M.A.D.-H.O.P.E.
WHATCOM YOUTH SUICIDE PREVENTION

Making a Difference -
Helping Other People Everywhere

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FACTS ABOUT SUICIDE

State

- Between 2003 and 2007, 539 Washington State youths completed suicide for an average of two youth suicides per week.
- In 2017, each day, approximately 3,400 suicide attempts are made by people between 7th and 12th grade.
- In 2016, 18% of Washington State 10th graders reported seriously considering suicide and 16% made a plan about how they would attempt suicide.
- Youth suicides outnumber youth homicides in Washington state (Washington State Department of Health)

National

- In 2017, 44,193 people completed suicide.
- Over 494,169 people with self-inflicted injuries were treated in U.S. emergency departments in 2013.
- About 8% of high school students have attempted suicide in the past year.
- In 2017 an average of 121 people died from suicide each day.
- Each suicide intimately affects at least six other people.
- Boys and young men are more likely to complete suicide but girls and young women are more likely to make suicide attempts that result in hospitalization (Washington State Department of Health)
- About 80% of the time, people who kill themselves have given definite signals or talked about suicide. ¹

¹ Sources: Washington State Department of Health; Center for Disease Control and Prevention; American Association of Suicidology
THE STIGMA OF SUICIDE

Stigma refers to a cluster of negative attitudes and beliefs that motivate the public to fear, reject, avoid, and discriminate against groups of people.

- Ignorance breeds fear, disgust, contempt, and lack of compassion resulting in stigma.

There exists a deep stigma related to suicide, born of our struggle to understand why a person would end his or her own life. Without knowledge of neurobiological disorders and why suicide occurs, people have decided that suicide is sinful, selfish, shameful, and weak. People fear it to the extent that they refuse to talk about it.

Suicide is a reality. It happens every day, 1,000,000 times a year worldwide. The stigma associated with suicide and the neurobiological disorders related to it keep people in need of help from seeking it and gets in the way of suicide prevention efforts.

What can be done to change this situation?

Reducing the power of any social stigma begins with sharing accurate information and having honest conversations about the issue. We eliminate the stigma surrounding suicide by seeking and then openly sharing accurate information.

“Our mission is to make suicide prevention everybody’s business through shared learning.” Suicide Prevention Australia
MYTHS ABOUT SUICIDE
Thomas Joiner

Myths about suicide are created by trying to reason about the suicidal mind from a non-suicidal place.

**MYTH:** Suicide is a coward's act. It is the easy way out.

**REALITY:** The human instinct to survive is deep and very, very strong. Suicide is fearsome, daunting and very difficult to complete. "Death by suicide requires staring the product of evolution in the face and not blinking; it is tragic, fearsome, agonizing and awful, but it is not easy." Suicide is not about weakness - it is about the fearless endurance of a certain kind of pain.

**MYTH:** Suicide is selfish.

**REALITY:** True suicidal thinkers feel alone in a way few people can fathom. Those who die by suicide do consider the impact of their deaths on others, they just see it differently - as a positive rather than a negative. They incorrectly perceive that their death will be a relief or blessing to others - that their death will be worth more than their life. The suicidal state is characterized by "cognitive constriction" – narrowing of focus or "tunnel vision." Attention is focused on here and now goals and tasks, abstract thought and forethought is impaired, resulting in reduced inhibitions. Suicidal thinkers are not selfish; they are simply unable to consider the most obvious consequences of their actions.
**MYTH:** People often die by suicide on a whim.

**REALITY:** Impulsive suicide attempters are not the norm. Mental preparation for the eventual act of suicide is essential. The extremely fearsome and painful prospect of bringing about one's own death requires previous experiences and psychological processes that take years. Suicide does not occur without prior consideration – those who complete suicide "impulsively" do so by resorting to a plan held in reserve. It may appear impulsive, but the idea and/or plan had been previously considered. Once someone has seriously considered suicide, the neural pathway for that option has been formed, which makes it readily available when faced with an emotionally trying situation.

**MYTH:** Most people who die by suicide don't make future plans.

**REALITY:** The suicidal mind is characterized by deep ambivalence. Two processes can and do occur simultaneously. A battle is waged between the instinct to live and the desire to die. The instinct to live still compels the suicidal thinker to make plans as usual, even though they are considering ending their own life. A tipping point can occur where the will to live eventually loses out to the desire for death.
MYTH: You can tell who will die by suicide from their appearance.

REALITY: People who are about to die by suicide may look very much like they always have. Suicidal thinkers can appear/behave absolutely normal just hours before ending their life. (However! A sudden change in appearance/grooming is a warning sign of suicide. If someone who is usually well groomed and nicely dressed suddenly shows lack of interest in their appearance, something is probably amiss and should be addressed.)

MYTH: You have to be crazy to die by suicide.

REALITY: Suicidal thinkers experience a break in the mind that is very different from psychosis or dementia. The break is very specific; it has to do with breaking from the universal fear and revulsion toward death, coming instead to embrace and invite it. Suicidal thinkers come to see death as a comfort to others and to themselves. Suicidal thinkers often do suffer from mental disorders – best evidence indicates that 95% of suicide victims suffer from a diagnosable mental disorder at the time of their death (e.g. depression, anxiety, bipolar disorder, schizophrenia, etc.).
**MYTH:** Most people who die by suicide leave a note.

**REALITY:** Approximately 25% of suicide victims leave a note. Suicide victims experience severe social disconnection so this percentage is not surprising. Most suicide notes do not contain much emotional content, rather they tend to be written in a matter-of-fact tone, using short sentences to give instructions regarding day-to-day matters. If emotional content is present, it is not uncommon for it to be positive in nature, reflecting the sense of peace and relief that is experienced once the decision to die has been made.

**MYTH:** If people want to die by suicide, we cannot stop them.

**REALITY:** The erection of suicide barriers on "suicide hot spot" bridges and tall buildings has effectively reduced the number of suicides at those locations, AND decreased the number of suicides in those locales, meaning suicidal thinkers did not go elsewhere or choose other means to die.
MYTH: Suicide is just a cry for help. If they were serious about dying, they would have already done it.

REALITY: Talking to others, especially about something painful and personal like ideas about suicide, represents a reaching out to others, a questioning about whether reliable social ties are there and can be counted on. Ignoring or otherwise mishandling suicide-related communications can have tragic consequence. Simple, genuine expressions of caring and availability can save a life.

MYTH: Suicidal behavior peaks around the Christmas holidays.

REALITY: Universally, suicidal behavior peaks in late spring and actually decreases around the holidays, presumably because it is a time of social connection and togetherness. Human biorhythms are such that people become more active/energetic in the spring, and for a subset of people, this activation may become overactivation (marked by restlessness, agitation and insomnia) which enables suicidal behavior. Manic phase of bipolar disorder occurs most often in spring. Suicides occur earlier in the week than later, especially on Monday. The thought is that rest/the inactive period of winter (or the weekend) followed by a surge of energy in spring (or Monday) is enough to facilitate suicidal behavior. Suicides do not surge around the time of a full moon, but do surge in later stages of menstruation when estrogen levels are low.
WHY PEOPLE DIE BY SUICIDE
Research from Thomas Joiner, Ph.D.

Two Fundamental Human Needs
1. Affiliation or sense of belongingness
   • The sense that we are connected to others
2. Effectiveness or sense of competence
   • The sense that we are positive contributors to our world (families, communities, relationships)

The need to belong and contribute in some way to society seems to be an essential part of what it means to be human. Connectedness and effectiveness are essential to the will to live. When these needs are perceived to be going unmet, the will to live may begin to deteriorate.

THREE COMPONENTS OF COMPLETED SUICIDE
People die by suicide because they have both the ability and the desire to do so.

1. Diminished fear about one's own death
   • Necessary for serious suicidal behavior to occur. Everyone who dies by suicide has to work up to the act, over long or short term.
   • Suicide victims have developed a sense of fearlessness of injury, pain and death through a process called "habituation"- "getting used to something."
Getting used to pain, injury and the idea of death – becoming fearless/losing natural inhibitions about it- is a prerequisite to serious suicidal behavior.

- Repeated painful experiences with pain & suffering lay groundwork for the ability to enact suicide i.e.: childhood physical and sexual abuse, history of painful injuries, self-injury (cutting), physician suicide rate – The more something painful is experienced, the more comfortable a person becomes with it– fear of pain is diminished and the main barrier to suicide erodes.
- The more times a person attempts suicide, the more serious and dangerous their attempts become. Previous experiences have diminished their fear of causing their own death.

2. Failed belongingness/social disconnectedness
   - The perception that one does not belong, the feeling that one is alienated from others and not an integral part of a family, circle of friends or other valued group
     - Isolation, withdrawal

3. Perceived burdensomeness/sense of incompetence/ineffectiveness
   - The perception that one’s existence is not of value, that one contributes so little that they are a burden to family, friends and society, that one's death is worth more than their life.
     - Very negative self-image
     - Feel out of control of own life
     - Possess a range of negative emotions that stem from idea that incompetence affects others
     - Continuing feelings of burdensomeness escalate into deep shame

IMPORTANT POINTS
1. Perceptions do not necessarily reflect reality. The suicidal thinker becomes increasingly incapable of seeing things as others see them. It is important to point out mistaken perceptions to suicidal thinkers.
2. The need to belong is SO POWERFUL that when satisfied, it can prevent suicide even when other components are in place. CONNECTION PREVENTS SUICIDE. When asked about likelihood of suicide, many depressed patients respond that their connection to a loved one makes it impossible.
3. We can reduce the likelihood that people will act on suicidal thoughts if we lessen their anguish.
SUICIDE RISK FACTORS

The risk for suicide frequently occurs in combination with external circumstances that seem to overwhelm at-risk teens who are unable to cope with the challenges of adolescence because of predisposing vulnerabilities such as mental disorders. Examples of stressors are disciplinary problems, interpersonal losses, family violence, sexual orientation confusion, physical and sexual abuse and being the victim of bullying.

- History of mental disorders
  - 95% of suicide victims have at least one diagnosable mental disorder
    - Depression, anxiety, bipolar disorder, schizophrenia, obsessive compulsive disorder
- Family history of suicide
  - People are at increased risk of suicide if someone in their family has died by suicide
- Previous suicidal behavior including attempts, aborted attempts, suicidal ideation
- History of trauma or physical/sexual abuse
  - Exposure to violence in home or social environment
- History of alcohol or other substance abuse
- Access to lethal methods
  - Presence of firearm in home increases risk of suicide
- Interpersonal conflict
  - Intimate relationship issues/breakup
  - Family instability/significant family conflict
  - Bullying
- Sexual orientation
  - LGBT teens and young adults have one of the highest rates of suicide attempts
- Recent death of a loved one – especially by suicide or other tragic loss
- Disciplinary problems at school or with law enforcement
- Other recent crisis/severe stressor
  - Family financial crisis
SUICIDE WARNING SIGNS

Expressing a desire to die
- Any mention of dying, disappearing, being "done," jumping, shooting oneself, or other types of self-harm
- 80% of suicide victims communicate in some way that they are considering suicide
- If someone is talking about suicide, they are considering suicide

Expressing feelings of social disconnection
- Talking about not "not fitting in," that no one understands them

Expressing a feeling of being a burden to others
- "Everyone would be better off without me"

Expressing low self esteem
- Feeling worthless, shame, overwhelming guilt, self-hatred

Expressing no hope for the future
- Talking about feeling trapped, that things will never get better, that nothing will ever change, that there is no reason to live

Change in Personality
- Displaying "dark" mood or change in demeanor or appearance
  - Sad, withdrawn, irritable, anxious, tired, indecisive, apathetic
  - Sudden change in grooming habits.

Change in Behavior
- Diminished ability to concentrate on school, work or routine tasks
- Acting anxious or agitated
- Behaving recklessly or erratically
- Increasing the use of alcohol or drugs
- Giving away personal belongings

Change in Sleep Patterns
- Sleeping too little or too much, insomnia often with early waking or oversleeping, nightmares

Change in Eating Habits
- Loss of appetite and weight or overeating/weight gain

Evidence of self-harm
- Cutting, burning, branding, hitting, purposeful overdoses of medication, poison ingestion
HOW TO RESPOND

Any suicidal intent must be taken seriously
• Every statement of suicidal intent is an expression of pain - the suicidal thinker needs professional help whether they actually intend to end their life or not.
• It does not matter if you think what the person is upset about is trivial, what matters is how the person feels.
• The suicidal thinker needs to feel accepted rather than judged or ignored.
• It is important to be aware of your own limitations to help - an ill-prepared support person can exacerbate the situation.
  o Ask for help/seek support.
  o Follow the Rule of Three's: There needs to be at least three people supporting the suicidal thinker.

Determine the urgency/seriousness of the situation
• Asking direct questions about suicidal intent does not provoke suicidal behavior. A suicidal thinker who has made a plan for suicide is far more likely to carry it out.
  o If the situation is urgent do not leave the suicidal thinker alone.
  o Remove the means of harm - weapons, sharp objects, medications, ropes, extension cords, belts.
  o If you are not communicating in person, act immediately:
    • Determine the suicidal thinker's location.
    • Contact anyone you know who can get to the person as soon as possible (including the police).

Communicating with the suicidal thinker
What to do:
• Use effective language
  o Avoid creating an "I'll show you!" attitude which could prompt a rash, impulsive act.
  o Make "I" statements vs. "You" statements. Keeping statements focused on "you" are less likely to be misconstrued or seen as shaming or blaming.
  o Avoid using "should" and "should not".
  o Talk with the person, not at the person. Avoid lecturing.
• Create a safe environment for sharing thoughts and feelings
  o Talk in a neutral place free of distraction.
  o Maintain eye contact and place yourself on the same physical level.
  o Speak clearly and calmly with even tone and soft expression.
• Acknowledge the suicidal thinker's pain.
  o Honor the suicidal thinker's experience/emotional state.
• Express love
  o Convey a deep sense of caring and acceptance.
  o Remind the suicidal thinker that suicide is a forever decision.
• Be genuine
  o The suicidal thinker will notice inconsistencies and may feel angry.
• Be present
  o Focus all attention on the suicidal thinker
    ▪ Silence your phone, turn off your TV, games, or other electronic distractions.
  o Be quiet and listen - hear more and speak less.

What not to do:
• Do not be afraid to talk about suicide. Addressing the reality of the situation is critical.
• Do not argue or attempt to prove what the suicidal thinker is saying doesn't make sense.
• Do not attempt to coax the person out of how he or she feels.
• Do not diminish the feelings of the suicidal thinker.
• Do not compare the suicidal thinker to others. This will increase their negative feelings of guilt and worthlessness.
• Do not give easy answers or suggest solutions to problems. The suicidal thinker does not want you to solve their problems, they want you to listen, acknowledge, and love.
• Do not keep suicidal intentions or any suicidal behavior confidential, including information about an aborted or previous attempt.

Secrets can be deadly. There is a difference between breaking a confidence through gossip and breaking a confidence to save a life. Do not be sworn to secrecy.
WORDS MATTER

Preparing yourself for an effective conversation with someone that is struggling.

OVERVIEW & PURPOSE

The purpose of this worksheet is to help you identify, in your own words, language that is effective to use both with yourself and with others when a conversation gets tense. Preparing yourself ahead of time can help you think on your feet and stay calm. This is important when talking about an emotional topic.

OBJECTIVES

In this activity, you will

(i) identify words and language that you find useful when talking to others, and
(ii) identify words and language that you find useful for others to say to you.

INSTRUCTIONS

1. Pair up with one other person. (A total of three people is acceptable but two is preferred)
2. Read through the examples below from both columns. (One person take the ‘effective language’ column, the other person can take the ‘ineffective language’ column.
3. Use this list to guide your group in creating your own list of words that matter.
   a. What are some things that people have said to you that helped? Or didn’t help when you were in a tense conversation?
   b. What are some things that you have said to others that has helped? Or not helped?
4. Bring this home and put it on your fridge, post it to Instagram, or just keep in mind so that when you are talking with others, you can use the language that you think is effective.
# Words Matter Examples

<table>
<thead>
<tr>
<th>Ineffective Language</th>
<th>Effective Language</th>
</tr>
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<tbody>
<tr>
<td>What is <strong>wrong</strong> with you?</td>
<td>I hear you. Do you want to talk about it?</td>
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<tr>
<td>Why do you keep <strong>doing</strong> this to yourself?</td>
<td>I hear you and I feel concerned.</td>
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<td>Why can’t you just <strong>forget</strong> about it?</td>
<td>I know it’s hard, would it help to talk about it?</td>
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<td>Come on, it’s not <strong>that</strong> bad!</td>
<td>I hear your pain, is there something I can do for you?</td>
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<td><strong>Don’t</strong> you know that I love you?</td>
<td>I love you.</td>
</tr>
<tr>
<td>You <strong>shouldn’t</strong> feel that way</td>
<td>I understand how you are feeling or I can’t imagine what that is like but I honor your feelings.</td>
</tr>
<tr>
<td><strong>Don’t</strong> think that way!</td>
<td>Would you like to tell me about it?</td>
</tr>
<tr>
<td><strong>Don’t</strong> do this to yourself!</td>
<td>You are important to me, it’s hard to see you going through this, can I help in any way?</td>
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<tr>
<td><strong>Can’t</strong> you forget about it?</td>
<td>I know it’s hard. How can I help you get through this?</td>
</tr>
<tr>
<td><strong>Can’t</strong> you see what this is doing to our family?</td>
<td>We are all concerned about you. Let us know what we can do.</td>
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<tr>
<td>You’re too emotional.</td>
<td>I appreciate that you are sharing this with me.</td>
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<tr>
<td>I just don’t understand you!</td>
<td>I care about you but I feel confused. Do you know what might help?</td>
</tr>
<tr>
<td>Cheer up.</td>
<td>I hear you.</td>
</tr>
<tr>
<td>Effective Language</td>
<td>Ineffective Language</td>
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ASKING THE QUESTION

Direct

1. Are you thinking about killing yourself?
2. Are you thinking about hurting yourself or ending your life?
3. Have you made a plan for ending your life?
4. You know, when people are as upset as you seem to be, they sometimes wish they were dead. I'm wondering if you're feeling that way too?
5. You look like you're feeling pretty miserable. I wonder if you're thinking about suicide?

Indirect

1. Have you ever felt life is not worth living?
2. Do you wish you were dead?
3. Have you been very unhappy lately?
4. Have you been so unhappy lately that you've been thinking about ending your life?
5. Do you ever wish you could go to sleep and never wake up?

Do not say: "You're not suicidal, are you?"

This statement is condemning and can keep a person from expressing their suicidal thoughts.
EXAMPLES OF A CONVERSATION

1. The "Trust your gut" moment.
   • "I wanted to talk with you because I noticed...
   • Want to talk about it?

2. Stating the concern.
   • "I'm worried that you might be very sad, depressed, really upset, or even suicidal."

3. Ask the Question.
   • "Are you thinking about killing yourself?"

4. Listen with compassion.
   • Use the Words Matter worksheet to respond to the suicidal thinker's answers.
   • Note: You are not trying to fix or correct anything.

5. Get adult or professional help.
   • "We need to get some adult help."
   • "Is there someone you feel comfortable talking to?"
   • "I know you like_____, let's go talk with him/her."
COMMUNITY RESOURCES

**Counseling/Mental Health:**
- **Catholic Community Services (CCS):** 360.676.2164 (takes Medicaid; emotional management and self-care)
- **Compass Health Counseling:** 360.676.2220 (in/outpatient to all of Whatcom County)
- **Sea Mar Community Health Center:** 360.734.5458 (conducts assessments)
- **Volunteers of America 24/7 crisis line:** 1.800.584.3578
- **Child Protective Services (CPS):** City: 1.866.829.2153 / County: 1.800.794.9402
- **Domestic Violence & Sexual Assault Services (DVSAS):** 360.715.1563 OR 1.877.715.1563
- **Domestic Violence Hotline:** 1.800.562.6025
- **Teen Line:** 1.877.345.8336
- **Lummi 24-hour helpline:** 360.384.2285
- **Opportunity Council:** 360.734.5121 (housing & homeless support)
- **Whatcom County Housing Authority:** 360.676.6887 (housing)

**National Services:**
- **National Suicide Prevention Hotline:** 1.800.273.8255
- **The Trevor Project (LGBTQ+):** 1.866.488.7386
- **24hr Crisis Care Hotline:** 1.800.584.3578
- **National Hotline Network:** 1.800.784.2433
- **Youth America Hotline - Counseling for Teens by Teens:** 1.877.968.8454

**Online Resources:**
- **IMALIVE - An Online Crisis Network Suicide & Crisis Chat:**
  [https://www.imalive.org/](https://www.imalive.org/)
- **CrisisChat.org - Online Emotional Support:**
  [https://www.contact-usa.org/chat.html](https://www.contact-usa.org/chat.html)
- **Crisis Text Line:**
  741-741, [https://www.crisistextline.org/](https://www.crisistextline.org/)
  Text “HELLO” or “WARM” to start the conversation.

**What happens when you call a helpline?**
Usually there will be a message confirming the number you have called, followed by on-hold music (1-4 minute wait on average) until someone can answer your call. Helplines generally ask you questions about why you called and will non-judgmentally listen and may help you plan some next steps.
ONLINE INTERVENTION

Here is a list of different social media sites and apps with how they address suicidal threats, risk, and reports. This should explain for you the processes of what happens when they are alerted that someone might be suicidal and in danger.

Facebook:

- **How to report threat of suicide:**
  - Select the “…” in the upper right corner of the post. Select “Give feedback on this post.” Select “Suicide or Self-Injury.” Select “Send.”
  - Or go to goo.gl/HEqPzK. It will ask you to fill in the person’s name, link to their profile, and link to the post.
- A member of Facebook’s Safety Team will send the at-risk user an email with the Lifeline number, and possibly a link to chat with a Lifeline counselor.
- Facebook uses patterns observed from previous reports to identify potentially concerning posts. If they think something someone posts might suggest they’re in danger of self-harm, they’ll quickly provide them with resources.
- Facebook’s resources:
  - If you yourself are at risk: goo.gl/ME4bAs
  - Helplines: goo.gl/cX4Xhs
  - Messaging a mental health or crisis counselor: goo.gl/qtruSO

Twitter:

- **How to report threat of suicide:**
  - Select the V-shaped icon in the upper right corner of the concerning tweet. Select “Report Tweet.” Select “It’s abusive or harmful.” Select “This person is encouraging or contemplating suicide or self-harm.” Select who is potentially in danger. Click next, and then it will provide you with the National Suicide Prevention Lifeline and resources.
  - Or go to help.twitter.com/forms/suicide. It will ask you to fill in the person’s username, a description of the problem, and some of your info.
- Twitter will contact the user and let them know that someone who cares about them identified that they may be at risk. They may then assist the person by providing them with resources, such as online resources, hotlines, and contact info for their mental health partners.
- Twitter’s resources:
  - Twitter’s Mental Health Partners: goo.gl/wNidR7
Tumblr:

- **How to report threat of suicide:**
  - Go to the person’s blog, then select the person-shaped icon in the upper right corner. Select “Report.” Select “Report something else.” Select “Self harm.” Fill in the link to the blog or post and some of your info, and select “Submit.”
  - Or go to [tumblr.com/abuse](tumblr.com/abuse), then follow the steps listed above.
- A member of Tumblr’s Safety Team will send the person an email with the Lifeline Number.
- Tumblr’s resources:
  - Counseling and prevention: [goo.gl/GUhXs3](goo.gl/GUhXs3)

Instagram:

- **How to report threat of suicide:**
  - Instagram may reach out to the person with helpful info.
- Instagram’s resources:
  - For yourself or someone else: [goo.gl/UMNbKX](goo.gl/UMNbKX)

Snapchat:

- **How to report threat of suicide:**
  - If it’s a concerning snap on someone’s story, hold down on the snap, and select the flag icon in the lower left corner. Select “More options.” Select “I’m worried this Snapchatter might hurt themselves.” Select “Submit.”
  - Or go to [goo.gl/gxjeGc](goo.gl/gxjeGc). Select “Report a safety concern.” Select where the concern is located (a story, discover, etc.). They then provide instructions on how to report in the app.
  - Snapchat’s resources:
    - Concern about someone’s safety: [goo.gl/b44NSg](goo.gl/b44NSg)

Twitch:

- Twitch’s resources:
  - Mental Health Support and tips for helping someone who is suicidal: [goo.gl/4ky1ff](goo.gl/4ky1ff)