be brief, clear and to the point. Be professional, yet maintain a conversational style.

Don’t say things just to say them; be clear and unequivocal. For example, if you need to explain the previous sentence, rework that sentence to avoid the explanation entirely.

Use a simple structure; express your opinion, use facts and an example or statistics to back it up, mention the event in question and conclude. The article should flow easily.

The text should be no longer than two pages, single spaced. The average op-ed ranges from 600-800 words, but newspapers have different requirements. Submissions may be edited for length. A rule of thumb is that the less there is to take out, the less the editor will want to take out.

Your submission should focus on one specific area.

The title of the op-ed must catch the reader’s attention. A good title will make the reader want to read the entire article; a bad title will make them move on to the next article.

Your first paragraph is the most important. This is where the reader will decide to read the whole thing or move on. Therefore, emphasize your main point here; the reader is more likely to read the entire article if you hook them in the beginning. You should be able to do so in two sentences.

As much as you can, support your ideas with facts and statistics. Remember to cite your sources.
Your last paragraph summarizes your point and leaves room for the reader to remain interested in your issues. Make the reader want more information from your organization and cause.

Include a paragraph at the end on who you are (your title and role in your organization) and your contact information (e-mail and phone).

Include a Letter:
With your submission, include a letter (on agency letterhead) explaining who you are and why you are submitting an article. Include your complete contact information (address, phone numbers, fax and email address).

If the event you are trying to promote is time sensitive, include such information in the letter. For example, “This article was written partially in light of the upcoming Suicide Prevention Week from September 7th to 13th.” This will help the editor determine when to put it to print.

If you are sending your submission to only one newspaper, emphasize the point theirs is the only one in that market that has received such a submission. If you have sent the same submission to more than one newspaper, simply state that this article was also submitted as such and to other newspapers.

Be open to the fact that the editor might send your article back in order for you to shorten or revise it and then resubmit it. The editor can also edit your article or title at his/her wish. Do not be surprised if there are changes. A simple and clear submission will avoid such editing.
SSRIs and Suicidal Behaviors

By Morton M. Silverman, M.D.

A recent controversy in the field of suicidology focuses on the relationship between selective serotonin reuptake inhibitors (SSRIs) and suicidal behaviors. The two key opposing questions that are being asked are: “Do SSRIs cause suicidal behaviors, especially in children and adolescents?” and “Are the increase in the prescription of SSRIs responsible for the decline in national youth suicide rates over the last few years?”

In 2004, as a result of public hearings, and after weighing all the available evidence and testimony, the U.S. Food and Drug Administration (FDA) directed manufacturers of antidepressant medications to revise the labeling on their products to include a “black-box” warning that notifies healthcare providers and consumers about an increased risk of suicidal thoughts and behaviors in children and adolescents who take antidepressants are twice as likely as those given placebos (4% vs. 2%) to become suicidal. However there were no reported suicides among any of the children and adolescents enrolled in any of the clinical trials.

There is clear evidence of efficacy of treatment with antidepressants in the pharmacological management of moderate to severe unipolar depression. However, patients and physicians should always be aware that suicidal ideation and suicide attempts may be present during the early phases of treatment. This may be due to the possibility that the medications have yet to be therapeutically effective, or possible because the SSRIs induce agitation or activation early in the treatment process.

The “black box” warning states that “antidepressants increased the risk of suicidal thinking and behavior (suicidality) in short-term studies in children and adolescents with Major depressive Disorder (MDD) and other psychiatric disorders.” In addition the FDA developed a patient medication guide that must be dispensed with each prescription. Only fluoxetine is currently approved by the FDA to treat major depression in children.

In May, 2006 the FDA and GlaxoSmithKline warned healthcare professionals regarding the potential increased risk for suicidal behavior associated with the use of paroxetine HCL tablets/oral solution or paroxetine extended-release tablets. Such monitoring may be of particular importance in young adults and those whose depression is improving. Recent study results show that paroxetine therapy compared to placebo was linked to an increased frequency of suicidal behavior in young adults aged 18 to 24 years. Although not statistically significant, the increase occurred in patients with depressive and non-depressive conditions.

Although many professional organizations have expressed concerns that such labeling might decrease the use of these medications, they supported the call of better monitoring of patients taking these medications and better education of family members and caregivers as to the benefits of treatments, as well as how to identify any possible adverse effects should they arise.

The positions of most professional organizations and suicide prevention organizations is that caution, additional research and full disclosure of the results of large-scale public clinical trials are needed to answer conclusively the questions about potential risk, and that, at this time, the potential benefits of these medications for treating major depressive disorders far outweighs the risk (based on all the available research studies and case reports).
DIRECT BENEFITS OF THE FDA RULING:

Despite mounting evidence that there is no direct connection between SSRIs and death by suicide, the FDA “black box” ruling remains in effect. As a result, some direct benefits in the prescribing of SSRIs to children and adolescents are:

1. The FDA specified that there needs to be regular contact between the patient and the physician leading to increased monitoring by the physician and increased adherence to the medication regimen by the patient.

2. There will be more involvement of family and support networks in the overall treatment plan.

3. Physicians will be expected to discuss potential side effects and benefits of medication prior to onset (informed consent) with the patient and his/her family and support network.

4. There will be more public access to data from clinical trials as well as unpublished research (leading to the establishment of a national clinical trials registry).

5. A coalition of major medical journals have implemented a new policy whereby studies that are sponsored by drug companies will only be published if the study has been registered with a public database.

6. There will be an intensification of research into the safety and efficacy of SSRIs through additional large-scale systematic studies, especially for children and adolescents.

Morton M. Silverman, MD, is Senior Advisor to the Suicide Prevention Resource Center (SPRC) and former Editor-in-Chief of Suicide & Life-Threatening Behavior, the official publication of the American Association of Suicidology.
Sample Op-Ed

Unrecognized Depression is Lethal

By Donna Cohen, Ph.D.

Depression is a serious public mental health challenge for our aging population. Depression goes unrecognized in half of the general population and in 80% of the older population (ages 65 and older). The lack of detection, diagnosis, and treatment of depression in Americans of all ages, but especially older Americans, is unacceptable, since depressive disorders are treatable.

Depression, coupled with other risk factors, can be lethal. Older persons, both in the United States and around the world have the highest suicide rates of any other age group, and the rates increase with advancing age. In the United States, older men complete 80% of all suicides in their age group. In other countries, older men and women appear to be equally likely to complete suicide.

Older adults show a greater degree of planning and are more intent on killing themselves than younger persons. Over 70% of older suicides involve firearms compared to 54% for the general population. The elderly are less likely to attempt suicide, with an average of 4 attempts for every completed suicide compared to, an estimated 100-200 attempts for every completed in younger age groups. Careful planning, increased vulnerability, decreased reserve capacity to recover, and relative social isolation contribute to increased lethality in the aged. Older persons are less likely to be discovered after a suicide attempt, and they are less communicative about their ideation than younger persons.

Suicides are acts mediated by mental health problems, hopelessness, perceived burdensomeness, and desperation. Suicide pacts are very rare, but the suicide pact of an older couple in South Florida illustrates the quiet desperation and emotional bankruptcy of elderly suicides. The method of death is unusual, but the antecedent circumstances—in incapacitating illness, depression, and a suicide note—are not.

MS, age 85, and ES, age 80, had planned to die on New Year’s Eve. They asked the condominium maintenance man to remove their bedroom window screens, complaining they blocked the ocean breeze. He removed them, and several hours later the couple completed suicide. The results of the medical examiner’s investigation showed that MS and ES had crawled across the bedroom floor to the window and fell 17 floors to their death. Both relied on walkers to get around their home. ES appeared to have helped her husband, who was weak and frail from emphysema, by pushing him out the window first before she followed. A note was taped to the telephone; ES had a note in her blouse pocket.

This tragedy illustrates many of the characteristics of the victims and circumstances of suicide pacts. Most couples have been married a long time and have enjoyed what appears to have been a successful marriage. However, disabling chronic or terminal illness accompanied by depression and other life stressor, intervene and begin to limit their control and independence. The decisions to complete suicide together is made reflectively, and typically the event is carefully planned. Often, the double suicide occurs on a date significant for the couple or at a time shortly after one or both experience a significant deterioration in health.
Physicians need to be aware of the warning signs. Most older patients who complete suicide have had a long-standing relationship with a primary care physician and have seen the doctor shortly before the suicide. Seventy percent have visited their physician within one month before killing themselves, 20% saw her/his physician the day they completed suicide, and 40% did so within one week.

Family members, friends, and neighbors need to be vigilant about risk factors for suicide. They may include advancing age, being male, chronic health problems, use of many medications, changes in health status, a previous suicide attempt, being unmarried, multiple losses, and firearms in the home. If you see signs there are several things you can do:

- Do not be afraid to ask if the older person has thoughts about suicide. You will not be giving them new ideas.
- Do not act surprised or shocked. This will make them withdraw from you.
- Continue talking and ask how you can help.
- Offer hope that alternatives are available. Do not offer glib reassurance. It may make the person believe that you do not understand.
- Get involved. Become available. Show interest and support. If you cannot do this, find someone who can, such as a neighbor or a minister, priest, or rabbi.
- Ask whether there are guns in the house. Ask the person what plays they have to die. The more detailed the plan, the higher the risk.
- Remove guns and other methods of death.
- Do not be sworn to secrecy. Get help from persons or agencies that specialize in crisis intervention.
- Call a crisis hotline in your area or 1-800-273-TALK (8255) or seek the help of a geriatric specialist. Do not try to do things by yourself.

There is help in the community. If you believe there is a risk for suicide, contact a professional immediately. Call a suicide crisis center, a crisis hotline, a family physician, a psychiatrist, a medical emergency room, or a community mental health center listed in the yellow pages. Not all suicides can be prevented, but we can be vigilant for the signs of this silent killer.

Donna Cohen, Ph.D., is a professor in the Department of Aging and Mental Health and Head of the Violence and Injury Prevention Program at the University of South Florida in Tampa, Florida (E-mail: cohen@fmhi.usf.edu).
Sample Op-Ed

Depression isn't part of growing older
It’s a serious disease with physical causes and can attack at any age, but treatment is available.

DONNA COHEN

Published January 27, 2004

Depression has many forms, from brief feelings of sadness to a serious medical condition. Most people feel sad and worried at some time in their life. These feelings are normal reactions to disappointments, illness or death. It is also normal to be moody, lose interest in people or favorite activities, have sleep problems and feel tired. There are all common expressions of what is known as normal reactive depression.

The circumstances that cause reactive depression may or may not go away, but you find ways to deal with your problems. In other words, you bounce back and feel better in a short time.

But when sadness persists and habits, such as eating, sleeping, working and enjoying life, continue to be difficult, you are dealing with something more serious than just “feeling down.” You are facing a clinical depression, an illness that requires treatment. Many people believe that depression is normal in older adults. It is not. Most people also believe that depression in adults with chronic illness is normal. It is not. Clinical depression is a medical disorder, and it is cause by biological and psychosocial factors.

Fortunately, most depressive disorders are treatable with psychotherapy, drugs and other interventions. But if undetected and untreated, clinical depression can destroy quality of life and exacerbate health problems. It can lead to person suffering, withdrawal from others, family disruption and sometimes suicide. Because it brings the potential for suicide, depression is a life-threatening illness.

Signs of Depression

Clinical depression affects the body and the mind, causing changes in thinking, mood, behavior and body functions. If you recognize the following changes in yourself or someone you know, seek help from a physician or mental health professional.

Thinking: Depressed individuals often feel inadequate or overwhelmed. Even easy tasks seem impossible. Concentration is difficult and decision-making is burdensome. The world appears bleak, and pessimism colors perceptions of self-worth. Even successes are interpreted as failures. Thoughts of suicide may occur when the depression is severe.

Mood: Depressed individuals feel empty, helpless, hopeless and worthless, and they may report feeling pain and despair. Individuals may cry a great deal, often for little or no reason. Many, especially older men, become agitated and worry about everything. It is common to feel anger or even rage, as well as irritation, frustration and anxiety. Depressed moods are pervasive and persistent and do not lift even when good things happen.

Behavior: Depressed individuals often show such behaviors as restlessness, hand-wrting, pacing, the inability to meet deadlines, withdrawal from friends, staying in bed most of the day, and decreased interest in sex. Many drink alcohol excessively or take sedatives to try to make the depression go away.
Body functions: Depression is a disease that affects the entire body. Individuals report physical pains as headaches, backaches, joint pain, stomach problems, chest pain and gastrointestinal distress.

Getting Help

It is not a sign of weakness to see a doctor when you are depressed. Unfortunately, the very nature of depression drains the desire and energy to talk with family members or seek professional help. Because depressed people often believe they are failures, many feel they are not worthy of help. The most courageous thing you can do is to get help.

Both men and women get depression. There is a widespread myth that depression is a woman’s disease. It is not unmanly or wimpy to admit feeling depressed. Unfortunately, men are reluctant to seek treatment and instead become irritable, angry, drink or use drugs, and withdraw from loved ones.

It is not unusual to resist getting help, but telling someone how bad you feel is the first step to feeling better. A physician is the best person to contact; they need to know your medical history.

To be clinically depressed is to have a medical illness. Treatment is needed. Depressive disorders are diseases of the brain, just as cardiovascular diseases are diseases of the heart and circulatory system. Depressive disorders are not the result of character flaws, bad parenting divine punishment, or personal weakness. They are not anything to be ashamed of.

Learning to spot the signs of depression is like learning to spot signs of cancer. It can save your life. Learning to detect the signs of depression and then getting help are essential steps to good health.

Donna Cohen, Ph.D., is a professor in the Department of Aging and Mental Health at the University of South Florida and also head of the Violence and Injury Prevention Project.

©Copyright 2003 St. Petersburg Times. All rights reserved.
June 14, 2002

Letters to the Journal
Albuquerque Journal
PO Drawer J
Albuquerque, NM 87103

Dear Letters to the Journal:

Nine years ago, when my sister Denise took her life by walking in front of a train, everything changed for me. Suddenly, I was thrust into the world of suicide survivorship, one of which I wanted no part. However, I couldn’t bring my sister back and was forced to cope with the fact that she chose to end her life.

Unfortunately, part of being a suicide survivor means one struggles through the insensitivity of others, including the Albuquerque Journal. Twice in this past week, the Journal has used the phrase “commit suicide” (see Monday, June 10, Health Section, New Mexico vital fact “Who are most likely to commit suicide: Men or women?” and Thursday, June 13, Front Section, “Priest Victims Speak” photo caption). To survivors, who had no say in their loved ones’ deaths, this phrase connotes murder. It also leaves the survivor in the closet, afraid to tell others what they are going through, thus complaining grief and leading to other emotional and physical difficulties.

In this country, a person takes his or her life approximately every 17 minutes, leaving behind at least six survivors per death. New Mexico has the fourth highest suicide rate in the United States with 18.3 suicide deaths per 100,000 people (see www.iusb.edu/~jmcintos/ for verification).

The Journal’s job is to educate the public, not hinder the grieving process of those left behind. Help us by using “died by suicide.”

Sincerely,

Michelle Linn-Gust, M.S.
Author, Do They Have Bad Days in Heaven? Surviving the Suicide Loss of a Sibling

© Copyright 2002 Albuquerque Journal. All rights reserved.
Here’s a little-known fact about suicide prevention: For far too long, many in the mental health field have been scared of suicidal people.

Under the old-fashioned way of thinking, it’s been considered dangerous to have people who’ve survived suicide attempts or suicidal thinking get together in something as simple as support groups, for fear that they would make each other worse or even refine methods to try again. The very few people who stood up and spoke publicly about their experience with suicidal thinking were watched with concern.

But that mindset is changing quickly, with a number of historic developments this year alone. A determined effort by a growing community of suicide attempt survivors is leading the mental health field to take a new look at a population that, while at the highest risk for suicide, has long been misunderstood.

One reason for misunderstandings is this: Just two states, Kentucky and Washington, require that mental health professionals be trained in suicide prevention. Most psychiatrists, therapists and social workers get little to no formal training in working with suicidal people, according to a striking 2012 report by the American Association of Suicidology (AAS), the country’s oldest suicide prevention group. How many professionals in other fields can say they aren’t trained in the worst-case scenario?

This situation has prolonged the culture of fear that has kept us from talking about suicide, one of the top 10 causes of death in this country, from a crucial point of view: that of the people who know what being suicidal feels like.

This emerging community is trying to tell us as best as they know how. In perhaps the most striking project, Live Through This, a young Brooklyn photographer challenges us with dozens of portraits of attempt survivors across the country. Each gazes into the camera, daring us to dismiss him or her as “the other.”

Other attempt survivors _ tech workers, journalists, artists, parents, grad students, mental health workers _ are pressing for systems change. This year, AAS made history by creating a division for people who’ve been suicidal, after a spirited grassroots campaign. The American Foundation for Suicide Prevention has started a national series of focus groups to explore how it can engage people who’ve been suicidal.
And an Academy Award-winning documentary team has turned its focus on attempt survivors for its next project, “The S Word.” For every death by suicide, there are dozens of people who survive an attempt. Who are they? Or perhaps more accurately, who are we?
These days, people who once shrank from the idea of suicidal thinking are hustling to keep pace with the changing times.

The U.S. has received quite the road map, too. The National Action Alliance for Suicide Prevention, the publicprivate partnership tasked with carrying out the National Strategy for Suicide Prevention, this summer released a groundbreaking report by its attempt survivor task force. The report, The Way Forward, addresses everything from police response to a suicidal crisis to the alarming practice of expelling or otherwise punishing students who’ve been suicidal. It demands peer support, training for mental health professionals, resources for loved ones and much more.

In short, people who’ve been suicidal are saying they need inclusion, respect and care _ real care. Now the task in the mental health field _ indeed, the health field at large _ is to show leadership and persuade the public that we can talk about suicidal thinking, that this pervasive taboo must come to an end. The
chances are quite good that each one of us knows and loves someone who has been suicidal, but chances are also good that the person has never dared say so.

For the record, that silence is over. Just as people once whispered about cancer, we will one day look back in wonder that we ever whispered about this.

(Links:)


Brooklyn photographer: http://livethroughthis.org/


“The S Word:” http://attemptsurvivors.com/2014/06/16/to-boldly-talk-about-suicide/

American Association of Suicidology

National Suicide Prevention Week

September 7 – 13, 2015

Flyer

Consider a flyer as a short information session. Only the most important and relevant information and statistics should appear.

Use the front page or flap as the introduction to your cause. Include titles and dates. The back of the flyer is a good place to display your contact information and website address so that participants can easily reach you after the event. Include a logo if you have one.

On the ‘inside’ of the flyer, use some space to list the activities that you are hosting, including the title of the activity, the date and time, as well as a location where the activity will take place or start from.

Also on the ‘inside’ on the flyer, include information and statistics on suicide. Edit the sample flyer to suit your needs. For example, if you are a youth organization, include more youth information from the Fact Sheets and omit less relevant material.

Sample Flyer (see next two pages)
[On this flap, insert resources and phone numbers that can help your participants seek information and help.]

[Include future events from your organization's calendar.]

[If you have a sponsor, include their logo, contact info and your appreciation.]

[Insert your list of activities for the week, with date and time as well as location of activity.]

Example:

Suicide Prevention Week Opening Ceremony
Monday, September 7th Noon
Convene at Central Library Park

Suicide Prevention Week Fundraiser Walk
Saturday, September 12th 10:00AM
Walk will begin in front of the Springfield Community Center

National Suicide Prevention Week
“Preventing Suicide: Reaching Out and Saving Lives”

September 7 - 13, 2015

Sponsored by

American Association of Suicidology
Some Facts About Suicide

In 2013, the latest year for which we have data, in the US:

More than 41,100 people died by suicide.

An average of 112.7 individuals per day (one per 12.8 minutes) will die by suicide.

Suicide is the 10th leading cause of death, with a rate of 13.0 per 100,000.

Males complete suicide at a rate 3.5 times that of females; however, females attempt suicide three times more often than males.

The suicide rates for Whites are approximately twice than those of non-Whites.

Mental health diagnoses are generally associated with a higher rate of suicide. The risk for suicide is increased in depressed and alcoholic individuals.

Feelings of hopelessness are found to be more predictive of suicide risk than depression per se.

The vast majority of individuals who are suicidal often display clues and warning signs.

Youth (ages 15-24)

Suicide is the second leading cause of death; only accidents and homicides are more frequent.

The 2013 rate was 11.1 per 100,000 (a total of 4,878).

One youth completes suicide every 1 hour and 48 minutes, which is about 13.4 per day.

Elderly (over 65)

The elderly make up 14.1 of the populations but account for 17.5% of all suicides.

In 2013, there were 7,215 elderly suicides (19.8 per day)

Warning Signs

Mnemonic IS PATH WARM?
I • Ideation
S • Substance Abuse
P • Purposelessness
A • Anxiety
T • Trapped
H • Hopelessness
W • Withdrawal
A • Anger
R • Recklessness
National Suicide Prevention Week
September 7 – 13, 2015

Publicity Ideas

- Send out the Public Service Announcements (PSAs) to the radio and television stations in your community. Send a 15 second and 45 second PSA. Insert your organization’s name.

- Contact the Mayor’s office and/or Governor’s office and request that September 7 -13 be proclaimed as [your city’s] Suicide Prevention Week; arrange press coverage.

- Send the Press Release (with inserts such as fact sheets, the events program, etc.) to all your local papers, to the attention of Health and Science Reporters.

- Contact local organizations to schedule speaking engagements.

- Invite public officials to your events (Mayor, City Council Member, State Senator, Head of the School board, etc.).

- Have an open house or visitors’ day to promote your services and expertise.

- Write an open letter to the editor of your local newspaper emphasizing the importance of early detection of suicidal behavior.

- Invite a “Features” reporter to do a newspaper article about suicide prevention and services for suicidal persons.

- Ask a local radio or television station to broadcast an editorial regarding suicide prevention and services for suicidal persons.

- Offer a training session on suicide assessment, intervention, and resources available in your community.
American Association of Suicidology
Suicide Prevention Week September 7 – 13, 2015

Media Guidelines

The following list of suggestions can help increase your education and prevention efforts in your area through the use of television, newspaper, radio or magazine stories and help you to minimize the potential dangers.

Utilizing the media for awareness, education and prevention:

• Become pro-active with the media. Establish a relationship beforehand. Initiate a contact with a phone call or press release and establish yourself or your agency as a contact on the issue of suicide prevention.

• Emphasize the warning signs of suicide, how to respond to someone who is at risk for suicide, and where to go for help in your community. Wherever possible, present examples of positive outcomes of people in suicidal crises.

• Using personal experiences and case studies can make a point more real and understandable, but be cautious not to reveal information which breaks client confidentiality.

Review statistics so you will not dispense erroneous information. Make it a point to be aware of local or regional statistics, as well as the state and national figures prepared by the American Association of Suicidology. The most current statistics for your state can be obtained from http://webapp.cdc.gov/sasweb/ncipc/mortality10.html.

Use clear, simple terminology that lay readers or viewers will understand.

Refer to www.reportingonsuicide.org for more information, resources and examples of good and bad reporting on suicide

Reporting on Suicide: Suggestions for Online Media, Message Board, Bloggers, & Citizen Journalists

The recommendations to media for reporting on suicide were updated and expanded to include online media. The excerpt below addresses online media reporting about suicide.

• Bloggers, citizen journalists and public commentators can help reduce risk of contagion with posts or links to treatment services, warning signs, and suicide hotlines.

• Include stories of hope and recovery, information on how to overcome suicidal thinking and increase coping skills

• Social networking sites often become memorials to the deceased and should be monitored for hurtful comments and for statements that others are considering suicide. Message board guidelines, policies, and procedures could support removal of inappropriate and/or insensitive posts.

For more information, see www.ReportingOnSuicide.org

In addition, if there are examples of articles that safely report on suicide and National Suicide Prevention Week, make sure to share them on your social network page and link them to your website.
The new recommendations were developed by the following organizations: American Association of Suicidology; American Foundation for Suicide Prevention; Annenberg Public Policy Center; Associated Press Managing Editors; Canterbury Suicide Project – University of Otago, Christchurch, New Zealand; Columbia University Department of Psychiatry; Connect Safely.org; Emotion Technology; International Association for Suicide Prevention Task Force on Media and Suicide; Medical University of Vienna; National Alliance on Mental Illness; National Institute of Mental Health; National Press Photographers Association; New York State Psychiatric Institute; Substance Abuse and Mental Health Services Administration; Suicide Awareness Voices of Education; Suicide Prevention Resource Center; The Centers for Disease Control and Prevention (CDC); and UCLA School of Public Health, Community Health Sciences.
American Association of Suicidology

Suicide Prevention Week September 7 – 13, 2015

Social Media

Like the American Association of Suicidology on Facebook:
https://www.facebook.com/pages/American-Association-of-Suicidology/302698033926

Follow us on Twitter:
https://twitter.com/AASuicidology

Hashtags

Hashtags turn into clickable links in your posts or tweets. This helps people find posts about topics they’re interested in. To create a hashtag, type # before a topic or phrase and add it to your post or tweet.

Suggested Suicide Prevention Week hashtags:
#NSPW (National Suicide Prevention Week)
#SPSM (Suicide Prevention Social Media)
#SuicidePrevention
#Suicide
#WSPD (World Suicide Prevention Day)

Profile Pictures:

You can change your profile pictures on Facebook and Twitter. Visit http://www.suicidology.org/about-aas/national-suicide-prevention-week/profile-pictures
Graphics to post

AAS has graphics that you can share via social media. To download go to: http://www.suicidology.org/about-aas/national-suicide-prevention-week/myth-fact
Part C. Information about Suicide

The Fact Sheets in this section are also available on our website. These information sheets are compiled by AAS and are available for public use. Make as many copies as you need.
**U.S.A. SUICIDE: 2013 OFFICIAL FINAL DATA**

<table>
<thead>
<tr>
<th>Group</th>
<th>Number</th>
<th>Per Day</th>
<th>Rate</th>
<th>% of Deaths</th>
<th>Group (Number of Suicides)</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nation</td>
<td>41,149</td>
<td>112.7</td>
<td>13.0</td>
<td>1.6</td>
<td>White Male (28,943)</td>
<td>23.4</td>
</tr>
<tr>
<td>Males</td>
<td>32,055</td>
<td>104.3</td>
<td>13.0</td>
<td>2.5</td>
<td>White Female (8,211)</td>
<td>6.5</td>
</tr>
<tr>
<td>Females</td>
<td>9,094</td>
<td>24.9</td>
<td>5.7</td>
<td>0.7</td>
<td>Nonwhite Male (3,112)</td>
<td>9.7</td>
</tr>
<tr>
<td>Whites</td>
<td>37,154</td>
<td>101.8</td>
<td>14.9</td>
<td>1.7</td>
<td>Nonwhite Female (883)</td>
<td>2.6</td>
</tr>
<tr>
<td>Nonwhites</td>
<td>3,995</td>
<td>10.9</td>
<td>6.0</td>
<td>1.1</td>
<td>Black Male (1,891)</td>
<td>9.0</td>
</tr>
<tr>
<td>Blacks</td>
<td>2,583</td>
<td>6.4</td>
<td>5.4</td>
<td>0.8</td>
<td>Black Female (462)</td>
<td>2.0</td>
</tr>
<tr>
<td>Elderly (65+ yrs)</td>
<td>7,215</td>
<td>19.8</td>
<td>16.1</td>
<td>0.4</td>
<td>Hispanic (2,865)</td>
<td>5.3</td>
</tr>
<tr>
<td>Young (15-24 yrs)</td>
<td>4,878</td>
<td>13.4</td>
<td>11.1</td>
<td>1.7</td>
<td>Native Americans (521)</td>
<td>11.7</td>
</tr>
<tr>
<td>Middle Aged (45-64 yrs)</td>
<td>15,755</td>
<td>43.2</td>
<td>19.0</td>
<td>3.1</td>
<td>Asian/Pacific Islanders (1,121)</td>
<td>6.0</td>
</tr>
</tbody>
</table>

**Fatal Outcomes (Suicides):** a minimal rate increase was seen from 2001 to 2013, continuing the recent rate increases after long-term trends of decline

- Average of 1 person every 128 minutes killed themselves
- Average of 1 person every 1 hour and 13 minutes killed themselves
- Average of 1 young person every 1 hour and 48 minutes killed themselves. (If the 395 suicides below age 15 are included, 1 young person every 1 hour and 40 minutes)

- 10 ranking cause of death in U.S. — 2nd for young people

- 35 male deaths by suicide for each female death by suicide
- Suicide ranks 10th as a cause of death; Homicide ranks 16th

**Nonfatal Outcomes (Attempts):** figures are estimates:

- 1,028,725 annual attempts in U.S. (using 25.1 ratio); 2013 SAMSHA study: 1.3 million adults (18 and up)
- Translates to one attempt every 31 minutes (based on 1,028,725 attempts) 1.3 million = 1 every 24 seconds
- 25 attempts for every death by suicide for nation (one estimate); 100-200 for young; 4-10 for elderly
- 3 female attempts for each male attempt

**Exposure to Suicide ("know someone who died by suicide") and Suicide Loss Survivors (those bereaved by suicide):**

- Recent (Cerd, 2015) research-based estimate suggests that for each death by suicide 115 people are exposed (4.7 million annually, and among those 25 experience a major life disruption (loss survivors)

- If each suicide has devastating effects and intimately affects 25 other people, there are over 1 million loss survivors a year

- Based on the 825,832 suicides from 1989 through 2013, therefore, the number of survivors of suicide loss in the U.S. is 20.6 million (1 of every 15 Americans in 2013); number grew by 1,028,725 in 2013

- If there is a suicide every 12.8 minutes, then there are 25 new loss survivors every 12.8 minutes as well

**Suicide Methods**

<table>
<thead>
<tr>
<th>Method</th>
<th>Number</th>
<th>Rate</th>
<th>Percent of Total</th>
<th>Number</th>
<th>Rate</th>
<th>Percent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Firearm suicides (1st)</td>
<td>21,755</td>
<td>6.7</td>
<td>51.9%</td>
<td>All but Firearms</td>
<td>10,974</td>
<td>6.2</td>
</tr>
<tr>
<td>Suffocation/Hanging (2nd)</td>
<td>10,062</td>
<td>3.2</td>
<td>24.5%</td>
<td>Poisoning (3rd)</td>
<td>6,337</td>
<td>2.1</td>
</tr>
<tr>
<td>Cut/pierce</td>
<td>783</td>
<td>0.2</td>
<td>1.9%</td>
<td>Drowning</td>
<td>397</td>
<td>0.1</td>
</tr>
</tbody>
</table>

**U.S. Suicide Rates 2003-2013**

<table>
<thead>
<tr>
<th>Group</th>
<th>Rate (per 100,000 population)</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
</table>
| 15 Leading Causes of Death in the U.S. 2013

- D/L of 2,896,993 deaths: 821.5 rate

- Group 1: Diseases of heart (heart disease)
- Group 2: Dis/accidents (miscellaneous injury)
- Group 3: Chronic lower respiratory disease
- Group 4: Accidents (miscellaneous injury)
- Group 5: Cerebrovascular diseases (stroke)
- Group 6: Alzheimer’s disease
- Group 7: Diabetes mellitus (diabetes)
- Group 8: Influenza & pneumonia
- Group 9: Nephritis, nephrosis (kidney disease)
- Group 10: Suicide (Intentional Self-Harm)
- Group 11: Septicemia
- Group 12: Chronic liver disease and cirrhosis
- Group 13: Hyperlipidemia and renal disease
- Group 14: Parkinson’s disease
- Group 15: Other causes (Residual)

- Old made up 14.3% of 2013 population but 17.5% of the suicides
- Young were 13.9% of 2013 population and 11.9% of the suicides
- Middle aged were 26.3% of the 2012 population but 38.3% of the suicides
- 1,109,291st Year of Potential Life Lost before Age 73 (37,729 of 41,149 suicides below age 73)

- Suicide rate = (number of suicides by group / population of group) X 100,000

Suicide Data Pages: 2013
Prepared for AAS by Christopher W. Deagean, MA, & John L. McIntosh, Ph.D. 7 January 2015 • Revised 22 January 2015 & 24 April 2015
# Rate, Number, and Ranking of Suicide for Each U.S.A. State*, 2013

<table>
<thead>
<tr>
<th>Rank</th>
<th>State [Division / Region]</th>
<th>Deaths</th>
<th>Rate</th>
<th>Division [Abbreviation]</th>
<th>Rate</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Alaska [P / West]</td>
<td>171</td>
<td>23.3</td>
<td>East South Central [ESC]</td>
<td>15.2</td>
<td>2,840</td>
</tr>
<tr>
<td>3</td>
<td>Wyoming [M / West]</td>
<td>129</td>
<td>22.1</td>
<td>West North Central [WNC]</td>
<td>14.4</td>
<td>3,005</td>
</tr>
<tr>
<td>4</td>
<td>New Mexico [M / West]</td>
<td>431</td>
<td>20.7</td>
<td>South Atlantic [SA]</td>
<td>13.3</td>
<td>8,244</td>
</tr>
<tr>
<td>5</td>
<td>Utah [M / West]</td>
<td>579</td>
<td>20.0</td>
<td>Nation</td>
<td>13.0</td>
<td>41,149</td>
</tr>
<tr>
<td>6</td>
<td>Nevada [M / West]</td>
<td>541</td>
<td>19.4</td>
<td>West South Central [WSC]</td>
<td>12.7</td>
<td>4,823</td>
</tr>
<tr>
<td>7</td>
<td>Colorado [M / West]</td>
<td>1,007</td>
<td>19.1</td>
<td>East North Central [ENC]</td>
<td>12.7</td>
<td>5,936</td>
</tr>
<tr>
<td>7</td>
<td>Idaho [M / West]</td>
<td>308</td>
<td>19.1</td>
<td>Pacific [P]</td>
<td>11.9</td>
<td>6,092</td>
</tr>
<tr>
<td>9</td>
<td>Maine [NE / Northeast]</td>
<td>245</td>
<td>18.4</td>
<td>New England [NE]</td>
<td>10.8</td>
<td>1,576</td>
</tr>
<tr>
<td>10</td>
<td>Vermont [NE / Northeast]</td>
<td>112</td>
<td>17.9</td>
<td>Middle Atlantic [MA]</td>
<td>10.2</td>
<td>4,232</td>
</tr>
<tr>
<td>11</td>
<td>Oregon [P / West]</td>
<td>698</td>
<td>17.8</td>
<td>Nation</td>
<td>13.0</td>
<td>41,149</td>
</tr>
<tr>
<td>12</td>
<td>North Dakota [WNC / Midwest]</td>
<td>128</td>
<td>17.7</td>
<td>Nation</td>
<td>13.0</td>
<td>41,149</td>
</tr>
<tr>
<td>13</td>
<td>Arizona [M / West]</td>
<td>1,163</td>
<td>17.6</td>
<td>Nation</td>
<td>13.0</td>
<td>41,149</td>
</tr>
<tr>
<td>14</td>
<td>Arkansas [WSC / South]</td>
<td>516</td>
<td>17.4</td>
<td>Nation</td>
<td>13.0</td>
<td>41,149</td>
</tr>
<tr>
<td>14</td>
<td>South Dakota [WNC / Midwest]</td>
<td>147</td>
<td>17.4</td>
<td>Nation</td>
<td>13.0</td>
<td>41,149</td>
</tr>
<tr>
<td>16</td>
<td>West Virginia [SA / South]</td>
<td>323</td>
<td>17.4</td>
<td>Nation</td>
<td>13.0</td>
<td>41,149</td>
</tr>
<tr>
<td>17</td>
<td>Oklahoma [WSC / South]</td>
<td>365</td>
<td>17.3</td>
<td>Nation</td>
<td>13.0</td>
<td>41,149</td>
</tr>
<tr>
<td>18</td>
<td>Kentucky [ESC / South]</td>
<td>701</td>
<td>15.9</td>
<td>Nation</td>
<td>13.0</td>
<td>41,149</td>
</tr>
<tr>
<td>18</td>
<td>Missouri [WNC / Midwest]</td>
<td>960</td>
<td>15.9</td>
<td>Nation</td>
<td>13.0</td>
<td>41,149</td>
</tr>
<tr>
<td>18</td>
<td>Tennessee [ESC / South]</td>
<td>1,030</td>
<td>15.9</td>
<td>Nation</td>
<td>13.0</td>
<td>41,149</td>
</tr>
<tr>
<td>21</td>
<td>Florida [SA / South]</td>
<td>2,928</td>
<td>15.0</td>
<td>Nation</td>
<td>13.0</td>
<td>41,149</td>
</tr>
<tr>
<td>22</td>
<td>Alabama [ESC / South]</td>
<td>721</td>
<td>14.9</td>
<td>Nation</td>
<td>13.0</td>
<td>41,149</td>
</tr>
<tr>
<td>23</td>
<td>Wisconsin [ENC / Midwest]</td>
<td>850</td>
<td>14.8</td>
<td>Midwest (WNC, ENC)</td>
<td>13.2</td>
<td>8,941</td>
</tr>
<tr>
<td>24</td>
<td>Kansas [WNC / Midwest]</td>
<td>425</td>
<td>14.7</td>
<td>Nation</td>
<td>13.0</td>
<td>41,149</td>
</tr>
<tr>
<td>24</td>
<td>Washington [P / West]</td>
<td>1,027</td>
<td>14.7</td>
<td>Nation</td>
<td>13.0</td>
<td>41,149</td>
</tr>
<tr>
<td>26</td>
<td>South Carolina [SA / South]</td>
<td>696</td>
<td>14.6</td>
<td>Nation</td>
<td>13.0</td>
<td>41,149</td>
</tr>
<tr>
<td>27</td>
<td>Iowa [WNC / Midwest]</td>
<td>447</td>
<td>14.5</td>
<td>Nation</td>
<td>13.0</td>
<td>41,149</td>
</tr>
<tr>
<td>28</td>
<td>Indiana [ENC / Midwest]</td>
<td>944</td>
<td>14.4</td>
<td>Nation</td>
<td>13.0</td>
<td>41,149</td>
</tr>
<tr>
<td>29</td>
<td>New Hampshire [NE / Northeast]</td>
<td>185</td>
<td>14.0</td>
<td>Nation</td>
<td>13.0</td>
<td>41,149</td>
</tr>
<tr>
<td>29</td>
<td>Kentucky [ESC / South]</td>
<td>701</td>
<td>14.0</td>
<td>Nation</td>
<td>13.0</td>
<td>41,149</td>
</tr>
<tr>
<td>31</td>
<td>Delaware [SA / South]</td>
<td>122</td>
<td>13.2</td>
<td>Nation</td>
<td>13.0</td>
<td>41,149</td>
</tr>
<tr>
<td>31</td>
<td>Ohio [ENC / Midwest]</td>
<td>1,526</td>
<td>13.2</td>
<td>Nation</td>
<td>13.0</td>
<td>41,149</td>
</tr>
<tr>
<td>33</td>
<td>Michigan [ENC / Midwest]</td>
<td>1,295</td>
<td>13.1</td>
<td>Nation</td>
<td>13.0</td>
<td>41,149</td>
</tr>
<tr>
<td>34</td>
<td>Mississippi [ESC / South]</td>
<td>388</td>
<td>13.0</td>
<td>Nation</td>
<td>13.0</td>
<td>41,149</td>
</tr>
<tr>
<td>34</td>
<td>North Carolina [SA / South]</td>
<td>1,284</td>
<td>13.0</td>
<td>Nation</td>
<td>13.0</td>
<td>41,149</td>
</tr>
<tr>
<td>34</td>
<td>Virginia [SA / South]</td>
<td>1,072</td>
<td>13.0</td>
<td>Nation</td>
<td>13.0</td>
<td>41,149</td>
</tr>
</tbody>
</table>

**Nation** | 41,149 | 13.0

### Source:
Note: Divisional and regional figures were calculated from state data. Some figures derived or calculated from data at the CDC’s WISQARS Fatal Injuries Report site downloaded 22 January 2015: [http://www.cdc.gov/injury/wisqars/fatal_injury_reports.html](http://www.cdc.gov/injury/wisqars/fatal_injury_reports.html).

**[data are by place of residence]**
**[Suicide = ICD-10 Codes X60-X84, Y87.0, U03]**

**Note:** All rates are per 100,000 population.

* Including the District of Columbia.

---

**Suicide State Data Page: 2013**
7 January 2015 Revised 22 January 2015
Prepared by Christopher W. Drapeau, M.A.
and John L. McIntosh, Ph.D. for

---

**American Association of Suicidology**
5221 Wisconsin Avenue, N.W.
Washington, DC 20015
(202) 237-2280

“to understand and prevent suicide as a means of promoting human well-being”

Visit the AAS website at: [http://www.suicidology.org](http://www.suicidology.org)

For other suicide data, and an archive of state data, visit the website below and click on the dropdown “Suicide Stats” menu:
[http://mypage.iusb.edu/~jmcintos/](http://mypage.iusb.edu/~jmcintos/)
<table>
<thead>
<tr>
<th>Rank</th>
<th>State</th>
<th>Rate</th>
<th>Rank</th>
<th>State</th>
<th>Rate</th>
<th>Rank</th>
<th>State</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Montana</td>
<td>23.9</td>
<td>1</td>
<td>Wyoming</td>
<td>30.5</td>
<td>1</td>
<td>Alaska</td>
<td>38.2</td>
</tr>
<tr>
<td>2</td>
<td>Alaska</td>
<td>23.3</td>
<td>2</td>
<td>Nevada</td>
<td>29.9</td>
<td>2</td>
<td>North Dakota</td>
<td>30.4</td>
</tr>
<tr>
<td>3</td>
<td>Wyoming</td>
<td>22.1</td>
<td>3</td>
<td>Idaho</td>
<td>25.5</td>
<td>3</td>
<td>South Dakota</td>
<td>29.6</td>
</tr>
<tr>
<td>4</td>
<td>New Mexico</td>
<td>20.7</td>
<td>4</td>
<td>New Mexico</td>
<td>24.6</td>
<td>4</td>
<td>Montana</td>
<td>28.3</td>
</tr>
<tr>
<td>5</td>
<td>Utah</td>
<td>20.0</td>
<td>5</td>
<td>Alaska</td>
<td>24.2</td>
<td>5</td>
<td>Wyoming</td>
<td>27.2</td>
</tr>
<tr>
<td>6</td>
<td>Nevada</td>
<td>19.4</td>
<td>6</td>
<td>Vermont</td>
<td>23.4</td>
<td>6</td>
<td>Idaho</td>
<td>20.4</td>
</tr>
<tr>
<td>7</td>
<td>Colorado</td>
<td>19.1</td>
<td>7</td>
<td>Oregon</td>
<td>22.9</td>
<td>7</td>
<td>New Mexico</td>
<td>18.7</td>
</tr>
<tr>
<td>8</td>
<td>Idaho</td>
<td>19.1</td>
<td>8</td>
<td>Colorado</td>
<td>22.7</td>
<td>8</td>
<td>Colorado</td>
<td>18.3</td>
</tr>
<tr>
<td>9</td>
<td>Maine</td>
<td>18.4</td>
<td>9</td>
<td>Arizona</td>
<td>22.6</td>
<td>9</td>
<td>Utah</td>
<td>18.1</td>
</tr>
<tr>
<td>10</td>
<td>Vermont</td>
<td>17.9</td>
<td>10</td>
<td>Utah</td>
<td>22.6</td>
<td>10</td>
<td>Arkansas</td>
<td>16.7</td>
</tr>
<tr>
<td>11</td>
<td>Oregon</td>
<td>17.8</td>
<td>11</td>
<td>Montana</td>
<td>22.5</td>
<td>11</td>
<td>Oregon</td>
<td>16.5</td>
</tr>
<tr>
<td>12</td>
<td>North Dakota</td>
<td>17.7</td>
<td>12</td>
<td>West Virginia</td>
<td>21.3</td>
<td>12</td>
<td>Hawaii</td>
<td>16.2</td>
</tr>
<tr>
<td>13</td>
<td>Arizona</td>
<td>17.6</td>
<td>13</td>
<td>Oklahoma</td>
<td>20.4</td>
<td>13</td>
<td>Maine</td>
<td>16.0</td>
</tr>
<tr>
<td>14</td>
<td>Arkansas</td>
<td>17.4</td>
<td>14</td>
<td>Washington</td>
<td>20.4</td>
<td>14</td>
<td>Oklahoma</td>
<td>14.7</td>
</tr>
<tr>
<td>15</td>
<td>West Virginia</td>
<td>17.4</td>
<td>15</td>
<td>Arkansas</td>
<td>20.0</td>
<td>15</td>
<td>Vermont</td>
<td>14.5</td>
</tr>
<tr>
<td>16</td>
<td>South Dakota</td>
<td>17.4</td>
<td>16</td>
<td>Florida</td>
<td>19.7</td>
<td>16</td>
<td>Kentucky</td>
<td>14.3</td>
</tr>
<tr>
<td>17</td>
<td>Oklahoma</td>
<td>17.3</td>
<td>17</td>
<td>Tennessee</td>
<td>19.3</td>
<td>17</td>
<td>Iowa</td>
<td>14.1</td>
</tr>
<tr>
<td>18</td>
<td>Kentucky</td>
<td>16.0</td>
<td>18</td>
<td>Alabama</td>
<td>19.1</td>
<td>18</td>
<td>Arizona</td>
<td>13.9</td>
</tr>
<tr>
<td>19</td>
<td>Missouri</td>
<td>15.9</td>
<td>19</td>
<td>Kentucky</td>
<td>19.1</td>
<td>19</td>
<td>Washington</td>
<td>13.5</td>
</tr>
<tr>
<td>20</td>
<td>Tennessee</td>
<td>15.9</td>
<td>20</td>
<td>South Carolina</td>
<td>18.1</td>
<td>20</td>
<td>Missouri</td>
<td>13.2</td>
</tr>
<tr>
<td>21</td>
<td>Florida</td>
<td>15.0</td>
<td>21</td>
<td>Maine</td>
<td>17.9</td>
<td>21</td>
<td>Kansas</td>
<td>13.1</td>
</tr>
<tr>
<td>22</td>
<td>Alabama</td>
<td>14.9</td>
<td>22</td>
<td>Missouri</td>
<td>17.4</td>
<td>22</td>
<td>Wisconsin</td>
<td>12.9</td>
</tr>
<tr>
<td>23</td>
<td>Wisconsin</td>
<td>14.8</td>
<td>23</td>
<td>California</td>
<td>17.0</td>
<td>23</td>
<td>Michigan</td>
<td>12.7</td>
</tr>
<tr>
<td>24</td>
<td>Washington</td>
<td>14.7</td>
<td>24</td>
<td>Louisiana</td>
<td>16.6</td>
<td>24</td>
<td>Indiana</td>
<td>12.5</td>
</tr>
<tr>
<td>25</td>
<td>Kansas</td>
<td>14.7</td>
<td>25</td>
<td>Virginia</td>
<td>16.5</td>
<td>25</td>
<td>South Carolina</td>
<td>12.5</td>
</tr>
<tr>
<td>26</td>
<td>South Carolina</td>
<td>14.6</td>
<td>26</td>
<td>Kansas</td>
<td>16.3</td>
<td>26</td>
<td>Minnesota</td>
<td>12.4</td>
</tr>
<tr>
<td>27</td>
<td>Iowa</td>
<td>14.5</td>
<td>27</td>
<td>Total - Elderly</td>
<td>16.1</td>
<td>27</td>
<td>Tennessee</td>
<td>12.3</td>
</tr>
<tr>
<td>28</td>
<td>Indiana</td>
<td>14.4</td>
<td>28</td>
<td>Texas</td>
<td>16.1</td>
<td>28</td>
<td>Pennsylvania</td>
<td>12.1</td>
</tr>
<tr>
<td>29</td>
<td>Pennsylvania</td>
<td>14.0</td>
<td>29</td>
<td>Nebraska</td>
<td>16.0</td>
<td>29</td>
<td>Nevada</td>
<td>12.0</td>
</tr>
<tr>
<td>30</td>
<td>New Hampshire</td>
<td>14.0</td>
<td>30</td>
<td>Iowa</td>
<td>15.8</td>
<td>30</td>
<td>Alabama</td>
<td>11.7</td>
</tr>
<tr>
<td>31</td>
<td>Ohio</td>
<td>13.2</td>
<td>31</td>
<td>Georgia</td>
<td>15.5</td>
<td>31</td>
<td>Virginia</td>
<td>11.2</td>
</tr>
<tr>
<td>32</td>
<td>Delaware</td>
<td>13.2</td>
<td>32</td>
<td>North Carolina</td>
<td>15.3</td>
<td>32</td>
<td>Delaware</td>
<td>11.2</td>
</tr>
<tr>
<td>33</td>
<td>Michigan</td>
<td>13.1</td>
<td>33</td>
<td>Ohio</td>
<td>15.2</td>
<td>33</td>
<td>Total - Young</td>
<td>11.1</td>
</tr>
<tr>
<td>34</td>
<td>North Carolina</td>
<td>13.0</td>
<td>34</td>
<td>Indiana</td>
<td>15.2</td>
<td>34</td>
<td>Nebraska</td>
<td>11.0</td>
</tr>
<tr>
<td>35</td>
<td>Virginia</td>
<td>13.0</td>
<td>35</td>
<td>Wisconsin</td>
<td>14.8</td>
<td>35</td>
<td>Louisiana</td>
<td>11.0</td>
</tr>
<tr>
<td>36</td>
<td>Mississippi</td>
<td>13.0</td>
<td>36</td>
<td>Mississippi</td>
<td>14.2</td>
<td>36</td>
<td>Texas</td>
<td>11.0</td>
</tr>
<tr>
<td>37</td>
<td>Louisiana</td>
<td>12.6</td>
<td>37</td>
<td>Nebraska</td>
<td>14.0</td>
<td>37</td>
<td>New Hampshire</td>
<td>10.6</td>
</tr>
<tr>
<td>38</td>
<td>Rhode Island</td>
<td>12.6</td>
<td>38</td>
<td>Michigan</td>
<td>13.9</td>
<td>38</td>
<td>Ohio</td>
<td>10.6</td>
</tr>
<tr>
<td>39</td>
<td>Minnesota</td>
<td>12.5</td>
<td>39</td>
<td>Minnesota</td>
<td>13.5</td>
<td>39</td>
<td>Mississippi</td>
<td>10.5</td>
</tr>
<tr>
<td>40</td>
<td>Hawaii</td>
<td>12.2</td>
<td>40</td>
<td>Delaware</td>
<td>12.9</td>
<td>40</td>
<td>Georgia</td>
<td>10.5</td>
</tr>
<tr>
<td>41</td>
<td>Georgia</td>
<td>12.1</td>
<td>41</td>
<td>Rhode Island</td>
<td>12.3</td>
<td>41</td>
<td>Maryland</td>
<td>10.1</td>
</tr>
<tr>
<td>42</td>
<td>Nebraska</td>
<td>11.8</td>
<td>42</td>
<td>New York</td>
<td>10.5</td>
<td>42</td>
<td>Florida</td>
<td>9.5</td>
</tr>
<tr>
<td>43</td>
<td>Texas</td>
<td>11.6</td>
<td>43</td>
<td>New Jersey</td>
<td>10.4</td>
<td>43</td>
<td>Illinois</td>
<td>9.1</td>
</tr>
<tr>
<td>44</td>
<td>California</td>
<td>10.5</td>
<td>44</td>
<td>New Hampshire</td>
<td>10.3</td>
<td>44</td>
<td>West Virginia</td>
<td>8.8</td>
</tr>
<tr>
<td>45</td>
<td>Illinois</td>
<td>10.3</td>
<td>45</td>
<td>Maryland</td>
<td>10.2</td>
<td>45</td>
<td>Massachusetts</td>
<td>8.3</td>
</tr>
<tr>
<td>46</td>
<td>Maryland</td>
<td>9.6</td>
<td>46</td>
<td>Hawaii</td>
<td>8.7</td>
<td>46</td>
<td>California</td>
<td>8.2</td>
</tr>
<tr>
<td>47</td>
<td>Connecticut</td>
<td>9.2</td>
<td>47</td>
<td>South Dakota</td>
<td>7.9</td>
<td>47</td>
<td>New Jersey</td>
<td>7.5</td>
</tr>
<tr>
<td>48</td>
<td>New York</td>
<td>8.6</td>
<td>48</td>
<td>Connecticut</td>
<td>7.9</td>
<td>48</td>
<td>New York</td>
<td>6.2</td>
</tr>
<tr>
<td>49</td>
<td>Massachusetts</td>
<td>8.6</td>
<td>49</td>
<td>Massachusetts</td>
<td>7.7</td>
<td>49</td>
<td>Connecticut</td>
<td>5.3</td>
</tr>
</tbody>
</table>


"Rate" refers to "Crude Rate" which are rates per 100,000 population

Prepared by John L. McIntosh, Indiana University South Bend for posting by the American Association of Suicidology (www.suicidology.org)
<table>
<thead>
<tr>
<th>Rank</th>
<th>State</th>
<th>Both Sexes Combined</th>
<th>Rank</th>
<th>State</th>
<th>Men</th>
<th>Rank</th>
<th>State</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Montana</td>
<td>23.9</td>
<td>1</td>
<td>Wyoming</td>
<td>37.7</td>
<td>1</td>
<td>Montana</td>
<td>12.1</td>
</tr>
<tr>
<td>2</td>
<td>Alaska</td>
<td>23.3</td>
<td>2</td>
<td>Montana</td>
<td>35.7</td>
<td>2</td>
<td>New Mexico</td>
<td>10.3</td>
</tr>
<tr>
<td>3</td>
<td>Wyoming</td>
<td>22.1</td>
<td>3</td>
<td>Alaska</td>
<td>35.5</td>
<td>3</td>
<td>Colorado</td>
<td>9.8</td>
</tr>
<tr>
<td>4</td>
<td>New Mexico</td>
<td>20.7</td>
<td>4</td>
<td>New Mexico</td>
<td>31.3</td>
<td>4</td>
<td>Alaska</td>
<td>9.7</td>
</tr>
<tr>
<td>5</td>
<td>Utah</td>
<td>20.0</td>
<td>5</td>
<td>Utah</td>
<td>30.9</td>
<td>5</td>
<td>Vermont</td>
<td>9.5</td>
</tr>
<tr>
<td>6</td>
<td>Nevada</td>
<td>19.4</td>
<td>6</td>
<td>Idaho</td>
<td>30.7</td>
<td>6</td>
<td>Nevada</td>
<td>9.1</td>
</tr>
<tr>
<td>7</td>
<td>Colorado</td>
<td>19.1</td>
<td>7</td>
<td>Maine</td>
<td>29.7</td>
<td>7</td>
<td>Utah</td>
<td>8.9</td>
</tr>
<tr>
<td>8</td>
<td>Idaho</td>
<td>19.1</td>
<td>8</td>
<td>Nevada</td>
<td>29.5</td>
<td>8</td>
<td>Oregon</td>
<td>8.2</td>
</tr>
<tr>
<td>9</td>
<td>Maine</td>
<td>18.4</td>
<td>9</td>
<td>West Virginia</td>
<td>29.5</td>
<td>9</td>
<td>Arizona</td>
<td>8.0</td>
</tr>
<tr>
<td>10</td>
<td>Vermont</td>
<td>17.9</td>
<td>10</td>
<td>South Dakota</td>
<td>29.2</td>
<td>10</td>
<td>Idaho</td>
<td>8.0</td>
</tr>
<tr>
<td>11</td>
<td>Oregon</td>
<td>17.8</td>
<td>11</td>
<td>North Dakota</td>
<td>29.2</td>
<td>11</td>
<td>Maine</td>
<td>7.7</td>
</tr>
<tr>
<td>12</td>
<td>North Dakota</td>
<td>17.7</td>
<td>12</td>
<td>Arkansas</td>
<td>29.0</td>
<td>12</td>
<td>Washington</td>
<td>7.2</td>
</tr>
<tr>
<td>13</td>
<td>Arizona</td>
<td>17.6</td>
<td>13</td>
<td>Colorado</td>
<td>28.3</td>
<td>13</td>
<td>Florida</td>
<td>6.9</td>
</tr>
<tr>
<td>14</td>
<td>Arkansas</td>
<td>17.4</td>
<td>14</td>
<td>Oklahoma</td>
<td>27.8</td>
<td>14</td>
<td>Oklahoma</td>
<td>6.9</td>
</tr>
<tr>
<td>15</td>
<td>West Virginia</td>
<td>17.4</td>
<td>15</td>
<td>Oregon</td>
<td>27.6</td>
<td>15</td>
<td>Kentucky</td>
<td>6.7</td>
</tr>
<tr>
<td>16</td>
<td>South Dakota</td>
<td>17.4</td>
<td>16</td>
<td>Arizona</td>
<td>27.2</td>
<td>16</td>
<td>New Hampshire</td>
<td>6.6</td>
</tr>
<tr>
<td>17</td>
<td>Oklahoma</td>
<td>17.3</td>
<td>17</td>
<td>Vermont</td>
<td>26.5</td>
<td>17</td>
<td>Delaware</td>
<td>6.5</td>
</tr>
<tr>
<td>18</td>
<td>Kentucky</td>
<td>16.0</td>
<td>18</td>
<td>Tennessee</td>
<td>26.2</td>
<td>18</td>
<td>Arkansas</td>
<td>6.3</td>
</tr>
<tr>
<td>19</td>
<td>Missouri</td>
<td>15.9</td>
<td>19</td>
<td>Missouri</td>
<td>26.0</td>
<td>19</td>
<td>Missouri</td>
<td>6.2</td>
</tr>
<tr>
<td>20</td>
<td>Tennessee</td>
<td>15.9</td>
<td>20</td>
<td>Kentucky</td>
<td>25.5</td>
<td>20</td>
<td>Alabama</td>
<td>6.2</td>
</tr>
<tr>
<td>21</td>
<td>Florida</td>
<td>15.0</td>
<td>21</td>
<td>Wisconsin</td>
<td>24.3</td>
<td>21</td>
<td>Tennessee</td>
<td>6.0</td>
</tr>
<tr>
<td>22</td>
<td>Alabama</td>
<td>14.9</td>
<td>22</td>
<td>Alabama</td>
<td>24.2</td>
<td>22</td>
<td>South Carolina</td>
<td>6.0</td>
</tr>
<tr>
<td>23</td>
<td>Wisconsin</td>
<td>14.8</td>
<td>23</td>
<td>Kansas</td>
<td>23.9</td>
<td>23</td>
<td>Wyoming</td>
<td>6.0</td>
</tr>
<tr>
<td>24</td>
<td>Washington</td>
<td>14.7</td>
<td>24</td>
<td>Iowa</td>
<td>23.7</td>
<td>24</td>
<td>North Carolina</td>
<td>5.8</td>
</tr>
<tr>
<td>25</td>
<td>Kansas</td>
<td>14.7</td>
<td>25</td>
<td>South Carolina</td>
<td>23.7</td>
<td>25</td>
<td>Pennsylvania</td>
<td>5.8</td>
</tr>
<tr>
<td>26</td>
<td>South Carolina</td>
<td>14.6</td>
<td>26</td>
<td>Florida</td>
<td>23.4</td>
<td>26</td>
<td>Hawaii</td>
<td>5.8</td>
</tr>
<tr>
<td>27</td>
<td>Iowa</td>
<td>14.5</td>
<td>27</td>
<td>Indiana</td>
<td>23.3</td>
<td>27</td>
<td>Ohio</td>
<td>5.7</td>
</tr>
<tr>
<td>28</td>
<td>Indiana</td>
<td>14.4</td>
<td>28</td>
<td>Pennsylvania</td>
<td>22.8</td>
<td>28</td>
<td>Indiana</td>
<td>5.7</td>
</tr>
<tr>
<td>29</td>
<td>Pennsylvania</td>
<td>14.0</td>
<td>29</td>
<td>Washington</td>
<td>22.3</td>
<td>29</td>
<td>North Dakota</td>
<td>5.7</td>
</tr>
<tr>
<td>30</td>
<td>New Hampshire</td>
<td>14.0</td>
<td>30</td>
<td>New Hampshire</td>
<td>21.8</td>
<td>30</td>
<td>West Virginia</td>
<td>5.7</td>
</tr>
<tr>
<td>31</td>
<td>Ohio</td>
<td>13.2</td>
<td>31</td>
<td>Mississippi</td>
<td>21.0</td>
<td>31</td>
<td>Virginia</td>
<td>5.6</td>
</tr>
<tr>
<td>32</td>
<td>Delaware</td>
<td>13.2</td>
<td>32</td>
<td>Ohio</td>
<td>21.0</td>
<td>32</td>
<td>Michigan</td>
<td>5.6</td>
</tr>
<tr>
<td>33</td>
<td>Michigan</td>
<td>13.1</td>
<td>33</td>
<td>Michigan</td>
<td>20.9</td>
<td>33</td>
<td>Rhode Island</td>
<td>5.5</td>
</tr>
<tr>
<td>34</td>
<td>North Carolina</td>
<td>13.0</td>
<td>34</td>
<td>North Carolina</td>
<td>20.8</td>
<td>34</td>
<td>Kansas</td>
<td>5.5</td>
</tr>
<tr>
<td>35</td>
<td>Virginia</td>
<td>13.0</td>
<td>35</td>
<td>Virginia</td>
<td>20.8</td>
<td>35</td>
<td>Total - Women</td>
<td></td>
</tr>
<tr>
<td>36</td>
<td>Mississippi</td>
<td>13.0</td>
<td>36</td>
<td>Total - Men</td>
<td>20.8</td>
<td>36</td>
<td>South Dakota</td>
<td>5.5</td>
</tr>
<tr>
<td>37</td>
<td>Louisiana</td>
<td>12.6</td>
<td>37</td>
<td>Delaware</td>
<td>20.3</td>
<td>37</td>
<td>Mississippi</td>
<td>5.4</td>
</tr>
<tr>
<td>38</td>
<td>Rhode Island</td>
<td>12.6</td>
<td>38</td>
<td>Rhode Island</td>
<td>20.0</td>
<td>38</td>
<td>Iowa</td>
<td>5.3</td>
</tr>
<tr>
<td>39</td>
<td>Minnesota</td>
<td>12.5</td>
<td>39</td>
<td>Minnesota</td>
<td>19.8</td>
<td>39</td>
<td>Minnesota</td>
<td>5.3</td>
</tr>
<tr>
<td>40</td>
<td>Hawaii</td>
<td>12.2</td>
<td>40</td>
<td>Georgia</td>
<td>19.3</td>
<td>40</td>
<td>Georgia</td>
<td>5.3</td>
</tr>
<tr>
<td>41</td>
<td>Georgia</td>
<td>12.1</td>
<td>41</td>
<td>Nebraska</td>
<td>18.8</td>
<td>41</td>
<td>Texas</td>
<td>5.0</td>
</tr>
<tr>
<td>42</td>
<td>Nebraska</td>
<td>11.8</td>
<td>42</td>
<td>Hawaii</td>
<td>18.5</td>
<td>42</td>
<td>Louisiana</td>
<td>5.0</td>
</tr>
<tr>
<td>43</td>
<td>Texas</td>
<td>11.6</td>
<td>43</td>
<td>Texas</td>
<td>18.2</td>
<td>43</td>
<td>California</td>
<td>4.9</td>
</tr>
<tr>
<td>44</td>
<td>California</td>
<td>10.5</td>
<td>44</td>
<td>California</td>
<td>16.2</td>
<td>44</td>
<td>Nebraska</td>
<td>4.8</td>
</tr>
<tr>
<td>45</td>
<td>Illinois</td>
<td>10.3</td>
<td>45</td>
<td>Illinois</td>
<td>16.2</td>
<td>45</td>
<td>Massachusetts</td>
<td>4.6</td>
</tr>
<tr>
<td>46</td>
<td>Maryland</td>
<td>9.6</td>
<td>46</td>
<td>Maryland</td>
<td>15.5</td>
<td>46</td>
<td>Massachusetts</td>
<td>4.4</td>
</tr>
<tr>
<td>47</td>
<td>Connecticut</td>
<td>9.2</td>
<td>47</td>
<td>Connecticut</td>
<td>14.7</td>
<td>47</td>
<td>Maryland</td>
<td>4.1</td>
</tr>
<tr>
<td>48</td>
<td>New York</td>
<td>8.6</td>
<td>48</td>
<td>New Jersey</td>
<td>13.6</td>
<td>48</td>
<td>New York</td>
<td>4.0</td>
</tr>
<tr>
<td>49</td>
<td>Massachusetts</td>
<td>8.6</td>
<td>49</td>
<td>New York</td>
<td>13.5</td>
<td>49</td>
<td>Connecticut</td>
<td>4.0</td>
</tr>
<tr>
<td>50</td>
<td>New Jersey</td>
<td>8.5</td>
<td>50</td>
<td>Massachusetts</td>
<td>12.9</td>
<td>50</td>
<td>New Jersey</td>
<td>3.7</td>
</tr>
<tr>
<td>51</td>
<td>District of Columbia</td>
<td>5.9</td>
<td>51</td>
<td>District of Columbia</td>
<td>9.8</td>
<td>51</td>
<td>District of Columbia</td>
<td>9.8</td>
</tr>
</tbody>
</table>


"Rate" refers to "Crude Rate" which are rates per 100,000 population

Prepared by John L. McIntosh, Indiana University South Bend for posting by the American Association of Suicidology (www.suicidology.org)
Health Regions & USA Suicide Rates

2013 Data

Source: data calculated from figures posted at CDC’s WISQARS website downloaded 22 January 2015 for 2013 data
Understanding and Helping the Suicidal Individual

BE AWARE OF THE WARNING SIGNS

Are you or someone you love at risk of suicide? Get the facts and take appropriate action.

Get help immediately by contacting a mental health professional or calling 1-800-273-8255 for a referral should you witness, hear, or see anyone exhibiting any one or more of the following:

- Someone threatening to hurt or kill him/herself, or talking about wanting to hurt or kill him/herself.
- Someone looking for ways to kill him/herself by seeking access to firearms, available pills, or other means.
- Someone talking or writing about death, dying or suicide, when these actions are out of the ordinary for the person.

Seek help as soon as possible by contacting a mental health professional or calling 1-800-273-8255 (TALK) for a referral should you witness, hear, or see anyone exhibiting any one or more of the following:

- Hopelessness
- Rage, uncontrolled anger, seeking revenge
- Acting reckless or engaging in risky activities, seemingly without thinking
- Feeling trapped – like there’s no way out
- Increase alcohol or drug use
- Withdrawing from friends, family and society
- Anxiety, agitation, unable to sleep or sleeping all the time
- Dramatic mood changes
- No reason for living; no sense of purpose in life

BE AWARE OF THE FACTS

1. Suicide is preventable. Most suicidal individuals desperately want to live; they are just unable to see alternatives to their problems.

2. Most suicidal individuals give definite warnings of their suicidal intentions, but others are either unaware of the significance of these warnings or do not know how to respond to them.

3. Talking about suicide does not cause someone to be suicidal.
4. Approximately 41,100 Americans kill themselves every year. The number of suicide attempts is much greater and often results in serious injury.

5. Suicide is the second leading cause of death among young people ages 15-24, and it is the tenth leading cause of death among all persons.

6. Youth (15-24) suicide rates increased more than 200% from the 1950’s to the late 1970’s. Following the late 1970’s, the rates for youth suicide have remained stable.

7. The suicide rate is higher among the elderly (over 65) than any other age group.

8. 3.5 times as many men kill themselves as compared to women, yet three times as many women attempt suicide as compared to men.

9. Suicide occurs across all age, economic, social, and ethnic boundaries.

10. Firearms are currently the most utilized method of suicide by essentially all groups (male, female, young, old, white, non-white).

11. Surviving family members not only suffer the trauma of losing a loved one to suicide, and may themselves be at higher risk for suicide and emotional problems.

WAYS TO BE HELPFUL TO SOMEONE WHO IS THREATENING SUICIDE

1. Be aware. Learn the warning signs.

2. Get involved. Become available. Show interest and support.

3. Ask if he/she is thinking about suicide.

4. Be direct. Talk openly and freely about suicide.


6. Be non-judgmental. Don’t debate whether suicide is right or wrong, or feelings are good or bad. Don’t lecture on the value of life.

7. Don’t dare him/her to do it.

8. Don’t give advice by making decisions for someone else to tell them to behave differently.

9. Don’t ask ‘why’. This encourages defensiveness.

10. Offer empathy, not sympathy.

11. Don’t act shocked. This creates distance.

12. Don’t be sworn to secrecy. Seek support.

13. Offer hope that alternatives are available, do not offer glib reassurance; it only proves you don’t understand.

14. Take action! Remove means! Get help from individuals or agencies specializing in crisis intervention and suicide prevention.
Nearly everyone at some point in his or her life thinks about suicide. Most everyone decides to live because they come to realize that the crisis is temporary, but death is not. On the other hand, people in the midst of a crisis often perceive their dilemma as inescapable and feel an utter loss of control. Frequently, they:

- Can’t stop the pain
- Can’t think clearly
- Can’t make decisions
- Can’t see any way out
- Can’t sleep, eat or work
- Can’t get out of the depression
- Can’t make the sadness go away
- Can’t see the possibility of change
- Can’t see themselves as worthwhile
- Can’t get someone’s attention
- Can’t see to get control

TALK TO SOMEONE – YOU ARE NOT ALONE CONTACT:

- A community mental health agency
- A school counselor or psychologist
- A suicide prevention/crisis intervention center
- A private therapist
- A family physician
- A religious/spiritual leader
Know the Warning Signs of Suicide

How do you remember the Warning Signs of Suicide?
Here's an easy-to-remember mnemonic:

IS PATH WARM?

I  Ideation
S  Substance Abuse
P  Purposelessness
A  Anxiety
T  Trapped
H  Hopelessness
W  Withdrawal
A  Anger
R  Recklessness
M  Mood Changes

A person in acute risk for suicidal behavior most often will show:

Warning Signs of Acute Risk:
  Threatening to hurt or kill him or herself, or talking of wanting to hurt or kill him/herself; and or,
  Looking for ways to kill him/herself by seeking access to firearms, available pills, or other means; and/or,
  Talking or writing about death, dying or suicide, when these actions are out of the ordinary.

These might be remembered as expressed or communicated ideation. If observed, seek help as soon as possible by contacting a mental health professional or calling 1-800-273-TALK (8255) for a referral.

Additional Warning Signs:

- Increased substance (alcohol or drug) use
- No reason for living; no sense of purpose in life
- Anxiety, agitation, unable to sleep or sleeping all of the time
- Feeling trapped - like there's no way out
- Hopelessness
- Withdrawal from friends, family and society
- Rage, uncontrolled anger, seeking revenge
- Acting reckless or engaging in risky activities, seemingly without thinking
- Dramatic mood changes
If observed, seek help as soon as possible by contacting a mental health professional or calling 1-800-273-TALK (8255) for a referral.

These warning signs were compiled by a task force of expert clinical-researchers and 'translated' for the general public. The origin of IS PATH WARM?
Some Facts about Suicide and Depression

WHAT IS DEPRESSION?

Depression is the most prevalent mental health disorder. The lifetime risk for depression is 6 to 25%. According to the National Institute of Mental Health (NIMH), 9.5% or 20.9 million American adults suffer from a depressive illness in any given year.

There are two types of depression. In major depression, the symptoms listed below interfere with one’s ability to function in all areas of life (work, family, sleep, etc). In dysthymia, the symptoms are not as severe but still impeded one’s ability to function at normal levels.

Common symptoms of depression, reoccurring almost every day:

- Depressed mood (e.g. feeling sad or empty)
- Lack of interest in previously enjoyable activities
- Significant weight loss or gain, or decrease or increase in appetite
- Insomnia or hypersomnia
- Agitation, restlessness, irritability
- Fatigue or loss of energy
- Feelings of worthlessness, hopelessness, guilt
- Inability to think or concentrate, or indecisiveness
- Recurrent thoughts of death, recurrent suicidal ideation, suicide attempt or plan for completing suicide

A family history of depression (i.e., a parent) increases the chances (by 11 times) than a child will also have depression.

The treatment of depression is effective 60 to 80% of the time. However, according to the World Health Organization, less than 25% of individuals with depression receive adequate treatment.

If left untreated, depression can lead to co-morbid (occurring at the same time) mental disorders such as alcohol and substance abuse, higher rates of recurrent episodes and higher rates of suicide.
FACTS ABOUT SUICIDE

In 2013, suicide was the tenth leading cause of death in the U.S., claiming 41,149 lives. Suicide rates among youth (ages 15-24) have increased more than 200% in the last fifty years. The suicide rate is also very high for the elderly (age 85+).

Four times more men than women kill themselves; but three times more women than men attempt suicide.

Suicide occurs across ethnic, economic, social and age boundaries.

Suicide is preventable. Most suicidal people desperately want to live; they are just unable to see alternatives to their problems. Most suicidal people give definite warning signals of their suicidal intentions, but others are often unaware of the significances of these warnings or unsure what to do about them.

Talking about suicide does not cause someone to become suicidal.

Surviving family members not only suffer the loss of a loved one to suicide, but are also themselves at higher risk of suicide and emotional problems.

THE LINKS BETWEEN DEPRESSION AND SUICIDE

Major depression is the psychiatric diagnosis most commonly associated with suicide. Lifetime risk of suicide among patients with untreated depressive disorder is nearly 20% (Gotlib & Hammen, 2002). The suicide risk among treated patients is 141/100,000 (Isacsson et al, 2000).

About 2/3 of people who complete suicide are depressed at the time of their deaths.

About 7 out of every 100 men and 1 out of every 100 women who have been diagnosed with depression in their lifetime will go on to complete suicide.

The risk of suicide in people with major depression is about 20 times that of the general population.

Individuals who have had multiple episodes of depression are at greater risk for suicide than those who have had one episode.

People who have had a dependence on alcohol or drugs in addition to being depressed are at greater risk for suicide.

Individuals who are depressed and exhibit the following symptoms are at particular risk for suicide:

- Extreme hopelessness
- A lack of interest in activities that were previously pleasurable
- Heightened anxiety and/or panic attacks
- Insomnia
- Talk about suicide or have a prior history of attempts
- Irritability and agitation

ANTIDEPRESSANTS

There is no evidence to date that the prescription of antidepressants for the treatment of depression increases suicidality in children, adolescents or adults.
BE AWARE OF THE WARNING SIGNS

A suicidal person may:

• Talk about suicide, death, and/or no reason to live.
• Be preoccupied with death and dying.
• Withdraw from friends and/or social activities.
• Have a recent severe loss (esp. relationship) or threat of significant loss.
• Experience drastic changes in behavior.
• Lose interest in hobbies, work, school, etc.
• Prepare for death by making out a will (unexpectedly) and final arrangements.
• Give away prized possessions
• Have attempted suicide before
• Take unnecessary risks; be reckless, and/or impulsive
• Lose interest in their personal appearance.
• Increase their use of alcohol or drugs
• Express a sense of hopelessness.
• Be faces with a situation of humiliation or failure.
• Have a history of violence or hostility.
• Have been unwilling to “connect” with potential helpers.

BE AWARE OF FEELINGS, THOUGHTS, AND BEHAVIORS

Nearly everyone at some time in his or her life thinks about suicide. Most everyone decides to live because they come to realize that the crisis is temporary, but death is not. On the other hand people in the midst of a crisis often perceive their dilemma as inescapable and feel and utter loss of control. Frequently, they:

• Can’t stop the pain
• Can’t think clearly
• Can’t make decisions
• Can’t see any way out
• Can’t sleep eat or work
• Can’t get out of the depression
• Can’t make the sadness go away
• Can’t see the possibility of change
• Can’t see themselves as worthwhile
• Can’t get someone’s attention
• Can’t seem to get control

If you experience any of these feelings, get help!

If you know someone who exhibits these feelings, offer help!
TALK TO SOMEONE – YOU ARE NOT ALONE. CONTACT:

- A community mental health agency
- A school counselor or psychologist
- A suicide prevention/crisis intervention center
- A private therapist
- A family physician
- A religious spiritual leader
Survivors of Suicide Loss Fact Sheet

A survivor of suicide loss is a family member or friend of a person who died by suicide.

SOME FACTS

Survivors of suicide loss represent “the largest mental health casualties related to suicide” (Edwin Shneidman, Ph.D., AAS Founding President).

There are currently over 41,100 suicides annually in the USA. It is estimated that for every suicide there are at least 6 survivors. Some suicidologist believe this to be a very conservative estimate.

Based on this estimate, approximately 6 million Americans became survivors of suicide in the last 25 years.

ABOUT SUICIDAL GRIEF

The loss of a loved one by suicide is often shocking, painful and unexpected. The grief that ensues can be intense, complex, and long term. Grief work is an extremely individual and unique process; each person will experience it in their own way and at their own pace.

Grief does not follow a linear path. Furthermore, grief doesn’t always move in a forward direction.

There is no time frame for grief. Survivors should not expect that their lives will return to their prior state. Survivors aim to adjust to life without their loved one.

Common emotions experienced in grief are:

<table>
<thead>
<tr>
<th>Shock</th>
<th>Denial</th>
<th>Pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guilt</td>
<td>Anger</td>
<td>Shame</td>
</tr>
<tr>
<td>Despair</td>
<td>Disbelief</td>
<td>Hopelessness</td>
</tr>
<tr>
<td>Stress</td>
<td>Sadness</td>
<td>Numbness</td>
</tr>
<tr>
<td>Rejection</td>
<td>Loneliness</td>
<td>Abandonment</td>
</tr>
<tr>
<td>Confusion</td>
<td>Self-blame</td>
<td>Helplessness</td>
</tr>
<tr>
<td>Anxiety</td>
<td>Depression</td>
<td></td>
</tr>
</tbody>
</table>

These feelings are normal reactions and the expression of them is a natural part of grieving. At, first, and periodically during the following days/months of grieving, survivors may feel overwhelmed by their emotions. It is important to take things one day at a time.

Survivors often struggle with the reasons why the suicide occurred and whether they could have done something to prevent the suicide or help their loved one. Feelings of guilt typically ensue if the survivor believes their loved one’s suicide could have been prevented.

At times, especially if the loved one had a mental disorder, the survivor may experience relief.
There is a stigma attached to suicide, partly due to misunderstanding surrounding it. As such, family members and friends of the survivor may not know what to say or how and when to provide assistance. They may rely on the survivor’s initiative to talk about the loved one or to ask for help.

Shame or embarrassment might prevent the survivor from reaching out for help. Stigma, ignorance and uncertainty might prevent others from giving the necessary support and understanding. Ongoing support remains important to maintain family and friendship relations during the grieving process.

Survivors sometimes feel that others are blaming them for the suicide. Survivors may feel the need to deny what happened or hide their feelings. This will most likely exacerbate and complicate the grieving process.

When the time is right, survivors will begin to enjoy life again. Healing does occur.

Many survivors find that the best help comes from attending a support group for survivors of suicide where they can openly share their own story and their feelings with fellow survivors without pressure or fear of judgment and shame. Support groups can be a helpful source of guidance and understanding as well as a support in the healing process.

CHILDREN AS SURVIVORS

It is a myth that children don’t grieve. Children may experience the same range of feelings as do adults; the expression of that grief might be different as children have fewer tools for communicating their feelings.

Children are especially vulnerable to feelings of guilt and abandonment. It is important for them to know that the death was not their fault and that someone is there to take care of them.

Secrecy about the suicides in the hopes of protecting children may cause further complications. Explain the situation and answer children’s questions honestly and with age-appropriate responses.

AMERICAN ASSOCIATION OF SUICIDOLOGY

The American Association of Suicidology (AAS) offers a variety of resources and programs to survivors in an attempt to lessen the pain as they travel their special path of grief. These include:

- Survivors of Suicide Kit: an information kit consisting of fact sheets, a bibliography and simple literature.
- Survivors of Suicide: Coping with the Suicide of a Loved One booklet and A Handbook for Survivors of Suicide.
- Surviving Suicide, a quarterly newsletter for survivors and survivor support groups.
- “Healing After Suicide”, an annual conference held every April, for and about survivors.
- Suicide Prevention and Survivors of Suicide Resource Catalog: a listing of books, pamphlets, etc. which can be ordered from AAS. Includes resources for children and those who care for them.
- Directory of Survivors of Suicide Support Groups – print version available for purchase and an online version available at www.suicidology.org
- Guidelines for Survivors of Suicide Support Groups: a how-to booklet on starting a support group.
Helping Survivors of Suicide Loss: What Can You Do?

The loss of a loved one by suicide is often shocking, painful and unexpected. The grief that ensues can be intense, complex and long term. Grief and bereavement are an extremely individual and unique process.

There is no given duration to being bereaved by suicide. Survivors of suicide are not looking for their lives to return to their prior state because things can never go back to how they were. Survivors aim to adjust to life without their loved one.

Common emotions experienced with grief are:
- Shock
- Denial
- Pain
- Numbness
- Anger
- Shame
- Despair
- Disbelief
- Depression
- Stress
- Sadness
- Guilt
- Rejection
- Loneliness
- Abandonment
- Anxiety

The single most important and helpful thing you can do as a friend is listen. Actively listen, without judgment, criticism, or prejudice, to what the survivor is telling you. Because of the stigma surrounding suicide, survivors are often hesitant to openly share their story and express their feelings. In order to help, you must overcome any preconceptions you have about suicide and the suicide victim. This is the best accomplished by educating yourself about suicide. While you may feel uncomfortable discussing suicide and its aftermath, survivor loved ones are in great pain and in need of your compassion.

Ask the survivor if and how you can help. They may not be ready to share and may want to grieve privately before accepting help.

Let them talk at their own pace; they will share with you when (and what) they are ready to.

Be patient. Repetition is a part of healing, and as such you may hear the same story multiple times. Repetition is part of the healing process and survivors need to tell their story as many times as necessary.

Use the loved one’s name instead of ‘he’ or ‘she’. This humanizes the decedent; the use of the decedent’s name will be comforting.

You may not know what to say, and that’s okay. Your presence and unconditional listening is what a survivor is looking for.

You cannot lead someone through their grief. The journey is personal and unique to the individual. Do not tell them how much they should act, what they should feel, or that they should feel better “by now”.

Avoid statements like “I know how you feel”, unless you are a survivor, you can only empathize with how they feel.
Survivors of suicide support groups are helpful to survivors to express their feelings, tell their story, and share with others who have experienced a similar event. These groups are good resources for the healing process and many survivors find them helpful. Please consult our website (www.suicidology.org) for listing of support groups in or near your community.

The American Association of Suicidology (AAS) offers a variety of resources and programs to survivors in an attempt to lessen the pain as they travel their special path of grief. These include:

- Survivors of Suicide Kit: an information kit consisting of fact sheets, a bibliography, and sample literature.
- *Survivors of Suicide: Coping with the Suicide of a Loved One* booklet and *A Handbook for Survivors of Suicide*.
- *Surviving Suicide*, a quarterly newsletter for survivors and survivor support groups.
- “Healing After Suicide”, an annual conference held every April, for and about survivors.
- Suicide Prevention and Survivors of Suicide Resource Catalog: a listing of books, pamphlets, etc. which can be ordered from AAS. Includes resources for children and those who care for them.

Directory of Survivors of Suicide Support Groups – print version available for purchase and an online version available at www.suicidology.org

Guidelines for Survivors of Suicide Support Groups: a how-to booklet on starting a support group.
Every year, nearly a million people in the United States try to kill themselves.

Suicidal thinking can happen to any of us. But until very recently, most people kept quiet about this experience. That is changing.

In April 2014, the American Association of Suicidology approved a new division for people who’ve been suicidal. It was a groundbreaking moment in suicide prevention that was written about by The New York Times.

The new division is currently led by Dr. DeQuincy Lezine, a young clinician who is also a veteran of suicide prevention work. He was lead author on “The Way Forward,” a July 2014 report by the National Action Alliance for Suicide Prevention attempt survivor task force. It lists dozens of ways that we all can better include, support and respect people who’ve had suicidal thinking.

Here are just a few of the ways we can help:

• Create support groups for suicide attempt survivors.

• Create resources to help support family and friends of attempt survivors.

• Include people who’ve been suicidal in all suicide prevention efforts, from policy-making to messaging.

• Increase the use of peer specialists in helping people recover after a suicide attempt.

• Better prepare employers and education; institutions to support workers or students who have suicidal thinking.

• Press for more research and evaluation of effective supports for people who’ve been suicidal.

• Press for more widespread training of mental health professionals, general health professionals, emergency responders and others in working with people who are suicidal.

• Welcome and share the personal stories of recovery.

Source: http://actionallianceforsuicideprevention.org/task-force/suicide-attempt-survivors
Part D.
American Association of Suicidology
General Information

What is the American Association of Suicidology?

- Edwin S. Shneidman, Ph.D. in Los Angeles, founded AAS in 1968.
- AAS is a non-profit organization devoted to suicide research, education, clinical practice, suicide prevention programming, services for those who have survived the loss of a loved one or survived a suicide attempt or suicidal thinking.
- AAS is comprised of some 1,000 individual and organizational members.
- The AAS Annual Conference is the only annual, national forum for the presentation of state-of-the-art research and professional training in suicidology. Similarly, the AAS Healing After Suicide Conference annually provides support and resources for hundreds of survivors of suicide.
- Over 85% of AAS’ annual funding goes directly to program support and development; administrative expenses are less than 15%.

AAS Exists to Promote:

- Early detection and treatment for those in suicidal despair.
- Prevention programs to forestall the potential suicidal despair.
- Research to better understand those at risk for suicidal despair.
- Better service delivery by crisis services and professionals positioned to intervene and help those in suicidal despair.
- Support services for those left to suffer a most painful survival after the death of those who complete suicide because we were not there in time to help.

How Your Support Can Help Save Lives:

- Promote programs to restrict access to lethal means by youth.
- Support development of new clinical interventions.
- Provide staffing and resources to increase public awareness.
- Develop programs to build resiliency and coping skills among at-risk youth.
- Increase services to families bereaved by suicide.
- Better educate professionals to recognize and respond to at-risk individuals.
Membership Information

Suicide Prevention is Everyone’s Business

AAS is a membership organization for all of those involved in suicide prevention and intervention, or touched by suicide. AAS is a leader in the advancement of scientific and programmatic efforts in suicide prevention through research, education and training, the development of standards and resources, and survivor support services.

Who are we?

We are your peers and colleagues. We are researchers and survivors of suicide loss or suicidal thinking, crisis workers, clinical and public health program professionals. We are crisis and suicide prevention centers, mental health emergency services, and school districts. We are members of the American Association of Suicidology (AAS), AAS is the only national organization to embrace all of us as members.

What is AAS?

AAS is a not-for-profit membership association founded in 1968. AAS’s mission is to understand and prevent suicide as a means of promoting human well-being. AAS promotes research, public and media awareness, professional education and gatekeeper training, and suicide prevention programs.

What does AAS do?

Since 1968, AAS has sponsored a major annual conference every spring at which state-of-the-art research presentations, training workshops, and networking opportunities are offered. Since 1990, AAS has sponsored a second annual conference, “Healing After Suicide,” for and by survivors of a suicide or other loved one. AAS publishes the oldest and internationally respected peer-reviewed journal Suicide and Life-Threatening Behavior. AAS produces and disseminates two quarterly newsletters, a resource guide, fact sheets and current statistics, directories of crisis centers and survivor support groups, standards and guidelines for caregivers and services. AAS serves as both a resource center and clearinghouse of information for those with a need to know.

AAS annually sponsors National Suicide Prevention week.

AAS annually presents awards to outstanding contributors in suicidology, both early career and lifetime contributions; student-conducted research; research in schizophrenia and suicide; for services to the field as a whole; to survivors and to crisis centers; and, for public policy leadership.

Why are we AAS?

Because approximately 41,100 Americans and more than 750,000 people world-wide annually take their own lives. Because a much larger number of people make non-fatal suicide attempts each year, often resulting in serious injuries, trauma, and economic loss to society.
Why are we AAS? continued
Because suicide is a leading cause of death in the United States, typically the second among our young. Because suicide knows no boundaries; it occurs among the old and the young, the rich and the poor, and people of all cultures, races, and religions. Because surviving family members and peers suffer great trauma and pain.
Because many suicides are preventable.
Because in partnership and associations, we can make a difference.

What does AAS do? continued
Since 1976, AAS has certified crisis services that meet established standards for service delivery. AAS certified centers are actively involved in the National Suicide Prevention Lifeline (1-800-273-TALK (8255)). AAS is educated and trains professionals and care givers to better assess and treat individuals at-risk for suicide. AAS considers education and training as significant to our mission.

AAS develops and supports committees and task forces to work on special topics in suicidology. Over the years, these have included such diverse topics as: Assisted Suicide and Euthanasia, School Suicide Prevention Guidelines, Suicide and Religion, Clinician Survivors of Suicide, and Hospital Discharge Planning Recommendations.

AAS advocates for public policy and effective suicide prevention. AAS publishes a Consensus Statement on Youth Suicide by Firearms, co-signed by more than 40 national organizations.

AAS contracts with federal agencies, state and community groups to provide services and expertise to meet individual, organizational, and community needs.

AAS mentors young researchers in suicidology.

AAS has had both federal and foundation grants to certify and network more than 250 crisis centers and help evaluate the effectiveness of crisis centers, help develop suicide prevention programs for both the Department of the Navy and the US Army, collaborate in the nation’s only Suicide Prevention Research Center in Nevada, create web-based resource center for prevention program evaluation, and provide training in early onset bipolar and suicide. AAS supports school and community prevention programs and state suicide prevention planning teams.
Why join AAS?

AAS membership gives you opportunities to be part of the solution.

**AAS membership offers you:**

- Our quarterly journal *Suicide and Life-Threatening Behavior*, featuring current research, case studies, and applied prevention articles.
- Our blog *Newslink*, featuring current national and international events and news intra-association information.
- Our quarterly newsletter *Surviving Suicide*, written for and by survivors.
- Annual statistical updates.
- Suicide Prevention Week Information & Media Kit.
- Directory of Suicide Prevention and Crisis Centers.
- Access to the members-only section of suicidology.org, for community forums and division content.

**AAS offers you deep discounts to our:**

- Annual conferences and training workshops.
- Publications and resources.
- Multiple annual uses of the Suicide Information and Education Center’s database.

**AAS offers you access to:**

- Our Listservs.
- Network with colleagues.
- Collaborate on projects of mutual interest.
- Participate on committees, Task Forces, and grant-funded projects.

For any additional information about AAS membership, please contact AAS at [info@suicidology.org](mailto:info@suicidology.org).

Apply online! www.suicidology.org
Organization Application Form

Organization Name: _____________________________________________________________

Mailing Address:
Street ________________________________________________________________________
City ________________________________________ State_________ Zip_________________

Phone:
Business Phone _______________________________________________________________
Business Fax _________________________________________________________________
Website _____________________________________________________________________
Email ____________________________________________________________

Emergency Phone:
Number ___________________________ Description (if any, e.g. teens)_________________
Number ___________________________ Description ________________________________
Number ___________________________ Description ________________________________

Title & Name of Principle Supervisor: _____________________________________________

AAS Interest Areas Please indicate your primary area of interest with a “P” and check all others in which you currently participate:

☐ Clinical    ☐ Crisis Centers
☐ Survivors    ☐ Research
☐ Students    ☐ Prevention Programs (school, community)  ☐ Attempt Survivor/Lived Experience

If your organizations is a suicide prevention or crisis intervention agency, please fill out the following:

Hours services available ________________________________________________________
Days/Week services available __________________________________________________
Please check the services your agency provides:

☐ Survivors support group  ☐ Attempters support group
☐ School Programs  ☐ Other  ____________________________________________

Organizational Member: Suicide prevention centers, crisis intervention centers, emergency mental health, and other institutions or agencies with suicide prevention interest. Dues do not include Surviving Suicide unless specifically ordered.

Dues:
(Based on annual organizational revenues)

<table>
<thead>
<tr>
<th>Revenue</th>
<th>Dues</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; $100,000</td>
<td>$220.00</td>
</tr>
<tr>
<td>$100,000 - $199,999</td>
<td>$270.00</td>
</tr>
<tr>
<td>$200,000 - $499,999</td>
<td>$390.00</td>
</tr>
<tr>
<td>$500,000 - $749,999</td>
<td>$530.00</td>
</tr>
<tr>
<td>$750,000 - $999,999</td>
<td>$650.00</td>
</tr>
<tr>
<td>$1,000,000+</td>
<td>$800.00</td>
</tr>
</tbody>
</table>

Membership Fee:
U.S. and Canadian Organizations $_________________________
(See above schedule for amount)

Foreign Organizations $ ______________________
(See above schedule for amount and add $10)

Surviving Suicide Newsletter
☐ $20 (check if you wish to receive the newsletter)

Payment

Credit Card:
☐ Visa  ☐ Master Card  ☐ Discover  ☐ American Express
Number ___________________________________ Exp. Date ____________________
Name on Card __________________________________________________________
Signature _____________________________________________________________

Check: Enclose a check in U.S. funds payable to the American Association of Suicidology. Send with application to:
American Association of Suicidology
5221 Wisconsin Avenue, NW, Second Floor
Washington, DC 20015
All organizations must provide documentation supporting the membership dues level indicated on the membership application or renewal form.

An organization may either submit the form below or provide a copy of the organization’s current budget. The documentation must be submitted within 30 days of sending in the membership application or renewal.

The form below may be submitted in lieu of a current budget. The signature of the Board Chair or Treasurer is required.

I, ____________________________________ the ______________________ of (position) ________________________ hereby (organization) affirm that the current annual operating budget for our organization is $______________.

Signed: _____________________________
Dated: _______________________________
Individual & Family Application Form

Name ________________________________________
Highest Degree ________________________________
Mailing Address: ___Work   ___ Home
Street ________________________________________
City_______________________ State____ Zip_______
Daytime Phone_________________________________
Evening Phone_________________________________
Fax__________________________________________
Email________________________________________

Class of Membership

(Please check appropriate box)

☐ Professional (e.g., MD, PhD, PsyD,MA, LCSW, LPC, LMFT, MBA, CPA, JD) and/or employed in suicide prevention or mental health - $180.00
☐ Survivor (Individuals who are exclusively loss survivors or those with lived experience [without additionally meeting criteria for professional membership]) - $160.00
☐ Fixed Income/Retired - $120.00
☐ Student/Volunteer (includes journal and Surviving Suicide) - $100.00
☐ Student/Volunteer (includes journal) - $85.00
☐ Student/Volunteer (without journal) - $45.00

Foreign Members: Add 10.00 to the fee.

Surviving Suicide Newsletter

☐ Non-Members - $25.00

If either student or volunteer, please fill out the following:

Student:
School Attending________________________________________________

(Please provide a copy of a valid student ID)

Volunteer:
Name of AAS Member Center__________________________________________
Profession:
(Check one)

☐ Clergy ☐ Corrections ☐ Counseling ☐ Education ☐ Nursing
☐ Psychology ☐ Psychiatry ☐ Public Health ☐ Social Work
☐ Volunteer ☐ Student ☐ Other ___________________________

AAS Interest Areas
Please indicate your primary area of interest with a “P” and check all others in which you currently participate:

☐ Clinical ☐ Crisis Centers ☐ Prevention ☐ Student
☐ Research ☐ Survivors of Suicide ☐ Attempt Survivor/Lived Experience

Do you consider yourself a survivor of suicide (experienced the suicide of someone close)?

☐ Yes ☐ No

How did you learn of AAS? __________________________________________________________

Payment

Credit Card:

☐ Visa ☐ Master Card ☐ Discover ☐ American Express
Number ____________________________ Exp. Date __________________
Name on Card ____________________________
Signature ____________________________

Check: Enclose a check in U.S. funds payable to the American Association of Suicidology. Send with Application to: American Association of Suicidology
5221 Wisconsin Avenue, NW, Second Floor
Washington, DC 20015
### Additional Resources

<table>
<thead>
<tr>
<th>Resource</th>
<th>URL</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Foundation for Suicide Prevention (AFSP)</td>
<td><a href="http://www.afsp.org">www.afsp.org</a></td>
</tr>
<tr>
<td>Centers for Disease Control and Prevention (CDC)</td>
<td><a href="http://www.cdc.gov">www.cdc.gov</a></td>
</tr>
<tr>
<td>The Jason Foundation</td>
<td><a href="http://www.jasonfoundation.com">www.jasonfoundation.com</a></td>
</tr>
<tr>
<td>The Jed Foundation</td>
<td><a href="http://www.jedfoundation.org">www.jedfoundation.org</a></td>
</tr>
<tr>
<td>The Links National Resource Center for Suicide Prevention and Aftercare</td>
<td><a href="http://www.thelink.org">www.thelink.org</a></td>
</tr>
<tr>
<td>National Center for Injury Prevention and Control (NCIPC)</td>
<td><a href="http://www.cdc.gov/ncipc/default.htm">www.cdc.gov/ncipc/default.htm</a></td>
</tr>
<tr>
<td>National Institute of Health (NIH)</td>
<td><a href="http://www.nih.gov">www.nih.gov</a></td>
</tr>
<tr>
<td>National Institute of Mental Health (NIMH)</td>
<td><a href="http://www.nimh.nih.gov">www.nimh.nih.gov</a></td>
</tr>
<tr>
<td>National Organization for People of Color Against Suicide (NOPCAS)</td>
<td><a href="http://www.nopcas.com">www.nopcas.com</a></td>
</tr>
<tr>
<td>National Strategy for Suicide Prevention (NSSP)</td>
<td><a href="http://www.mentalhealth.org/suicideprevention">www.mentalhealth.org/suicideprevention</a></td>
</tr>
<tr>
<td>National Suicide Prevention Lifeline</td>
<td><a href="http://www.suicidepreventionlifeline.org">www.suicidepreventionlifeline.org</a></td>
</tr>
<tr>
<td>Organization for Attempters and Survivors of Suicide and Interfaith Services (OASSIS)</td>
<td><a href="http://www.oassis.org">www.oassis.org</a></td>
</tr>
<tr>
<td>Samaritans USA</td>
<td><a href="http://www.samaritansnyc.org">www.samaritansnyc.org</a></td>
</tr>
<tr>
<td>Suicide Awareness Voices of Education (SAVE)</td>
<td><a href="http://www.save.org">www.save.org</a></td>
</tr>
<tr>
<td>Centre for Suicide Prevention</td>
<td><a href="http://www.suicideinfo.ca">www.suicideinfo.ca</a></td>
</tr>
<tr>
<td>Suicide Prevention Action Network (SPAN USA)</td>
<td><a href="http://www.spanusa.org">www.spanusa.org</a></td>
</tr>
<tr>
<td>Suicide Prevention Resource Center (SPRC)</td>
<td><a href="http://www.sprc.org">www.sprc.org</a></td>
</tr>
<tr>
<td>Yellow Ribbon Suicide Prevention Program</td>
<td><a href="http://www.yellowribbon.org">www.yellowribbon.org</a></td>
</tr>
</tbody>
</table>
Visit the AAS Online Store for publications, webinars, and more!

**Survivors of Suicide Newsletter**
Member Fee: $25.00  
Non-Member Fee: $25.00

**Wrist Bands**
Member Fee: $10.00  
Non-Member Fee: $12.00

**IS PATH WARM? posters**
Member Fee: $8.00  
Non-Member Fee: $10.00

**Clinician Mug**
Member Fee: $12.00  
Non-Member Fee: $12.00

**Survivor Pins**
Member Fee: $10.00  
Non-Member Fee: $12.00

**SOS: A Handbook for Survivors of Suicide**
Member Fee: $2.00  
Non-Member Fee: $2.00

**Bullying & Suicide**
(Recorded Webinar)
Member Fee: $20.00  
Non-Member Fee: $25.00

**The Lessons from Attempting to Prevent College Suicide**
(Recorded Webinar)
Member Fee: $0.00  
Non-Member Fee: $35.00

**RRSR-PC Webinar**
(Recorded Webinar)
Member Fee: $40.00  
Non-Member Fee: $40.00

**Communicating Risk and Resilience Webinar**
(Recorded Webinar)
Member Fee: $0.00  
Non-Member Fee: $35.00

**Non-Suicidal Self-Injury Webinar**
(Recorded Webinar)
Member Fee: $0.00  
Non-Member Fee: $35.00

**Post Treatment Caring Contacts for Suicide Prevention**
(Recorded Webinar)
Member Fee: $0.00  
Non-Member Fee: $35.00

Visit [www.suicidology.org/store](http://www.suicidology.org/store) to see all of the products AAS has to offer.
Why not mark Suicide Prevention Week with an AAS training or certification?

AAS Crisis Call Center Accreditation

Be competent and confident in crisis intervention with AAS Accreditation. For crisis centers and individual workers.

http://www.suicidology.org/training-accreditation/crisis-center-accreditation

AAS’s School Suicide Prevention Accreditation Program

For school psychologists, social workers, counselors, nurses, and all other dedicated to or responsible for reducing the incidence of suicide and suicidal behaviors among today’s school-age youth.

http://www.suicidology.org/training-accreditation/school-suicide-prevention-accreditation

The Forensic Suicidology Certification Program

A board-certification program for those with exemplary credentials in suicidology and courtroom testimony.

http://www.suicidology.org/training-accreditation/forensic-suicidology-certification

Recognizing and Responding to Suicide Risk: Essential Skills for Clinicians (RRSR)

An advanced, interactive training based on established core competencies that mental health professionals need in order to effectively assess and manage suicide risk.

http://www.suicidology.org/training-accreditation/rrsr

Recognizing and Responding to Suicide Risk: Essential Skills in Primary Care (RRSR-PC)

The RRSR-PC was developed to provide Physicians (PCPs), the Nurses/Nurse Practitioners, and Physicians Assistants with the knowledge they need in order to include suicide risk assessments in routine office visits, to elicit risk, and work with patients to create treatment plans. The RRSR-PC can be delivered in person or by webinar.

http://www.suicidology.org/training-accreditation/rrsr-pc
Psychological Autopsy Consultation and Training Services

AAS offers a face-to-face training program in the psychological autopsy leading to certification as a Psychological Autopsy Investigator. The psychological autopsy, furthermore, helps promote understandings to the often-asked “why?” question raised by survivors regarding the suicide of their loved one, is used in case control research studies to better ascertain risk factors for suicide, and helps to answer questions of causation in both individual cases of suicide and interconnections between cases, hence lessons learned to inform prevention efforts.

http://www.suicidology.org/training-accreditation/psychological-autopsy-certification

Check out our website for more information!
www.suicidology.org
Are you or someone you love at risk of suicide?

NATIONAL SUICIDE PREVENTION LIFELINE™
1-800-273-TALK
www.suicidepreventionlifeline.org

Get the facts and take appropriate action.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
www.samhsa.gov
Mark your Calendar!

Join us in Chicago, Illinois at the
Palmer House for the
49th Annual Conference
March 30 – April 2, 2016

Call for Papers 2016 at www.suicidology.org

For more information:
American Association of Suicidology
5221 Wisconsin Avenue, NW
Second Floor
Washington, DC 20015
Phone: (202) 237-2280
Fax: (202) 237-2282
www.suicidology.org