

September 8 – 14, 2014

**National Suicide Prevention Week
Information & Media Kit**

“Suicide Prevention: One World Connected”

Sponsored by



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American Association of Suicidology

National Suicide Prevention Week

September 8 – 14, 2014

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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:

Crisis Centers

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.



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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 www.suicidology.org 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, 2014. This year's theme is "Suicide Prevention: One World Connected," 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 (www.med.uio.no/iasp).

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 (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 (www.wfhm.org).

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

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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.



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Timeline

As you embark on engaging the media to promote your organization for National Suicide Prevention Week, consider the following timeline to guide your efforts:

Week of

Activity

8/11 **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.

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.

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.

SPEAKING ENGAGEMENTS: Contact local organizations to schedule speaking engagements by their staff to occur during Suicide Prevention Week.

8/18 **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.

PRESS RELEASE: Draft a press release and highlight your organization. Add local statistics regarding suicide in your state, county or region of the country.

LEGISLATIVE OUTREACH: Begin a dialogue with your mayor’s and governor’s offices to pitch the idea of a signed proclamation noting Suicide Prevention Week.

OP-ED: Prepare and finalize an op-ed for dissemination to print media the following week.



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Governor's (or Mayor's) Proclamation

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) (<http://www.cdc.gov/ncipc/>).

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 7/3/2014*

Governor's Proclamation for Suicide Prevention Week of September 8-14, 2014

WHEREAS, in the United States, one person dies by suicide every 13.3 minutes, with 39,518 deaths by suicide in our country during 2011;

WHEREAS, in our country, suicide is the 3rd 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 2012, 505 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 8th through 14th, 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*.

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Press Release

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

Website 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 8th to 14th." 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 2014 is set for September 8th through 14th. [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 13.3 minutes.

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

The elderly make up 13.3% of the population, but comprise 16.0% of all suicides.

Approximately 987,950 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 19,500 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 8th through 14th. This year's theme is "Suicide Prevention: One World Connected."

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



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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 8th.

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 8th through September 14th 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 8th through September 14th 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 8th through September 14th is National Suicide Prevention Week. This year's theme is "Suicide Prevention: One World Connected." Please join [your agency] in supporting suicide prevention. Together we can reduce the number of lives shaken by a needless and tragic death.

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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 8th to 14th." 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.

Sample Op-Ed

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.



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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—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 plans 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 caused 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



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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-wringing, 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.

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Sample Op-Ed

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 complicating 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*

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Sample Op-Ed

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 public-private 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:)

Just two states: http://www.suicidology.org/c/document_library/get_file?folderId=266&name=DLFE-615.pdf

Brooklyn photographer: <http://livethroughthis.org/>

New AAS division: <http://www.nytimes.com/2014/04/14/us/suicide-prevention-sheds-a-longstanding-taboo-talking-about-attempts.html>

"The S Word:" <http://attemptsurvivors.com/2014/06/16/to-boldly-talk-about-suicide/>

The Way Forward: <http://actionallianceforsuicideprevention.org/task-force/suicide-attempt-survivors>



AMERICAN ASSOCIATION OF SUICIDOLOGY

American Association of Suicidology

National Suicide Prevention Week September 8 – 14, 2014

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
Sunday, September 7th Noon
Convene at Central Library Park

Suicide Prevention Fund-raiser Walk
Saturday, September 13th 10 AM
Walk will begin in front of the Springfield Community Center.

National Suicide Prevention Week

September 8-14, 2014

“Suicide Prevention:
One World Connected”

Sponsored by



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OF
SUICIDODOLOGY

Some Facts about Suicide

In 2011, the latest year for which we have data, in the U.S.:

More than 39,500 people died by suicide.

An average of 108.3 individuals per day (one per 13.3 minutes) will die by suicide

Suicide is the 10th leading cause of death, with a rate of 12.7 per 100,000.

Males complete suicide at a rate 3.6 times that of females; however, females attempt suicide three times more often than males.

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

Mental health diagnoses are generally associated with a higher rate of suicide. The risk for suicide is increase 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 2011 rate was 11.0 per 100,000 (a total of 4,822).

One youth completes suicide every 1 hour and 43 minutes, which is about 13 each day.

Males die by suicide over 4 times than that of female youth.

For every completed suicide by youth, it is estimated that 100 to 200 attempts are made.

Elderly (over 65):

The elderly make up 13.3% of the population but account for 16.0% of all suicides.

In 2011, there were 6,321 elderly suicides (17.3 per day).

The rate of suicide for women declines after age 60 (after peaking in the middle of adulthood, ages 40-54).

Although older adults attempt suicide less often than those in other age groups, they have a higher completion rate. Over the age of 65, there is 1 suicide for every 4 attempts.

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
- M • Mood Change

National Suicide Prevention Week

September 8 – 14, 2014

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 organizations name.
- Contact the Mayor's office and/or Governor's office and request that September 8 -14 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 8 – 14, 2014

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/mortrate10.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.

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: 2011 OFFICIAL FINAL DATA

	Number	Per Day	Rate	% of Deaths	Group (Number of Suicides)	Rate
Nation	39,518	108.3	12.7	1.6	White Male (28,103)	23.0
Males	31,003	84.9	20.2	2.5	White Female (7,672)	6.2
Females	8,515	23.3	5.4	0.7	Nonwhite Male (2,900)	9.4
Whites	35,775	98.0	14.5	1.7	Nonwhite Female (843)	2.5
Nonwhites	3,743	10.3	5.8	1.0	Black Male (1,828)	9.0
Blacks	2,241	6.1	5.3	0.8	Black Female (413)	1.9
Elderly (65+ yrs.)	6,321	17.3	15.3	0.3	Hispanic (2,720)	5.2
Young (15-24 yrs.)	4,822	13.2	11.0	16.3	Native Americans (459)	10.6
Middle Aged (45-64 yrs.)	15,379	42.1	18.6	3.0	Asian/Pacific Islanders (1,043)	5.9

Fatal Outcomes (Suicides): *a rate increase was seen from 2010 to 2011, continuing the recent rate increases after long-term trends of decline*

- Average of 1 person every 13.3 minutes killed themselves
- Average of 1 old person every 1 hour and 23 minutes killed themselves
- Average of 1 young person every 1 hour and 49 minutes killed themselves. (If the 287 suicides below age 15 are included, 1 young person every 1 hour and 43 minutes)

Leading Causes of Death 15-24 yrs

- 10th ranking cause of death in U.S.— 2nd for **young** ----->>> Cause Number Rate
- 3.6 male deaths by suicide for each female death by suicide All Causes 29,667 67.7
- Suicide ranks 10th as a cause of death; Homicide ranks 16th | 1-Accidents 12,330 28.2

Nonfatal Outcomes (Attempts) (figures are estimates; no official U.S. national data compiled):

- 987,950 annual attempts in U.S. (using 25:1 ratio); 2012 SAMHSA study: 1.3 million adults (18 and up) | 2-Suicide 4,822 11.0
- Translates to one attempt every 32 seconds (based on 987,950 attempts) [1.3 million = 1 every 24 seconds] | 3-Homicide 4,554 10.4
- 25 attempts for every death by suicide for nation (one estimate); 100-200:1 for young; 4:1 for elderly | 10-14 yrs 282 1.4
- 3 female attempts for each male attempt | 15-19 yrs 1,802 8.3
- 20-24 yrs 3,020 13.6

Survivors (i.e., family members and friends of a loved one who died by suicide):

- Each suicide intimately affects at least 6 other people (estimate)
- Based on the 805,286 suicides from 1987 through 2011, estimated that the number of survivors of suicides in the U.S. is 4.8 million (1 of every 64 Americans in 2011); number grew by at least 237,108 in 2011
- If there is a suicide every 13.3 minutes, then there are 6 new survivors every 13.3 minutes as well

Suicide Methods	Number	Rate	Percent of Total		Number	Rate	Percent of Total
Firearm suicides	19,990	6.4	50.6%	All but Firearms	19,528	6.3	49.4%
Suffocation/Hanging	9,913	3.2	25.1%	Poisoning	6,564	2.1	16.6%
Cut/pierce	660	0.2	1.7%	Drowning	354	0.1	0.9%

U.S.A. Suicide Rates 2001-2011												15 Leading Causes of Death in the U.S.A., 2011				
Group/		(Rates per 100,000 population)										Group/		(total of 2,515,458 deaths; 807.3 rate)		
Age	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	Age	Rank	Cause of Death	Rate	Deaths
5-14	0.7	0.6	0.6	0.7	0.7	0.5	0.5	0.6	0.7	0.7	0.7	5-14	1	Diseases of heart (heart disease)	191.5	596,577
15-24	9.9	9.9	9.7	10.3	10.0	9.9	9.7	10.0	10.1	10.5	11.0	15-24	2	Malignant neoplasms (cancer)	185.1	576,691
25-34	12.8	12.6	12.7	12.7	12.4	12.3	13.0	12.9	12.8	14.0	14.6	25-34	3	Chronic lower respiratory diseases	45.9	142,943
35-44	14.7	15.3	14.9	15.0	14.9	15.1	15.6	15.9	16.1	16.0	16.2	35-44	4	Cerebrovascular diseases (stroke)	41.4	128,932
45-54	15.2	15.7	15.9	16.6	16.5	17.2	17.7	18.7	19.3	19.6	19.8	45-54	5	Accidents (unintentional injuries)	40.6	126,438
55-64	13.1	13.6	13.8	13.8	13.9	14.5	15.5	16.3	16.7	17.5	17.1	55-64	6	Alzheimer's disease	27.3	84,974
65-74	13.3	13.5	12.7	12.3	12.6	12.6	12.6	13.9	14.0	13.7	14.1	65-74	7	Diabetes mellitus (diabetes)	23.7	73,831
75-84	17.4	17.7	16.4	16.3	16.9	15.9	16.3	16.0	15.7	15.7	16.5	75-84	8	Influenza & pneumonia	17.3	53,826
85+	17.5	18.0	16.9	16.4	16.9	15.9	15.6	15.6	17.6	16.9	16.9	85+	9	Nephritis, nephrosis (kidney disease)	14.6	45,591
65+	15.3	15.6	14.6	14.3	14.7	14.2	14.3	14.8	14.8	14.9	15.3	65+	10	Suicide [Intentional Self-Harm]	12.7	39,518
Total	10.8	11.0	10.8	11.0	11.0	11.1	11.5	11.8	12.0	12.4	12.7	Total	11	Septicemia	11.5	35,748
Men	17.6	17.9	17.6	17.7	17.7	17.8	18.3	19.0	19.2	20.0	20.2	Men	12	Chronic liver disease and cirrhosis	10.8	33,642
Women	4.1	4.3	4.3	4.6	4.5	4.6	4.8	4.9	5.0	5.2	5.4	Women	13	Essential hypertension and renal disease	8.9	27,853
White	11.9	12.2	12.1	12.3	12.3	12.4	12.9	13.3	13.5	14.1	14.5	White	14	Parkinson's disease	7.4	23,111
Nonwh	5.6	5.5	5.5	5.8	5.5	5.5	5.6	5.7	5.8	5.8	5.8	NonWh	15	Pneumonitis	5.8	18,195
Black	5.3	5.1	5.1	5.2	5.1	4.9	4.9	5.2	5.1	5.1	5.3	Black	-	All other causes (Residual)	162.9	507,588
45-64	14.4	14.9	15.0	15.4	15.3	16.0	16.7	17.5	18.0	18.6	18.6	45-64	16	Homicide	5.2	16,238

Old made up 13.3% of 2011 population but represented 16.0% of the suicides.

Young were 14.1% of 2011 population and comprised 12.2% of the suicides.

1,142,673* Years of Potential Life Lost Before Age 75 (36,366 of 39,518 suicides were below age 75)

Middle Aged were 26.6% of the 2011 population but were 38.9% of the suicides

* WISQARS YPLL figure: 1,140,275 using individual years rather than 10-year age groups as above.

Many figures appearing here are derived or calculated from data in the following *official data source*: obtained 17 June 2014 from CDC's WISQARS website (fatal injuries report figures) <http://www.cdc.gov/injury/wisqars/index.html>.

SAMHSA 2012 study (2013): Substance Abuse and Mental Health Services Administration [SAMHSA] (2013). *Results from the 2012 National Survey on Drug Use and Health: Mental Health Findings*. NSDUH Series H-47, HHS Publication No. (SMA) 13-4805. Rockville, MD: SAMHSA.

$$\text{suicide rate} = \frac{\text{number of suicides by group}}{\text{population of group}} \times 100,000$$

Suicide Data Page: 2011

19 June 2014

Prepared for AAS by John L. McIntosh, Ph.D., & Christopher W. Drapeau, M.A.

Rate, Number, and Ranking of Suicide for Each U.S.A. State, 2011*

Rank	State [Division] (2010 rank)	Deaths	Rate	Division [Abbreviation]	Rate	Number
1	Wyoming [M] (1)	132	23.3	Mountain [M].....	18.6	4,156
1	Montana [M] (3)	232	23.3	East South Central [ESC].....	14.4	2,673
3	New Mexico [M] (5)	420	20.2	West North Central [WNC]	13.9	2,859
4	Alaska [P] (2)	143	19.8	South Atlantic [SA].....	13.2	7,968
5	Vermont [NE] (12)	120	19.2	Nation	12.7	39,518
6	Nevada [M] (4)	516	19.0	West South Central [WSC].....	12.5	4,624
7	Oklahoma [WSC] (13)	693	18.3	Pacific [P].....	11.9	5,997
8	Arizona [M] (10T)	1,160	17.9	East North Central [ENC].....	11.9	5,538
9	Colorado [M] (8T)	913	17.8	New England [NE].....	11.1	1,609
9	Utah [M] (10T)	502	17.8	Middle Atlantic [MA].....	10.0	4,094
11	Idaho [M] (6)	281	17.7			
11	Maine [NE] (26)	235	17.7	<u>Region [Subdivision Abbreviations]</u>	<u>Rate</u>	<u>Number</u>
13	Oregon [P] (7)	656	17.0	West (M, P).....	13.9	10,153
14	West Virginia [SA] (17)	306	16.5	South (ESC, WSC, SA)	13.2	15,265
15	Arkansas [WSC] (15)	462	15.7	Nation	12.7	39,518
16	South Dakota [WNC] (8T)	128	15.5	Midwest (WNC, ENC).....	12.5	8,397
16	Missouri [WNC] (22)	933	15.5	Northeast (NE, MA).....	10.3	5,703
16	North Dakota [WNC] (14)	106	15.5			
19	Kentucky [ESC] (21)	675	15.5			
20	Florida [SA] (20)	2,880	15.1	Source: Obtained 17 June 2014 from CDC's WISQARS website		
21	New Hampshire [NE] (18T)	198	15.0	(fatal injuries report figures)		
21	Washington [P] (23T)	1,021	15.0	http://www.cdc.gov/injury/wisqars/index.html [Note: divisional and		
23	Tennessee [ESC] (18T)	955	14.9	regional figures were calculated from state data]		
24	South Carolina [SA] (28)	658	14.1	[data are by place of residence]		
25	Iowa [WNC] (37)	422	13.8	[Suicide = ICD-10 Codes X60-X84, Y87.0, U03]		
26	Kansas [WNC] (25)	394	13.7	Note: All rates are per 100,000 population.		
26	Pennsylvania [MA] (33)	1,747	13.7	* Including the District of Columbia.		
28	Alabama [ESC] (23T)	654	13.6			
29	Indiana [ENC] (29)	881	13.5	Suicide State Data Page: 2011		
30	Hawaii [P] (16)	181	13.1	19 June 2014		
30	Mississippi [ESC] (30)	389	13.1			
30	Wisconsin [ENC] (27)	745	13.1	Prepared by John L. McIntosh, Ph.D.		
33	Virginia [SA] (38)	1,054	13.0	and Christopher W. Drapeau, M.A. for		
34	Minnesota [WNC] (42)	683	12.8			
35	Ohio [ENC] (32)	1,465	12.7			
	United States - Total	39,518	12.7	American Association		
36	North Carolina [SA] (34T)	1,213	12.6	of Suicidology		
37	Louisiana [WSC] (34T)	573	12.5	5221 Wisconsin Avenue, N.W.		
38	Michigan [ENC] (31)	1,221	12.4	Washington, DC 20015		
39	Georgia [SA] (40)	1,157	11.8	(202) 237-2280		
40	Delaware [SA] (39)	105	11.6			
41	Texas [WSC] (41)	2,896	11.3	<i>“to understand and prevent suicide</i>		
42	California [P] (44)	3,996	10.6	<i>as a means of promoting human well-being”</i>		
43	Nebraska [WNC] (43)	193	10.5			
44	Connecticut [NE] (45)	370	10.3	-----		
45	Rhode Island [NE] (34T)	101	9.6	Visit the AAS website at:		
45	Maryland [SA] (48)	558	9.6	http://www.suicidology.org		
47	Illinois [ENC] (46)	1,226	9.5			
48	Massachusetts [NE] (47)	585	8.9			
49	New York [MA] (50)	1,658	8.5			
50	New Jersey [MA] (49)	689	7.8			
51	District of Columbia [SA] (51)	37	6.0			

Caution: Annual fluctuations in state levels combined with often relatively small populations can make these data highly variable. The use of several years' data is preferable to conclusions based on single years alone.

Suggested citation: McIntosh, J. L., & Drapeau, C. W. (for the American Association of Suicidology). (2014). *U.S.A. suicide 2011: Official final data*. Washington, DC: American Association of Suicidology, dated June 19, 2014, downloaded from <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/>

USA State Suicide Rates and Rankings Among the Elderly and Young, 2011

65 and Above Years of Age				Nation - All Ages Combined				15-24 Years of Age			
Rank	State	Deaths	Crude Rate	Rank	State	Deaths	Crude Rate	Rank	State	Deaths	Crude Rate
1	Wyoming	20	27.8	1	Wyoming	132	23.3	1	Alaska	36	33.2
2	Vermont	26	27.6	1	Montana	232	23.3	2	South Dakota	26	22.5
3	Nevada	92	27.1	3	New Mexico	420	20.2	3	Idaho	50	22.2
4	New Mexico	64	22.7	4	Alaska	143	19.8	4	Wyoming	17	21.7
5	Montana	34	22.5	5	Vermont	120	19.2	5	Montana	28	20.7
6	Maine	47	21.8	6	Nevada	516	19.0	6	New Mexico	60	20.5
7	Oregon	120	21.7	7	Oklahoma	693	18.3	7	Hawaii	36	19.6
8	Utah	54	20.9	8	Arizona	1,160	17.9	8	Vermont	17	18.9
9	Arizona	190	20.7	9	Colorado	913	17.8	9	North Dakota	19	17.5
10	Alaska	12	20.5	9	Utah	502	17.8	10	Kansas	68	16.6
10	Colorado	118	20.5	11	Idaho	281	17.7	10	Oklahoma	89	16.6
12	Mississippi	76	19.6	11	Maine	235	17.7	12	Nevada	59	16.3
13	Kentucky	115	19.5	13	Oregon	656	17.0	13	Colorado	112	16.1
14	Oklahoma	99	19.2	14	West Virginia	306	16.5	14	Utah	72	15.9
15	Virginia	191	18.9	15	Arkansas	462	15.7	15	Arizona	144	15.8
16	Idaho	38	18.8	16	South Dakota	128	15.5	16	West Virginia	37	15.6
17	Florida	618	18.4	16	Missouri	933	15.5	17	Maine	25	15.0
18	Washington	154	17.9	18	North Dakota	106	15.5	18	Arkansas	60	14.8
19	Tennessee	151	17.2	19	Kentucky	675	15.5	18	Delaware	19	14.8
20	California	742	16.9	20	Florida	2,880	15.1	18	Wisconsin	116	14.8
21	Louisiana	95	16.6	21	New Hampshire	198	15.0	21	Missouri	117	14.0
22	North Carolina	209	16.3	21	Washington	1021	15.0	21	New Hampshire	25	14.0
22	South Carolina	107	16.3	23	Tennessee	955	14.9	23	Washington	123	13.2
24	Alabama	109	16.2	24	South Carolina	658	14.1	24	Oregon	66	12.9
25	West Virginia	48	16.0	25	Iowa	422	13.8	25	Ohio	202	12.8
26	Missouri	134	15.7	26	Kansas	394	13.7	26	Kentucky	75	12.7
27	Georgia	167	15.5	26	Pennsylvania	1,747	13.7	27	Minnesota	89	12.3
28	Texas	416	15.4	28	Alabama	654	13.6	28	Iowa	53	12.2
	Total - 65 and above		15.3	29	Indiana	881	13.5	29	Virginia	137	12.1
29	Arkansas	64	15.0	30	Hawaii	181	13.1	30	South Carolina	78	11.8
30	Pennsylvania	286	14.5	30	Mississippi	389	13.1	31	Alabama	79	11.6
31	Nebraska	36	14.4	30	Wisconsin	745	13.1	32	Louisiana	75	11.4
32	North Dakota	14	14.2	33	Virginia	1,054	13.0	33	Michigan	159	11.3
32	Kansas	54	14.2	34	Minnesota	683	12.8	34	Pennsylvania	198	11.2
34	Indiana	120	14.0	35	Ohio	1,465	12.7		Total - 15-24 years		11.0
35	Iowa	63	13.8		Total - Nation		12.7	35	Texas	399	10.6
36	Minnesota	96	13.7	36	North Carolina	1,213	12.6	36	Tennessee	90	10.4
37	Michigan	187	13.5	37	Louisiana	573	12.5	36	North Carolina	138	10.4
38	Maryland	96	13.2	38	Michigan	1,221	12.4	38	Nebraska	26	10.1
39	Ohio	201	12.2	39	Georgia	1,157	11.8	39	Indiana	92	9.9
40	New Hampshire	22	12.0	40	Delaware	105	11.6	40	Illinois	176	9.8
41	Wisconsin	94	11.8	41	Texas	2,896	11.3	41	Florida	241	9.7
41	South Dakota	14	11.8	42	California	3,996	10.6	42	Mississippi	40	9.2
43	Hawaii	23	11.4	43	Nebraska	193	10.5	43	Georgia	125	8.9
44	Illinois	177	10.8	44	Connecticut	370	10.3	44	Connecticut	42	8.7
45	Connecticut	54	10.5	45	Rhode Island	101	9.6	45	Maryland	64	8.0
46	New York	265	9.9	45	Maryland	558	9.6	46	New York	218	7.9
47	Delaware	13	9.7	47	Illinois	1,226	9.5	47	California	439	7.8
47	New Jersey	117	9.7	48	Massachusetts	585	8.9	48	New Jersey	83	7.3
49	Rhode Island	12	7.8	49	New York	1,658	8.5	49	Massachusetts	67	7.1
50	Massachusetts	63	6.8	50	New Jersey	689	7.8	50	Rhode Island	10	6.2
	Deaths fewer than 10 for District of Columbia - not listed			51	District of Columbia	37	6.0		Deaths fewer than 10 for District of Columbia - not listed		

Data source: CDC's WISQARS website "Fatal Injury Reports," <http://www.cdc.gov/injury/wisqars/index.html>; downloaded 17 June 2014

* = rates based on < 20 deaths are considered unreliable; "Crude Rate" refers to 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)



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USA State Suicide Rates and Rankings by Gender, 2011

Nation - Both Sexes Combined			Men			Women		
Rank	State	Crude Rate	Rank	State	Crude Rate	Rank	State	Crude Rate
1	Wyoming	23.3	1	Wyoming	36.3	1	Montana	11.1
1	Montana	23.3	2	Montana	35.3	2	New Mexico	10.0
3	New Mexico	20.2	3	Vermont	31.7	3	Wyoming	9.7
4	Alaska	19.8	4	New Mexico	30.6	4	Nevada	9.1
5	Vermont	19.2	5	Alaska	30.3	5	Alaska	8.3
6	Nevada	19.0	6	Oklahoma	29.5	6	Utah	8.2
7	Oklahoma	18.3	7	Nevada	28.6	6	Colorado	8.2
8	Arizona	17.9	8	Maine	28.5	6	Arizona	8.2
9	Colorado	17.8	9	Arizona	27.8	9	Idaho	7.8
9	Utah	17.8	10	Idaho	27.6	10	Washington	7.4
11	Idaho	17.7	11	Colorado	27.4	10	Oklahoma	7.4
11	Maine	17.7	11	Utah	27.4	10	Maine	7.4
13	Oregon	17.0	13	Oregon	27.1	13	Oregon	7.0
14	West Virginia	16.5	13	West Virginia	27.1	14	Vermont	6.9
15	Arkansas	15.7	15	Kentucky	25.9	15	Missouri	6.6
16	South Dakota	15.5	16	Arkansas	25.6	15	South Dakota	6.6
16	Missouri	15.5	17	Missouri	24.8	17	Florida	6.4
16	North Dakota	15.5	17	North Dakota	24.8	18	Tennessee	6.3
19	Kentucky	15.5	19	South Dakota	24.5	19	South Carolina	6.2
20	Florida	15.1	20	New Hampshire	24.4	19	West Virginia	6.2
21	New Hampshire	15.0	21	Florida	24.1	19	Arkansas	6.2
21	Washington	15.0	22	Tennessee	24.0	22	Wisconsin	6.1
23	Tennessee	14.9	23	Alabama	22.8	23	Indiana	6.0
24	South Carolina	14.1	24	Pennsylvania	22.7	24	North Dakota	5.9
25	Iowa	13.8	25	Washington	22.5	24	Virginia	5.9
26	Kansas	13.7	25	Iowa	22.5	24	New Hampshire	5.9
26	Pennsylvania	13.7	27	South Carolina	22.4	27	North Carolina	5.7
28	Alabama	13.6	28	Kansas	22.0	28	Kansas	5.5
29	Indiana	13.5	29	Mississippi	21.4	28	Hawaii	5.5
30	Hawaii	13.1	30	Indiana	21.3	30	Kentucky	5.4
30	Mississippi	13.1	31	Ohio	20.7		Total - Women	5.4
30	Wisconsin	13.1	31	Hawaii	20.7	31	Iowa	5.2
33	Virginia	13.0	33	Minnesota	20.5	31	Pennsylvania	5.2
34	Minnesota	12.8	34	Virginia	20.4	31	Louisiana	5.2
35	Ohio	12.7	34	Michigan	20.4	31	Mississippi	5.2
	Total - Nation	12.7	36	Louisiana	20.2	35	Delaware	5.1
36	North Carolina	12.6		Total - Men	20.2	35	Minnesota	5.1
37	Louisiana	12.5	37	Wisconsin	20.1	35	Ohio	5.1
38	Michigan	12.4	38	North Carolina	19.9	38	California	5.0
39	Georgia	11.8	39	Georgia	18.9	38	Alabama	5.0
40	Delaware	11.6	40	Delaware	18.4	38	Georgia	5.0
41	Texas	11.3	41	Texas	18.1	41	District of Columbia	4.9
42	California	10.6	42	Connecticut	16.7	42	Michigan	4.7
43	Nebraska	10.5	43	Nebraska	16.5	43	Texas	4.6
44	Connecticut	10.3	44	California	16.3	44	Nebraska	4.5
45	Rhode Island	9.6	45	Maryland	16.2	45	Connecticut	4.3
45	Maryland	9.6	46	Rhode Island	15.9	46	Massachusetts	4.2
47	Illinois	9.5	47	Illinois	15.8	47	Rhode Island	3.7
48	Massachusetts	8.9	48	New York	13.9	48	Illinois	3.5
49	New York	8.5	49	Massachusetts	13.8	49	New York	3.4
50	New Jersey	7.8	50	New Jersey	12.5	49	Maryland	3.4
51	District of Columbia	6.0	51	District of Columbia	7.2	51	New Jersey	3.3

Data source: CDC's WISQARS website "Fatal Injury Reports," <http://www.cdc.gov/injury/wisqars/index.html>; downloaded 17 June 2014

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

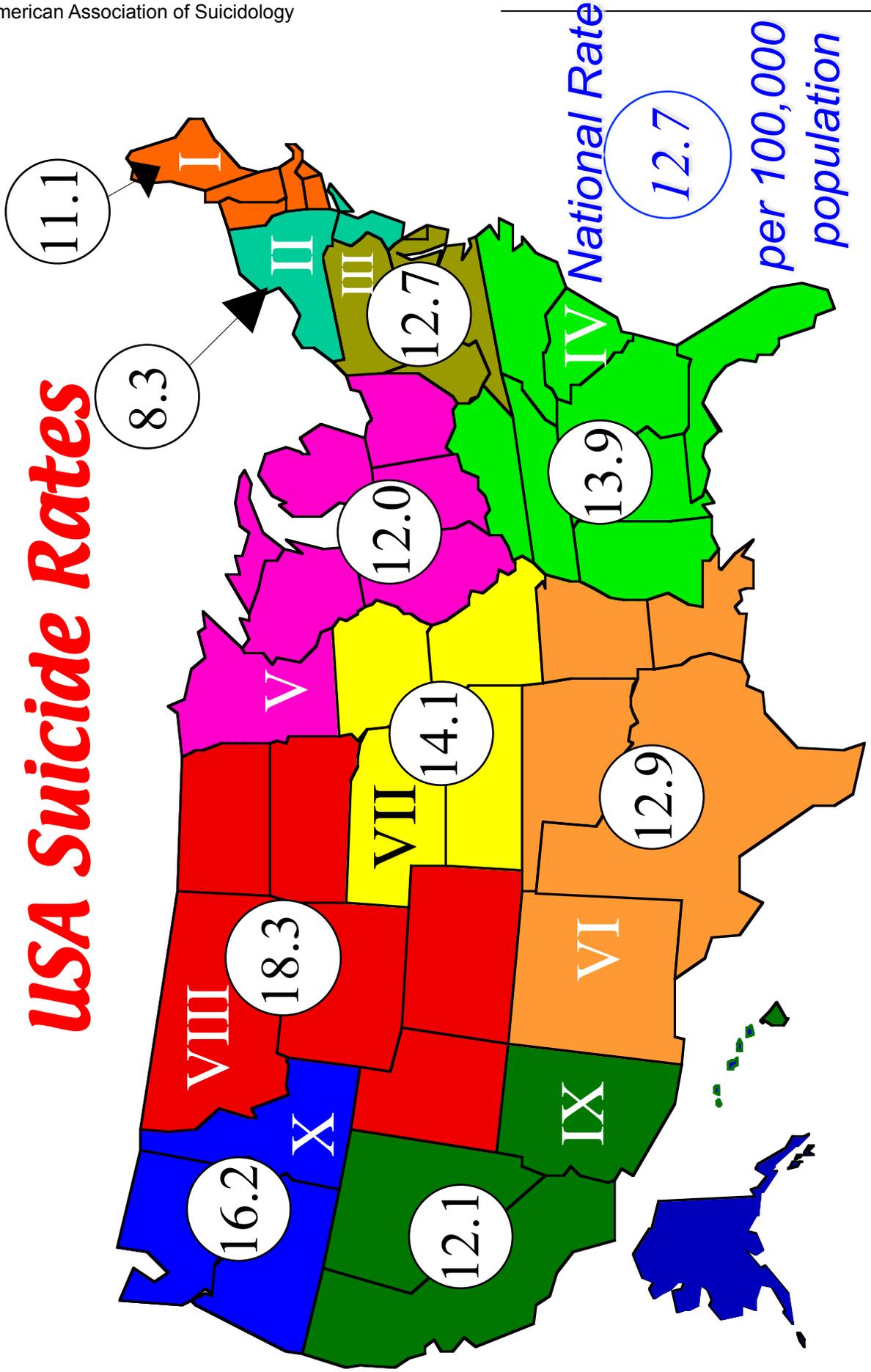
Prepared by John L. McIntosh, Indiana University South Bend for posting by the American Association of Suicidology (www.suicidology.org)



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Health Regions & USA Suicide Rates





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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 38,000 Americans kill themselves every year. The number of suicide attempts is much greater and often results in serious injury.

1. Suicide is the third leading cause of death among young people ages 15-24, and it is the eighth leading cause of death among all persons.
2. 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.
3. The suicide rate is higher among the elderly (over 65) than any other age group.
4. Four times as many men kill themselves as compared to women, yet three times as many women attempt suicide as compared to men.
5. Suicide occurs across all age, economic, social, and ethnic boundaries.
6. Firearms are currently the most utilized method of suicide by essentially all groups (male, female, young, old, white, non-white).
7. 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.
5. Be willing to listen. Allow for expression of feelings. Accept the Feelings.
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.

1. Take action! Remove means! Get help from individuals or agencies specializing in crisis intervention and suicide prevention.

BE AWARE OF FEELINGS, THOUGHTS AND BEHAVIORS

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

Warning Signs of Suicide

The mnemonic IS PATH WARM? can be used to remember the warning signs of suicide:

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 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.





AMERICAN ASSOCIATION OF SUICIDOLOGY

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 2011, suicide was the tenth leading cause of death in the U.S., claiming 39,518 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.



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- 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 faced 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 private therapist |
| • A school counselor or psychologist | • A family physician |
| • A suicide prevention/crisis intervention center | • A religious spiritual leader |



AMERICAN ASSOCIATION OF SUICIDOLOGY

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 39,500 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:

Shock	Denial	Pain
Guilt	Anger	Shame
Despair	Disbelief	Hopelessness
Stress	Sadness	Numbness
Rejection	Loneliness	Abandonment
Confusion	Self-blame	Anxiety
Helplessness	Depression	

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 tot 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.



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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.

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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.



AMERICAN ASSOCIATION OF SUICIDOLOGY

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 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.



AMERICAN ASSOCIATION OF SUICIDOLOGY

Surviving suicidal thinking: How we all can help

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>



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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.



American Association of Suicidology

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, survivors of suicide attempts 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?

The 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.

Why are we AAS?

Because approximately 39,500 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.

What does AAS do?

Since 1968, AAS has sponsored a major annual conference every spring at which start-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 quarterly 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? continued

Because suicide is a leading cause of death in the United States, typically the third 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 suicide 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 educates 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 contract 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 to 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 disorder and suicide.

AAS supports school and community prevention programs and state suicide prevention planning teams.

AAS publishes School Suicide Postvention Guidelines, Guidelines for Survivor Support Groups, Guidelines

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 quarterly newsletter *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 Listserves.
- Network with colleagues.
- Collaborate on projects of mutual interest.
- Participate on committees, Task Forces, and grant-funded projects.

For any addition information about AAS membership, please contact AAS at info@suicidology.org.

Apply online!
www.suicidology.org



AMERICAN ASSOCIATION OF SUICIDOLOGY



AMERICAN ASSOCIATION OF SUICIDOLOGY

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 organization 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)

Revenue	Dues
< \$100,000	\$220.00
\$100,000 - \$199,999	\$270.00
\$200,000 - \$499,999	\$390.00
\$500,000 - \$749,999	\$530.00
\$750,000 - \$999,999	\$650.00
\$1,000,000	\$800.00

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

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





AMERICAN ASSOCIATION OF SUICIDOLOGY

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: _____



AMERICAN ASSOCIATION OF SUICIDOLOGY

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)

- Regular (U.S. and Canada) - \$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)

- | | | |
|-------------------------------------|--|--------------------------------------|
| <input type="checkbox"/> Clergy | <input type="checkbox"/> Corrections | <input type="checkbox"/> Counseling |
| <input type="checkbox"/> Education | <input type="checkbox"/> Nursing | <input type="checkbox"/> Psychology |
| <input type="checkbox"/> Psychiatry | <input type="checkbox"/> Public Health | <input type="checkbox"/> Social Work |
| <input type="checkbox"/> Volunteer | <input type="checkbox"/> Student | <input type="checkbox"/> 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
- 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





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Additional Resources

<p>American Foundation for Suicide Prevention (AFSP) www.afsp.org</p> <p>Centers for Disease Control and Prevention (CDC) www.cdc.gov</p> <p>The Jason Foundation www.jasonfoundation.com</p> <p>The Jed Foundation www.jedfoundation.org</p> <p>The Links National Resource Center for Suicide Prevention and Aftercare www.thelink.org</p> <p>National Center for Injury Prevention and Control (NCIPC) www.cdc.gov/ncipc/default.htm</p> <p>National Institute of Health (NIH) www.nih.gov</p> <p>National Institute of Mental Health (NIMH) www.nimh.nih.gov</p> <p>National Organization for People of Color Against Suicide (NOPCAS) www.nopcas.com</p> <p>National Strategy for Suicide Prevention (NSSP) www.mentalhealth.org/suicideprevention</p> <p>National Suicide Prevention Lifeline www.suicidepreventionlifeline.org</p>	<p>Office of the Surgeon General www.surgeongeneral.gov</p> <p>Organization for Attempters and Survivors of Suicide and Interfaith Services (OASSIS) www.oassis.org</p> <p>Samaritans USA www.samaritansnyc.org</p> <p>Suicide Awareness Voices of Education (SAVE) www.save.org</p> <p>Centre for Suicide Prevention www.suicideinfo.ca</p> <p>Suicide Prevention Action Network (SPAN USA) www.spanusa.org</p> <p>Suicide Prevention Resource Center (SPRC) www.sprc.org</p> <p>Yellow Ribbon Suicide Prevention Program www.yellowribbon.org</p>
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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-centers>

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-professionals>

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-suicidologists>



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/recognizing-responding-suicide-risk>

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/recognizing-responding-suicide-risk-primary-care>

There are some things you do **not** want to learn by experience...



One of them is recognizing suicide risk in one of your clients.



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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-training>

Check out our website for more information!

www.suicidology.org/web/guest/education-and-training



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Are you or
someone you love
at risk of suicide?



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



AMERICAN ASSOCIATION OF SUICIDOLOGY

Mark your Calendar!

Plan to join us in Atlanta, Georgia
at the
Hyatt Regency
for the

47th AAS Annual Conference

April 15th – 17th, 2015

Call for Papers 2015 at

www.suicidology.org

For more information:

American Association of Suicidology

5221 Wisconsin Avenue, N.W.

Second Floor

Washington, DC 20015

Phone: (202) 237-2280

www.suicidology.org

info@suicidology.org