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MONTANA
DPHHS
Healthy People. Healthy Communities.
Department of Public Health & Human Services

Suicide in Montana

A Guide for Primary Care Physicians and Emergency Departments

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"Suicide is a particularly awful way to die: the mental suffering leading up to it is usually prolonged, intense, and unpalliated. There is no morphine equivalent to ease the acute pain, and death not uncommonly is violent and grisly. The suffering of the suicidal is private and inexpressible, leaving family members, friends, and colleagues to deal with an almost unfathomable kind of loss, as well as guilt. Suicide carries in its aftermath a level of confusion and devastation that is, for the most part, beyond description."

Kay Redfield Jamison, Ph.D.
Professor of Psychiatry
Johns Hopkins University
"Night Falls Fast: understanding suicide", pg. 24

Suicide Fact Sheet

Source: Center for Disease Control – WISQARS website, http://www.cdc.gov/injury/wisqars/index.html, (July, 2014), 2013 National Vital Statistics Reports (January, 2015)

- For the first time, suicide has surpassed car accidents as the No. 1 cause of injury-related death in the United States. There has been a 15% increase in the number of suicides in the United States between 2000-2009. (American Journal of Public Health, November, 2012)
- In 2013 there were **41,149 suicides in the U.S.** (112 suicides per day; 1 suicide every 13 minutes). This translates to an annual **suicide rate of 13 per 100,000**.
- Suicide is the tenth leading cause of death.
- Males complete suicide at a rate four times that of females. However, females attempt suicide three times more often than males.
- Firearms remain the most commonly used suicide method, accounting for 51% of all completed suicides.

Missed Opportunities

(Source: The WICHE Center for Rural Mental Health Research, 2009)

- 1 in 10 suicides are by people seen in an ED within 2 months of dying.
- 45% of individuals who die by suicide visit their primary care provider within a month of their death, 20% of those visited their primary care provider within 24 hours of their death.
- Most people who commit suicide see their primary care doctor twice as often as a mental health professional.
- Almost 73% of the elderly who have completed suicide had contact with their primary care physician within a month of their suicide.

4 < 14 yrs

Suicide among Children

- In 2013, **395 children ages 5 to 14 completed suicide in the U.S. (increase from 311 in 2012)**
- Suicide rates for those between the **ages of 5-14 increased 60%** between 1981 and 2010.

Suicide among the Young

- Suicide is the 2nd leading cause of death among young (15-24) Americans; only accidents and homicides occur more frequently. In **2013, there were 4,878 suicides by people 15-24 years old** (increase from 4,872 in 2012)
- Youth (ages 15-24) suicide rates increased more than 200% from the 1950's to the mid 1990's. The rates dropped in the 1990's but went up again in the early 2000's.
- Research has shown that most adolescent suicides occur after school hours and in the teen's home.
- Within a typical high school classroom, it is likely that three students (one boy and two girls) have made a suicide attempt in the past year.
- *Most* adolescent suicide attempts are precipitated by interpersonal conflicts. The intent of the behavior appears to be to effect change in the behaviors or attitudes of others.
- The biggest factor associated with adolescent suicidal ideations is parental disconnect (not feeling validated or accepted by their parents)

Suicide among our Veterans

Source: Source: Kemp & Bossarte, R, Suicide Data Report, 2012 (2013), Department of Veteran Affairs

- The VA estimates the suicide rate for young veteran men between the ages 18-29 is around 56 per 100,000 (compared to 20 for non-vet males 18-29)
- In the US, a veteran dies by suicide every 65 minutes, 22 a day, or over 8,000 suicides a year.
- The suicide rate for the Army is 20 per 100,000, compared to 12 for the nation.
- Between 2004 and 2013, there were 566 suicides by Montana veterans of all ages (Office of Epidemiology and Scientific Support, Montana DPHHS, August, 2014), which gives Montana veterans an estimated rate of 54 per 100,000

Suicide among College Students

- It is estimated that there are more than **1,100 suicides on college campuses per year.**
- **1 in 12** college students has made a suicide plan (**2nd leading cause of death**)
- In 2000, the American College Health Association surveyed 16,000 college students from 28 college campuses.
  - **9.5% of students had seriously contemplated suicide.**
  - An estimated **24,000 suicide attempts** occur annually among US college students age 18-24 (JAMA).

***Source**: American Association of Suicidology webpage. http://www.suicidology.org/web/guest/stats-and-tools/statistics , May 24, 2010, Journal of the American Medical Association (2006), Vol. 296, No. 5*

Suicide among the Elderly

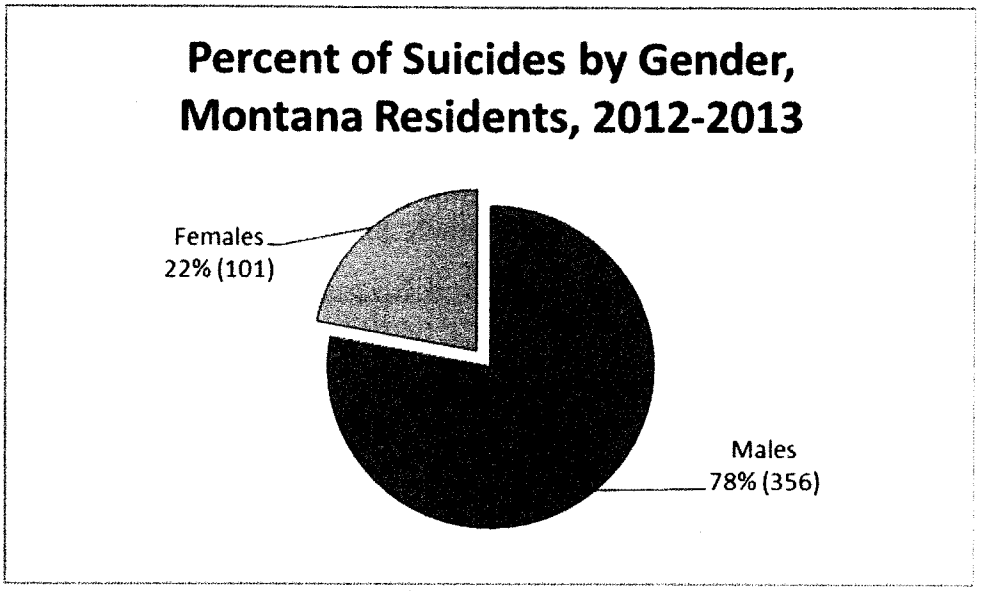
- In 2013, 7,215 Americans over the age of 65 died by suicide for a rate of 16.1 per 100,000
- The rate of suicide for women typically stabilizes after age 64 (after peaking in middle adulthood)
- 85% of elderly suicides were male; the rate of male suicides in late life was 7 times greater than for female suicides.
- White men over the age of 85, who are labeled "old-old", were at the greatest risk of all age-gender-race groups. In 2013, the suicide rate for these men was 52.6 per 100,000.

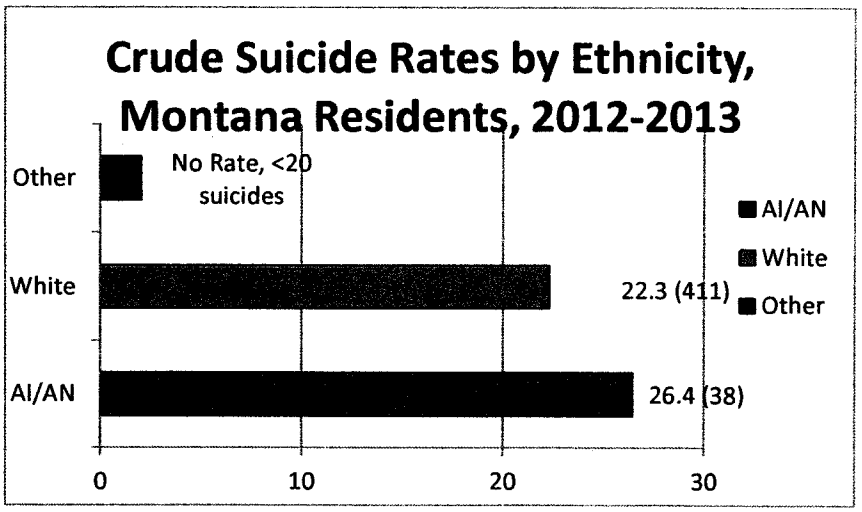
Suicide in Montana

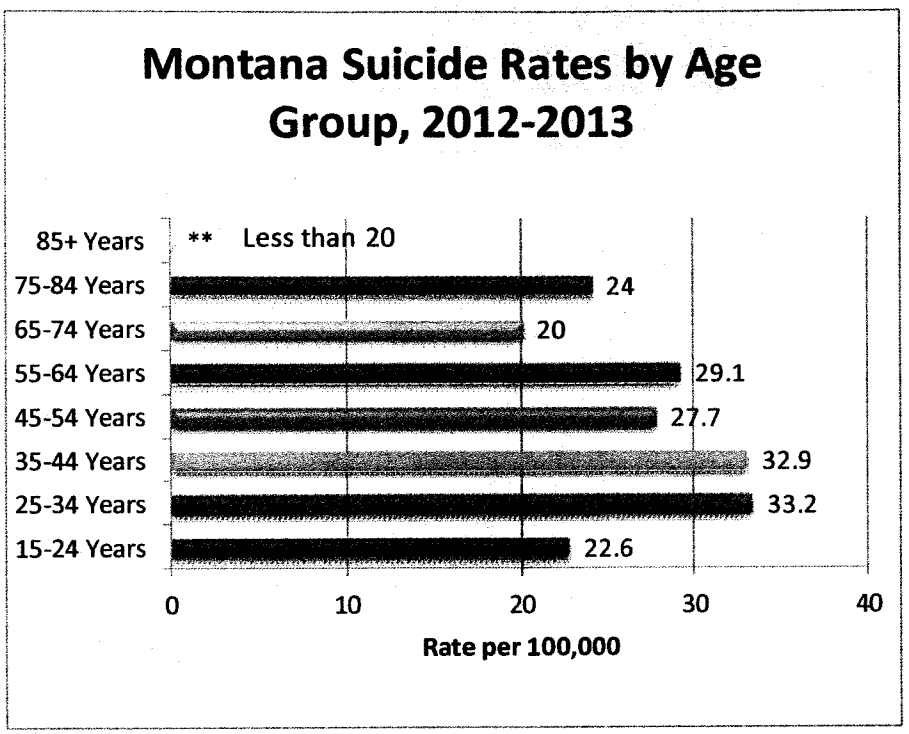
Data Source: 2013 National Vital Statistics Reports (January, 2015), Montana Office of Epidemiology and Scientific Support (August, 2014), Montana Youth Risk Behavior Survey (July, 2013)

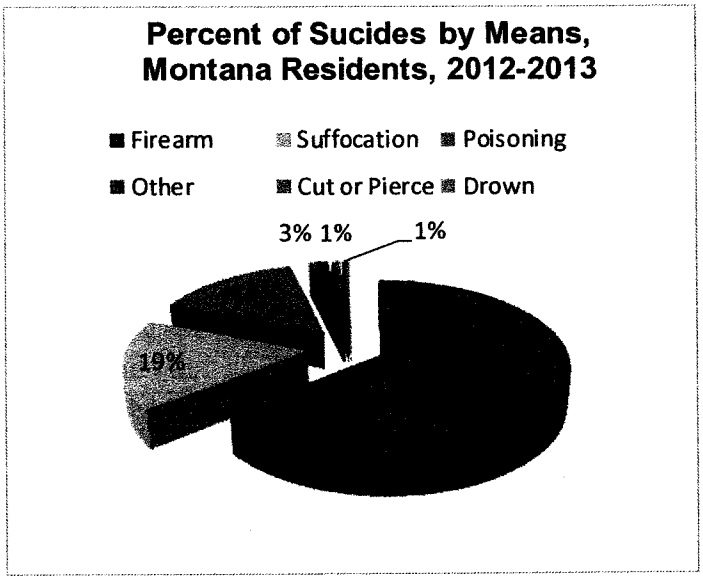
- For all age groups, Montana has ranked in the **top five** for suicide rates in the nation, for the past forty years. **In a report for 2013 in the National Vital Statistics Report, Montana has the highest rate of suicide in the nation** (243 suicides for a crude rate of 23.9)
- In 2014, there were 243 suicides for a rate of 23.8/100,000 compared to a national rate of 13 (UNOFFICIAL)
- Suicide has ranked as the 7th or 8th leading cause of death for Montanans for more than two decades. Gender differences are similar with national statistics, with males at greater risk.
- In Montana, the highest rate of suicide is among American Indians (26.4 per 100,000) although they only constitute 6% of the state's population. Caucasians are second at 22.3 per 100,000.
- Firearms (64%), suffocation (17%), and poisoning (15%) are the most common means of suicide in Montana. Other means include carbon monoxide, overdose, motor vehicles accidents, and jumping from heights.
- In Montana in 2013 there were 39 youth suicides (ages 15-24) for a rate of 23. This compares to the national rate for the same age group of 10.54. *Over the last two years 75% of the youth suicides were completed by firearms.*
- According to the 2013 Youth Risk Behavior Survey, during the 12 months before the survey, 7.9% of all Montanan students in grades 9 through 12 had made a suicide attempt and 12.1% of 7th and 8th graders. For American Indian students on reservations, 15.1% had attempted suicide one or more times in the twelve months before the survey and 20.6% of American Indian students attending school in an urban setting.
- Suicide is the number **one** cause of preventable death in Montana for children ages 10-14

- Over the past ten years suicide is the number **two** cause of death for children ages 10-14, adolescents ages 15-24 and adults ages 25-44.
- Studies show that for every completed suicide, there are 6 survivors. Given there are approximately 220-230 suicides in Montana every year, that means there are about 1,400 new survivors every year in Montana. *A survivor of suicide is 3x the risk of completing suicide themselves.*









Suicide Rates, By Mechanism, 2012-2013
Montana Residents

Provided by Office of Epidemiology and Scientific Support, Montana DPHHS

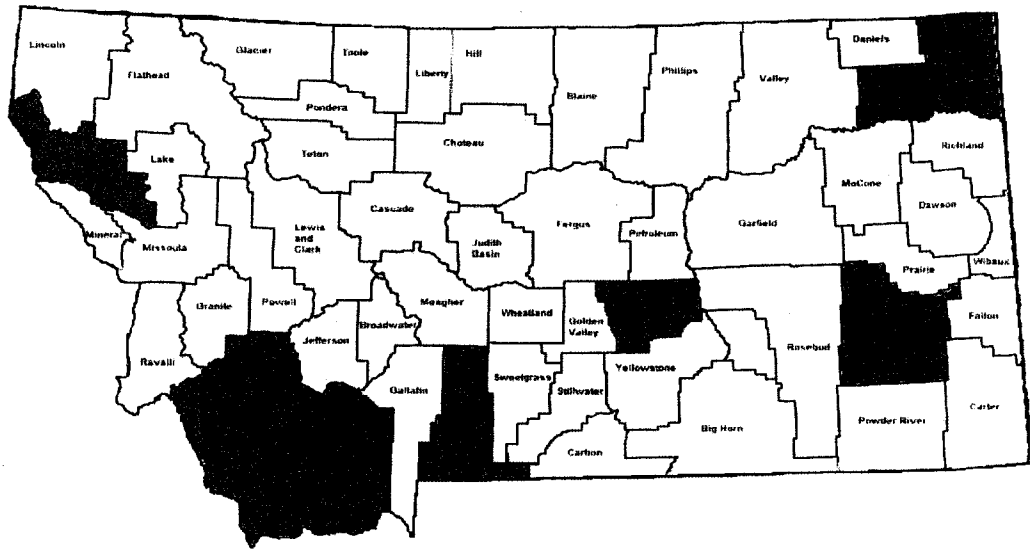
	AGE			
	UNDER 18		18 AND OLDER	
	Num	Pct	Num	Pct
All	16	100	441	100
Firearm	12	75	278	63
Suffocation	4	25	84	19
Poisoning	0	0	59	13
Other Methods	0	0	13	2.9
Drown	0	0	4	0.9
Cut or pierce	0	0	3	0.7

Frequency and Rate of Suicide by County of Residence, Montana Residents, 1994-2013

Montana counties with the highest rate of suicide between 1994 and 2013

Data is only provided for counties that had 20 or more suicides. Numbers below 20 are statistically unreliable, especially when we presenting 15 years of data. Counties with fewer than 5 suicides are only identified with a <5 indication.

The population is the total number of people who lived in the county for each year between 1994 and 2013.



County	Suicides	Population	Rate
BEAVERHEAD	47	182,684	25.7
BIG HORN	43	253,231	17
BLAINE	30	135,060	22.2
BROADWATER	24	95,732	25.1
CARBON	30	194,180	15.4
CARTER	<5	25,944	-
CASCADE	343	1,617,743	21.2
CHOUTEAU	21	116,478	18
CUSTER	65	234,408	27.7
DANIELS	<5	38,017	-
DAWSON	31	180,777	17.1
DEER LODGE	54	189,121	28.6
FALLON	7	57,603	-
FERGUS	46	235,906	19.5
FLATHEAD	331	1,622,072	20.2
GALLATIN	250	1,534,987	16.3
GARFIELD	<5	25,500	-
GLACIER	46	264,776	17.4
GOLDEN VALLEY	<5	19,343	-
GRANITE	18	58,625	-
HILL	56	329,605	17
JEFFERSON	39	208,669	18.7
JUDITH BASIN	8	43,690	-
LAKE	123	542,939	22.7
LEWIS & CLARK	229	1,169,129	19.6
LIBERTY	<5	45,228	-
LINCOLN	91	381,654	23.8
MCCONE	8	37,453	-

County	Suicides	Population	Rate
MADISON	37	142,857	25.9
MEAGHER	7	38,159	-
MINERAL	17	79,594	-
MISSOULA	394	2,017,420	19.5
MUSSELSHELL	24	89,446	26.8
PARK	89	313,209	28.4
PETROLEUM	<5	9,987	-
PHILLIPS	15	89,514	-
PONDERA	18	125,637	-
POWDER RIVER	<5	36,692	-
POWELL	36	140,984	25.5
PRAIRIE	<5	23,719	-
RAVALLI	170	747,641	22.7
RICHLAND	27	195,486	13.8
ROOSEVELT	56	211,648	26.5
ROSEBUD	45	189,019	23.8
SANDERS	59	214,799	27.5
SHERIDAN	23	76,699	30
SILVER BOW	189	684,671	27.6
STILLWATER	33	168,426	19.6
SWEET GRASS	15	71,209	-
TETON	19	124,815	-
TOOLE	19	103,545	-
TREASURE	<5	15,901	-
VALLEY	27	152,626	17.7
WHEATLAND	8	43,998	-
WIBAUX	<5	20,974	-
YELLOWSTONE	509	2,734,418	18.6

Social Factors Associated With Suicide

Suicidal behavior is associated with a wide variety of social factors, but correlates most highly with:

- Social Isolation (isolation from peers or social relationships that are troubled)
- Social Disorganization (society lacks the regulatory constraints necessary to control the behavior of its members.)
- Downward Social Mobility (socioeconomic)
- Rural Residency

Mental Illness and Suicide

Approximately **90%** of those who complete suicide suffer from mental illness.

- The most frequent diagnosis is a mood disorder (Major Depression, Bipolar)
- The 2nd most frequent diagnosis is Alcoholism

Rebound Effect – This is a very important effect to watch for. People do not recover overnight unless there is a very important reason. People tend to come out of wanting to commit suicide slowly. Sometimes, people who have decided to kill themselves may appear quite happy. This is because they have finally made up their minds and see an end to their pain and anguish. They aren't really happy. They are simply relieved of their burden or stress or pain. Also, sometimes people who are severely depressed and contemplating suicide don't have enough energy to carry it out. But, as the disease begins to "lift" they may regain some of their energy but will still have feelings of hopelessness.

You can't tell the difference by looking at them.

- The greatest suicidal risk is not when the people are in the depths of depression, but during the first 90 days after the depression begins to lift. 1
- Suicidal thoughts or attempts were four times more likely during the first 10 days of treatment than after three months. 2
- The highest rate of suicide is not while a person is in inpatient treatment, it is the first 30 days after discharge.3

Source: 1 *The Center for Information on Suicide*, Marv Miller, Ph.D. Suicidologist, Sand Diego, CA.
2 *Journal of the American Medical Association.* 2004;292:338-343.
3 American Association of Suicidology National Convention, San Francisco, CA, April 16-18,2009

REMEMBER: *Depression is Treatable!*

Depression is one of the most treatable of all psychiatric disorders in adolescents

- 86% treatment rate with a combination of antidepressants and therapy*
- Only between 40-70% with either by themselves.

* Source: The TADS Team. The Treatment for Adolescents with Depression Study (TADS): Long-term Effectiveness and Safety Outcomes. Archives of General Psychiatry. Oct 2007; VOL 64(10).

Warning Signs of Suicide

Here's an Easy-to-Remember Mnemonic for the Warning Signs of Suicide: **IS PATH WARM?**

Ideation	Expressed or communicated ideation threatening to hurt or kill him/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.
Substance Abuse	Increased alcohol or drug use
Purposelessness	No reason for living; no sense of purpose in life, start giving things away because there's no purpose in keeping anything, no reason to maintain their hygiene

Anxiety	Anxiety, agitation, unable to sleep or sleeping all the time, difficulty concentrating
Trapped	Feeling trapped (like there's no way out and things will never get better)
Hopelessness	Hopelessness, no future orientation
Withdrawal	Withdrawal from friends, isolating from family and society
Anger	Rage, uncontrolled anger, seeking revenge, irritable
Recklessness	Acting reckless or engaging in high risk activities, seemingly without thinking, impulsive behavior (especially in younger people)
Mood Change	Dramatic mood changes, flat affect, depressed mood, acting out of character

Warning Signs specific to Adolescents

- Volatile mood swings or sudden change in personality
- Indications that they are in unhealthy, destructive, or abusive relationships
- Sudden deterioration in hygiene
- Self-mutilation
- Fixation with death (poems, letters, chat rooms)
- Eating disorders, especially combined with dramatic shifts in weight
- Gender identity issues
- Depression

Warning Signs specific to the Elderly

- Stockpiling medications
- Buying a gun
- Giving away money or possessions or sense of urgency to settle estate or finalize will.
- Taken sudden interest or loss of interest in religion.
- Failure to care for themselves in terms of the routine activities of daily living.
- Withdrawing from relationships
- Experiencing failure to thrive, even after appropriate medical treatment
- Scheduling a medical appointment for vague symptoms.
- Chronic issues of pain management (MAJOR INDICATOR OF RISK)
- Undiagnosed depression

Depression in the Elderly

Before a diagnosis of depression is made, screen for some common health issues that can affect mood, including:

- Alzheimer's
- Thyroid disorders
- Multiple Sclerosis
- Heart attack
- Stroke
- Parkinson's disease
- Cancer
- Diabetes
- Hormonal imbalances
- Vitamin B12 deficiency
- Electrolyte imbalances or dehydration
- Some Viral Infections

The following medications may cause symptoms of depression:

- blood pressure medication
- arthritis medication
- hormones
- steroids

Medications and Suicide

Specific medications that are currently being investigated for their role in *possibly* causing suicidal ideations:

- Antiepileptic drugs including gabapentin, pregabalin, topiramate and carbamazepine. (although a report to the contrary came out by Robert D. Gibbons; Kwan Hur; C. Hendricks Brown; J. John Mann. **Relationship Between Antiepileptic Drugs and Suicide Attempts in Patients With Bipolar Disorder**. *Arch Gen Psychiatry*, 2009; 66 (12): 1354-1360)
- Smoking cessation medication Chantix.
- Allergy medication Singulair.
- Acne medication Accutane
- And, the SSRI's when used with young people.
  - September, 2004: the FDA issues a "black box" warning for all antidepressants used to treat depression in children and adolescents.
  - The following year, SSRI prescriptions for young people decreased by 22% in the U.S.
  - In the U.S., the suicide rate increased 8% for youth 10-24 years of age in one year.
    Source: *Early Evidence on the Effects of Regulators' Suicidality Warnings on SSRI Prescriptions...Gibbons et al. Am J Psychiatry.2007; 164: 1356-1363*
  - There is now research indicating that there is no evidence of increased suicide risk in youth receiving active medication.
    Source: *Arch Gen Psychiatry. Published online February 6, 2012. Doi:10.1001/archegenpsychiatry.2011.2048*

Other Factors

- Past suicide attempt increases risk for a subsequent attempt or suicide; multiple prior attempts dramatically increase risk. A previous attempt is the strongest behavioral warning sign of suicide risk.
- Triggering events leading to humiliation, shame, or despair elevate risk. These may include loss of relationship, financial or health status - real or anticipated.
- Firearms accessible to a person in acute risk magnifies that risk. Inquire and act to reduce access.
- Patients may not spontaneously report suicidal ideation, but 70% communicate their intentions to significant others.

Ask patients directly and seek collateral information from family members, friends, EMS personnel, police, and others.

A few things to remember concerning the method of attempted suicide

- 70-90% of attempted suicides involve drug overdose, but only between 2-11% complete while over 90% of suicides attempts using guns complete (CDC, 7/1/08).
- Both sexes prefer overdose, but males tend toward violent means (guns)

VERY IMPORTANT - All suicidal ideations are serious and every precaution needs to be taken, even if you believe the action is purely to gain attention. NEVER PUT A PERSON IN THE POSITION OF NEEDING TO PROVE THAT THEY ARE SERIOUS. Suicidal ideations are a cry for help. **DON'T AVOID THE TOPIC, TALK ABOUT THE FEELINGS AND DON'T BE AFRAID TO MENTION THE WORD "SUICIDE."** Most people will respond honestly. Many people are hesitant to bring up the subject of suicide for fear that they will be planting the idea in the mind of the person. This is a serious mistake! If the person is suicidal, asking them might lead to a conversation that could prevent the suicide.

Assessing the Degree of Risk – Mental health professionals should be used whenever possible, but once you suspect potential suicide, the best procedure is to approach the person in a **warm, accepting, non-judgmental manner** and ask a question similar to:

"Have you had thoughts of killing yourself?" or "Are you suicidal?"

Be careful with how you word your questions. Avoid asking questions that start with "why...". This elicits a defensive response and may cause the youth to close down. For example, don't ask a youth, "Why would you

want to do something like that?" Instead ask, ***"How would you harm yourself?"*** This will let you quickly know if the youth has a **suicide plan.**

Four factors to use to access the current level of risk (given an attempt)

The strongest behavioral warning is an attempted suicide.

- **Dangerousness** – The greater the dangerousness of the attempt, the higher the current level of risk. *e.g. Did the person take five pills or twenty five?*
- **Intent** – Did the person believe that taking five pills was going to actually kill him?
- **Rescue** – Did the person tell anyone that they made the attempt? Did the person leave any signs (notes, give away possessions), or just acted normally? *70% of all people who complete suicide gave some type of warning*
- **Timing** – The more recent the attempt, the higher the current level of risk.

Asking the question

- ❖ *How you ask the questions affects the likelihood of getting a truthful response. Use a non-judgmental, non-condescending, matter of-fact approach.*

If you see signs or suspect acute risk, **ASK THE QUESTION** *(regardless of chief complaint)*

1. Are you currently thinking about ending your life?
2. Are you suicidal?
3. Have you ever thought that life was not worth living?
4. Have you ever thought about ending your life?
5. Have you ever attempted suicide?
6. What are your reasons for wanting to die and your reasons for wanting to live?
   - ❖ Patients who respond "no" to the first question may be "faking good" to avoid talking about death or suicide. Always continue with subsequent questions.

These questions ease the patient into talking about a very difficult subject.

- ❖ When suicidal ideation is present physicians should ask about:
  - frequency, intensity, and duration of thoughts;
  - the existence of a plan and whether preparatory steps have been taken; and
  - intent (e.g., "How much do you really want to die?" and "How likely are you to carry out your thoughts/plans?")
  - Complete a mental status examination

There is a great deal of ambivalence with a suicidal person. Seldom is a person 100% suicidal, Most describe a part of them that wants to live and a part that wants to die. This is one of the reasons why overdose often doesn't result in death, they get a chance to change their mind. You don't get a second chance with a firearm. The part that makes the suicidal statement or behavior is the part that wants to live. It is a cry for help.

Evaluation and Rapid Triage

High risk patients include those who have:
- Made a serious or nearly lethal suicide attempt
- Persistent suicide ideation or intermittent ideation with intent and/or planning
- Psychosis, including command hallucinations
- Recent onset of major psychiatric symptoms, especially depression
- Been recently discharged from a psychiatric inpatient unit.
- History of acts/threats of aggression or impulsivity

Interventions for **High Risk Patients**:
- Rapid evaluation by a qualified mental health professional
- One-to-one constant staff observation and/or security
- Locked door preventing elopement from assessment area
- Inpatient admission
- Administer psychotropic medications and/or apply physical restraints as clinically indicated
- Other measures to guard against elopement until evaluation is complete

Moderate Risk patients include those who have:
- Suicide ideation with some level of suicide intent, but who have taken no action on the plan
- No other acute risk factors
- A confirmed, current and active therapeutic alliance with a mental health professional

Interventions to consider for **Moderate Risk**:
- Guard against elopement until evaluation is complete
- Psychiatric/psychological evaluation soon/when sober
- Use family/friend

Low Risk patients include those who have:
- Some mild or passive suicide ideation, with no intent or plan
- No history of suicide attempt
- Available social support

Interventions to consider for **Low Risk**:
- Allow accompanying family/friend to monitor while waiting
- May wait in ED for non-urgent psychiatric/psychological evaluation or referral to mental health professional.

Before discharging the Patient

Check that:
- Firearms and lethal medications have been secured or made inaccessible to patient.
- A supportive person is available and instructed in follow-up observation and communication regarding signs of escalating problems or acute risk.
- A follow-up appointment with a mental health professional has been recommended and, if possible, scheduled.
- The patient has the name and number of a local agency that can be called in a crisis, knows that the Montana Suicide Prevention Lifeline, 1-800-273-TALK (8255) is available at any time, and understands the conditions that would warrant a return to the ED.

Document:
- Observations
- Mental status
- Level of risk
- Rationale for all judgments and decisions to hospitalize or discharge
- Interventions based on level of risk
- Informed consent and patient's compliance with recommended interventions
- Attempts to contact significant others and current and past caregivers

When patients elope

- Follow policies and procedures specific to retrieving all suicidal patients who have eloped (if your facility doesn't have any, WRITE THEM)
- Document the timeliness and reasonableness of actions taken.
- The following actions may need to be modified to match each situation:
  1. For Involuntary Patients or Patients with High Suicidal Intent:
     - Follow your state's mental health statute (**Montana Code Annotated, 53-21-129**) dealing with involuntary returns.
     - Immediately ask security and law enforcement personnel to return patient
     - Have a policy for authorizing physical restraint matching the risks posed
  2. For Most Voluntary Patients with Low Suicidal Intent:
     - Attempt to contact the patient or significant others and request return

If an emergency exists, it may be necessary to breach patient confidentiality (**HIPAA does not apply to patients at risk of suicide.**) http://www.hhs.gov/ocr/privacy/hipaa/faq/ferpa_and_hipaa/520.html

If you need to contact law enforcement

- If the person is uncooperative, combative, or unwilling to seek help, and you sense that the person is in acute danger or imminent risk, call 911 and tell the dispatcher that the person ***"is at imminent risk of danger to self or others"***.
- This key phrase alerts the dispatcher to locate immediate care for this person with the help of police.

Helping yourself and your colleagues

- Physicians are not immune to suicide. The chances of dying by suicide are substantially higher for physicians than non-physicians, about 70% higher for male physicians than for men in the general population (including other professionals) and between 250% and 400% higher for female physicians than other women. (Source: JAMA, September 14, 2005, Vol. 294, No. 10)
- The stress associated with making life and death decisions, along with long hours and grueling schedules, put physicians at a higher risk to become depressed themselves.
- We all need to know the warning signs, not just in others, but also in ourselves, and seek help when needed.

Resources for Physicians

- **Suicide Prevention Toolkit for Rural Primary Care Physicians**
  Suicide assessment and intervention toolkit designed for physicians practicing in rural communities. This toolkit and other resources can be downloaded at no cost from www.dphhs.mt.gov/amdd/Suicide
- **Suicide Prevention Resource Center (SAMHSA)** http://www.sprc.org/for-providers/primary-care

Suicide Prevention Resources

- Montana Suicide Prevention Website at www.dphhs.mt.gov/amdd/Suicide
- **Montana Statewide Suicide Hotline - 1-800-273-TALK**, TTY: 1-800-799-4TTY (4889). *National number then routed regionally to either Voices of Hope (Great Falls) or the Help Center (Bozeman) depending on prefix of phone number.*
- Shodair Children's Hospital (Acute Crisis Unit), Helena, 800-447-6614
- **American Academy of Child and Adolescent Psychiatry (800) 333-7636** *www.aacap.org*
- **American Association of Suicidology (202) 237-2280** *www.suicidology.org*
- **American Foundation for Suicide Prevention (888) 333-AFSP (2377)** *www.afsp.org*
- **National Suicide Prevention Lifeline 800-273-TALK (8255)** *www.suicidepreventionlifeline.org*
- **Suicide Prevention Resource Center (SPRC) 877-GET-SPRC (438-7772)** *www.sprc.org.*