This 4-lesson plan set, developed by the Centre for Suicide Prevention, is for Health and Life Skills teachers teaching about suicide prevention using the Jay Asher novel *Thirteen Reasons Why*. The novel is intended to be read between lessons #1 and #2.

Unit rationale

Students will begin to identify the complexity of suicide in order to increase help seeking behaviours in themselves and others.

Unit learning objectives

At the end of this unit, students will be able to:

1. Recognize that suicide is complex;
2. Identify protective factors, risk factors and warning signs; and
3. Describe how they would respond to a friend in crisis.

Lesson 1: Why do people kill themselves?

A. Learning objective: At the end of this lesson, students will begin to recognize that suicide is complex.

B. Learning activities
   1. Teacher-led discussion
      i. What do you know about suicide?
      ii. Why do people die by suicide?
      iii. Why is it difficult to talk about it?
      iv. Teacher discusses the complexity of suicide. (See Teacher Resource "Why do people kill themselves?" – excerpt from the iE by the same title.)
      v. Lead students through Myths and Facts as a large group.

   2. Learning groups (divide students into small groups)
      i. Discussion: Reflecting on the large group presentation: What did you learn in the Myths and Facts? How is this different than what we brainstormed at the beginning of the class? What if anything reinforces your initial thinking? What surprises you? What is new to you? What did you know before?
      ii. Journaling: After small-group discussion time, have students journal what they feel is their most salient learning from today and what they hope to learn by the end of the unit.

   3. Teacher-led discussion: summarize day
      i. Bring whole class back together and have small groups share their responses.

   4. Novel reading
      i. Arrange for student reading of the novel; either independently or as a class or in small groups. Alternatively, clips from the Netflix series or the audiobook could be used.
      ii. Task students with comparing Hannah's experience with the facts they have learned in lesson #1: Does Hannah's experience corroborate the main theories of suicide? Are her experiences complex?
      iii. Talk to students about mental health support for themselves while reading the book. What will they do if something in the book triggers them? Arrange formal support structures for students (Eg. alert parents to this novel, provide increased teacher access for students, list Kids Help Phone number).

C. Materials
   1. Teacher Resources: "Why do people kill themselves?" and "Myths and Facts"
   2. White board and markers
   3. Student journals
   4. Copies of the novel

Lesson 2: Identifying protective and risk factors

A. Learning objective: At the end of this lesson, students will be able to identify protective and risk factors.

B. Learning activities:

1. Teacher-led discussion: focus on the rarity of suicide
    i. What are your impressions of the book?
    ii. Does Hannah's experience corroborate the main theories of suicide? Are her experiences complex?
    iii. Do events cause suicide? Or is it how we respond to the events and other circumstances in our life that may lead us to suicide? Why? What is the difference?
    iv. Emphasize the rarity of suicide: While every death is one too many, very few people actually kill themselves. Many people think about suicide at one time in their lives but very few actually die.

2. Teacher demonstration: weigh scale
    i. Using a weigh scale, put blocks on either side so that it is balanced.
    ii. Define protective and risk factors and label each side of the scale as such.
    iii. Explain that risk factors outweighing protective factors leads some people to hopelessness and the possibility of suicide.
    iv. Ask: Is it the risk factors themselves or the way the person views the risk factors that brings someone to a point of crisis? What's the difference? Why is this important? And what is most people's response to life circumstances? Why?

3. Learning groups (divide students into small groups)
    i. Have students draw a scale in their journal and brainstorm Hannah's protective and risk factors, drawing them as blocks on the scale.
    ii. Have each group choose 2 risk factors and 2 protective factors of Hannah's; then have them identify Hannah's feelings about and responses to each.
    iii. Have the small groups discuss: How do Hannah's feelings about the risk factors affect her behaviour? How do Hannah's feelings about the protective factors affect her behaviour?

4. Teacher-led discussion
    i. Bring whole class back together and have small groups share their responses.
    ii. Through the discussion, help students identify the following 5 precipitating factors for suicide prominent in the research:
        - lack of belonging,
        - feeling useless (being a burden to others),
        - negative self-perception,
        - hopelessness, and
        - distorted thinking.

5. Journaling
    i. Begin brainstorming in your journal about how we can promote protective factors for each other. How can we create a climate of inclusivity and hope in our school?

C. Materials:
1. Weigh scale and blocks
2. White board and markers
3. Student journals
4. Student novels

Lesson 3: Identifying warning signs of suicide

A. Learning objective: At the end of this lesson, students will be able to identify warning signs of suicide.

B. Learning activities:

1. Teacher-led discussion
    i. Review protective and risk factors
    ii. Ask students what they remember from Myths and Facts regarding ”Suicide happens without warning”?
    iii. What do they think? Is suicide a surprise?
    iv. Ask students to think of a time when they were carrying a burden – How did it affect them? How was it resolved? How did they want it to be resolved?
    v. Watch this video about debt: https://www.youtube.com/watch?v=p_jtmETBfeo
    vi. Having suicide ideation can be a lot like the woman in this commercial. Asking for help directly is hard! We need to learn how to read people’s indirect requests for help.

2. Learning groups
    i. What are some of the signs people may give off if they are at risk of suicide?
    ii. Is there a difference between giving off these signs and attention seeking? Why or why not?
    iii. Does Hannah give off signs? If so, what are they?

3. Teacher-led discussion
    i. Bring whole class back together, have small groups share their responses
    ii. Through the discussion, present students with the idea that attention-seeking is necessary for some people: they *need* attention, they need help. Often attention-seeking behaviours are actually warning signs. We must take them seriously.

4. Share post-it video, journaling
    i. Review journaling from last class: How can we promote protective factors for each other? Here is an example from a school: http://globalnews.ca/news/1847835/students-stick-positive-post-it-notes-on-lockers-to-end-bullying/
    ii. Add to your list of promoting protective factors.
    iii. Are there things we do to take away from our school culture and environment? Write about these, too.

C. Materials

1. Links to the 2 videos
2. White board and markers
3. Student journals and novels

Lesson 4: Talking to someone at risk of suicide

A. Learning objective: At the end of this lesson, students will be able to describe how they would respond to a friend in crisis.

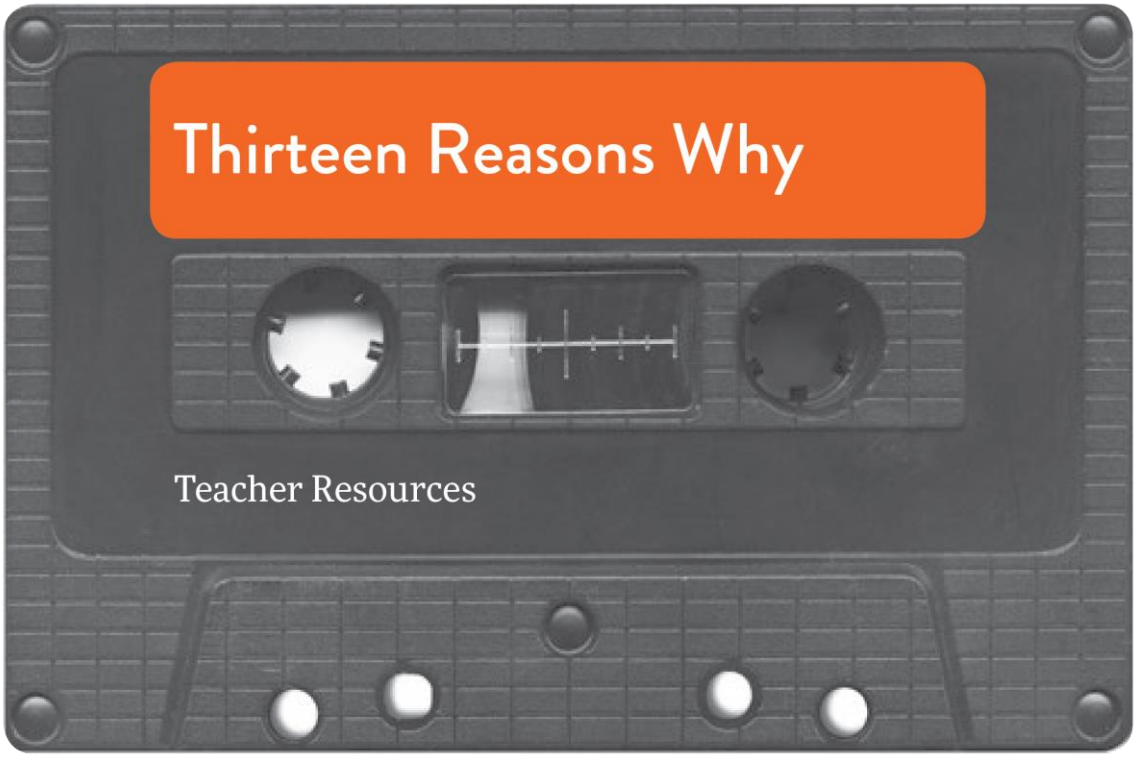
B. Learning activities:
   1. Teacher-led discussion
      i. Review protective and risk factors, and warning signs. Review the feelings associated with them and how we can sometimes change our feelings even if we cannot change our circumstances.
      ii. How can we help tip the scale the other way? Towards resilience?
      iii. Think back to the *Get debt off your back* video: How can we help each other with our burdens?

   2. Learning groups
      i. Discussion: It seemed like Hannah thought of herself as powerless -- sort of a victim of circumstances. Was Hannah powerless? Why or Why not? How could she have been more in control of her own life when everyone around her seemed to be pushing her down?
      ii. How could things have been different for Hannah? Who could have talked to her and what would he/she have said? Who were the trusted adults in Hannah's life?
      iii. Discussion and journal: How can you help someone at risk of suicide?

   3. Teacher-led discussion: How to help a friend
      i. Bring whole class back together, have small groups share their responses.
      ii. Through the discussion, stress the importance of involving a trusted adult if your friend is at risk of suicide. NEVER KEEP SUICIDAL RISK A SECRET.
      iii. Discuss scripts: What would you say to a friend? How could you ask for help for yourself?
      iv. Brainstorm community resources for help, the role of each and the access point (e.g. in person, phone, text, chat).

   4. Final project
      i. Bring journaled ideas together as a class. Final project can be implemented as a whole class or in learning groups.
      ii. How could they be implemented? How many could be implemented? How can we sustain these efforts until they become part of our culture?
      iii. Examples of final project include: publish scripts on what to say to a friend; create an infographic of where and how to seek help, identifying "trusted adults"; post-it on locker project;

C. Materials
   1. White board and markers
   2. Student journals and novels



From the Alberta Education Health and Life Skills Program of Studies, stem R-8.2
Students will describe signs associated with suicidal behaviour, and identify interventional strategies.

Unit rationale

Students will begin to identify the complexity of suicide in order to increase help seeking behaviours in themselves and others.

Unit learning objectives

At the end of this unit, students will be able to:

1. Recognize that suicide is complex;
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3. Describe how they would respond to a friend in crisis.

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Teacher Resource: Depression and Suicide Prevention

The following is excerpted from Centre for Suicide Prevention's toolkit*: Depression and Suicide Prevention* (https://www.suicideinfo.ca/resource/depression-suicide-prevention/).

Major Depressive Disorder (MDD) is the most prevalent psychiatric disorder in the world. MDD is also known as **clinical depression, unipolar depression** or, simply, **depression.**

People with depressive illnesses carry out the majority of suicides. (Mood Disorders Society of Canada, 2013). The World Health Organization (WHO) predicts that by the year 2030 depression will be the leading cause of disability worldwide (World Federation for Mental Health, 2012). Less than 1 out of 5 teenagers with depression receive treatment (Essau, 2005).

Statistics

- Percentage of the Canadian population that experiences a major depressive episode in a given year has been estimated at 5-8.2% (Canadian Medical Association Journal, 2013)
- Lifetime risk of suicide among people with untreated depression ranges from 2.2-15%
- Depression is present in at least 50% of all suicides
- Those suffering from depression are at 25 times greater risk for suicide than the general population (American Association of Suicidology, 2014)
- Only 1/3 of those with depression seek help (Mood Disorders Society of Canada, 2013)

Major Depressive Disorder Symptoms

- Persistently sad mood
- Loss of interest/pleasure in activities
- Anger, irritability
- Significant change in weight and/or eating patterns
- Sleeping too little or too much
- Low self-esteem or body image
- Fatigue, loss of energy
- Feelings of worthlessness, excessive or inappropriate guilt
- Diminished ability to think or concentrate
- Loss of interest/pleasure in activities
- Recurring thoughts of death, suicidal ideation, or having a suicide plan or suicide attempt

(American Psychiatric Association, 2013)

The American Psychiatric Association classifies Major Depression Disorder as existing when:

- 5 or more of the above symptoms present for at least 2 weeks
- Symptoms cause distress or impairment in social, school, family, or other areas of functioning

American Association of Suicidology. (2014). *Depression and suicide risk.* Retrieved from http://www.suicidology.org/Portals/14/docs/Resources/FactSheets/2011/DepressionSuicide2014.pdf

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (5th ed.)*. Arlington, VA: American Psychiatric Publishing.

Canadian Mental Health Association, British Columbia. (2013). *Learn about depression.* Retrieved from http://www.heretohelp.bc.ca/sites/default/files/ depression.pdf

Mood Disorders Society of Canada. (2013). *What is depression?* Retrieved from http://www.mooddisorderscanada.ca/documents/Publications/DepressEngMaster_v18_Nov_2013.pdf

Teacher Resource: Distorted Thinking and Suicide

Suicide theories suggest that people arrive at suicidal crisis partly because they have learned to think in negative ways, resulting in suicide becoming a more likely solution to their pain (Jager-Hyman et al. 2014). According to these theories, the way people in suicidal crisis think about stressful situations (rather than the stressors themselves) can predict suicide. Unhealthy and unrealistic thought patterns, called *cognitive distortions*, can propel someone toward depression and suicide (Nock & Kazdin, 2002).

The following types of distorted thinking can relate to suicide:

Externalizing of self-worth: the development of self-worth based primarily on others' opinions (e.g. needing others to approve of me to feel good about myself).

Fortune telling: predicting and firmly believing that negative outcomes will arise from future events (e.g. acting as if I have a crystal ball predicting negative events in my life).

Comparison to others: the act of negatively comparing oneself to others (e.g. thinking most people are better at things than I am).

Magnification: the tendency to exaggerate or magnify the negative impact of a personal trait or circumstance (e.g. blowing things out of proportion and assuming worse outcomes than what generally happens).

Labeling: applying an overall, negative label to oneself or others (e.g. calling myself negative names).

Jager-Hyman, S., Cunningham, A., Wenzel, A., Mattei, S., Brown, G. K., & Beck, A. T. (2014). Cognitive distortions and suicide attempts. *Cognitive therapy and research*, *38*(4), 369-374.

Nock, M. K., & Kazdin, A. E. (2002). Examination of affective, cognitive, and behavioral factors and suicide-related outcomes in children and young adolescents. *Journal of clinical child and adolescent psychology*, *31*(1), 48-58.

Teacher Resource: Hopelessness and Suicide

Hopelessness refers to an expectation that your negative situation will not get better no matter what you do to change the situation. Hopelessness is a particularly significant precipitating factor in suicidal thought (Saltz & Marsh, 1990).

Hopelessness may be revealed in how a person speaks about themselves, their relationships with others, or their future.

Here are some examples:

- Things will never get better.
- There is nothing I can do to fix my problem.
- I will never be happy again.
- Nobody cares what happens to me.
- I will never get over what happened.
- I don't see things ever improving.
- There is nothing that I can do to make things better with my friends.
- There is no point in trying anymore.
- I just want to give up.
- What do I have to look forward to?
- The future is empty for me.
- I only see things getting worse in the future.
- Everything is going downhill.
- I will never get back to the way I was.
- It's too late for me to change things.

Saltz, A., & Marsh, S. (1990). Relationship between hopelessness and ultimate suicide: a replication with psychiatric outpatients. *American journal of Psychiatry*, *147*(2), 190-195.

Teacher Resource: Myths and Facts about Suicide

Myth
Talking about suicide will give my friend the idea to attempt suicide.

Fact
Talking about suicide does *not* cause people to think about killing themselves. Asking about suicide gives them the opportunity to speak openly about what's going on and shows your friend that you care about them!

Myth
Suicide happens without warning.

Fact
Even when suicidal behaviour seems impulsive, there have usually been prior warning signs and behaviours.

Myth
If my friend is suicidal now, they will be suicidal forever.

Fact
No, your friend's suicidal thoughts may be related to a temporary situation that is causing them great stress or emotional pain. These feelings will pass especially if they have help working through them.

Myth
My friend will be angry if I try to help them.

Fact
Your friend might become angry or defensive because of embarrassment or shame or feeling that they do not need help. Even if your friend doesn't accept help, you need to tell an adult you trust that your friend is suicidal.

Myth
My friend seems to be feeling better so they are no longer at risk.

Fact
Unfortunately, this is not necessarily true. Sometimes when people act like everything is okay, or they act happy after a long period of sadness, they are still struggling. They may appear suddenly calm after a period of anxiety and agitation. This may indicate they have decided to take their life and are resigned with the decision. Make sure that an adult knows that your friend is/was struggling with thoughts of suicide.

Myth
People who talk about suicide are just trying to get attention.

Fact
People who die by suicide usually talk about it first. They are in pain and oftentimes reach out for help because they do not know what to do and have lost hope. Always take talk about suicide seriously. Always.

Myth
People who are suicidal do not usually seek or want help

Fact
The vast majority of people who are suicidal do not want to die. They are in pain, and they want to stop the pain. People who are suicidal almost always want help.

Myth
People who are suicidal want to die.

Fact
Most people who die by suicide do not want to die. They simply want the pain of living to stop.

Myth
Bullying causes suicide.

Fact
There is rarely just one factor that will cause someone to think of suicide. People who think of suicide are usually experiencing many negative things, not just one. On the other hand, it only takes one positive thing to prevent people from thinking of suicide. For example, if someone has even one good relationship or one activity that they really love, or if they have one really great personality trait like high self-esteem, this can prevent them from considering suicide.

Myth
People who are lesbian, gay, transgendered, or questioning their sexuality have a high risk of suicide throughout their lives.

Fact
LGBTQ youth are more at risk of suicide than the general population of youth, but their risk drops when they become adults. This is because adults generally are more accepting of who they are, and they've usually build up friendships with people who accept them.

Teacher Resource: Risk and Protective Factors for Suicide

Youth are at greater risk of suicide if they have:

- Mental illness (depression, anxiety, etc.)
- Family or personal history of suicide
- Physical or sexual abuse
- Feelings of hopelessness
- Self-harm
- Access to lethal means (a gun, prescription drugs)
- Struggle with gender identification
- Recent stressful events (divorce, loss of a family member)
- Family disconnection
- Having "tunnel vision," not being able to see past the difficulties of today and into the future

Youth are at a reduced risk of suicide if they have:

- A positive school environment
- A strong family connection
- Supportive relationships with friends
- A positive relationship with a trusted adult that is not a family member (e.g. a teacher or coach)
- Good self-esteem
- Hope in the future, and are not overly focused on their day to day emotions
- Involvement in positive activities outside of regular school hours (e.g. volunteering, participating in cultural activities, sports)

Center for Disease Control and Prevention (n.d.). *Suicide: Risk and protective factors*. Retrieved from https://www.cdc.gov/violenceprevention/suicide/riskprotectivefactors.html

Substance Abuse and Mental Health Services Administration (2012). *Preventing suicide: A toolkit for high schools*. Retrieved from http://store.samhsa.gov/shin/content/SMA12-4669/SMA12-4669.pdf

Suicide Prevention Resource Center, & Rodgers, P. (2011). *Understanding risk and protective factors for suicide: A primer for preventing suicide*. Newton, MA: Education Development Center, Inc.

Teacher Resource: Suicide and Stigma

The following is adapted from Centre for Suicide Prevention's infoExchange column *Suicide and Stigma* (https://www.suicideinfo.ca/resource/suicideandstigma/) as well as an article from the Halton Suicide Prevention Coalition.

Stig·ma: noun - a mark of shame or disgrace (Merriam-Webster).

People who are responsible for perpetuating suicidal stigma engage in behaviors such as **stereotyping, distrust, shunning,** and **avoidance** toward those affected by suicide (Cvinar, 2005).

Suicide stigma has deep roots in religion and law. The world's major religions have taken a dim view of suicide if not explicitly condemning the act. Most states considered suicide a crime until the twentieth century and under Canadian law, suicide was a crime until the 1970s. Thus, the term "committed suicide" strongly suggests suicide is a crime, thereby further entrenching the stigma associated with suicide. Today, we use the phrase 'died by suicide' instead of "committed suicide" to show the shift in thinking.

While public perceptions around suicide are shifting, stigma persists. Stigma often keeps people who at risk of suicide from seeking help or openly talking about their thoughts and feelings with family and friends. Further, stigma plagues people who are bereaved by suicide, those who have lost someone to suicide as well. These 'survivors' often benefit from professional grief support but may be reluctant to seek it because of the stigma.

Although suicide in Canada is no longer a crime, the stigma persists. The many myths associated with suicide have also contributed to the perseverance of stigma. Notions that people who kill themselves are "cowards" and "selfish" persist to this day, while attempters are often viewed as "attention seekers" who are not to be taken seriously.

What can we all do to fight stigma about suicide?

- Talk openly about suicide
- Reserve judgement when others share their thoughts and feelings about suicide and mental health
- Be aware of suicide facts so that you can help dispel some of the myths around suicide.

Cvinar, J.G. (2005). Do suicide survivors suffer social stigma: A review of the literature. *Perspectives in Psychiatric Care, 41*(1),14-21.

Halton Suicide Prevention Coalition. Retrieved from http://www.suicidepreventionhalton.ca/suicidefacts/stigma1.php

Teacher Resource: Theories of suicide: Why do people kill themselves?

The following is excerpted from Centre for Suicide Prevention's infoExchange column *Why do people kill themselves?* (https://www.suicideinfo.ca/resource/suicidetheories/)

The reasons for why a person dies by suicide are usually numerous and complex, it is rarely the outcome of one single factor. Why do some people consider suicide while others with seemingly similar circumstances do not? Though researchers are unclear, some suggest that the *thoughts* and *feelings* a person has about their circumstances play a role in bringing them to the point of considering suicide. Researchers also contend that people who consider, attempt or die by suicide do not actually want to die: they want their intolerable psychological pain to end and at the point of crisis, they do not see another way out (Baumeister, 1990; Shneidman, 1996).

What could cause so much emotional pain a person would consider suicide?

1. Feeling a **lack of belonging** or acceptance (Joiner, 2005: Shneidman; Leenaars, 1996). We all have a core need to feel relationally connected to others. If we feel socially isolated it can cause deep emotional pain.
2. A belief they are a **burden to others** or feel useless (Joiner, 2005). The idea they are invisible to others and would not be missed can transform the act of suicide from a selfish act to a response that seems reasonable.
3. They have a strongly **negative self-perception** (Baumeister 1990: Beck 1975). There can be a powerful sense of not liking themselves, which can contribute to the perception they are not accepted by others and they would not be missed.
4. They feel **hopelessness** and are convinced their painful life circumstances will never change (Beck, 1996; Shneidman, 1993). Without hope for a better future, it can be difficult to find a reason to go on living.
5. They experience a **hypersensitivity to emotions** and upsetting situations. These extreme emotional states are intense and aversive. Sufferers desperately attempt to cope or regulate the pain through self-injury or suicide. (Crowell, Beauchaine & Linehan, 2009).
6. **Distorted thinking** can worsen these issues (Beck, 1996; Bridge et al., 2012; Jager-Hyman et al., 2014).
    - Overly negative or distorted thinking can contribute to all of the factors listed above and is often found in people who attempt suicide (Bridge et al., 2012).
    - Distorted thinking can:
        - increase someone's feelings of not belonging
        - convince someone they are a burden to others
        - contribute to a negative self-perception
        - reinforce the belief that life is hopeless

Beck, A., Kovacs, M., & Weissman, A. (1975). Hopelessness and suicidal behavior: An overview. *Jama*, *234*(11), 1146-1149.

Baumeister, R. (1990). Suicide as escape from self. *Psychological review*, *97*(1), 90.

Bridge, J., McBee-Strayer, S., Cannon, E., Sheftall, A., Reynolds, B., Campo, J., ... & Brent, D. (2012). Impaired decision making in adolescent suicide attempters. *Journal of the American Academy of Child & Adolescent Psychiatry*, *51*(4), 394-403.

Crowell, S. E., Beauchaine, T. P., & Linehan, M. M. (2009). A biosocial developmental model of borderline personality: Elaborating and extending linehan's theory. *Psychological bulletin*, *135*(3), 495.

Jager-Hyman, S., Cunningham, A., Wenzel, A., Mattei, S., Brown, G. K., & Beck, A. T. (2014). Cognitive distortions and suicide attempts. *Cognitive therapy and research*, *38*(4), 369-374.

Joiner, T. (2005). *Why people die by suicide*. Cambridge, MA.: Harvard University Press.

Leenaars. A. (1996). Suicide: A multidimensional malaise. *Suicide and Life-Threatening Behaviour*, 26(3), 221-236.

Shneidman. E. (1993). *Suicide as psychache: A clinical approach to self-destructive behavior.* Northvale, NJ.: Jason Aronson, Inc.

Teacher Resource: Warning Signs for Suicide

There are certain things people who are suicidal may say or do to indicate their thoughts. Be on the lookout for the warning signs!

Things they may be saying

Some of the things the suicidal person might say and the associated feelings include:

- **Hopelessness**
  "What's the point of even trying?"
  "Nothing is ever going to change."
  "Nothing matters."
  "What difference does anything make?"

- **Social Isolation**
  "I don't have any friends."
  "Nobody cares about me."
  "Nobody likes me."
  "I feel like I'm invisible to everyone"

- **Low self-esteem**
  "I hate myself."
  "I'm such a failure."
  "Everybody thinks I'm a loser."

  Note: Signs of low self-esteem include refusing to accept praise or rewards.

- **Psychological pain**
  "I'm so miserable."
  "I'm never happy."
  "Nothing is fun anymore."
  "I feel so empty inside"

- **Feeling worthless or a burden to others**
  "Nobody would care if I was gone."
  "Everyone would be better off if I was dead."
  "Nobody would miss me if I didn't come to school."

- **Wanting to die:**
  "I'm going to kill myself."
  "I wish I were dead."
  "I wish I had never been born."

- **Talking or joking about death**
  "Why don't I just off myself?"

Things they may be doing

Watch for any significant changes in behaviour:

- **Significant mood changes:**
  - being really sad when usually they're happy
  - being really happy when they're usually pretty down or easily annoyed
  - getting angry, annoyed, or frustrated easily
- **Withdrawal:**
  - staying home more often, not hanging out with friends much
  - not doing things they normally enjoy like playing sports, music, or going to parties
  - skipping school more often than usual
  - deleting social media accounts
- **Other Changes in Behaviour:**
  - grades are dropping
  - paying less attention to their personal appearance, e.g. having dirty clothes or unwashed hair when they are usually quite clean
  - change of eating habits e.g. loss of appetite or overeating
- **Risk-taking, spontaneous behaviour that is out of the ordinary**
  - driving while drunk
  - drinking more alcohol or taking more drugs than usual
  - wanting to run away from home
  - pulling dangerous stunts
- **Physical symptoms**
  - always complaining of stomach aches or headaches
  - always being tired or feeling sick
- **Giving away things they like**
  - asking someone if they want a favorite possession
  - asking someone to take care of a pet

All suicidal thoughts or threats must be taken seriously. If you are concerned about someone, tell an adult about it, or call your local crisis line. Get help from family, friends, teachers, counsellors, doctors, crisis lines, mental health services or hospital emergency departments.