SAVING LIVES:

Understanding Depression And Suicide In Young People – A Training For Teachers

Sponsored by the Ohio Department of Mental Health in Partnership with the ADAMH Board of Franklin County and the Ohio Suicide Prevention Team

Developed by Ellen Anderson, Ph.D., LPCC, 2003-2004

"Still the effort seems unhurried. Every 17 minutes in America, someone commits suicide. Where is the public concern and outrage?"

Kay Redfield Jamison

Author of *Night Falls Fast: Understanding Suicide*

Goals For Suicide Prevention

- Increase community awareness that suicide is a preventable public health problem
- Increase awareness that depression is the primary cause of suicide
- Change public perception about the stigma of mental illness, especially about depression and suicide
- Increase the ability of the public to recognize and intervene when someone they know is suicidal

Training Objectives

- Increase knowledge about the impact of suicide within the community
- Learn the connection between depression and suicide
- Dispel myths and misconceptions about suicide
- Learn risk factors and signs of suicidal behavior in youth
- Learn to assess risk and find help for those at risk – Asking the "S" question

Prevention Strategies

- General suicide and depression awareness education
- Depression Screening programs
- **Community gatekeeper trainings**
- Crisis Centers and hotlines
- Peer support programs
- Restriction of access to lethal means
- Intervention after a suicide

Suicide Is The Last Taboo – We Don't Want To Talk About It

- Suicide has become the Last Taboo – we can talk about AIDS, sex, incest, and other topics that used to be unapproachable. We are still afraid of the "S" word
- Understanding suicide helps communities become proactive rather than reactive to a suicide once it occurs
- Reducing stigma about suicide and its causes provides us with our best chance for saving lives
- Ignoring suicide means we are helpless to stop it

What Makes Me A Gatekeeper?

- Gatekeepers are not mental health professionals or doctors
- Gatekeepers are responsible adults who spend time with kids who might be vulnerable to depression and suicidal thoughts
- Coaches, 4H leaders, Youth Group leaders, Scout masters, and of course, teachers and school staff

Why Should I Learn About Suicide Prevention?

- It is the 3rd largest killer of youth ages 10-24
- As many as 25% of adolescents and 15% of adults consider suicide seriously at some point in their lives
- No one is safe from the risk of suicide – wealth, education, intact family, popularity cannot protect us from this risk
- A suicide attempt is a desperate cry for help to end excruciating, unending, overwhelming pain, sometimes called psychache

(Schneidman, 1996)

Is Suicide Really a Problem?

- **81** people complete suicide every day
- **31,655** people in 2002 in the US
- Over **1,000,000** suicides worldwide (reported)
- This data refers to completed suicides that are documented by medical examiners – it is estimated that 2-3 times as many actually complete suicide

(Surgeon General's Report on Suicide, 1999)

The Unnoticed Death

- For every 2 homicides, 3 people complete suicide yearly– data that has been constant for 100 years
- During the Viet Nam War from 1964-1972, we lost 55,000 troops, and 220,000 people to suicide

Comparative Rates Of U.S. Suicides-2002

- Rates per 100,000 population
  - National average - 11 per 100,000*
  - White males - 19.9
  - African-American males - 9.1 **
  - Asians - 5.2
  - Caucasian females - 4.8
  - African American females - 1.5
  - Males over 85 - 67.6
- Annual Attempts – 790,000 (estimated)
  - 150-1 completion for the young - 4-1 for the elderly

(*AAS website),**(Significant increases have occurred among African Americans in the past 10 years - Toussaint, 2002)

Suicide Methods - 2002

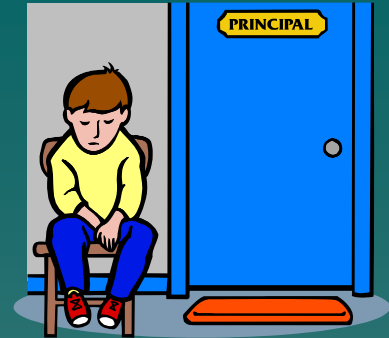
Method	Number	Percent
Firearm suicides	17,108	54.0%
Suffocation/Hanging	6,462	20.4%
Poisoning	5,486	17.3%
Falls	740	2.3%
Cut/pierce	566	1.8%
Drowning	368	1.2%
Fire/flame	150	0.5%

(AAS website – 2005)

The Gender Issue

- Women perceived as being at higher risk than men
- Women do make attempts 4 x as often as men
- But - Men complete suicide 4 x as often as women
- Women's risk rises until midlife, then decreases
- Men's risk, always higher than women's, continues to rise until end of life
- Are women more likely to seek help? Talk about feelings? Have a safety network of friends?
- Are men more likely to feel that who they are is what they do, and to feel hopeless when what they do is lost?

Youth Suicide



- Persons under age 25 accounted for 13.6% of all suicides in 2000
- In a NW Ohio county, 27% of high school students admitted to experiencing significant suicidal thoughts within the past year
- Every year we lose more than 4,000 young people to suicide, and 90% of them are experiencing depression- a preventable disease

(President's New Freedom Council Report, 2003)

Is Someone In Your Class Depressed?

- In a recent health risk assessment, 24% of high school students in Oregon had experienced at least one episode of major depression, either past or current
- This is consistent with local data
- **Based on this study, if you are a teacher with 30 students in your class, *at least 7 of your students* will have experienced clinically significant depression by adulthood, depression that causes problems at home, with peers, in the classroom and/or on the job**

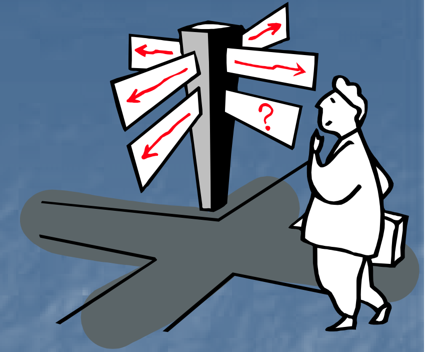
(Oregon SHDP)

Depression Leads To Suicide

- Depression affects children starting at a younger age than in the past
- Children as young as four years of age have been treated for depression
- Children as young as seven have completed suicide
- Upon reaching puberty, girls are affected by clinical depression twice as often as boys (as far as we know)
- While girls are three times more likely to attempt suicide, boys are three times more likely to die by suicide, in part because boys tend to use more lethal means (e.g., guns)

(Oregon HDP)

What Factors Put A Kid At Risk For Suicide?



- Some factors are biological, some psychological, and some are social
- A family history of suicide increases risk by 6 times
- Access to firearms – people who use firearms in their suicide attempt are more likely to die
- A significant loss by death, separation, divorce, moving, or breaking up with a boyfriend or girlfriend
- Shock or pain can affect the manufacture of neural transmitters

- Social Isolation: people who are rejected because they are "weird", because of their sexual orientation, or because

  they just don't fit in

- Aggressiveness or

  impulsiveness-people with

  these traits may not stop and think about the real consequences of their death
- The 2nd biggest risk factor is having an alcohol or drug problem. However, many people with alcohol and drug problems are significantly depressed, and are self-medicating for their pain

(Surgeon General's call to Action, 1999, Berman & Jobes, 1992)

- The biggest risk factor for suicide completion?

  Having a Depressive Illness
- Someone with clinical depression often feels helpless to solve his or her problems, leading to hopelessness
- Depression leads to intolerable, endless emotional pain
- At some point, suicide seems like the only way out of the pain and suffering
- Many Mental health diagnoses have a component of depression: anxiety, PTSD, Bi-Polar, etc
- 90% of suicide completers have a depressive illness

(Lester, 1998)

Depression Is An Illness

- Suicide has been viewed for countless generations as:
  - a moral failing, a spiritual weakness
  - an inability to cope with life
  - “the coward’s way out”
  - A character flaw

- Our current cultural view of suicide is wrong - invalidated by current understanding of brain chemistry and it’s interaction with stress, trauma and genetics on mood and behavior

(Anderson, 1999)

- The research evidence is overwhelming- what we think of as depression is far more than a sad mood. It includes:
  1. Sad mood
  2. Loss of interest in pleasurable things, lack of motivation
  3. Weight gain/loss
  4. Sleep problems
  5. Sense of tiredness, exhaustion
  6. Irritability
  7. Confusion, loss of concentration, poor memory
  8. Negative thinking
  9. Withdrawal from friends and family
  10. Sometimes, suicidal thoughts

(DSMIVR, 2002)

- 20 years of brain research teaches that these symptoms are the **behavioral** result of
  - **Internal changes in the physical structure of the brain**
  - **Damage to brain cells in the hippocampus, amygdala and limbic system**
  - **increased agitation in the limbic system**
- As Diabetes is the result of low insulin production by the pancreas, depressed people suffer from a physical illness – what we might consider "faulty wiring"

(Braun, 2000; Surgeon General's Call To Action, 1999, Stoff & Mann, 1997, The Neurobiology of Suicide)

Faulty Wiring?

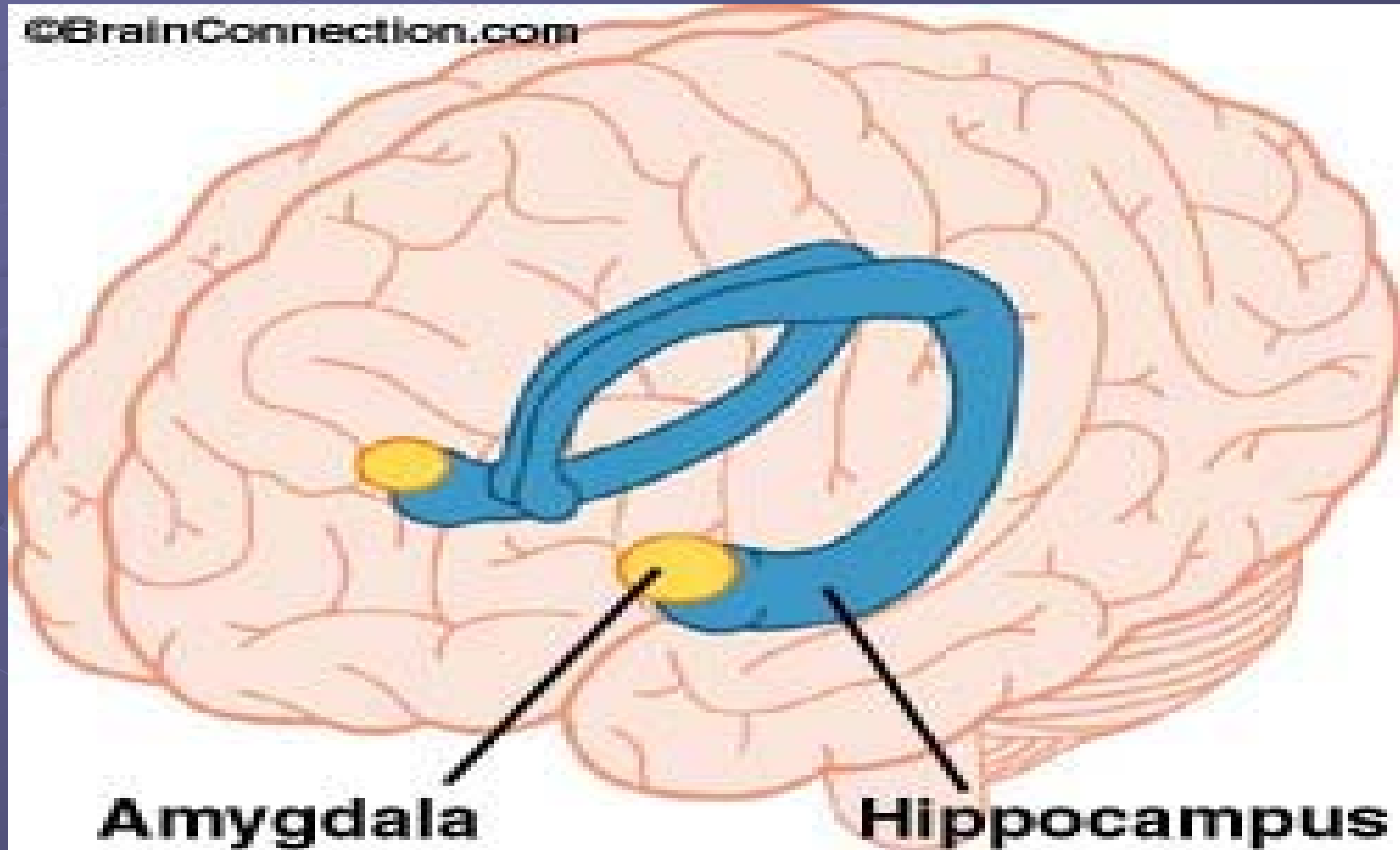
- Literally, damage to certain nerve cells in our brains - the result of too many stress hormones – cortisol, adrenaline and testosterone – the hormones activated by our Autonomic Nervous System to protect us in times of danger
- A situation of chronic stress causes a dysregulation or imbalance in the functioning of the ANS, so that a high level of activation occurs with very little stimulus
- We then see patterns of dysregulation in muscle tension, imbalances in blood flow patterns leading to certain illnesses such as asthma, IBS and depression

- (Braun, 1999)

Faulty Wiring?

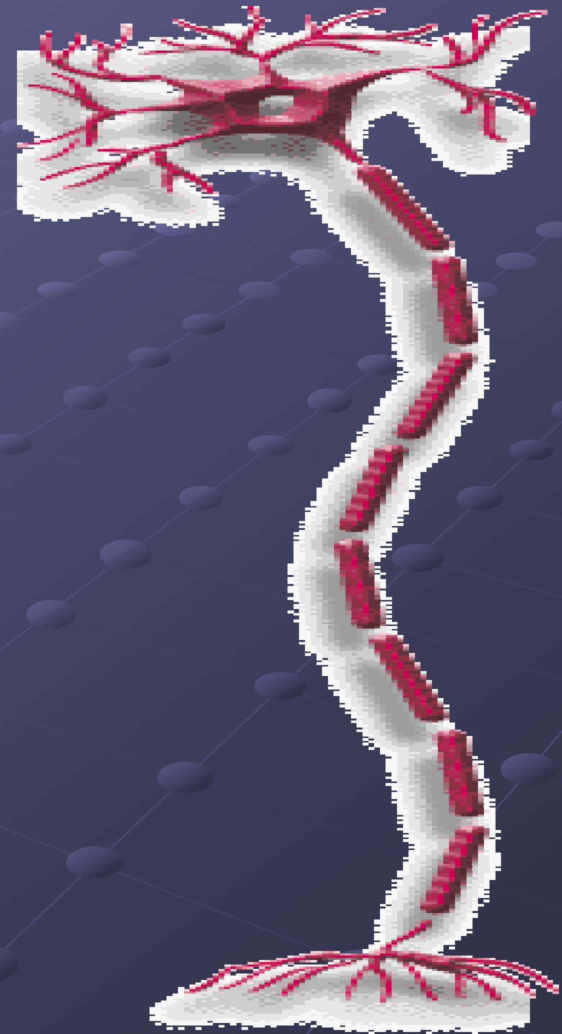
- Every time something upsets us it causes an activation in the ANS – without a way to detach and go back to a baseline of rest, stresses accumulate and keep us in a state of high arousal
- Stress alone is not the problem, but our interpretation of the event
- People with **genetic predispositions**, placed in a highly **stressful environment** will experience damage to brain cells from stress hormones
- This leads to the cluster of **thinking and emotional changes** we call depression (Goleman, 1997; Braun, 1999)

Where It Hits Us



One of Many Neurons

- Neurons are the basic units of information storage
- Synapses formed by connections (through dendrites and axons) are where storage and transfer of information takes place
- Stress hormones damage dendrites and axons, causing them to "shrink" away from other connectors
- As fewer and fewer connections are made, more and more symptoms of depression appear



- As damage occurs, thinking changes in the predictable ways identified in our list of 10 criteria
- "Thought constriction" can lead to the idea that suicide is the only option
- How do antidepressants affect this "brain damage"?
- They may counter the effects of stress hormones
- We know now that antidepressants stimulate genes within the neurons (turn on growth genes) which encourage the growth of new dendrites

(Braun, 1999)

- Renewed dendrites:
  - increase the number of neuronal connections
  - allow our nerve cells to begin connecting again
- The more connections, the more information flow, the more flexibility and resilience the brain will have
- Why does increasing the amount of serotonin, as many anti-depressants do, take so long to reduce the symptoms of depression?
- It takes 4-6 weeks to re-grow dendrites & axons

(Braun, 1999)

How Does Psychotherapy Help?

- Medications may relieve immediate suffering and improve brain function, but do not change how we **interpret** stress
- Psychotherapy, especially cognitive or interpersonal therapy, helps people change the (negative) patterns of thinking that lead to depressed and suicidal thoughts
- Research shows that cognitive psychotherapy is as effective as medication in reducing depression and suicidal thinking
- Changing our beliefs and thought patterns alters our response to stress – we are not as reactive or as affected by stress at the physical level (Lester, 2004)

What Therapy?

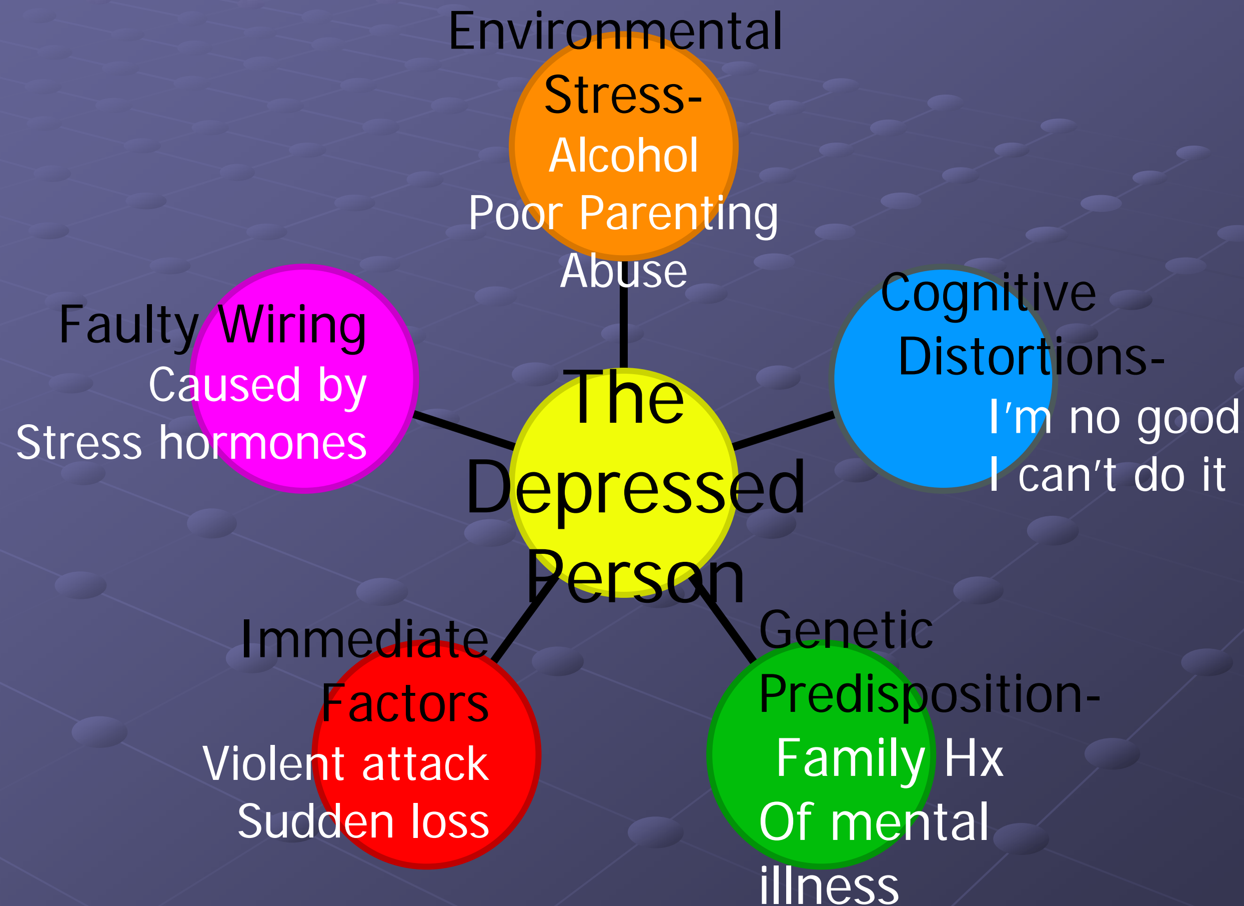
- The standard of care is medication and psychotherapy combined
- At this point, only cognitive behavioral and interpersonal psychotherapies are considered to be effective with clinical depression (evidence-based)
- Patients should ask their doctor for a referral to a cognitive or interpersonal therapist

Possible Sources Of Depression

- Genetic: a predisposition to this problem may be present, and depressive diseases seem to run in families
- Predisposing factors: Childhood traumas, car accidents, brain injuries, abuse and domestic violence, poor parenting, growing up in an alcoholic home, chemotherapy
- Immediate factors: violent attack, illness, sudden loss or grief, loss of a relationship, any severe shock to the system

(Anderson, 1999,Quinnett, 2000)

Internal And External Factors



What Happens If We Don't Treat Depression?

- Significant risk of increased alcohol and drug use
- Significant relationship problems
- Increased school problems – lowered grades, behavior problems, tardiness and absenteeism
- High risk for suicidal thoughts, attempts, and possibly death

(Surgeon General's Call To Action, 1999)

- Depression is a medical illness that will likely affect the youth later in life, even after the initial episode improves
- Youth who experience a major depressive episode have a 70% chance of having a second major depressive episode within five years
- Many of the same problems that occurred with the first episode are likely to return, and may worsen

(Oregon SHDP)

Suicide Myths – What Is True?

1. **Talking about suicide might cause a person to act**
   - False – it is helpful to show the person you take them seriously and you care. Most feel relieved at the chance to talk
2. **A person who threatens suicide won't really follow through**
   - False – 80% of suicide completers talk about it before they actually follow through
3. **Only "crazy" people kill themselves**
   - False - Crazy is a cruel and meaningless word. Few who kill themselves have lost touch with reality – they feel hopeless and in terrible pain

(AFSP website, 2003)

4. **No one I know would do that**
   - False - suicide is an equal opportunity killer – rich, poor, successful, unsuccessful, beautiful, ugly, young, old, popular and unpopular people all complete suicide
5. **They're just trying to get attention**
   - False – They are trying to get help. We should recognize that need and respond to it
6. **Suicide is a city problem, not in the country or a small town**
   - False – rural areas have higher suicide rates than urban areas

- **Suicide myths, continued:**

7. **Once a person decides to die nothing can stop them - They really want to die**
   - NO - most people want to be stopped – if we don’t try to stop them they will certainly die - people want to end their pain, not their lives, but they no longer have hope that anyone will listen, that they can be helped

(AFSP website, 2003)

SSRI's And Suicide More Mythology?

- Media has sensationalized the idea that "Prozac" causes suicide in teens
- There is a very low risk that SSRI's can induce suicidal agitation in a very few individuals
- Many teens on SSRI's are, in fact already suicidal, and meds may not work well enough, or in time
- The FDA has recently banned the use of Paxil for depression in adolescents, but Prozac has been approved for use in teens

- The American College of Neuropsychopharmacology's Task Force report from January 21, 2004, which reviewed all clinical trials, epidemiological studies and toxicology studies in autopsies did not find evidence for a link between SSRI's and increased risk of suicide in children and adolescents
- In a recent preliminary study of 49 adolescent suicides, researchers found that 24% had been prescribed antidepressants, but none had any trace of SSRI's in their system at the time of their death
- There is an increased risk of suicide in depressed individuals who do not take their medication; which is a factor common to adolescents
- A 2003 World Health Organization study in over fifteen countries found a significant reduction, averaging about 33%, in the youth suicide rate that coincided with the introduction of SSRI's

(Altesman, 2005)

- A review of all the research on this topic was conducted recently
- CONCLUSION: "No increased susceptibility to aggression or suicidality can be connected with fluoxetine or any other SSRI. In fact SSRI treatment may reduce aggression toward self or others"
- "In the absence of any convincing evidence to link SSRI's causally to violence and suicide, the recent media reports are potentially dangerous, unnecessarily increasing the concerns of depressed patients who are prescribed antidepressants" (Goldberg, 2003)
- Clearly, this question requires more research

What Should Teachers Be Looking For

1. Depressed or irritable mood—look for:

- Directly and indirectly says "I hate my life"
- Easily irritated
- Rebellious behavior
- Seldom looks happy
- Frequent crying spells
- Wears somber clothes
- Listens to music or has themes in writing with depressive or violent undertones
- Has friends who appear depressed or irritable

2. Marked decrease in interest or pleasure in activities—look for:

- Frequently says "I'm bored"
- Withdraws or spends much time in his or her bedroom
- Declining hygiene
- Changes to a more troubled peer group

3. Psychomotor agitation or slowing— look for:

- Agitated, always moving
- Mopes around the house or school

4. Significant change in appetite or weight—look for:

- Becomes a picky eater
- Snacks frequently and eats when stressed
- Quite thin or overweight compared to peers

5. Significant changes in sleeping habits— look for:

- Takes more than an hour to fall asleep
- Multiple awakenings
- Wakes in early morning hours and can't return to sleep
- Sleeps more than normal

(Oregon SHDP)

6. Fatigue or loss of energy—look for:

- Too tired to do schoolwork, play or work
- Comes home from school exhausted
- Too tired to cope with conflict

7. Feelings of worthlessness or inappropriate guilt—look for:

- Describes self as "bad" or "stupid"
- Has no hope or goals for the future
- Always trying to please others
- Blames self for causing divorce or a death, when not to blame

8. Decreased concentration or indecisiveness —look for:

- Often responds "I don't know"
- Takes much longer to get work done
- Drop in grades
- Headaches, stomachaches
- Poor eye contact

(Oregon SHDP)

Depression May Look Different In Teens

- It is important to understand that the brain determines one's mood, thoughts, actions and judgment.
- When a medical illness like depression affects the brain, the individual's mood, thoughts, actions and judgment will be negatively affected
- Many adults view youth who are irritable or who act out as behavior-problem youth, without being aware that a very treatable underlying cause such as depression may be affecting the youth
- While youth must be held accountable for their actions, it is equally important that their depression, if present be recognized, evaluated and treated

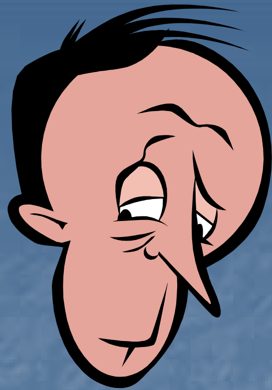
(Schneidman, 1996)

High Risk Behaviors and Suicide

- Miller and Taylor (2000) analyzed high risk behaviors in 9th-12th graders and found a correlation with suicide ideation and attempts
- High risk health behaviors included
  - High Risk Sex (multiple partners, before age 14)
  - Binge Drinking (5 or more in several hours)
  - Drug Use
  - Disturbed eating patterns (boys do not get asked about this)
  - Smoking
  - Violence (girls do not get asked about this)

- The 17% of youth with more than three problem behaviors were the youth who acted
- They accounted for 60% of medically treated suicidal acts
- Compared to adolescents with zero problem behaviors, the odds of a medically treated suicide attempt were
  - 2.3 times greater among respondents with one
  - 8.8 with two
  - 18.3 with three
  - 30.8 with four
  - 50.0 with five
  - 227.3 with six
- A count of problem behaviors may offer a reliable way to identify suicide risk

(Miller & Taylor, 2000)



How Do I Know If Someone Is Suicidal?

- Now we understand the connection between depression and suicide
- We have reviewed what a depressed person looks like
- Not all depressed people are suicidal – how can we tell?
- Suicides don't happen without warning - verbal and behavioral clues are present, but we may not notice them

Verbal Expressions

- Direct statements
  - "I don't want to live anymore"
  - "I wish I were dead"
  - "I'm going to end it all"
  - "I am going to kill myself"
- Indirect statements
  - "No one cares if I live or die"
  - "Life is just too hard – it isn't worth it"
  - "My Mom would be better off without me"
  - "I just can't take it anymore"

Some Behavioral Warning Signs

- Previous suicide attempts
- Serious expressions of hopelessness
- More than 6 criteria from the list of symptoms
- Increased substance abuse
- Unmotivated, irresponsible, uncaring
- Sudden happiness after a long period of depression
- Cleaning up "loose ends"
  - Giving away prized possessions
  - Making a will
  - Quitting a job

- Expressing feelings of hopelessness or guilt
- School problems – a big drop in grades, falling asleep in class, emotional outbursts or other behavior unusual for this student
- Wants to join a person in heaven
- Themes of death in artwork, poetry, etc
- Substance abuse
- Giving away possessions – CD's, favorite jewelry or clothing, driver's license

What On Earth Can I Do?

- We are reluctant to ask questions of depressed people because we feel it is "none of my business", or fear the responsibility
- Depression is an illness, like heart disease, and **suicidal thoughts are a crisis, like a heart attack**
- You would not leave a heart attack victim lying on the sidewalk. You would make some attempt to administer CPR
- Anyone can learn to ask the right questions to help a depressed and suicidal person

What Stops Us?

- Most of us still believe suicide and depression are "none of our business"
- Most are fearful of getting a yes answer
- What if we knew how to respond to "yes"?
- What if we could recognize depression symptoms like we recognize symptoms of a heart attack?
- What if we were no longer afraid to ask for help for ourselves, our parents, our children?
- What if we no longer had to feel ashamed of our feelings of despair and hopelessness, but recognized them as symptoms of a brain disorder?

Reduce Stigma

- Stigma about having mental health problems keeps students from seeking help or even acknowledging their problem
- Reducing the fear and shame we carry about having such "shameful" problems is critical
- People must learn that depression is truly a disorder that can be treated – not something to be ashamed of, not a weakness
- Learning about suicide (and teaching students) makes it possible for us to overcome our fears about asking the "S" question

Learning "QPR" – Or, How To Ask The "S" Question

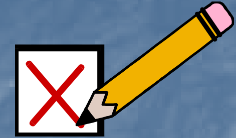
- It is essential, if we are to reduce the number of suicide deaths in our country, that community members/gatekeepers learn "**QPR**"
- First identified by dr. Paul Quinnett as an analogue to CPR, "**QPR**" consists of
  - **Q**uestion – asking the "S" question
  - **P**ersuade– getting the person to talk, and to seek help
  - **R**efer – getting the person to professional help

(Quinnett, 2000)

Ask Questions!

- You seem pretty down. Do things seem hopeless to you? Have you ever thought it would be easier to be dead? Have you considered suicide?
- Remember, you cannot make someone suicidal by talking about it. If they are already thinking of it they will probably be relieved that the secret is out.
- If you get a yes answer, don’t panic. Ask a few more questions.

How Much Risk Is There?



- Assess lethality
  - You are not a doctor, but you need to know how imminent the danger is
  - Has he or she made any previous suicide attempts?
  - Does he or she have a plan?
  - How specific is the plan?
  - Do they have access to means?

Risk Assessment Mnemonic

- Do you feel you are up the creek without a paddle?
- Previous attempts
- Alcohol, drug use, agitation
- Depression
- Developed a plan
- Loss of hope, lack of support
- Expressed suicidal thoughts, exhausted

Do . . .

- Talk openly- reassure them that they can be helped - Try to instill hope
- Encourage expression of feelings
- Listen without passing judgment
- Make empathic statements
- Use warning signs to get help
  early for the individual,
  not as a reason to exclude, isolate, or punish
- Stay calm, relaxed, rational

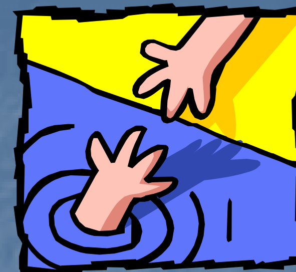
Don't…

- make moral judgments– don't argue or lecture
- Encourage guilt
- Promise total confidentiality/offer reassurances that may not be true
- offer empty reassurances – "you're luckier than most people" won't help
- Minimize the problem/offer simplistic solutions(e.g. "all you need is a good night's sleep")
- Dare the suicidal person (e.g."You won't really do it.")
- Use reverse psychology (e.g. "Go ahead and kill yourself.")
- Leave the youth alone

Never Go It Alone!

- Collaborate with others
  - The person him/herself
  - Family and friends
  - School Personnel or Co-workers
  - Community Agencies
  - Family doctor
  - Crisis Hotline

Getting Help



- Refer for professional help
  - When youth exhibit signs of depression
  - When risk is present (e.g. specific plan, available means)
  - Know your community resources
  - Maintain collaboration with treating agency to provide behavioral information to therapists

Local Professional Resources

- Your Hospital Emergency Room
- Your Local Mental Health Agencies
- Your Local Mental Health Board
- School Guidance Counselors
- Local Crisis Hotlines
- National Crisis Hotlines
- Your family physician
- School nurses
- 911
- Local Police/Sheriff
- Local Clergy

Bereavement After A Suicide Loss

- Compared with homicide, accidental death or natural death, suicide death is the most difficult for family members and friends to resolve
- Friends of youth who complete suicide may experience:
  - Great pain
  - More difficulty finding meaning in the death
  - More difficulty accepting the death
  - Less support and understanding
  - More need for mental health care

- Teachers are often the only source of support for friends of suicide completers

(Smith, Range & Ulner, 1991)

Helping Your Students Through A Suicide At Your School

- Suicidal death is so stigmatized that many people never talk about it, creating a "conspiracy of silence" that keeps people hurting
- Teach your students about the seriousness of untreated depression – help them understand they are not at fault if a friend dies

(Anderson, 1999)

- Help them understand about the unendurable psychache their friend experienced so they can resolve some of their anger
- Assist other people in supporting the family, since lack of support is the biggest problem survivors of suicide face
- Reduce the stigma against depression in your school, so kids will feel safer talking about their loss

Teachers Are Also Survivors

- Remember, you too, are a survivor and it can be difficult to maintain your professional stance while trying to help your students
- Many professionals know the pain of losing a young person to suicide, and the struggle to be supportive to those who depend on you while you are hurting
- Do not be too hard on yourself if you are not sure what to do or say – we are all struggling

Consider A School-wide Suicide Prevention Program

- Impact the entire school environment by:
- Developing written policies and procedures for responding to suicidal warning signs, gestures, threats, attempts, and completions
- Training every member of the school staff, not just teachers and counselors, in how to recognize, respond to, and refer youth at high suicide risk
- Educating parents to take all talk of suicide seriously and know how to help their child
- Giving students the skills to intervene with a suicidal friend

Empirically Based Models

- Ohio is recommending the Columbia Teen Screen
- Others are using the free program provided for Middle schools by the Ohio Department of Mental Health and the Ohio Department of Education – Red Flags
- The Jason Foundation, a program geared to high schools, will come in and educate staff and students, and now have an office in Cleveland
- Some schools incorporate this information in health classes
- Despite the current pressures to succeed, remember that depressed students may not fare well on standardized tests – they can't concentrate enough

Permanent Solution- Temporary Problem

- Remember a depressed person is physically ill, and cannot think clearly about right or wrong, cannot think logically about their value to friends and family
- You would try CPR if you saw a heart attack victim. Don't be afraid to "interfere" when someone is dying more slowly of depression
- Most kids, when treated, are able to overcome their suicidal thoughts, and recover from their depression
- Depression is a treatable disorder
- Suicide is a preventable death

Websites For Additional Information

- Ohio Department of Mental Health

  www.mh.state.oh.us
- NAMI

  www.nami.org
- National Institute of Mental Health

  www.nih.nimh.gov

American Association of Suicidology

www.suicidology.org

- Suicide Awareness/Voice of Education

  www.save.org
- American Foundation for Suicide Prevention

  www.afsp.org
- Suicide Prevention Advocacy Network

  www.spanusa.org

QPR Institute

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A Brief Bibliography

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