



Beyond September

UNTANGLING THE COMPLICATED NATURE
OF SUICIDE - A PERSONAL JOURNEY

WRITTEN BY KATI ALLEN

Beyond September

by Kati Allen

Table of Contents

Chapter 1: The Phone Call That Changes Everything

Chapter 2: The Question That Doesn't Go Away

Chapter 3: There Isn't One Suicide Story

Chapter 4: The Body Is Part of the Story

Chapter 5: "But They Didn't Look Suicidal"

Chapter 6: When Someone Says They Don't Want to Be Here

Chapter 7: What Happens After You Ask for Help?

Chapter 8: The Person Beside You May Matter More Than You Know

Chapter 9: Making Sense of the Science: What We Understand and What We Don't

Chapter 10: Prevention Before the Crisis

Chapter 11: Filling the Gaps: Building Better Support Systems

Chapter 12: Beyond September: Care That Lasts All Year

Chapter 13: Finding a Hand to Hold: Where to Get Support

Chapter 14: When Help Is Refused: Navigating Difficult Decisions

Chapter 1

The Phone Call That Changes Everything

It was ten o'clock in the morning, and I was sitting in a Starbucks in town waiting for my children to finish a summer program. I was working while I waited when my phone rang. It was my mother, and all I heard was her screaming, "He did it. He did it. He did it. He went and killed himself."

I was shocked, stunned, absolutely incredulous. I didn't know what to say or what to think. I didn't even know there was a problem, much less that this was a possibility. I was sitting in the middle of a Starbucks trying to comprehend that my brother had just died by suicide. The people around me could see that something terrible had happened, and several of them immediately came over to help. A couple of women took my phone and helped finish the call because I couldn't. They got me seated and stayed with me while I tried to pull myself together. I don't know their names, but I remember how kind they were to me in the middle of the worst day of my life.

Eventually, I composed myself enough to pick up my children and drive them home. Then came the impossible task of figuring out what we were supposed to do next.

Years later, a friend wrote to me about the day she lost her brother, David, to suicide. Her circumstances were completely different, but there was something painfully familiar about her story. She had been in her home office finishing a meeting on an ordinary Monday afternoon when her sister called. She answered distractedly, expecting a normal conversation. Instead, her sister told her that their mother had called and said David was gone.

At first, she didn't understand. Gone where? What had happened? Then her sister told her that David had taken his own life.

This chapter now has two stories from two different families, because together they illustrate something important. Neither of our brothers looked the way we expected a suicidal person to look.

They weren't visibly falling apart or obviously withdrawing from everyone around them. Neither appeared to be experiencing the kind of mental health crisis that the people closest to them recognized as dangerous. They were funny, vibrant men with friends, families, children, homes and jobs. David loved music and made people laugh. My friend told me that only a few days before his death, he had been making plans and talking about future events. He seemed normal.

My brother's circumstances were different, but the normalcy was the same. My mother had been with him the night before he died, and she didn't notice anything that made her believe something was seriously wrong.

That is one of the reasons suicide can be so difficult for families to understand afterward. We are taught to look for warning signs, and we should know them. Talking about wanting to die, expressing hopelessness, withdrawing from people, giving away meaningful possessions, saying goodbye and significant changes in behavior or mood can all be reasons to pay attention and ask questions. The problem comes when we begin to believe those signs will always be obvious. Sometimes they aren't.

After someone dies by suicide, the people who loved them often go back through everything looking for what they

missed. Conversations take on new meanings. Text messages get reread. Ordinary moments suddenly feel as though they must contain clues. You find yourself wondering whether there was something you should have noticed or a question you should have asked. That search can become its own source of pain because hindsight gives us information we did not have at the time. Something that seems significant after a death may not have seemed significant when it happened. There may also have been things happening internally that the person never shared with anyone.

People can be in terrible psychological pain and continue going to work, parenting, paying bills, laughing with friends and making plans. Some people deliberately hide what they are experiencing. Others may not know how to explain it, may be ashamed of it, may believe they are a burden, or may simply be trying to keep functioning while they figure out how to get through another day. This is why I don't think we serve anyone well when we reduce suicide prevention to a checklist of warning signs. Warning signs matter, but they are one part of a much larger picture. Their absence does not prove that someone is okay, just as the presence of one warning sign does not automatically mean someone is suicidal.

That distinction matters for another reason. When we tell people that suicide is always predictable if you know what to look for, we unintentionally hand grieving families another burden to carry. If the signs were supposedly there, someone must have missed them. A parent should have known. A spouse should have noticed. A sibling should have asked.

Love does not make us psychic.

My brother's death forced me to confront how much more complicated suicide is than I had understood. My friend's experience reinforced it. As I began learning more and listening to other families, survivors and people who had experienced suicidal thoughts themselves, I became increasingly interested in everything that happens before someone reaches an obvious crisis.

That is where this book begins.

We are going to talk about warning signs, but we are also going to talk about conversations. We are going to talk about how to ask someone if they are thinking about suicide and what to do with the answer. We will look at how to find help, what to do when help isn't immediately available, and what happens when someone does ask for help but the help doesn't work. We will talk about supporting someone at home, continuing to look for options, and maintaining realistic hope when everyone involved is exhausted.

Most importantly, I don't want to pretend that suicide prevention is simple. There isn't a perfect sentence you can say, a checklist you can memorize, or a single intervention that guarantees an outcome. Human beings are more complicated than that.

I think back sometimes to those women in Starbucks. They had no idea what had happened before my phone rang. They couldn't change what had happened to my brother, and they certainly couldn't solve what my family was about to face. They simply saw that I was in trouble and came over to help.

There is something worth remembering in that. We don't have to have every answer before we are willing to notice another person, ask a question, listen to the answer, and stay long enough to help them figure out what comes next.

That is where I think we should begin.

Chapter 2

The Question That Doesn't Go Away

Emily remembers the phone call clearly. It was early on a Wednesday morning in November when she saw her sister's number on the caller ID. Her heart immediately did that little stutter-step because her sister never called that early unless something was wrong. "He's gone," her sister whispered. "Ethan's gone."

Ethan was her brother, and at first the words didn't make sense. He had just been at a family dinner the week before, making jokes, talking about his new job and planning to help Emily fix a leaky faucet the following weekend. She remembers asking, "Gone where?" Her voice sounded strangely calm, almost as though it belonged to someone else.

"He killed himself," her sister said, and that was when the calm disappeared.

For a long time afterward, maybe years, Emily said the word *why* became a constant companion. It wasn't simply a question. It was something that followed her around. Why him? Why then? Why didn't I see it? Why didn't we know? Why didn't he tell us?

If you've lost someone to suicide, you may recognize that feeling. There is grief, of course, but suicide loss can bring confusion, guilt and an almost obsessive need for an explanation along with it. We want to find the missing piece that will finally allow everything else to make sense. I know that search well.

The problem is that *why* rarely has a simple answer.

When someone dies by suicide, we naturally search for a reason. Sometimes an explanation appears almost immediately. He was struggling with depression. She had financial problems. Their relationship had just ended. Those things may absolutely be part of what happened, and sometimes they are significant parts of the story, but they rarely tell us everything we want to know.

Ethan was unpredictable and moody. He could be very impulsive and, honestly, he lived life on his own terms right to the end. Looking back, Emily can see that he probably wasn't coping as well as he pretended. He always seemed to have more month left than money and usually had some new scheme he was working on that was going to make quick money. He sometimes hung around people his family wasn't particularly thrilled about, and he had a habit of laughing off serious conversations.

"It's fine. Stop worrying," he would tell his mother when she asked how he was going to pay the rent, whether he was going to find a steady job or, in the way mothers sometimes do, when he was finally going to meet a nice girl. That was Ethan.

After he died, his parents kept coming back to something they had said about him throughout his life: "He was always that way, from the day he was born."

That history made everything harder to sort out afterward. What was simply Ethan being Ethan, and what, if anything, had changed? He had always been impulsive. He had always bounced around. He would hop from job to

job, but he explained that he was trying to find work he actually liked. He had a decent apartment. He had friends. He was funny, quick with a joke and always willing to lend a hand. He was living his life. Until he wasn't.

This is part of what makes the question of why so difficult after suicide. When someone dies from a heart attack, we may ask why and eventually be given an explanation involving heart disease, genetics or other medical factors. It doesn't take away the grief, but there may be some medical finality to the explanation. We generally don't spend years wondering whether we should have interpreted a conversation differently or whether a laugh at dinner was somehow concealing a fatal heart problem we should have recognized.

Suicide feels different because human behavior is involved. We naturally think about agency, choice and responsibility, and then the questions become much more personal. What could we have done differently? Was there something we should have said? Was there something they were trying to tell us?

We replay conversations and look for clues. We remember smiles and laughter and try to reconcile those moments with what eventually happened. We wonder how someone could be planning to fix a leaky faucet next weekend while also carrying something we didn't understand. What Emily and her family experienced with Ethan was only one layer of his reality. That doesn't mean every smile was fake or every plan for the future was an act. Human beings aren't that simple. Someone can genuinely laugh at a joke, enjoy dinner with their family and make plans for next weekend while also struggling in ways the people around them don't fully understand.

That is one reason simple explanations can feel so inadequate after a suicide. We want to create a narrative because narratives help us make sense of things. We want a beginning, a middle and an end. We want cause and effect. If we can identify the thing that caused this, perhaps everything will finally fall into place.

People around us sometimes try to help by supplying that explanation. "He had bipolar disorder." "She had been through a lot of trauma." "He was depressed." They usually mean well. They're trying to give us something solid to hold onto. But those explanations may not account for the whole person we knew, including the contradictions, the good days, the plans for the future and everything else happening in that person's life. Mental illness is an important part of this conversation, but it isn't the only part. Mental health conditions can increase suicide risk, but having a mental health condition does not mean someone will become suicidal. Likewise, not everyone who dies by suicide had a diagnosed mental illness that was known to the people around them.

There are many other things that can become part of a person's story. Trauma can matter, including childhood trauma and recent traumatic experiences. So can relationship problems, job loss, financial difficulties, legal problems, isolation and major life changes. Physical health can matter. Chronic pain, debilitating illness and frightening diagnoses can alter someone's quality of life and sense of the future. Substance use can complicate things further. Medications and changes in physical or neurological health may sometimes be relevant as well. Loneliness, feeling disconnected from other people or believing oneself to be a burden can weigh heavily.

Sometimes several of these things are happening at once. Sometimes the factor that looks enormous to an outsider isn't the one the person themselves experienced as unbearable. Sometimes something that appears relatively solvable from the outside may feel completely impossible from inside that person's circumstances.

Over the years, through my support work, I have encountered this complexity again and again.

I met a mother whose son was brilliant, athletic and appeared to have everything going for him. His parents had no indication that he was struggling in the way they discovered after his death. In a note, he described a profound feeling of not belonging that he had hidden from the people around him. His family knew the son they loved, but there was an internal experience he had never fully allowed them to see. I also encountered the story of a veteran who had lived with PTSD for years. He had sought help. He went to therapy. From the outside, he was doing the things we tell people they are supposed to do. Then an unexpected eviction notice arrived during an already difficult economic period, and his circumstances deteriorated.

What caused his suicide? Was it PTSD? Housing insecurity? Financial pressure? Something else happening that nobody knew about? Trying to force a single answer onto a life like that doesn't necessarily help us understand it.

That is one of the hardest things I have had to accept in the years since my own brother died. I may never get a single answer to why. There may not be one.

Before my brother's death, I probably would have reached fairly quickly for the explanation that someone who died by suicide "must have been depressed." Maybe my brother was. I can't know everything that was happening inside his mind. What I do know now, after years of speaking with families, listening to survivors, reading and learning, is that suicide is more complicated than the explanations we sometimes reach for after the fact.

That doesn't mean we can't learn anything from a person's death. Quite the opposite. Understanding the many factors associated with suicide can help us recognize vulnerability earlier and build better ways to respond. But understanding complexity is different from pretending we can reconstruct someone's final thoughts with certainty. For families, that distinction can be everything.

The endless search for one missed clue can become another form of suffering. We convince ourselves there must have been one conversation we handled incorrectly, one warning sign we overlooked, or one moment when everything could have been changed if only we had known what to do.

Sometimes there were opportunities to intervene. We should be willing to learn from those. Sometimes systems failed people badly. We should be willing to say that too. Sometimes someone asked for help and didn't receive what they needed. Sometimes people around them genuinely did not know how much danger they were in.

All of those realities can exist without reducing an entire life-or-death situation to one cause. This is also why I would never describe suicide simply as a failure. Calling it a failure immediately makes us look for the person who failed. Was it the family? The healthcare system? A therapist? A spouse? The person themselves?

Sometimes there really are failures that need to be confronted. But sometimes there is no single person to blame and no satisfying explanation waiting to be uncovered.

Emily still has questions about Ethan. David's family still don't know why. I still have questions about my brother. Most families I have known through this work have all those questions and more of their own.

Over time, perhaps the goal isn't to stop asking why. I don't know that we ever completely do. Maybe the goal is to become more comfortable with the possibility that the answer contains many things we know, some things we suspect and other things we will simply never know. That changes the prevention conversation too. If there isn't one

suicide story, there cannot be one prevention story either. We need to understand mental health, but we also need to understand physical health, trauma, substances, medications, relationships, isolation, financial stress, impulsivity, chronic pain, and the many other circumstances that can affect how a person experiences their life. We need to pay attention to what is happening in someone's mind without forgetting that the mind exists inside a body and that both exist inside a life.

That is where we're going next. In the next chapter, we'll look more closely at the connection between physical and mental health and why separating the two too neatly can cause us to miss important parts of the picture.

Chapter 3

There Isn't One Suicide Story

“I just don't understand,” my friend said. “He had everything. A great job, a beautiful family, he just bought a new house. And he was always so happy. Always laughing. How could he possibly do this?”

I have heard some version of that question more times than I can count over the years. Maybe you've asked it yourself. Maybe you've even been the person who appeared to have everything on the outside while struggling with something nobody else could see. We want the explanation to be obvious because an obvious explanation feels safer. If there is one cause, one missed sign or one thing that went terribly wrong, then maybe we can identify it next time. Maybe we can prevent it. Maybe we can protect the people we love. But as we talked about in the last chapter, suicide doesn't give us that kind of simplicity. There isn't one suicide story, and there isn't one pathway that brings someone to the point where death begins to feel like an option.

For a long time, much of the public conversation about suicide centered heavily on mental illness. Mental health conditions absolutely belong in this discussion. Depression, bipolar disorder, schizophrenia and other psychiatric conditions can be associated with increased suicide risk. Untreated or inadequately treated mental illness can also create tremendous suffering.

The problem isn't talking about mental illness. The problem is stopping there.

In fact, I lost a very, very good friend in September of last year. They took their own life after a manic episode because they could no longer live with what had happened during that episode. The tragedy is that it wasn't the bipolar mania itself that ultimately facilitated the suicide. It was the aftermath. It was the shame of what had happened while they were manic and the belief that they could no longer live with themselves afterward. They said so explicitly in the note they left behind.

That distinction has stayed with me. It would be easy to say that my friend died because they had bipolar disorder, and of course bipolar disorder was part of what happened. But even within a known mental illness, the pathway to suicide can be more complicated than the diagnosis itself. In my friend's case, the manic episode ended. What followed it was the shame they believed they couldn't survive. Millions of people live with mental health conditions and never attempt suicide. Meanwhile, some people who experience suicidal thoughts are also dealing with trauma, physical illness, chronic pain, substance use, medication effects, financial problems, relationship breakdowns, isolation, neurological changes or circumstances that have become overwhelming. Sometimes several of those things are happening at once. If we automatically label every suicidal person as simply “mentally ill,” we may miss information that could matter enormously. Trauma is one example. We often associate trauma with a single catastrophic event, but it can also develop through experiences that happen repeatedly over time. Childhood abuse, neglect, bullying, violence and growing up in an environment where a child never feels safe can affect a person long after the immediate circumstances have ended.

I once worked with a young man in a peer support setting whom I'll call Frank. He had been diagnosed with severe depression and anxiety in his teens, so naturally those diagnoses became the explanation for his suicidal thoughts. He believed it too. As we talked, though, another part of his history emerged. Frank had grown up in a home with unpredictable violence. For eighteen years, he learned to monitor everything around him. He watched moods. He

anticipated explosions. He lived on eggshells because knowing what might happen next was part of how he kept himself safe.

Eventually he left home and went to college. The physical threat was gone, but his body didn't seem to understand that the danger had ended. He was still constantly on edge. He carried that hypervigilance into classrooms, relationships and ordinary situations where there was no obvious threat.

His depression was real. His anxiety was real. But those diagnoses weren't the entire story. Years of living without a reliable sense of safety mattered too. Understanding that connection changed the way he understood himself and, eventually, the way he approached getting better. This is one of the reasons I think we have to be careful about labels. A diagnosis can be incredibly useful. It can give someone language for what they are experiencing and point toward treatments that may help. But a diagnosis can also become the end of our curiosity when it should sometimes be the beginning.

Physical health is another part of this conversation that is too easy to overlook.

We have a strange tendency to talk about mental health and physical health as though the brain has somehow been issued its own apartment and no longer lives in the body. It doesn't work that way.

Anyone who has lived with significant chronic pain understands this immediately. Pain affects sleep. Poor sleep affects mood, cognition and the ability to cope. Pain can limit work, relationships, independence, hobbies and social interaction. When that continues month after month or year after year, it can fundamentally change how someone experiences their life and their future.

I know a woman who developed a severe neurological condition that caused constant pain and disrupted her motor skills. Before becoming ill, she was active and fiercely independent. As her condition progressed, she lost her job, much of her independence and many of the social connections that had once been part of her everyday life.

Her doctors understandably focused on her physical symptoms. But there was another loss happening at the same time. She was grieving the person she had been and the life she expected to have. Her thoughts became increasingly dark as her world became smaller.

Reducing that experience to “depression” would have missed an enormous part of what was actually happening to her. Chronic pain isn't the only physical issue that can affect mental health. Neurological disorders, hormonal changes, autoimmune and inflammatory conditions, infections and illnesses that cause severe fatigue or cognitive changes can all affect how someone feels and functions. Conditions such as long COVID have also forced more people to confront something patients with chronic illness have been saying for years: what happens in the body can profoundly affect what happens in the mind.

This is an area where my own experiences and advocacy changed the way I think about mental health.

Through my own experience and my work with families affected by PANS and PANDAS, I know far too many children whose psychiatric and behavioral symptoms appeared suddenly and dramatically, or crept up with an intensity that eventually became uncontrollable. Many parents of children with neuroimmune disorders, particularly PANDAS, describe it as though their child changed almost overnight. PANS and PANDAS can involve severe

anxiety, obsessive-compulsive symptoms, food restriction, behavioral changes and rage, and some children experience suicidal thoughts.

For those families, being told the problem is simply behavioral or psychiatric, or that PANS and PANDAS aren't real, creates an entirely different problem. Just because some doctors remain skeptical doesn't make what these families are experiencing disappear.

I became involved in advocacy and legislation surrounding these conditions because I watched my own family and other families struggle to get clinicians, schools and sometimes even their extended families to understand what was happening. I was involved with efforts surrounding South Carolina's H.3725, legislation introduced to establish a state advisory council on PANS and PANDAS. Other states have pursued their own approaches. Massachusetts, for example, ultimately established a PANS/PANDAS advisory council and insurance coverage requirements. Whatever debates continue within medicine about diagnosis, mechanisms and treatment, one lesson from that continuing experience has stayed with me: we cannot assume that a psychiatric symptom tells us everything about its cause.

There is something else about this that has bothered me for years. If an older person presents at the emergency room with altered mental status, doctors investigate. Blood, urine, labs, scans. There isn't much argument about whether something medical might be causing the change.

When a child arrives combative, angry, loud or aggressive, the conversation can be very different. There can be lots of tsk-tsking and “don't allow them to...” conversations, but far less curiosity about why the child's behavior changed in the first place.

I did medical transcription for a long time, and behavioral health was one of my accounts. I typed the phrase “of no clinical significance” so many times that I eventually had a shortcut for it. I would see children with abnormal or unusual lab results, only to hear those findings dictated as being “of no clinical significance.”

That stuck with me.

Sometimes we need to ask what changed in the brain. Sometimes we need to ask what changed in the body. Often we need to ask both. It's not a failure to not immediately understand the why. It's only a failure when we choose not to keep looking.

Substance use adds another layer. People may use alcohol or drugs because they are already hurting and are trying to numb themselves, sleep, quiet intrusive thoughts or simply escape for a while. At the same time, intoxication can affect judgment and impulse control, and ongoing substance use can worsen other problems in a person's life. The thing someone reaches for because they are struggling can become another factor making the struggle harder.

Ironically, in the quest to escape, a person may actually exacerbate the very mental health challenges they are trying to escape. Cannabis is one example worth talking about because increased availability and potency have changed the conversation around it. Cannabis-induced psychosis can present with paranoia or persecutory delusions, hallucinations, significant anxiety, agitation and mood instability. Distinguishing it from a primary psychotic disorder isn't always simple because the symptoms can overlap. The timing of symptoms in relation to THC use and what happens after cannabis is discontinued can become important parts of the clinical picture.

That doesn't mean everyone who uses cannabis will experience psychosis. It means substance use belongs in the conversation when we're trying to understand a sudden or dramatic change in someone's mental state.

Medications also deserve a place in an honest conversation about suicide. Medications can save lives and dramatically improve mental health, but medications can also have side effects. Some medications carry specific warnings about changes in mood, behavior or suicidal thoughts in certain populations and circumstances. Starting a medication, stopping one or changing a dose should not mean handing someone a prescription and assuming the rest will take care of itself. Monitoring matters. Communication matters. When someone says they feel dramatically different after a medication change, that information deserves attention.

Antidepressants are one example. In 2004, the FDA required a boxed warning concerning increased risk of suicidal thinking and behavior in children and adolescents treated with antidepressants. The warning was later expanded to include young adults under age 25.

Antiepileptic medications have also carried warnings concerning suicidal thoughts and behavior. Some of these medications are prescribed not only for seizure disorders but for other conditions, including bipolar disorder.

Then there is montelukast, commonly known by the brand name Singulair. In 2020, the FDA required a boxed warning about serious neuropsychiatric effects associated with the medication and recommended restricting its use for allergic rhinitis when other options are effective.

That one is personal for me.

My own child was prescribed what amounted to a double dose of Singulair for years, beginning when he was two, for chronic allergies. He was receiving 8 mg, two sachets, for years. That was only the beginning of a journey that still hasn't found its fairytale ending. None of this means medication is inherently dangerous, and it certainly doesn't mean someone should stop a prescribed medication on their own. It means treatment needs to focus on the individual person rather than assuming everyone will respond the same way. You have to learn things you never imagined you would need to know.

Learn what medications the person you love is taking. Pay attention to side effects. Know when multiple medications are being used. Ask about interactions. Even medications that seem ordinary can interact in ways people don't expect. Diazepam and diphenhydramine, for example, can both cause central nervous system effects, and using them together may increase drowsiness, dizziness, confusion and problems with concentration or coordination.

This isn't about becoming your loved one's doctor. It's about being an informed participant in their care and knowing enough to ask questions when something changes.

Then there is isolation.

Being alone and feeling alone aren't necessarily the same thing. Someone can have coworkers, a spouse, children, hundreds of Facebook friends and a phone that never stops buzzing and still feel profoundly disconnected from other people.

I've encountered this repeatedly in support work. Sometimes people aren't literally isolated. They simply don't believe anyone around them would understand what they are experiencing. They feel as though there is no one they can actually open up to. They may be afraid that telling a therapist about suicidal thoughts will automatically get them hospitalized. They may fear that their family will have them committed. They may worry their friends will laugh, judge them or begin treating them differently.

Some are ashamed. Some don't want to frighten their families. Some believe they have already become a burden and don't want to add one more problem to somebody else's life.

From the outside, they may look surrounded. Inside, they may feel completely alone.

Conversely, some people really are alone. Through no fault of their own, or sometimes because their neurodivergent behaviors are misunderstood, they are labeled weird, creepy or odd and ostracized from as early as kindergarten. Growing up feeling that no one particularly likes you, or worse, being mocked and humiliated simply for being yourself, doesn't exactly create the foundation for becoming an outgoing, confident adult who feels safe reaching out to other people.

Research on suicide and social isolation has found an association between greater isolation and suicidality, while social support appears to have a protective relationship. That doesn't mean loneliness causes every suicide or that being surrounded by people prevents one. It tells us that connection is another part of the picture we should not ignore.

And sometimes the problem isn't primarily internal at all. Sometimes life has simply become extraordinarily difficult. A job disappears. A marriage ends. Debt becomes unmanageable. Someone is facing eviction. There is a legal problem. A child or spouse dies. A person loses their business, their reputation, their home or the future they thought they were building.

Years ago, I remember hearing about farmers in a rural community who were facing consecutive years of drought. Crops were failing. Debt was accumulating. Some were facing the possibility of losing land that had been in their families for generations. Were some of them depressed? Absolutely.

But simply saying "they were depressed" would leave out almost everything important about what was happening. Their distress existed in the context of enormous financial pressure, family responsibility, identity, history and the potential loss of something that represented generations of work.

When several pressures converge, they can begin feeding one another. Chronic pain can interfere with work, which creates financial problems, which strains a marriage, which increases isolation, which makes someone drink more heavily, which damages sleep and judgment, which makes everything else harder to manage.

That doesn't mean every suicidal person follows that sequence. Most don't. The point is that human problems don't stay politely in their assigned categories.

Physical problems affect emotional health. Emotional distress affects physical health. Financial stress affects relationships. Trauma affects the way people respond to current events. Isolation changes the way problems feel. Substance use can change judgment. Sleep affects nearly everything.

This is why prevention has to be broader than simply asking whether someone has a psychiatric diagnosis or whether they are feeling suicidal, hopeless or depressed.

We need to be curious about what is happening in the person's life.

Has something changed recently? Are they sleeping? Are they in pain? Did they start or stop a medication? Are they drinking more? Did they lose a job? Are they facing a legal or financial crisis? Have they become isolated? Are they living with trauma? Is there a medical problem nobody has adequately investigated? Do they feel trapped? Do they believe they are a burden? Has something happened that makes the future look completely different from the future they imagined six months ago?

None of those questions diagnoses suicide risk by itself. They simply help us see the person more completely.

Someone can have a beautiful family and still be suffering. Someone can have money and still feel trapped. Someone can be laughing and still be struggling. Someone can have depression and chronic pain, anxiety and trauma, or a psychiatric diagnosis alongside a physical condition that deserves investigation. Someone can receive excellent treatment and still encounter a life event that overwhelms the coping mechanisms that were working yesterday.

When we understand that there are many possible pathways into suicidal thinking, we also create more possible pathways back out. Maybe someone needs psychiatric treatment. Maybe they need trauma therapy. Maybe their medication needs to be reviewed. Maybe they need treatment for pain. Maybe they need help getting through an eviction, navigating debt, leaving an abusive relationship or finding somewhere safe to sleep tonight. Maybe they need treatment for substance use. Maybe they need someone to investigate a physical problem that has been dismissed. Maybe they need connection.

Often they need more than one of those things.

That is why I don't want this book to reduce suicide prevention to recognizing a handful of warning signs and handing someone a phone number. Those things have a place, and we are going to talk about them. But prevention also means becoming willing to look at the whole person and ask a much more useful question: What is making life feel unbearable right now, and what can we do about that? The answer will be different for everyone. And that is exactly why there cannot be only one way to help.

Before leaving this chapter, I want to talk about Robin Williams because his story illustrates just how badly we can misunderstand a suicide when we look only at the part of someone's life we can see.

After Williams died in 2014, he was frequently held up as an example of the apparently happy person who dies by suicide. How could someone so funny, successful, beloved and larger than life have been suffering enough to end his life?

But there was far more happening than the public knew.

Williams had spoken openly about periods of substance use and addiction earlier in his life. He had also experienced depression and anxiety. In the months before his death, however, something frightening was happening

to him neurologically. He experienced worsening anxiety, paranoia, confusion, sleep problems, cognitive changes and movement difficulties. He and his wife, Susan Schneider Williams, knew something was terribly wrong and sought medical help, but they did not know what was causing it. Williams himself never learned the full answer.

After his death, an autopsy revealed diffuse Lewy body disease, an advanced neurodegenerative disease. Susan later became an advocate for Lewy body dementia awareness and has spoken extensively about what they experienced while trying to understand the changes happening to her husband.

That changes the way I think about his story.

We cannot know precisely what Robin Williams was thinking when he died, and I don't think we should pretend that we can. We cannot say with certainty that one diagnosis, one symptom or one event caused his suicide. But neither should we reduce his death to the image of a secretly unhappy comedian who appeared to “have everything.” His brain was sick. The person experiencing those changes did not even know exactly what was happening to him. Neither did the people trying desperately to help him.

Would Robin Williams have died by suicide had Lewy body disease not entered his life? We cannot know. Would he have continued living, working, making people laugh, and enjoying his family? We cannot know that either. But those are precisely the questions that make his story important here.

His death reminds us why we have to look at the whole person. Mental health history is important. Physical health is important. Neurological disease is often misunderstood. His symptoms were a clue. His circumstances were chaotic, and I imagine he was frantic, trying to figure out what was happening. So many things were in play; no one could piece it all together, not the way medicine operates today anyway. The changes occurring in his brain had an impact that no one understood until after the fact. The person standing in front of us is never just a diagnosis, a symptom, or a checklist of warning signs. Sometimes we have to keep asking what else is happening.

Chapter 4

The Body Is Part of the Story

When we talk about mental illness, we tend to picture something happening in the mind. Depression is emotional. Anxiety is psychological. Suicidal thoughts are psychiatric. A bad back belongs to the body. So does a thyroid problem, an infection, an autoimmune disease or chronic pain.

We have built entire medical specialties around those divisions, and there are good reasons for that. Cardiologists specialize in hearts. Gastroenterologists specialize in digestive systems. Neurologists specialize in the nervous system. Psychiatrists specialize in mental health. The problem comes when we begin treating those specialties as though they represent completely separate human beings.

They don't.

Your brain isn't an organ floating in a jar. It is part of your body. It is supplied by your blood, influenced by hormones, affected by sleep, nutrition, medications, infections, inflammation and disease. What happens elsewhere in the body can affect how the brain functions, just as what happens in the brain can affect the rest of the body.

That seems incredibly obvious when you say it out loud, yet we still have a tendency to separate physical and mental health in ways that can make it harder to understand what is actually happening to someone.

I remember talking with a woman who had struggled with severe depression for years. She would call me regularly on my work phone. She had been through every therapy and tried a dozen or more different medications, but nothing seemed to make a lasting difference. She described it as constantly fighting herself, and eventually the fight itself became exhausting. She told me her kids were sick of her, her husband had left, and she couldn't work. It was all-consuming.

At the same time, she was living with a severe thyroid condition. It wasn't the problem everyone was focused on when they talked about her mental health, but it was always there. She was uncomfortable, her body wasn't functioning normally, and she was dealing with chronic inflammation.

The British Thyroid Foundation lists anxiety, depression, mood swings and irritability among the psychological symptoms that can accompany thyroid disorders.

I explained over and over that, in my layman's opinion, her thyroid condition needed to be treated more effectively and that, if it were, something might begin to change. She never pursued it. She was so depressed she didn't want to. Her depression would never magically disappear, and she didn't stop needing mental health treatment. When I left, she still didn't feel better. She told me that her medication seemed to work sometimes, but therapy and medication alone weren't helping.

Was her thyroid disease the cause of her depression? I honestly have no idea. We can't say that because, to my knowledge, she never pursued it.

Was what was happening in her body relevant to what was happening in her mind? I think it was a huge mistake not

to ask.

One area researchers have become increasingly interested in is the communication between the gastrointestinal system and the brain, often referred to as the gut-brain axis. The digestive tract has its own extensive nervous system and communicates with the brain through neurological, immune, hormonal and metabolic pathways.

Serotonin is an interesting example. Most of the body's serotonin is produced outside the brain, much of it in the gastrointestinal tract. That does not mean, as some popular explanations oversimplify it, that increasing serotonin in your gut automatically increases serotonin in your brain or cures depression. The biology is considerably more complicated than that.

Even the familiar explanation that depression is caused by a serotonin or “chemical imbalance” in the brain has been seriously challenged. Writing in *The Conversation*, Professor Joanna Moncrieff and Dr. Mark Horowitz, both of UCL Psychiatry, reported on their research finding no clear evidence that serotonin levels or serotonin activity are responsible for depression.

What it does illustrate is how artificial the dividing line between “mental” and “physical” can become.

Inflammation is another area that deserves attention. Researchers have investigated associations between inflammatory processes and several psychiatric conditions, including depression. There is also research examining inflammatory markers in people with suicidal thoughts or a history of suicide attempts.

That does not establish inflammation as the cause of suicide. It does tell us that the relationship between immune function, inflammation and mental health is worth understanding rather than dismissing. Worth exploring rather than ignoring.

For me, that subject isn't theoretical.

My experiences with PANS and PANDAS fundamentally changed the way I think about the relationship between the brain and the body. PANS stands for Pediatric Acute-onset Neuropsychiatric Syndrome. PANDAS stands for Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections. The names are cumbersome, but the experiences of families living through them can be startling. Children can develop abrupt and dramatic neuropsychiatric symptoms, particularly obsessive-compulsive symptoms or severely restricted eating, along with combinations of anxiety, behavioral regression, sleep disruption, changes in school performance, sensory or motor abnormalities, urinary symptoms and other behavioral or neurological changes. Some children also experience suicidal thoughts. Parents sometimes describe it in the most unsettling way possible: “My child changed overnight.”

I have seen versions of that story in my own life and in families I've worked with.

One family's brilliant, cheerful nine-year-old daughter suddenly became terrified of stepping on sidewalk cracks. Within days, she was refusing certain foods, having panic attacks and saying she wished she could disappear. Dissociation, intrusive thinking, hiding in closets from the slightest change in weather, panicking when Mom left the house. The changes kept coming. We parents absolutely know when something has changed. We aren't imagining it. We know our children. But finding someone who will investigate why our kids changed can be another

matter.

Anxiety. Depression. Acting out and poor behavioral control become part of the conversation. Parents go from one professional to another, trying to understand how the child they knew could change so dramatically in such a short period of time.

Eventually, finding a clinician familiar with PANS can lead to an investigation from a different perspective, including the possibility that infection and immune dysfunction contribute to what happened. Treatment isn't an overnight miracle, but acute symptoms can begin to recede when treated appropriately. That isn't typically a standalone SSRI or antipsychotic; it is a tailored treatment to address inflammation, immune disruption, infections or viruses, and more.

Personal experiences and stories like this are one reason I became involved in PANS and PANDAS advocacy and legislation, as I discussed in the previous chapter. I watched families, my own included, fight to have their children's physical health considered alongside their psychiatric symptoms.

And it brought me back to something that had bothered me long before I knew the terminology for PANS or PANDAS. After years spent doing medical transcription and listening to physicians dictate medical records day after day, I had a keen understanding of both sides of the discussion. The phrase “no clinical significance” stuck with me long after I ended my contract with the transcription company. I would see abnormal or unusual findings in children being evaluated for behavioral or psychiatric problems and then hear those findings dismissed in the dictation as being of no clinical significance.

To be fair, doctors are busy and overwhelmed. They work within strict confines of what's covered by insurance, what's considered standard of care, what's in the current literature and what isn't. Many doctors wait for definitive clinical direction before treating a complicated or complex patient. They walk a very tight line around “do no harm.”

But parents, loved ones, caregivers, people trying to help someone they love, sometimes we don't have the luxury of time. Maybe many of those findings truly weren't clinically significant. I wasn't the physician evaluating the patient, and abnormal doesn't automatically mean anything meaningful.

But the pattern stayed with me because of the difference in how we sometimes respond to sudden behavioral changes depending on the age of the person experiencing them.

If an older adult suddenly becomes confused, combative or dramatically different from their normal self, we know enough to ask what happened. Did they have a stroke? Do they have a urinary tract infection? Is there a medication problem? Are they dehydrated? Is their blood sugar abnormal? Is there something neurological happening?

We investigate.

When a child suddenly becomes aggressive, irrational, terrified, obsessive or completely unlike themselves, the response can sometimes move much faster toward behavior.

What changed at home? Are the parents setting appropriate boundaries? Is the child being oppositional? Do they

need psychiatric medication? Those may sometimes be appropriate questions. But I think another question belongs beside them: What changed in this child's body?

That doesn't mean every psychiatric symptom has an undiscovered infection behind it. It doesn't mean every behavioral problem is autoimmune. It doesn't mean conventional psychiatric treatment should be discarded while everyone searches endlessly for an obscure medical explanation. It means we stay curious.

Sometimes a psychiatric symptom is exactly what it appears to be. Sometimes it is one manifestation of something happening elsewhere in the body. Sometimes both are true.

PANS and PANDAS are particularly dramatic examples, but they aren't the only reason physical health belongs in a conversation about suicide. Chronic pain is one of the clearest.

Living in pain changes things. It can disrupt sleep, reduce mobility, interfere with work and independence, strain relationships and gradually eliminate activities that once made life enjoyable. Someone who once worked, traveled, gardened, exercised or went out with friends may find their world becoming progressively smaller.

There is an emotional consequence to losing those things, but researchers have also been studying the biological relationships among chronic pain, stress systems, inflammation, sleep and brain function.

So when someone living with severe chronic pain becomes depressed or suicidal, saying “of course they're depressed because pain is awful” may be true, but it may not be complete.

Their pain matters. Their sleep matters. Their loss of independence matters. Changes in their nervous system matter. The medications they are taking may matter. Their financial situation may matter if they can no longer work. Their relationships may change if they increasingly depend on other people for care.

Once again, there may not be one thing.

Other physical illnesses can create their own risks. A serious diagnosis can change someone's understanding of their future in a matter of minutes. Progressive neurological disease can affect cognition, behavior, movement and personality. Hormonal disorders can produce psychiatric symptoms. Thyroid disease can affect mood. Sleep disorders can profoundly affect emotional regulation and cognition. Some nutritional deficiencies can cause neurological or psychiatric symptoms. Medications prescribed for physical illnesses can sometimes produce psychiatric side effects.

We talked about Robin Williams at the end of the last chapter for exactly this reason. For years, his death was often discussed through the familiar story of the funny, successful person who must have been hiding terrible depression. The reality was much more complicated.

His autopsy revealed diffuse Lewy body disease. Before his death, he and his wife knew that something frightening was happening to him, but they did not know the full explanation. He was experiencing changes in anxiety, cognition, sleep, movement and perception while living inside a brain affected by an aggressive neurodegenerative disease. Knowing what was happening physically makes it impossible to tell his story responsibly without including his body.

The same principle applies even when the medical condition is far less dramatic.

Diabetes, cardiovascular disease, autoimmune disease, chronic infection, cancer, neurological disorders and other chronic illnesses can intersect with mental health in different ways. Sometimes the effect is psychological. Being sick is frightening. Losing abilities is painful. Medical bills create stress. Chronic illness can be isolating.

Sometimes there may also be biological effects involving inflammation, hormones, metabolism, neurological function or medication. Usually, human beings refuse to fit neatly into one explanation.

This is why I become uncomfortable when someone experiencing severe psychiatric symptoms is told, "It's all in your head." Of course it's in their head. Their brain is in their head. But their brain is attached to everything else.

If someone develops severe depression, a dramatic personality change, new cognitive problems or suicidal thoughts, particularly when the change is sudden or unusual for that person, I think physical health deserves to be part of the conversation.

Are there physical symptoms that appeared around the same time as the psychiatric ones? When was the last time anyone looked at the entire medical picture rather than only the symptom that landed the person in a psychiatrist's office?

Those questions aren't a diagnostic checklist, and they aren't instructions to order every laboratory test imaginable. They are questions designed to keep us from forgetting that the person experiencing suicidal thoughts has a body.

This also means healthcare has to communicate better across specialties.

The psychiatrist needs to know what the neurologist prescribed. The primary care physician should know what changed after the psychiatric medication was started. The gastroenterologist may need to know that the patient's depression became significantly worse when their physical disease flared. The family member sitting beside the patient may know that a dramatic behavioral change began three days after an illness or medication change.

That information is important. And families shouldn't have to become medical detectives simply because every clinician is looking at a different piece of the same person.

I know that is easier to say than to accomplish. Our healthcare system isn't always built for that kind of integration. Appointments are short. Specialists work in different systems. Records don't always follow patients. Insurance determines what gets covered. Families become exhausted. I have lived enough of that myself to know how frustrating it can be.

But if something doesn't make sense, I believe we are allowed to keep asking questions.

That doesn't mean rejecting a psychiatric diagnosis because we don't like it. It doesn't mean assuming doctors are wrong. It means recognizing that a diagnosis describes something that is happening to a person. Sometimes we still need to understand why it is happening, what else is happening at the same time and whether there are additional things we can address.

There is another reason this matters in suicide prevention.

If we assume suicidal thinking can only be addressed through mental healthcare, then every intervention begins to look psychiatric. Therapy. Medication. Hospitalization. Crisis intervention.

Those interventions can be lifesaving.

But what if the person is suicidal because uncontrolled pain has reduced their life to something they no longer recognize? What if a medication is causing severe agitation? What if someone hasn't slept properly in weeks? What if there has been a sudden neurological change? What if an illness has taken away their ability to work and they are about to lose their home? Treat the depression, certainly. But don't stop looking at the person.

Sometimes reducing pain may create enough room for hope to return. Sometimes improving sleep changes someone's ability to cope. Sometimes changing a medication matters. Sometimes treating a physical illness improves psychiatric symptoms. Sometimes helping someone understand what is happening to their body removes the terrifying belief that they are simply losing their mind. And sometimes none of those things will be the answer. We have to be honest about that too.

The point isn't that there is always a hidden medical explanation waiting to be discovered. The point is that we should not decide in advance that there isn't one.

We can say it over and over: the brain and the body are not two separate patients. When one changes, the other may change with it. When someone is struggling badly enough that life itself has begun to feel unbearable, I think we should be willing to look at all of them. Not just the diagnosis or the behavior. Not just the thoughts. The whole person.

And ask: "What is happening to you?"

Chapter 5

“But They Didn't Look Suicidal”

“But they didn't look suicidal.”

If you spend any amount of time talking to families after a suicide, you will hear some version of that sentence. They were laughing. They had plans. They went to work. They took the kids somewhere that weekend. They had just booked a vacation. They were talking about something happening six months from now. Nothing about the last conversation seemed unusual.

I understand it because I have lived it. My brother didn't look suicidal to me. I had no idea there was even a problem, much less that I was about to get a phone call that would divide my life into before and after. David's family didn't know either. As we talked about earlier, he had been making plans for the future. Afterward, of course, you go back and look at everything differently. Every conversation gets examined. Every strange comment becomes potentially important. You wonder what you missed.

That is one of the reasons I have a problem with the way we sometimes talk about suicide warning signs. Warning signs are important. We absolutely should know them. But somewhere along the way, I think we have allowed “know the warning signs” to become “if you know the warning signs, you will know when someone is suicidal.”

Those are not the same thing.

There is no way to look at another human being and know what is happening inside their head. I wish there were. It would have saved a lot of people I have known an enormous amount of pain.

Some people who are suicidal are visibly struggling. They withdraw. They stop doing things they normally enjoy. Their sleep changes. Their behavior changes. They may become more reckless, use more alcohol or drugs, talk about being a burden, say they feel trapped or hopeless, give things away, or actually tell someone they don't want to live anymore. Those things matter. If someone you know suddenly begins behaving in a way that is completely unlike them, pay attention.

But some people continue living their lives while they are thinking about suicide. I don't actually find that difficult to understand. People function through terrible things every day. I have gone to work when my life was falling apart. I have smiled at people when I wasn't okay. I have answered “I'm fine” because I didn't feel like explaining why I wasn't fine. Most of us have.

Why would suicidal thoughts be different?

We have created this picture of a suicidal person as someone who has essentially stopped functioning. They can't get out of bed. They are crying all the time. They have stopped taking care of themselves. They are obviously depressed and everyone around them knows something is terribly wrong.

That person certainly exists.

So does the person who gets up, showers, goes to work, makes dinner, talks to their children, laughs at something funny and goes to bed while carrying thoughts nobody around them knows about.

I think this is particularly important when we talk about people who have learned to hide what they are feeling. We use the word “masking” more now, especially when talking about neurodivergence, but human beings have been masking things forever. We learn what is socially acceptable to say. We learn when someone really wants to know how we are doing and when “How are you?” is simply something people say in the grocery store. We learn very quickly which truths make other people uncomfortable.

And there can be real fear attached to telling someone you are having suicidal thoughts. What happens if I tell my therapist? Are they going to send me to the hospital? What happens if I tell my family? Will they panic? Will they watch everything I do? Will somebody call the police? If I have children, will someone question whether I should be caring for them? What happens at work if people find out? Will everyone look at me differently from now on?

Then there are people who have tried to tell someone they were struggling and weren't taken seriously. Or they were told to think positively. Pray more. Exercise. Get outside. Be grateful. Think about their children. Think about how much worse someone else has it. I can't imagine why they might decide not to bring it up again.

This is where I think we need to get better, because asking someone how they are doing isn't particularly useful if we have already decided which answers we are comfortable hearing.

If I ask you, “You're not thinking about doing something stupid, are you?” I haven't really asked you anything. I have told you the correct answer.

If I say, “You would never do that to your children,” I have done the same thing.

There is nothing wrong with asking the actual question. “Are you thinking about suicide?”

We will talk much more about what to do if the answer is yes, because that answer scares people and, understandably, they don't always know what to do next. But the question itself should not scare us so much that we avoid asking it.

At the same time, I don't want to turn everyone reading this book into a detective. That isn't healthy either, and I don't think it helps. You cannot analyze every smile. You cannot decide that because someone laughed at dinner they must have been hiding something. You cannot look back after a suicide and turn every ordinary thing the person did into evidence that was sitting there waiting for you to discover it. Hindsight is cruel that way.

Once you know how the story ended, the beginning and middle look different. You know something now that you did not know while you were living it. Of course the missed phone call looks different now. Of course you remember that odd conversation. Of course you wonder why they said that particular thing three months ago. Your brain is trying desperately to make the pieces fit because if you can figure out exactly what happened, perhaps you can also figure out where you could have stopped it. Maybe there were signs. Sometimes there are.

But sometimes the vacation plans were real plans. Sometimes the person laughing at dinner was actually laughing because something was funny. Sometimes someone thinking about suicide also expected to be alive next Christmas.

People are complicated. Thoughts change. Circumstances change. A terrible night can happen in the middle of an otherwise ordinary week. We have to leave room for what we simply cannot know.

That doesn't make warning signs unimportant. It makes them what they actually are: information. They are reasons to pay attention, ask another question, stay a little longer, make the phone call, or check on someone who suddenly doesn't seem like themselves. They are not a crystal ball.

I tend to pay more attention to changes than to a generic picture of what distress is supposed to look like. You know your people. You know that your husband has always been terrible about answering his phone. You know your daughter has always needed to disappear into her room after school and decompress. Those things may be completely normal for them. But if someone who has called you every morning for ten years suddenly stops calling, you notice. If your kid who has talked nonstop since the day they learned their first word suddenly stops talking to everyone, you notice that too.

You don't need to diagnose them. You can just ask what changed. And then listen. Really listen, because we are not particularly good at that either. We want to fix things. We want to reassure people. We want to tell them why what they are thinking isn't true. Sometimes we are so desperate to make someone feel better that we don't let them finish telling us how bad they feel.

There will be time to figure out what comes next. There will be times when the situation is urgent, and somebody needs immediate help. There will be times when you need professionals involved, and there will be times when the first thing a person needs is simply another human being who can hear something difficult without falling apart.

The point isn't that everyone around us might secretly be suicidal. I don't want people walking away from this chapter afraid of every quiet day, every unanswered text or every friend who says they're fine.

The point is that people don't have to look suicidal to be suicidal.

So know the warning signs. Pay attention to changes. Ask when you are concerned. Don't be afraid of the word suicide. Make it possible for people in your life to tell you the truth when the truth isn't pretty.

But if you are reading this because someone you loved died by suicide and you didn't see it coming, please don't take everything I have just written and use it to punish yourself.

Knowing the warning signs today doesn't mean you should have understood something then.

You didn't know the ending. I didn't either. Fun Fact - I STILL DON'T

I can go back through the days, weeks, and months before my brother died and ask myself a thousand questions. I can wonder whether there was something I should have noticed, something I should have asked, or some conversation that might have changed everything.

I will never know.

That may be one of the hardest things about losing someone to suicide. There are questions that don't eventually

reveal their answers. We have to learn to live with some of them.

Suicide prevention means we learn more. We pay closer attention. We ask better questions. We become less afraid of difficult conversations. We intervene when we know someone is in danger.

It does not mean we become mind readers.

The next chapter is the other side of this entirely. What happens when you do know? When someone you love tells you they don't want to be here, perhaps more than once, and now you are living with the fear, responsibility, and exhaustion of trying to keep another human being alive. I know that world too.

Chapter 6

When Someone Says They Don't Want to Be Here

My father-in-law told us he was suicidal. Not once, and not in some vague way that we only understood after he died. We knew. He told us, we talked about it, we tried to help, and every time we got scared enough to think we needed to do more, he reassured us that he wasn't going to do anything.

That makes his story very different from my brother's.

My father-in-law had been through an enormous amount of trauma. There had been an accident that resulted in the death of his wife, followed by roughly three years of hospitalizations, pain, illness, depression, anxiety, grief, and the roller coaster of emotions that comes with all of it. By the time he started telling us that he was suicidal, this wasn't a story that could be neatly explained by saying he had a mental illness. He was experiencing incredible mental anguish after three years of trauma, loss, physical pain, stress, and his own declining health. Life had become incredibly hard.

And we knew he was struggling.

The problem was that he lived in another state. We were trying to help from a distance, which is its own special kind of helplessness. We looked for treatment. We looked for places he could go. We looked at churches. We talked to him over and over. We tried to figure out what might help him rebuild some kind of life because simply telling someone to “get help” isn't particularly useful when you are the person on the other end of the phone actually trying to figure out what that help is supposed to look like.

The weekend before he died, our whole family went to stay with him. It was a beautiful weekend. He was laughing and happy and seemed like his old self again. Or so we thought. We talked about the future. We talked about getting him an RV so he could travel, come spend time with us, visit his other children and maybe find some community along the way. It seemed like a possibility. Something different. A way for him to have people around him and something to look forward to after several years in which life had given him very little to look forward to. Before we left, we talked about the suicide again. He assured us he was getting help. He assured us he wasn't going to do anything. We left believing him.

Then eventually the phone call came. Someone called to tell us that he had shot himself.

It was over.

So now I have lived both sides of one of the things we talk about constantly in suicide prevention. With my brother, I didn't know. With my father-in-law, we knew. We knew he was suicidal. We talked about it. We tried to find help. We spent time with him. We made future plans. We took him seriously. We believed him when he told us he would be okay.

Neither story ended the way I wanted it to.

I think that's important to say because we have a tendency to make suicide prevention sound much neater than it

actually is. Know the warning signs. Ask the question. Get the person help. Absolutely. Do all of those things. But I'm not going to tell you that if you do them correctly, you are guaranteed a particular outcome, because I know that isn't true.

Knowing that someone is suicidal creates a completely different kind of fear. Suddenly the phone ringing at an unusual time means something. An unanswered text means something. You listen differently when they talk. You wonder if they sound okay. You wonder if they sound too okay. You wonder whether you should call again, whether you are calling too much, whether you should drive there, whether you're overreacting or whether you're not reacting enough. When the person lives in another state, as my father-in-law did, you have the added reality that you cannot physically see what is happening.

And meanwhile, your own life doesn't stop. You still have children and jobs and a marriage and bills and dinner and laundry and all the stupidly normal things that require attention while part of your brain is somewhere else wondering whether somebody you love is going to survive the night.

I have spent enough years around families dealing with suicide to know how exhausting that can become, and I think we need to be able to talk about that without making families feel guilty. You can love somebody desperately and still be tired. You can understand that they are suffering and still get frustrated. You can be compassionate and angry at the same time. You can need a break. None of those things mean you don't love the person enough. It means you are a human being trying to function in an incredibly difficult situation.

One of the other things I've learned is that when somebody tells us they don't want to live, we tend to panic and start talking. We want to say the thing that will fix it. "You have so much to live for." "Think about your children." "Things will get better." "You don't really mean that." We remind them that people love them or that other people have it worse. Most of the time I think those responses come from fear. We are desperately throwing reasons to live at someone because we don't know what else to do.

But they know they have children. They know people love them. They know other people have problems. None of that necessarily changes whatever has made their own life feel unbearable at that moment.

Sometimes we need to talk less.

"Tell me what's happening."

"How long have you felt like this?"

"Are you thinking about suicide?"

And then let them answer.

Asking someone directly if they are thinking about suicide is uncomfortable, but I would much rather have an uncomfortable conversation than spend the rest of my life wondering why I didn't ask. And if somebody tells you they are suicidal, take them seriously. That doesn't necessarily mean they are going to die by suicide that night. Suicidal thoughts can exist at very different levels of intensity, which is why we need to understand what the person is actually telling us instead of either panicking immediately or dismissing them because they've said it before.

Please don't assume that someone who talks about suicide won't actually do it.

My father-in-law talked about it. He also repeatedly told us that he wasn't going to do it. I have thought about those conversations many times since. Maybe he completely meant what he said when he reassured us. Maybe at that moment he had every intention of continuing to fight. Maybe something changed later. Maybe the anguish became too much in one particular moment. I don't know.

There's that answer again. I don't know. What I do know now is that a promise isn't a plan. When somebody we love says, "I promise I won't do anything," we desperately want to believe them because for a moment we can breathe again. I understand that because we did it. But if someone is experiencing recurring suicidal thoughts, we need more than reassurance. We need to know what happens when those thoughts get worse. Who will they call? What has helped before? What makes things worse? Who are they willing to involve? What professional support do they have? What are we going to do if we believe the danger has become immediate?

Those conversations are much easier to have before everyone is terrified.

And this is also where I have a problem with the phrase "get help." I agree. Get help. BUT WHERE?

Who are we calling? Do they take insurance? Are they accepting new patients? Can they see this person today, or is the first appointment six weeks away? What happens if it's ten o'clock at night? What if the person lives somewhere without many mental health services? What if they don't have transportation? What if they finally see a therapist and that therapist is a terrible fit? What if the medication doesn't help? What if it makes them feel worse? What if they have already been hospitalized and they come home still suicidal?

What does "get help" mean then?

We ran into some of those questions with my father-in-law, and over the years I have watched countless other families run into them too. Help isn't one thing. Sometimes it's a hospital. Sometimes it's a therapist or psychiatrist. Sometimes it's a crisis service or support group. Sometimes it's medical care for something contributing to the problem. Sometimes it's community. Sometimes it is another person sitting beside you while you figure out who the hell you're supposed to call next.

And sometimes the help doesn't work. That does not mean nothing will work.

I think this is incredibly important because people can become hopeless about treatment too. They finally do what everyone has been telling them to do. They ask for help. They go to therapy. They take the medication. They go to the hospital. And they still feel terrible. Okay. That didn't work. What is next?

Maybe we need another doctor. Maybe we need to look at the medication. Maybe we need a different kind of therapy. Maybe there is something physical contributing to what is happening, as we talked about earlier. Maybe the person's living situation is unbearable. Maybe they're isolated. Maybe they're in pain. Maybe we haven't found the right piece yet.

Keep looking.

The family needs support during all of this too. When one person is suicidal, the entire family can begin organizing itself around keeping that person alive. People sleep with phones beside their heads. They cancel plans. They check in constantly. They rearrange work schedules. They argue about whether something is serious enough to warrant calling for emergency help. They become afraid of saying the wrong thing. They stop trusting good days because they are waiting for the next bad one.

Eventually people get tired. We have to allow them to say that.

One of the reasons support groups became so important to me was because there are some things you can explain to someone and some things you don't have to explain to a person who has lived them. You can say, "He didn't answer the phone," and another person understands why your stomach dropped. You don't have to spend twenty minutes explaining why an unanswered phone call became an emergency in your head. I also believe we need to make plans with people, not just around them. If somebody experiences recurring suicidal thoughts, talk about what helps while they are able to have that conversation. Ask what they want you to do when things get bad. Ask who they trust. Ask what has made previous crises worse. Ask what has helped, even a little. Know what professional support already exists and what you will do if you believe the situation becomes immediately dangerous. Write it down if that helps. Change it when it stops working.

The person who is struggling should be part of that conversation whenever possible. It is their life. We shouldn't build an entire emergency response around them without ever asking them what has actually helped them survive before.

I wish I could tell you that doing all of this guarantees an ending. It doesn't.

You can love someone. You can listen. You can ask the question. You can search for treatment. You can call churches. You can drive across state lines. You can spend a beautiful weekend together laughing. You can talk about buying an RV and traveling around the country visiting children and finding community. You can leave believing that maybe, finally, something is shifting.

And you can still get the phone call.

I hate that this is true, but pretending otherwise doesn't make suicide prevention stronger. It just gives grieving families another reason to blame themselves when the ending isn't the one everyone worked so hard for.

What happened to my father-in-law does not make me believe intervention is pointless. Quite the opposite. It made me realize how much more we need. We need somewhere for people to go. We need professionals who can see them before six weeks from Thursday. We need options when the first treatment doesn't work. We need people willing to keep asking what else might be contributing. We need support for the families who are trying to hold everything together. And we need community, because isolation and distance make an already impossible situation harder.

I would learn that last part in another terrible way.

Before my father-in-law, one of the regular people in our support groups disappeared. He had been part of our community, and then he was just gone. We thought he had moved to Denver because that's what he said he was

doing. He hadn't.

By the time I found out where he actually was, he was in a hospital being treated for a gunshot wound after another suicide attempt. That was his seventh attempt. Eventually there would be an eighth and that was the time, his family finally lost him to his illness.

I remember thinking afterward that this was brutal. We couldn't keep losing people this way. We couldn't build a community for people who were struggling and then lose track of them when they disappeared. If somebody was part of our groups, part of our community, then I believed we had some obligation to notice when they stopped showing up.

That belief would eventually become something tangible. It was how the drop-in center was born.

Chapter 7

What Happens After You Ask for Help?

We tell people to ask for help all the time. Reach out. Call someone. Talk to your doctor. Find a therapist. Go to the hospital. Call a crisis line. We put “help is available” on websites, posters and social media graphics as though asking for help and receiving useful help are the same thing.

They aren't.

I have a problem with telling someone who is suicidal to “reach out” without being willing to talk honestly about what can happen after they do. Sometimes they reach out and something wonderful happens. They find the right therapist. They get a doctor who listens. A treatment works. Someone answers the phone at exactly the right time. They find a support group where, for the first time in months or years, they don't have to explain themselves.

And sometimes they get voicemail. Sometimes nobody calls back. Sometimes the therapist isn't taking new patients. The psychiatrist can see them in three months. The provider doesn't accept their insurance. They go to the emergency room, are evaluated, and eventually go home with instructions to follow up with someone who can't see them for another six weeks.

Then what?

There is another problem with telling people to “get help” that I don't think we talk about nearly enough. What if the person isn't mentally ill? What if they are suicidal because their life, at that particular moment, is genuinely awful?

I'm not suggesting that we ignore depression or mental illness. We have already spent plenty of time talking about both. But suicidal ideation doesn't automatically tell me why someone is suicidal, and I think we make a mistake when we treat the thought itself as though it is the entire problem.

Imagine someone who is about to become homeless. They lost their job. They're behind on rent. Their landlord has started the eviction process. Their car barely runs. They have almost no money left and they are completely out of ideas. Eventually they start thinking, I can't do this anymore.

Where exactly are we telling that person to go?

If they tell someone they are suicidal, eventually we may tell them to go to the hospital. If they are in immediate danger, then yes, keeping them alive is obviously the first priority. But the hospital isn't going to give them a better job. It isn't going to pay their rent. It isn't going to give them somewhere affordable to live. Depending on their circumstances, they may leave with exactly the same problems they walked in with and now possibly another bill.

We treated the suicidal crisis. Did we treat the problem? I think those are sometimes two very different things.

Maybe what that person actually needs is housing. Maybe they need somebody to help them negotiate an eviction or find emergency financial assistance. Maybe they need childcare so they can work. Maybe they need a better job.

Maybe they are living in a situation that is making them miserable and they genuinely cannot see a practical way out of it.

Therapy might help them cope with all of that, and there is certainly value in having somebody help you survive an awful period of your life. But therapy doesn't pay the electric bill. We have to be able to say that without somehow making it sound like we're against therapy. My father-in-law is an example I keep coming back to. After everything he had experienced over those three years, who was going to bring him back from that?

I don't actually know.

How do you undo an accident that resulted in the death of your wife? How do you erase years of hospitals and physical pain and grief and anxiety and stress? How do you take somebody who has become completely depleted by what life has done to them and make them believe that the next three years might be worth sticking around for?

There isn't a prescription for that.

Maybe therapy could have helped. Maybe medication could have helped with some of it. Maybe the RV idea would have helped. Maybe traveling and seeing his children and finding community would have slowly given him pieces of a life he wanted again. Maybe something else entirely would have reached him.

I don't know because we didn't get enough time to find out.

And that is the conundrum. Sometimes keeping somebody alive means treating an illness. Sometimes it means treating pain. Sometimes it means helping them find a competent psychiatrist. And sometimes I think suicide prevention might look a whole lot more like helping somebody find housing, get food, leave a terrible situation, solve a financial problem, find a job, get transportation or simply find other human beings so they aren't trying to survive everything alone.

If the thing making someone's life feel unlivable is something happening in their actual life, then maybe part of suicide prevention needs to be helping them change the thing that is making their life feel unlivable.

That seems incredibly obvious when I write it down. I'm not sure why we've made it so complicated.

This was one of the things that became impossible for me to ignore after spending so much time with people in support groups and eventually opening the drop-in center. People weren't necessarily refusing help. Many of them had been looking for it for years.

They were tired of looking. There is a difference.

We ask somebody who may already be depressed, overwhelmed, sleep-deprived, frightened, unable to concentrate, physically ill, or actively questioning whether they want to continue living to suddenly become remarkably good at navigating one of the most complicated systems we have. Find your insurance card. If you even have insurance. Call the number. Figure out whether you need a referral. Find an in-network provider. Call them. Leave a message. Wait. Call another one. Explain the whole thing again. Find out they're not accepting patients. Call somebody else. Wait on hold. Fill out fourteen pages of paperwork. Tell another stranger the worst things that have ever happened

to you. Oh, and please advocate for yourself while you're doing it.

There are days when I don't want to call anyone because I don't have the emotional energy for it. And somehow we expect a person who isn't sure they want to be alive tomorrow to make twelve phone calls looking for a psychiatrist. This is where “just get help” begins to fall apart for me.

Cost is obviously part of it. If you have no insurance, good luck. Even people with insurance can quickly discover that having insurance and being able to afford care aren't necessarily the same thing. There are deductibles, copays, providers who don't participate with your plan, medications that aren't covered, and treatments that insurance won't pay for. Someone can technically have access to mental healthcare on paper and still not have practical access to it in their actual life.

And the numbers are staggering. A 2026 KFF analysis of commercial insurance claims found that the average total cost of an inpatient mental-health admission was about \$15,900. That is the total cost, not necessarily what the patient personally pays, and individual costs vary enormously depending on the facility, insurance coverage, deductible, and other factors.

I can tell you what that looks like in my own house. We pay \$845 a month for health insurance and have a \$12,000 deductible. So when somebody tells me that the “average out-of-pocket cost” for treatment is some relatively manageable number, my immediate question is: Has the deductible been met? Because ours hasn't magically disappeared just because somebody needs mental-health treatment. Depending on your insurance, you can be staring at thousands of dollars in medical costs at exactly the moment your family is already in crisis. And remember the person we were talking about earlier who is suicidal because they are drowning financially. Now imagine telling them that the answer is treatment they are terrified they cannot afford.

I'm not arguing that someone in immediate danger shouldn't receive emergency treatment because it costs money. Keeping them alive comes first. I'm saying the financial reality doesn't disappear just because we have correctly identified an emergency. Eventually that person goes home, and whatever was sitting on the kitchen table before they went to the hospital is still sitting there.

Then there is time.

If I tell you today that I'm afraid I might hurt myself, an appointment six weeks from now isn't really an answer to the problem I brought you today.

That doesn't mean the therapist is doing something wrong. They may have every appointment filled. The psychiatrist may be seeing as many people as one human being can reasonably see. The community clinic may be overwhelmed. I have met plenty of people working inside these systems who are doing everything they can.

But from the perspective of the person asking for help, the reason there isn't an appointment doesn't change the fact that there isn't an appointment.

Geography. Transportation. Whether you can take time off work. Whether you have somebody to watch your children. Whether you have had a terrible experience with mental healthcare before. Whether you trust the person sitting across from you. Fit. All of these are part of the equation because treatment isn't one hour and done. It can be

weeks, months and possibly years.

I think sometimes we talk about therapy as though therapists are interchangeable. They're not. They're people. You can sit across from a perfectly competent therapist and know that you are never going to tell that person anything important.

That doesn't mean therapy doesn't work. It means that therapist didn't work for you. Try another one.

I realize how frustrating that advice is when it took everything someone had to make the first appointment. Now we're telling them to start again. Tell another person the story. Fill out more paperwork. Wait another month.

But I would rather tell someone the truth than allow them to decide, after one bad experience, that they are the problem.

You are allowed to get another therapist. You are allowed to get another opinion. You are allowed to tell a doctor something isn't working. You are allowed to ask whether a medication could be contributing to how you feel. You are allowed to ask whether something physical should be investigated. You are allowed to say, "I tried that. It didn't help. What else do we have?"

I wish more people knew that.

One failed treatment does not make you untreatable. One terrible therapist does not mean therapy cannot help you. One medication that made you feel awful does not mean there are no other options. One bad experience asking for help does not define every possible kind of help. And one doctor saying, "I don't know," doesn't necessarily mean there isn't an answer.

Sometimes there isn't an immediate answer. I know that too. But "we haven't found it" and "it doesn't exist" are two very different things. The drop-in center came from my frustration with some of this. We thought one of our group members had moved to Denver but later learned that he hadn't moved at all. He was in the hospital recovering from another suicide attempt.

Through a series of circumstances that still feels remarkably small-world to me, I learned that his mom and brother lived a few doors away from me. This wasn't just someone who used to come to group and disappeared. This was my community, my neighbor, and there was an entire family around him too. He was deeply loved.

He had kept reassuring everyone that he was okay, but eventually his family lost him for good. I couldn't get past the fact that we didn't know where he was, that he was in so much distress again, and we were supposed to be part of the solution. I felt like we had failed him a little. We had the tangible things to offer: pamphlets, support groups and information, but it still wasn't enough.

NAMI has amazing support groups where people can go and talk about what is happening in their day-to-day lives, but then they leave the room and often disappear back into their lives. If someone stopped coming, unless another member happened to know them outside the group, we might have absolutely no idea why.

That didn't feel like enough. I remember thinking, we can do more. We can't lose people and find out afterward

what happened to them. If we are a community, then maybe community has to mean something after the meeting ends.

That was how the drop-in center was born. I wanted somewhere people could actually go. Not an appointment three weeks from Thursday. Not another phone number. Not another waiting list. Somewhere you could walk through the door and another human being would be there. I never believed peer support was a replacement for professional mental healthcare. It isn't. There are situations that need psychiatrists and therapists and physicians and hospitals. There are emergencies that require emergency intervention.

But there is an enormous amount of human life that happens between a weekly therapy appointment and a psychiatric emergency. Where are people supposed to go then?

Sometimes what someone needs is clinical treatment. Sometimes they need help finding clinical treatment. Sometimes they need somebody to sit beside them while they make the call because making the call feels impossible. Sometimes they need to be around people who understand what they're talking about without requiring the entire backstory first. Sometimes they need practical help solving the thing that is actually making their life unbearable.

And sometimes they just need somewhere to be. I think we underestimate the importance of that. We have made mental health support incredibly appointment-based. You schedule your hour. You arrive. You talk. You leave. Then you go back to your life and whatever is waiting for you there.

The eviction notice is still on the counter.

Your husband is still dead.

Your job is still gone.

Your body still hurts.

Your marriage is still falling apart.

You still don't know where you're sleeping next month.

That doesn't make the hour of therapy worthless. It means the hour of therapy was never going to be capable of solving every problem in the first place.

This is where community and peer support can fill what licensed professional treatment was never really designed to fill. Not instead of treatment. Alongside it. And sometimes community may be the thing that keeps somebody connected long enough for something else in their life to change.

I also learned that people who have been through these systems know things about them that people designing the systems often don't. Ask somebody who has spent years trying to get mental healthcare what doesn't work. Ask the mother who has called twenty psychiatrists trying to find one who will see her child. Ask the person who has sat in an emergency department while suicidal. Ask someone who has been hospitalized what actually made them feel

safer and what made them afraid to ever ask for help again. Ask the person who couldn't afford the recommended treatment. Ask the family who went home terrified because they didn't know what they were supposed to do next. Their experience is information.

It doesn't mean every conclusion any of us draws from our own experience will always be correct. But lived experience should be part of how we build better systems because the people using those systems can see the holes from the inside.

I don't want "reach out" to disappear from suicide prevention. I just want us to finish the sentence. "Reach out, and someone will be there to reach back."

If the first person doesn't, try another. If the first treatment doesn't help, ask what else exists. If the therapist is wrong for you, find another one if you can. If the problem is housing, let's look for housing resources. If the problem is food, let's find food. If somebody is drowning financially, maybe the most useful person in that particular moment isn't a psychiatrist. Maybe it's somebody who knows how to navigate financial assistance, employment services or benefits.

And if you're the person standing beside someone who is struggling, don't simply hand them a phone number and consider your job finished. Help them make the call if they want you to. Help them figure out the insurance. Drive them if they need a ride. Sit in the waiting room. Help them fill out the paperwork. Check on them tomorrow.

We make "asking for help" sound like the finish line. It isn't. Sometimes it's the beginning of a ridiculous amount of work, and if the person asking for help is already exhausted, maybe the rest of us need to carry some of that work for a while.

Because telling someone "you are not alone" only means something if, when they finally look around, somebody is actually there.

Chapter 8

The Person Beside You May Matter More Than You Know

We spend a lot of time looking for the big solution. The right doctor. The right therapist. The right medication. The right diagnosis. The right treatment. And all of those things can matter enormously. But after years of working in support groups, running a drop-in center, working in peer support and simply living through some of this myself, I think we sometimes underestimate something much more ordinary. Another person.

Not another person who knows exactly what to do. Not someone who has the perfect words or can fix what is happening. Sometimes just another human being who understands enough to sit there with you while things are awful.

I learned this myself years ago when I was struggling with the weight of navigating chronic illness with my child. I wasn't suicidal, but I was exhausted and felt incredibly alone in what our family was going through. I had been to doctors. I had read medical journals. I had tried diets and treatments and spent more hours than I could possibly count trying to understand what was happening. I had information coming out of my ears.

What I needed at that particular moment wasn't more information. I needed somebody who understood.

I ended up at a local NAMI class, one of the first I had ever attended, and I remember walking in feeling completely out of place. Then the man teaching the class started talking about his experience with his child. He talked about the symptoms, the sleepless nights, and the frustration of trying to get doctors to understand what they had seen. I knew exactly what he meant because we were living a version of this too. At some point during the class, it was my turn to share. That was it. I thought, "I found my people."

There wasn't some enormous revelation. This class didn't give me an answer that changed everything. They didn't solve any medical problems. It was a nod from a group who understood what I was talking about without requiring me to spend an hour explaining why this life we lived was so hard.

I think that was one of my earliest real lessons in what peer support can do.

Years later, after becoming board-certified as a patient advocate, I earned additional certifications as a Peer Support Specialist and an i-FPRS, a forensic peer recovery specialist. I let all my certifications lapse this year, but what I learned doing that work never left me. Peer support isn't about one person fixing another person. In fact, one of the first things you have to get over is the idea that you're there to fix anybody. You're not. You're there because lived experience has value. You are there to listen.

There are things you can explain to someone and things you don't have to explain to somebody who has been there. If you've spent years trying to get help for a child nobody seems to understand, another parent who has done the same thing understands a part of your life immediately. If you've lived with addiction, grief, mental illness, chronic pain, incarceration, suicidal thoughts or the aftermath of a suicide attempt, somebody else who has lived something similar may understand things that a person with every credential in the world simply cannot understand in quite the

same way.

That doesn't make the person with lived experience more knowledgeable than a physician or therapist about medicine or clinical treatment. It means they possess a different kind of knowledge.

I think we get ourselves into trouble when we insist one kind has to cancel out the other. There is professional expertise, and there is lived expertise. We need both.

NAMI understood this long before peer support became a phrase people threw around so casually. Their support groups and education programs brought people together around shared experiences. Families sat with other families. People living with mental-health conditions sat with other people who understood what that actually meant in day-to-day life. You could talk about something that sounded completely irrational outside that room and watch half the people in the room nod because they knew exactly what you meant.

Over the years I heard variations of the same thing repeatedly: "I finally felt understood." Sometimes someone would tell me they learned more from another parent who had been through something similar than they had learned from months of trying to explain it to people who hadn't. I don't hear that as an indictment of therapy. I hear it as evidence that the two relationships do different things.

I've also been involved with peer-support platforms like Supportiv and ShareWellNow, where people can connect online rather than walking into a physical support group. That matters too because not everybody has a group down the street. Not everyone is comfortable walking into a room full of strangers. Sometimes it is two o'clock in the morning. Sometimes you don't want anyone to know who you are yet. Sometimes you aren't looking for an appointment. You just don't want to be alone with whatever is happening in your head.

Technology can create connection in places where geography used to make it impossible. It isn't the same as having someone physically sitting beside you, but I have watched people who began as complete strangers connect remarkably quickly once one person said something honest and somebody else answered, "Me too."

Those two words can carry a surprising amount of weight. One of the most important things I learned through peer-support work was how difficult it actually is to listen. Everybody thinks they know how to listen. We don't. I had to learn and work really hard on this. I have ADHD, so my thoughts come bounding in on horseback, not gently, into spaces left by other people. I know how conversation works, but ask a person with ADHD not to share their passions or their thoughts, and you will see someone who struggles to breathe. Eventually, I discovered a simple trick: I place my finger over my lips. It looks like I am pondering what you are saying, but in reality it is to give me a reminder to be quiet. It took a long time, and I don't always get it right, but if you are having an intense conversation with me and you see my finger on my lip, know it's there to keep me quiet.

Most of us listen while simultaneously preparing our response. Someone tells us something terrible, and our brain immediately starts searching for the thing we're supposed to say. Again, the ADHD: I have a vault of resources and information on the tip of my tongue, and I want to share them ALL with you. It's natural; you want to reassure that person in front of you. You want to fix the problem. You want to tell them about the time something similar happened to you, share how you felt, what you thought; it's a bonding moment. We want to explain why things aren't as hopeless as they think.

Sometimes we just need to shut up and let them tell their story. From start to finish, end to end. Sometimes it's as cathartic as hours and hours of therapy. Just getting it all out there.

I don't mean that flippantly. Listening without trying to change what someone is saying is a skill, and it can be incredibly uncomfortable when the thing they're saying frightens us. If someone says, "I don't know how much longer I can do this," our instinct may be to immediately tell them all the reasons why they can. But maybe the better first response is, "Tell me why," or "That's a valid feeling to have in these circumstances." and allow them to continue.

If someone says, "Nobody understands what this is like," we don't have to respond, "Of course we understand." Maybe we say, "You're probably right. But I am here to listen." There is a difference between listening for the opportunity to respond and listening because you genuinely want to know what another person's experience feels like from where they are standing.

That became particularly important to me when working around suicide because people are often afraid to tell the whole truth about suicidal thoughts. We talked about that earlier. They may be afraid they'll scare you. They may be afraid you'll call the police. They may be afraid they'll be hospitalized. They may be afraid you'll tell their family, judge them, treat them differently, or never trust them alone again. If someone finally tells you what is happening and your immediate response is panic, they may decide not to tell you again for fear of making their situation and yours, worse.

That doesn't mean you ignore danger. If somebody is in immediate danger, safety matters more than our desire to preserve a comfortable conversation. There are times when professional crisis intervention or emergency care is necessary.

But every conversation about suicide is not identical, and every person experiencing suicidal thoughts is not at exactly the same level of danger. If we want people to tell us what is really happening, we have to become people who can hear difficult things.

Sometimes that means sitting in silence for a minute. Sometimes it means saying, "That sounds absolutely awful." Sometimes it means asking, "What has kept you here so far?" Sometimes it means asking directly, "Are you thinking about killing yourself?"

And then actually listening to the answer instead of asking the question simply so we can move on to the part where we tell them what to do. I think empathy gets confused with agreement sometimes. You don't have to agree with someone's conclusion that their life is hopeless in order to understand that it feels hopeless to them. Those are different things.

If someone tells me they can't see a way out, telling them, "Of course there is a way out," doesn't actually answer what they just told me. Maybe there is a way out. I certainly hope there is. But right now they can't see it. So perhaps we start there.

"Okay. You can't see it right now. Let's talk about what that looks like together." That is very different from, "Don't say that. You have so much to live for." One response tells someone their perception is wrong. The other says they don't have to find the answer alone.

Connection matters because suicidal thinking can become incredibly isolating. Sometimes people physically withdraw from everyone around them. Other times they remain surrounded by people and still feel completely alone. As we've already talked about, somebody can go to work, make dinner, laugh at something funny and answer "fine" when asked how they're doing while carrying thoughts nobody around them knows exist.

Being seen, feeling like you belong, having somebody notice when you disappear is all important. I learned that last one the hard way. Aaron's suicide changed the way I thought about community. I have already told you his story, so I'm not going to tell it again here. But I will tell you what stayed with me. We hadn't noticed soon enough. That bothered me then, and it still bothers me.

Not because I believe we could have guaranteed a different ending. After everything I've told you in this book, I hope it is obvious that I don't believe that. But I do believe people matter enough to be noticed. If somebody comes to your group every Thursday for six months and suddenly disappears, would you notice? If you stand in front of a group of high schoolers and tell your story with this person for months, and then they are suddenly not there. If your friend who texts you constantly suddenly stops. If someone who normally shows up doesn't, we have to notice.

That doesn't mean every absence is a suicide emergency. People get busy. They move. They get annoyed with support groups, or they feel they outgrow the space. They lose their phones. Life happens. Call anyway. "Hey, haven't seen you. You okay?" That's community. It doesn't require a degree; it doesn't even require a lived experience; it just requires us to care.

And community doesn't always have to be organized. You don't have to start a nonprofit, become a certified peer specialist, or create a support group. Sometimes community is a neighbor who knows you're having a terrible week and brings dinner. Sometimes it's the friend who sends a second text after you didn't answer the first. Sometimes it's somebody who drives you to an appointment because you can't make yourself go alone. Sometimes it's the person who sits in the emergency department with you at two in the morning. Sometimes it's somebody who doesn't know what the hell to say and stays anyway.

I actually trust that person more than the person who thinks they have the perfect thing to say. You don't need the perfect thing. You need to be willing to stay in the conversation.

There is another side to this that I think we have to talk about, though, because otherwise we create another impossible burden. If you are the person beside someone who is suicidal, you are important, but you are not omnipotent, meaning you don't have all the power at your fingertips. Those are very different things.

I don't want anyone reading this chapter to come away believing that if they listen correctly, check in often enough, say the right words, or love somebody hard enough, they can guarantee that person's survival. I know too much to tell you that.

My family loved my father-in-law. We all listened. We all checked. We all drove across state lines. We all tried to find help. We all made future plans. We all believed in a future for him when he was struggling to believe in one himself. We still lost him.

The importance of human connection cannot become another weapon grieving families use against themselves later. You do what you can; you are present; you connect; your phone calls and willingness to listen make a difference.

But you are still just one person. If someone is in serious danger, bring in more people. Bring in professional help. Bring in family if appropriate. Use crisis resources. Call emergency services when the situation requires it. Don't accept sole responsibility for keeping another human being alive because no individual person can carry that indefinitely.

This is especially important for families because loving someone who repeatedly experiences suicidal thoughts can slowly turn into monitoring them every minute of every day. We talked about this in the last few chapters. Eventually the supporter needs support too. Community has to work in more than one direction. The struggling person needs people. The person supporting them needs people. The family needs people. Sometimes the people doing the helping need somebody to sit beside them too.

That may be the thing peer support taught me more than anything else. We like to divide people into helpers and people who need help, but life doesn't work that way. At different points, most of us are going to be both. I have been both. I am still both. There have been times when I knew what resource to call, what question to ask, and how to help someone navigate a system they didn't understand. There have also been times when I was exhausted, frightened, overwhelmed, and desperately grateful that somebody else understood something I didn't have the energy to explain.

I don't think being on either side of that equation makes me stronger or weaker. It just means that sometimes I have something useful to offer and sometimes I need somebody else to have something useful to offer me. That's how people work.

After everything I've seen, I still believe strongly in professional care. We need good doctors, therapists, and psychiatrists. We need hospitals that know what to do with psychiatric emergencies instead of simply containing them until they can be discharged. We need crisis services, better access to care, better research, and more treatment options. None of that changes the fact that there are a whole lot of hours in a person's life when none of those people are sitting beside them.

That's where the rest of us come in.

We aren't there to diagnose anyone or become their therapist. We don't have to know exactly what to say, and quite frankly, sometimes trying so hard to say the right thing is what gets us into trouble in the first place. We can listen. We can notice when something changes. We can call when somebody disappears. We can sit in an emergency room, help make the phone call, bring dinner, send another text, or admit that we have absolutely no idea how to solve what is happening.

"I don't know what to do either, but let's figure out the next thing together" is actually a perfectly reasonable thing to say.

Maybe that's why the person beside you matters more than you know. They aren't necessarily the person who will solve the problem. Most of the time they probably can't. But when life has become so overwhelming that someone cannot imagine carrying all of it for another day, having another person willing to pick up even a tiny corner of it for a while can matter enormously. Sometimes that is all we can do. And sometimes, for that particular day, it will have to be enough.

Chapter 9

Making Sense of the Science: What We Understand and What We Don't

We've already talked about how often suicide gets reduced to a simple explanation. Suicide is caused by mental illness. People who talk about suicide are looking for attention. Someone who is really going to do it won't tell you. If you know the warning signs, you'll know when someone is suicidal.

After everything we've talked about so far, I think it's pretty obvious that I have a problem with simple explanations.

The science isn't that simple either, and I don't think that's necessarily a bad thing. Science isn't supposed to give us an answer and then stop. We're supposed to keep asking questions, testing what we think we know, finding the places where something doesn't fit, and then asking more questions. That is actually one of the things I love about research, although I will admit it can also make me a little crazy.

I am not going to turn this into a statistics class because nobody is reading this book for that, but I do think we need to understand the difference between something being associated with suicide and something causing suicide. We throw the word “cause” around pretty easily. Depression is probably the easiest example. Depression is strongly associated with suicide risk. That is important information, and treating depression can absolutely be part of suicide prevention. But saying depression is associated with an increased risk of suicide is not the same thing as saying depression causes suicide. Most people with depression do not die by suicide, and people become suicidal for reasons that extend well beyond depression.

I know that can sound like semantics, but I don't think it is. If we decide depression causes suicide, then naturally we go looking for depression. We find it, treat it, and assume we've addressed the problem. Maybe we have. But what if the person is also living with terrible chronic pain? What if they are experiencing psychosis? What if something changed after starting a medication? What if they're about to lose their home? What if their spouse died? What if they haven't slept properly in six months? What if something physical changed in their brain or body? What if they are self-medicating?

Treat the depression. Of course. But keep asking questions.

Researchers have looked at genetics, brain chemistry, inflammation, immune function, hormones, neurological conditions, trauma, impulsivity, substance use, chronic pain, social isolation, financial stress, relationships, discrimination, access to lethal means, and more things than I could reasonably list here. Some of that research is very strong. Some of it shows associations we don't fully understand yet. Some of what looks promising right now may eventually turn out to be much less important than we thought, and something we're barely paying attention to today may turn out to matter a great deal twenty years from now.

That's science. It changes as we learn more, which is why I get a little twitchy when I see a headline saying a study has “proven” something. I want to know what they actually did. How many people were studied? Who were they? How were they chosen? What exactly were the researchers measuring? Was there a control group? How long did they follow people? Did they actually show that one thing caused another, or did they find that the two things

occurred together more often? Has anyone else been able to reproduce the results?

And yes, I want to know who paid for it. Funding doesn't automatically invalidate research. A pharmaceutical company funding a study doesn't mean the medication doesn't work, just as an advocacy organization funding research into a particular disease doesn't mean the disease isn't real. But I want to know about the potential conflicts because that's information too. Then I want to know whether independent researchers have looked at the same question and what they found. I don't consider that anti-science. I consider it reading the science.

And I feel the same way about lived experience. A personal story isn't a randomized controlled trial, but that doesn't make it meaningless. If twenty parents who don't know one another describe the same sudden change in their children after an infection, we should be interested. Maybe they're wrong about what caused it. Maybe they're right. Maybe they're seeing part of something we don't understand yet. But dismissing all twenty because they're parents rather than researchers seems just as foolish to me as declaring the mechanism proven because twenty parents experienced it.

Something happened. Let's investigate it.

We've talked about PANS and PANDAS already, and my own experience there changed the way I think about all of this. Families can notice things before medicine has a name for them. Patients can notice things before researchers have studied them. Doctors have knowledge families don't have. Researchers can see patterns that an individual doctor or patient couldn't possibly see.

Why have we decided these things have to compete? A doctor can know something I don't know. I can know something about my child the doctor doesn't know. A researcher can identify something neither of us has considered. Maybe there's something sitting in the medical record that nobody has connected yet. Maybe the lab work has another piece. Maybe the patient says something that changes the whole picture. I'd rather have all of it. Put it on the table and let's see what we're missing.

Suicide research has another problem that makes all of this even more complicated, and this is something I have thought about for years without really having a name for it. In a lot of suicide deaths, we don't actually know why the person died.

The obvious problem is that the person who could probably tell us the most about what was happening isn't here to answer the questions. We tend to imagine suicide notes as though most people leave behind some final explanation that lets everybody understand what happened. They don't. One large study of nearly 3,000 suicide deaths found a note in only about 18 percent of cases. That means more than four out of five people in that study left no note at all.

And a note doesn't necessarily solve the mystery anyway. People leave instructions, apologies, expressions of love, anger, blame, explanations that make perfect sense and explanations that make no sense to anyone left behind. A note written during the final moments of someone's life can tell us something about what that person was thinking at that moment. It doesn't necessarily tell us everything that brought them to that moment.

So how do we study why people die by suicide when the person who died can't tell us? Sometimes researchers essentially reconstruct the story. They review medical records, interview family and friends, and look at what was happening in the person's life before the death. It's called a psychological autopsy, and I understand why researchers

do it. In many cases, what other option is there?

But here's the part that bothers me. Everyone being interviewed knows the ending. I know exactly what that does because I've done it myself. You start going backward through somebody's life. What did he say? What was happening that week? Was he acting differently? Did I miss something in that conversation? Was that comment important? What about this illness? That medication? That relationship? That argument? Something he said two weeks earlier suddenly sounds completely different because now I know what happened two weeks later.

I've always thought of it as retroactive reasoning. Apparently researchers have a more respectable term for at least part of it: recall bias. I still prefer retroactive reasoning. It describes what it feels like. We know how the story ended, so we go backward through it looking for the pieces that explain the ending.

That doesn't mean the family is wrong. They may be giving researchers incredibly important information. Sometimes they may be the only people who have that information. But knowing the outcome can change the way we remember and interpret what happened before it. I think we have to account for that when we're trying to understand suicide after the fact.

My brother is a perfect example for me. I can go back through everything I knew about him and try to find an explanation. I've done it. Of course I've done it. Over and over and over. But I don't know what was happening inside his head when he died. He didn't leave me an explanation. We will never, ever know, and that's so hard to live with.

So when somebody tells me confidently why a person died by suicide when that person never actually told them why, it can get uncomfortable. Maybe that's what happened. Maybe it's part of what happened. Maybe we're filling in the blanks because human beings hate blank spaces. Having a hole and not being able to fill it in can be maddening. It feels like you'll always be searching for the missing pieces.

This is also why population research fascinates me. When we can't know everything about an individual, we can look at thousands or millions of people and see whether patterns emerge. That's incredibly useful, but then we have to remember that the pattern is not the person. The research on adoption and suicide has stuck in my head for years because of our personal circumstances, for exactly this reason. Large Swedish studies have found substantially higher rates of suicide attempts and suicide deaths among adoptees compared with non-adopted people. In one study, international adoptees had more than three times the risk of suicide death and more than four times the risk of suicide attempt compared with non-adopted people after the researchers adjusted for age, sex, and socioeconomic factors. Domestic adoptees also had significantly elevated risks.

Of course, my brain immediately goes to why. Is it genetics? The circumstances that resulted in the adoption? Prenatal exposures? Early childhood experiences? Separation from biological parents? Attachment? Institutional care in some cases? Identity? Discrimination? Something about the adoptive environment? A combination of fifteen things? Probably another ten things I haven't thought of? How can I affect change if I don't know?

Researchers have also used adoption to try to separate inherited influences from the environment in which someone was raised. A Danish study looked at biological and adoptive siblings of adoptees who died by suicide. The biological siblings also showed a substantially increased suicide risk. Other large studies looking at biological and adoptive families have found evidence suggesting both inherited and environmental contributions to suicidal

behavior. I find that interesting and scary because this isn't just some random statistic I happened to read. Adoption is part of my own life, so of course this research sticks with me. This is information that may help me.

But I can't read those studies and conclude that adoption causes suicide. That would be doing exactly what I've spent this chapter saying we shouldn't do. An adopted child doesn't arrive in a research study as a single variable called "adoption." There is an entire human life attached to that word. Genetics, prenatal health, ACE scores, why the adoption happened, what occurred before the adoption, how old the child was, whether they spent time in institutional care, their biological family history, their adoptive family, their health, relationships, identity, and probably variables nobody has thought to measure yet.

So the statistical difference interests me enormously, but I'm much less certain about what explains it. And that's really the point. We can find something that clearly deserves our attention without immediately knowing what caused it. We can know that a group has a higher risk without knowing which pieces of that very complicated human experience created the difference. Then we have to be even more careful when we take information about thousands of people and try to use it to explain what happened to one particular person.

Look at the people I've already told you about. My brother didn't hand us a checklist. We didn't know. David's family didn't know. My father-in-law told us he was suicidal, received help, reassured us, spent a beautiful weekend with us laughing and making plans, and then died. Aaron had attempted suicide repeatedly, participated in support groups, stood beside me telling his story to high school students, and was deeply loved by his family, and eventually his family lost him too. Then there was the friend I told you about earlier who died after a manic episode and left behind a very different explanation of what she believed she could no longer live with.

Five people, and I couldn't give you one formula that explains all five.

That becomes even more obvious when you think about how many things can be happening in one person's life at the same time. Someone can be depressed, have chronic pain, be getting divorced, and be terrified about money. Someone else can have a neurological illness, sleep three hours a night, and slowly lose their social life because they physically can't participate in it anymore. Someone can lose a spouse, spend years dealing with medical problems, and gradually stop believing anything is going to improve. At that point, asking which one thing caused the suicidal thoughts may be the wrong question entirely.

And once again I end up back at the answer nobody likes: I don't know.

I used to think "I don't know" was an incredibly unsatisfying answer. I still think it's an incredibly unsatisfying answer when the question is why somebody I loved died. I would very much prefer an answer. But "I don't know" is also sometimes the only answer we can actually give. Medicine changes constantly because people keep learning things. We diagnose conditions today that weren't even recognized when I was younger. We have treatments now that didn't exist. Other treatments that were once used routinely have fallen out of favor because we learned more. Technology lets us see things in the brain and body that couldn't be seen before. Of course our understanding changes along with that. Where I get uncomfortable is when any of us become so convinced that we already know the answer that we stop looking at information that doesn't fit it. And I really do mean any of us. Researchers can get excited about early findings. Drug companies have a financial interest in their products. Advocacy organizations can become deeply invested in the explanation they've been fighting to have recognized. Government agencies make recommendations from the information available at the time and sometimes change those recommendations later.

Patients can improve dramatically after trying something and understandably believe they now know exactly what made them better. I've probably done my own version of this too. We're human. We like answers, particularly when an answer makes sense of something that has been frightening or confusing.

That doesn't mean everybody is lying or that research can't be trusted. It means I want to see what the evidence actually supports before I decide how certain I am. I want to know whether we're looking at a randomized trial, an observational study, a case report, a collection of patient experiences or an adverse-event signal. They can all give us information, but they don't necessarily answer the same question. I don't see why we need to throw one away in order to consider another. I am always looking for "the" answer.

Maybe that's why "What are we missing?" has become one of the questions I ask most often. Suicide leaves us with a ridiculous number of missing pieces, but uncertainty doesn't mean we know nothing or that we sit around waiting for science to figure out every last detail before we do anything. We know enough to take suicidal thoughts seriously, ask directly about them, treat mental and physical illness, address pain, look at medications, pay attention to sudden changes, help with practical problems that are making someone's life unbearable, connect people with care, and respond when someone is in immediate danger.

What I don't think we have is a formula where we identify the correct risk factors, make the correct diagnosis, provide the correct treatment, and therefore know what the ending will be. I wish we did. If we did, I probably wouldn't be writing this book.

So I'll keep reading the research, and I'll probably keep questioning half of it because apparently that's just who I am. I'll listen to doctors, researchers, patients, and families, and I'll pay attention when people keep reporting something we don't yet understand. I'll also try not to turn an interesting association or a powerful personal experience into proof of something it can't actually prove. And when the answer really is "we don't know yet," I'd rather say that.

I have filled in enough blanks in my own head trying to understand my brother's death to know that an answer isn't automatically better just because it fills the hole.

Chapter 10

Prevention Before the Crisis

Most of what we call suicide prevention happens surprisingly late.

Someone says they want to die. Someone notices the warning signs. A family realizes something is seriously wrong. We call 988, go to an emergency room, find a therapist, remove access to something dangerous, or try to figure out whether the person can safely be left alone. All of that is suicide prevention, and obviously we need it. If somebody is in immediate danger, that is exactly where our attention should be. But what happened before that? What was happening six months earlier? A year earlier? Five years earlier? When did this person's life start becoming harder to live, and was there anything we could have done then?

This is where the idea of upstream prevention comes in. It's a public-health concept, and the basic idea isn't particularly complicated. Instead of only responding to a problem after it becomes an emergency, we also look further back and ask what conditions make the emergency more likely in the first place.

We already do this in other areas of health. We don't wait until someone has advanced heart disease before we decide cardiovascular health matters. We don't only care about diabetes when someone lands in the hospital. We talk about prevention, screening, early treatment, and the things that increase or decrease risk over a lifetime.

Why would suicide be the one thing where prevention starts at the emergency room door? After everything we've talked about in this book, I don't think it can. But how do we change such a deeply ingrained system and process like psychiatry and mental health?

If suicide were caused by one thing, upstream prevention would be fairly straightforward. Find that thing and address it earlier. Unfortunately, I just spent an entire chapter explaining why I don't believe we have that luxury. People become suicidal for different reasons, and often several things are happening at once. Mental illness can be part of the story. So can physical illness, chronic pain, grief, trauma, isolation, financial problems, housing instability, substance use, relationship problems, medications, lack of sleep, discrimination, neurological changes, and a dozen other things. So upstream prevention has to be bigger than mental-health treatment.

I think that's where we have made suicide prevention unnecessarily narrow. We have spent years telling people to “get help,” and then we define help almost entirely as mental-health care. Sometimes that's exactly what the person needs. Sometimes what they need is somewhere to live.

That doesn't sound like suicide prevention until you think about it for more than thirty seconds.

If someone is about to be evicted, terrified about where their children are going to sleep and already overwhelmed, helping that family remain housed may reduce a level of desperation that therapy alone cannot touch. If somebody has been unemployed for months and has no idea how they're going to pay the electric bill, helping them find work or emergency financial assistance isn't a substitute for mental health care if they need it, but it may be part of what keeps their life from feeling impossible.

We talked about this earlier when I said therapy doesn't pay the electric bill. I wasn't being flippant. I meant it. The

circumstances of our lives affect our ability to cope with them.

That makes economic stability part of suicide prevention. Housing can be part of suicide prevention. Access to food can be part of suicide prevention. Childcare can be part of suicide prevention. Transportation can be part of suicide prevention because the best doctor in the world isn't particularly useful if you can't get there. Paid time away from work can matter because people who will lose their job for attending an appointment are being asked to choose between two things they may desperately need. America is really bad at this. FMLA covers some major life events but without pay. Vacation time is really limited. Sick time is the same. Work, work, work takes priority.

None of this means poverty automatically makes someone suicidal or that giving somebody money cures suicidal thoughts. That would be another ridiculous cause-and-effect conclusion after we just talked about how we shouldn't do that. It means the conditions people live in affect their stress, their options, and sometimes their ability to imagine a way out of whatever is happening.

Community is another piece, and I have seen it and thought about it from just about every direction.

When I worked with NAMI, the support groups were important because people could walk into a room and discover they weren't the only person dealing with whatever had brought them there. When we built the drop-in center, part of what I wanted was somewhere people could actually go. Not another phone number. Not another pamphlet. Somewhere to be.

Years later, working in online peer support showed me the same thing in a completely different format. Sometimes people need somebody who understands enough that they don't have to spend the first forty-five minutes explaining why what they're experiencing is difficult. None of that replaces treatment. I feel like I have said that approximately seventeen times by now, but apparently I want to make sure nobody misses it.

It does tell me that belonging has a place in prevention. And belonging doesn't have to mean having twenty close friends and an incredibly active social life. Some people would find that exhausting. It can be a church, a support group, a neighborhood, a gaming community, a group of parents who understand your child, people you volunteer with, a library program, a senior center, or three people you text regularly. It can be having somewhere you are expected to show up and somebody who notices when you don't.

I recently came across a campaign in the UK called Empty Chairs, and I absolutely love the simplicity of it. They book a small table in a pub and leave a few chairs empty. If you're lonely or just want some company, you can sit down. That's it. You don't have to register. You don't have to have a diagnosis. You don't have to explain why you're there. You don't even have to stay very long. A host is there, and there is an empty chair if you want it. They are also very clear that this isn't mental-health treatment or crisis support. Except it is because it's all about connection.

And maybe that's why the idea stuck with me. We make some of these things so complicated. There are people sitting alone in their houses who aren't necessarily looking for a therapist or a support group. Maybe they don't think anything is "wrong" with them. They're lonely. They would like to sit across from another human being for an hour and have somebody to talk to. So somebody left a chair empty.

I think we need more ideas like that. Not necessarily the exact same idea, and obviously the pub part is particularly British, but places where a person can show up without first having to prove they have a problem serious enough to

qualify for being there. Connection before crisis. Somewhere to go before you need an emergency room. Aaron changed the way I think about that.

We thought he had moved; he hadn't. He was in the hospital. That stayed with me because we were a support community. We knew he struggled. We cared about him. And still, he disappeared from our view.

I don't say that because I think we could have guaranteed a different ending. I've already told you what eventually happened, and I refuse to turn community into another way for people to blame themselves after somebody dies. But it did make me think differently about what community actually means. If somebody who has been coming to an event you host for months and suddenly stops coming, maybe somebody should notice. Maybe somebody sends a text. Maybe the answer is simply, "I'm fine. I got a new job, and Thursdays don't work anymore." Great. That's a wonderful answer. But at least we asked.

I also think prevention starts much earlier in life than we usually talk about.

Children need to learn what emotions feel like and what to do with them. They need adults who take them seriously when something changes. They need to know that asking for help doesn't automatically mean something terrible is going to happen to them. Parents and teachers need enough information to recognize when a child has changed significantly instead of immediately deciding the child is lazy, difficult, dramatic or badly behaved.

And as I have probably made abundantly clear by now, if a child changes dramatically, I want somebody asking what changed physically too. Early intervention shouldn't mean waiting until a child's anxiety, depression, obsessive behavior, eating problems, aggression, withdrawal, or whatever else is happening becomes so severe that the family finally qualifies for crisis services. We should be able to say, "Something is different here. Let's figure out what."

Or that child has always been this way. Always a handful. Always a little chaotic. Difficult to manage, and the interventions should be available, plentiful, not hidden, not a challenge to find and get into, and not scarce. That applies to adults too.

One of the things we've talked about throughout this book is noticing changes from someone's normal. Maybe the person who always goes hiking suddenly doesn't want to leave the house. Maybe somebody who normally calls you every few days hasn't called in three weeks. Maybe the person who is usually meticulous at work suddenly can't keep up. Maybe your teenager abandons everything they used to love. None of those things means the person is suicidal. They do give us an opportunity to ask what's going on before we are asking the question in an emergency room. I don't even think the question has to be particularly sophisticated. "You haven't seemed like yourself lately. What's going on?" works pretty well. Then listen to the answer.

The problem, of course, is that early intervention only works if there is somewhere to go after we identify the problem. We can educate every parent in America to recognize signs of trouble in their child, but if the next available appointment is four months away, we have only solved half the problem. We can tell adults to seek help when they're beginning to struggle, but if they can't afford the deductible, can't miss work, can't find a psychiatrist accepting patients or had such a terrible experience the last time they asked for help that they are afraid to try again, awareness isn't enough.

This is probably where my own thinking about suicide prevention has changed the most over the years. I used to

think primarily about awareness. Teach people the signs. Talk about mental illness. Reduce stigma. Encourage people to seek treatment. Those things are still important. I spent years doing exactly that work, and I don't regret a minute of it. I just don't think it's enough anymore.

If we tell people to ask for help, we have to build somewhere for them to go. If we tell families to intervene early, they need access to something before the situation becomes an emergency. If we tell people connection matters, then we need communities where people can actually connect. If someone's biggest problem is that they are about to become homeless, our suicide-prevention toolbox cannot contain only a therapist and a crisis number.

This is where suicide prevention starts becoming much bigger than suicide. It starts looking like decent healthcare. Stable housing. Strong schools. Safe communities. Support for families. Treatment for substance-use problems. Better pain management. Access to physical and mental health care. Places for people to belong. Resources that people can actually find and use. Employers who understand that human beings occasionally have crises. Communities that don't wait until somebody is standing at the absolute edge before deciding their problems are serious enough to deserve attention. I realize that's an enormous list. I also don't think one organization, one government program, or one person is going to solve all of it. I'm certainly not going to solve all of it with Beyond September. Find Support Today or The Surgeon Project. But I am willing to try, do my best, and offer the solutions I can.

But we can stop pretending suicide prevention is something that happens only when somebody says, "I want to die."

By then we are already downstream.

Sometimes the work starts much earlier, when somebody is losing their housing, when a child suddenly changes, when chronic pain has taken over someone's life, when a family can't find care, when somebody has slowly stopped showing up, or when a person is becoming so isolated that nobody would notice if they disappeared.

Maybe we can't fix every one of those things. Probably we can't. But we can notice them sooner, take them seriously, and stop treating the circumstances of someone's life as though they're unrelated to whether that life eventually begins to feel unbearable. That's where I think prevention really starts.

Chapter 11

Filling the Gaps: Building Better Support Systems

I have a habit of seeing something that doesn't work and wondering why nobody has fixed it yet. Then I'll have an idea about how it could work differently, immediately followed by, "Who the hell am I to think I know how to fix this?" Surely people much smarter than me have already thought of this. Surely there is some very good reason it doesn't exist. If I tell people who actually know what they're doing about my idea, they'll probably explain exactly why I'm wrong.

I wish I could tell you the next part is where I become incredibly confident in myself and march forward anyway. That's generally not how it goes. I second-guess myself. I research it to death. I talk to people. I discover twelve additional problems I hadn't considered, which is always helpful for the self-doubt. Sometimes I decide the idea really isn't workable. But every once in a while I keep coming back to the same question: okay, but why doesn't this exist? And I find myself at my computer at 3 am writing another book that I feel like I don't have either the experience, education, or prowess to write, but I write it anyway. That's exactly why I turn around and give it away. I don't believe I have any right to charge for what seems obvious.

A lot of my mental health work happened this way.

We've spent a good portion of this book talking about gaps. We tell people to reach out, but the appointment is three months away. We tell families to get help, but they have no idea where to start. We tell someone to go to the emergency room, but eventually they are discharged, and whatever was happening in their life is still waiting for them when they get home. We tell people they need community, but there may not be anywhere for them to go. There are all these places where technically something exists, but when you actually need it, you discover there is a giant space between what the system says is available and what a person can actually use.

I live with some of those gaps in my own house, as millions of other families do. The last twenty years of my life have included the constant flux, stress, and chaos of loving someone who isn't ever quite at their best and trying to make sure they will always be okay. Of course, that's an impossible quest. But it has given me a very different perspective on what we call support because I have spent years looking at the space between what people need and what is actually available to them.

The drop-in center was one of the first times I saw that gap really clearly. I've already told you about Aaron. We were supposed to be part of the support system around people like Aaron, but someone could stop showing up and essentially disappear from our view. At the same time, there was an obvious hole in the services that already existed. Sure, there were therapists, psychiatrists, hospitals, and support groups. But what if you didn't need to be in a hospital; you needed outpatient treatment? What if you were patient 22 when the hospital only had 20 beds? What if the next closest bed was an hour and a half away? What if your therapist appointment was next Tuesday and today was Thursday? What if you had just gotten out of the hospital? What if you were lonely, struggling, or simply having an absolutely terrible day and didn't want to sit alone in your house?

Where did you go?

I kept thinking there should be somewhere. Not another number to call. Not another pamphlet. Not another

appointment. An actual place where people could walk through the door.

That eventually became the drop-in center I helped create and run. It wasn't a hospital, and it wasn't a therapist's office. It was a judgment- and diagnosis-free zone. People didn't have to be in a psychiatric emergency to belong there. They could come in, be around people who understood, talk, participate, or sometimes just exist for a while.

I think we need far more of that middle space in mental-health care. We have become very good at separating people into categories. You are stable enough to be outpatient or sick enough to be inpatient. You have an appointment or you don't. You qualify for this service or you don't. You meet the criteria or you don't. Real life isn't nearly that organized.

There is an enormous amount of life between a weekly therapy appointment and a psychiatric emergency.

That's where peer-support programs, drop-in centers, support groups, respite programs, community centers, mobile crisis teams, warm lines, day programs, clubhouses, recovery programs, and simply places where people can safely be around other people can fill a very real need. They don't all serve the same purpose, and none replaces medical or psychiatric treatment when that treatment is needed. But treatment doesn't have to be the only thing available.

And we have to make those services easier to find.

Anyone who has ever tried to find help for themselves or somebody they love knows what can happen. You start searching online, and suddenly you have twenty tabs open. One organization only serves children. Another only serves a particular county. One program sounds perfect until you discover it closed two years ago. Another phone number doesn't work. You find a therapist who takes your insurance, but they aren't accepting new patients. You find another one, but they're an hour and a half away.

And you're supposed to do all of this while you're struggling to survive.

Or you're the mother, spouse, sibling, or friend trying to do it while you're scared, exhausted, and possibly trying to keep somebody safe at the same time.

We tell people help is available, but if somebody has to become an investigative researcher to locate it, is it really available to them? That was the thinking behind Find Support Today, so I built it. It's a website with around 24,000 resources. I obviously didn't create 24,000 services. The services already existed. What I built was a way to find them. I aggregate the services under logical headings in one place, with geographical and support-related search functions designed to help people find what they need without having to pull their hair out. Sometimes the gap isn't that the resource doesn't exist. The gap is between the resource and the person who needs it.

We've built programs, nonprofits, government services, support groups, treatment centers, and community organizations all over the place and scattered the information about them across thousands of websites and directories. Somewhere in all of that may be exactly what a person needs. But how are they supposed to find it?

Find Support Today can't create a peer-support specialist where there isn't one. It can't make somebody take your insurance, eliminate your deductible, or make a six-month waiting list disappear. But if the help exists, finding it shouldn't be another obstacle somebody has to overcome while they're already overwhelmed. I built it because I

can, I fund it because I am focused, and I keep maintaining it because I hope one day it saves someone in their darkest hour. It makes me zero dollars.

Finding the service is only one problem, though. There is another gap I think we need to talk much more seriously about, and that is what happens to families once the person needing care is an adult.

I understand why medical privacy exists. Adults have a right to privacy and autonomy, including adults with mental-health conditions. Not every family is safe or supportive, and nobody should automatically surrender their privacy simply because somebody else says they are family. But the way this can play out in mental-health and substance-use care creates a very real problem.

An adult can be hospitalized while psychotic, manic, severely depressed, suicidal, cognitively impaired, using substances, or simply not thinking clearly, while the people who have known that person for twenty, thirty, or fifty years may be almost completely outside the conversation. Unless the patient has given permission for information to be shared, the family may know very little about what is happening during treatment or what is happening when the person is released.

Meanwhile, the family may have information the treatment team desperately needs.

They know this person hasn't slept in six days. They know what medications were stopped. They know that this behavior is completely unlike them. They know about the previous episodes. They know what happened last week, what the house looks like, what substances are being used, what the person told them before going to the hospital, and what actually happened the last time they were discharged.

The person receiving treatment may also be the worst historian in the world at that particular moment. That's not an insult. Think about how accurately any of us describe our lives when we're exhausted, frightened, sick, intoxicated, in severe pain, or desperate to get out of somewhere we don't want to be. Now add psychosis, mania, distorted thinking, severe depression, cognitive impairment, or substance use.

Sometimes the person genuinely believes they're fine. Sometimes they don't believe they're sick. Sometimes they know what to say to get discharged. Sometimes they want to get back to the substance they were using. Sometimes they simply remember events differently from everyone else who was standing in the room when they happened.

This is where I think we need to stop treating communication as though it only means giving private medical information to families. It doesn't. Communication can also mean receiving information.

A treatment team may be limited in what it can disclose to a family member, but that doesn't mean the family has nothing useful to say. We need systems that make it easy for appropriate family members and caregivers to provide relevant history, changes from baseline, medication information, safety concerns, previous episodes, and information about the home the patient will return to. That information should become part of the clinical picture rather than being treated as background noise.

Then there is discharge.

If someone is going home to live with a spouse, parent, adult child, sibling, or other caregiver, that person is part of

the reality of the discharge whether the healthcare system acknowledges it or not. They may be the person watching for deterioration, driving to appointments, managing the household, trying to keep substances out of the home, dealing with medication problems, making phone calls, or trying to decide at two in the morning whether something has become an emergency again.

We need a better way to involve willing, appropriate caregivers in discharge planning while still respecting the patient's legal rights and privacy. I don't pretend the answer is simple because there are legitimate issues of autonomy, abuse, capacity, safety, and confidentiality. But there has to be more thoughtful ground between unrestricted access to somebody's private medical information and sending them home to a family that knows virtually nothing about what just happened.

And if the patient doesn't have a safe family or caregiver, then that is important information too. The system needs to know what they're actually being discharged into.

A discharge plan is only as useful as its relationship to real life.

Does the person have somewhere safe to sleep? Can they afford the medication? Can they get to the follow-up appointment? Is the psychiatrist actually accepting them as a patient, or did somebody hand them a phone number? Is the appointment in three days or three months? Is there food in the house? Are they going back to the environment that contributed to the crisis? Is there substance use in the home? Does somebody know they were discharged? What happens tonight?

Those questions are not separate from mental health care.

And housing cannot only be a question we ask at discharge. For a lot of families, it is the question sitting in the background for years. What happens when I'm gone?

Parents caring for an adult child who cannot live completely independently think about this. So do siblings who know they may eventually become the person responsible for helping. Families age. Parents get sick. People die. Financial situations change. The house that has always been home may eventually be sold. And somewhere in all of that is a person who may still need support for another thirty, forty, or fifty years. Families need realistic long-term housing options before they reach that crisis. Affordable housing matters, but affordability alone isn't always enough. Some people can live completely independently with financial help. Some need supportive housing. Some need help with medication, appointments, transportation, meals, budgeting, or keeping a household running. Some mostly live independently but need somebody who notices when they haven't been seen for several days. Some need considerably more support. And people's needs can change over time. We need more options between "live completely independently" and "live in an institution," because once again, real human beings don't fit neatly into two categories.

Housing is also part of suicide prevention because stability matters. If somebody is already struggling with serious mental illness, substance use, chronic illness, disability, or repeated psychiatric crises, adding the possibility of homelessness doesn't make anything easier. A person shouldn't have to become homeless before they qualify for help finding somewhere safe and sustainable to live.

I think this is also where peer support could be used much more effectively. Someone leaving inpatient treatment

could benefit from a person whose job is specifically to help bridge that transition. Not to replace the doctor or therapist, but to help navigate everything that happens afterward. Did you make the appointment? Did the provider call back? Do you understand the discharge instructions? Do you need transportation? Did the resource they gave you actually answer the phone? What happened when you got home?

Because handing somebody a list isn't the same thing as connecting them to care.

The same applies much earlier, before hospitalization ever happens. We need easier access to outpatient care, more places people can go without waiting months, more mobile services that can come to the person when appropriate, more peer support, more community-based programs, and better coordination between medical, psychiatric, substance-use, and social services.

And we need to stop assuming every psychiatric symptom begins and ends in psychiatry.

The advocacy work I've done around PANS and PANDAS taught me that lesson in a completely different way. Those conditions became part of my world because they affected my own family. I watched how difficult it could be to get people to consider that something physical might be contributing to what looked psychiatric.

So I researched. I talked to families. I talked to people who initially knew far more than I did. I became involved in advocacy, education, legislative efforts, and task-force work because families were experiencing something that many of the systems around them didn't understand. What I learned through that work applies far beyond PANS and PANDAS. The person, the family, the doctor, the researcher, the therapist, the teacher, the peer-support specialist, and the person working in the emergency room may all have different pieces of the same story.

I don't understand why those pieces have to compete. Put everybody at the table. If we're designing a program for people leaving psychiatric hospitals, talk to people who have actually left psychiatric hospitals. Then talk to the families who picked them up. Ask what happened that first night.

If we're designing services for people with serious mental illness, ask them which services they actually use and why. Ask what makes them stop going. If we're creating programs for families, ask families what they needed six months before the crisis, not just what they needed while sitting in the emergency room. If we're trying to reduce loneliness, ask lonely people why they aren't participating in the programs that already exist.

And maybe what they tell us won't require a \$20 million program.

That's one reason the Empty Chairs campaign I talked about in the last chapter stuck with me. Somebody left some chairs open at a pub table so people who wanted company could sit down.

That's it.

We have a tendency to look at enormous problems and assume every solution must be equally enormous. Some solutions absolutely require major policy changes, significant funding, research, hospitals, clinicians, insurance reform, housing programs, and changes in law. But there are other gaps we could start filling now.

Maybe there isn't a support group in your community for what your family is dealing with, and six people could

start meeting once a month at the library. Maybe your community has excellent services, but nobody can find them, so somebody needs to organize the information. Maybe people leaving the local psychiatric hospital need peer support. Maybe caregivers need their own group. Maybe your church has an unused room. Maybe the local library could host something. Maybe the missing piece isn't another program at all but transportation to the programs that already exist.

Start by asking what is actually missing. Then ask the people living with the problem. Then look at what already exists, because sometimes the answer isn't building something new. Sometimes it's connecting things that already exist but don't communicate with each other. That may be one of the biggest opportunities we have. Mental-health care doesn't operate in isolation from the rest of a person's life, but our systems often do. The psychiatrist may not know what the primary-care doctor is seeing. The emergency department may not know what the therapist knows. The family may know something nobody else knows. The school knows what happens between eight and three. The substance-use counselor sees another piece. The housing program knows the eviction is coming.

The person is the only one living in all of those systems at once. Why are we making them responsible for connecting all of them, especially when they're the person who is struggling?

I don't think we need one giant new system that controls everything. I think we need better bridges. Between inpatient and outpatient care. Between hospitals and families. Between mental and physical healthcare. Between treatment and peer support. Between housing and the people who need it. Between the resource and the person searching for it. Between somebody saying, "I need help," and an actual human being helping them get it.

That's the kind of gap I keep trying to fill. The drop-in center was one attempt. Find Support Today and The Burgeon Project are other ways I hope to fill gaps. My outreach and advocacy position and the task force I convened approached it through education and policy. And now there is Beyond September.

Every September we talk about suicide. The statistics come out. The graphics turn purple and teal. We tell people to check on their friends. We talk about warning signs. We remind everyone about crisis numbers. Organizations run campaigns. People share their stories. Then September ends.

The person whose husband died is still grieving in October. The teenager who couldn't get a psychiatric appointment still can't get one in November. The family trying to understand why their child changed is still searching for answers in January. The person who can't pay the rent still can't pay it in February. The person sitting alone at home is still lonely.

Suicide doesn't know it's no longer September.

That's where Beyond September came from. I don't think awareness is useless. I spent years doing awareness work. Awareness can teach someone a warning sign they didn't recognize, give somebody language for something they've been afraid to say, or make a family realize they need to ask another question. But awareness needs somewhere to go.

Recognize the warning signs. Okay, now what? Reach out. To whom? Get help. Where? Keep trying. With what?

Those are the questions I want Beyond September to help answer.

I want people to be able to find resources without opening twenty browser tabs. I want people to have hope that their loved one will always have somewhere to live, even if that person will never be able to live completely independently. I want parents to be able to grow older without lying awake wondering what will happen to their adult child after they're gone. I want families to know there are options before homelessness, jail, repeated emergency-room visits, or another hospitalization becomes the default answer.

I want families to understand what they can do when the first treatment doesn't work. I want caregivers to know how they can provide information even when privacy laws limit what can be disclosed back to them. I want people leaving a hospital to leave with a plan that actually works outside the hospital, not simply a sheet of phone numbers. I want someone to follow up and make sure the connection to outpatient care actually happened.

I want people to understand the options between doing nothing and going to an emergency room because there should be a lot of options in between. I want peer support and community support to be normal parts of the system instead of things people stumble across by accident. I want families, when appropriate, to be treated as part of the solution instead of an inconvenience standing outside the door asking somebody to please tell them what is happening.

I want us to pay attention to physical health, medications, substance use, pain, housing, finances, relationships, isolation, and everything else that can be part of why a life has become unbearable.

Mostly, I want us to build a system where the answer to “What happens next?” isn't another problem the person or their family has to solve alone.

And I want us to stop building suicide prevention entirely around the moment somebody says they want to die.

By that point, we are already downstream.

There is an enormous amount we can do before then. We can make care easier to find. We can build better transitions out of hospitals. We can create more places for people to go. We can build more long-term housing options that recognize different people need different levels of support. We can involve families appropriately instead of automatically treating them as outsiders. We can strengthen peer support. We can connect medical and psychiatric care. We can build practical resource networks. We can ask people what they actually need instead of deciding for them. We can notice when somebody disappears.

None of those things will prevent every suicide. I don't think anything will.

But they give us more opportunities to intervene before the only option left feels like an emergency.

And that, to me, is what filling the gaps is actually about.

Chapter 12

Beyond September: Care That Lasts All Year

I started this book with a phone call from my mother screaming, “He did it. He did it. He did it. He went and killed himself.”

I didn't know.

That is probably one of the reasons I have spent so many years trying to understand something that I am increasingly convinced we don't completely understand. How did I not know? What did I miss? Was there something I could have done? Those questions seem very reasonable when you're asking them, particularly after someone dies, but they also assume there was an answer available to you at the time and you somehow failed to find it. I don't know that there was. I certainly didn't know the ending of my brother's story while I was standing in Starbucks that morning. I only knew it afterward, which makes everything that happened before it look different.

Then my father-in-law died by suicide and managed to destroy the theory that knowing would have solved everything anyway.

We knew. He told us. We talked about it. His family surrounded him. We tried to find help. There were hospitals and treatment and conversations and years of trying to get him through what had happened after the accident that killed his wife and left him dealing with his own physical and emotional aftermath. We spent that beautiful final weekend together when he seemed so much like himself again. He laughed. He talked about buying an RV and traveling and visiting his children. We talked about the future because, as far as we knew, there was going to be one. Then we went home, and eventually another phone call came.

So I have lived both versions. I didn't know, and then I did know. Neither one ended the way I wanted.

There has been a lot of “I don't know” in this book, which I realize isn't the most satisfying thing to read in a book that is supposed to be helping you understand suicide. I could probably make myself sound much more authoritative if I removed all of those parts. The problem is that I don't believe it. I think we know a tremendous amount, and we should absolutely use what we know. Warning signs are useful. Asking directly about suicide is useful. Treatment helps people. Connection helps people. Restricting access to lethal means can matter. We know mental illness, physical illness, trauma, substances, medications, pain, financial problems, relationships, housing, isolation and many other things can become part of someone's story. We have decades of research to learn from.

What we don't have is a formula that allows us to plug in all of those variables and know what one particular human being will do tomorrow. If we had that, this would be a very different book.

I also think our desire for a formula has created an enormous burden for families. We tell the suicidal person to reach out at exactly the point when they may have the least ability or desire to do it. We tell the family to know the warning signs, pay attention, get the person help, remove the danger, call somebody, take them somewhere and don't leave them alone. All of those things may be completely appropriate, particularly when somebody is in immediate danger, but there is an entire reality behind the sentence “get them help” that we don't talk about nearly enough.

The person you're trying to help may not want your help.

They may be angry that you're trying. They may be argumentative, irrational, depressed, frightened, aggressive, crying, using substances, obsessing about something that makes absolutely no sense to you but feels completely real to them, or changing between several of those states faster than everyone around them can keep up. They may agree to see somebody and change their mind. They may go to the hospital and leave. They may tell the doctor one version of events while the family sitting outside knows a completely different version. They may refuse the medication, take it for a while and stop, relapse after treatment, hate the therapist you spent three weeks finding, or refuse the program that looked absolutely perfect when you found it at eleven o'clock the night before.

And sometimes they want help desperately. You finally get them to agree, make the call, and discover the appointment is four months away. None of this makes the person bad. It doesn't mean they're deliberately trying to make everyone around them miserable. Someone who is mentally ill, addicted, suicidal, terrified, physically unwell or simply unable to cope may be experiencing the world very differently from the people around them. I can understand that and still say something else that is also true: living beside it can be absolutely exhausting. I don't think we talk about that enough.

Mental illness and substance-use disorders can affect an entire household. One person's crisis can determine what everybody else does that day. Plans get canceled. Work gets interrupted. People don't sleep. Someone is researching symptoms at two in the morning. Someone else is trying to decide whether an argument is an argument or the beginning of another crisis. Everybody becomes very aware of tone and mood. There can be anger and guilt and fear and resentment followed almost immediately by guilt for feeling resentful because this is someone you love and you know they're struggling.

You can love someone more than anything in the world and still be tired.

You can understand that someone is sick and still be hurt by what they say. You can have compassion for what they're experiencing and still be angry about what is happening in your home. You can spend twenty years trying to make sure someone will always be okay and occasionally want one completely boring Tuesday when nobody needs anything from you.

I don't think admitting that diminishes the person who is struggling. I think pretending otherwise leaves families feeling ashamed about a perfectly understandable response to living under prolonged stress.

It also matters for suicide prevention because families are frequently part of the infrastructure keeping someone afloat, whether our healthcare system recognizes that or not. They're driving to appointments, paying bills, finding doctors, watching for changes, answering calls, picking someone up from the hospital, dealing with insurance, trying to keep substances out of the house, researching treatments and deciding whether what is happening at two in the morning requires another trip to the emergency room. Then we tend to talk about supporting the family as though handing them a caregiver pamphlet is going to take care of all of that.

Families need support too, and sometimes what they need is incredibly practical. They need respite. They need somebody who understands the system. They need other families who don't require a twenty-minute explanation before the conversation can even begin. They need clinicians who will listen to what they know about the person, even when privacy laws appropriately limit what can be disclosed back. They need a discharge plan that recognizes

the person being discharged is actually coming home to somebody.

Some families are also living with a much bigger question that doesn't disappear when the immediate crisis does: What happens when I can't do this anymore?

I know that question.

Parents get older. People get sick. Financial situations change. Eventually parents die. If you love an adult who may never be completely independent, you don't get to think only about this week's appointment. Somewhere in the back of your mind is the question of what happens thirty years from now. Where will they live? Who will help them? Will somebody notice if things begin falling apart? Will they have enough money? Will they have people around them? Will there be somewhere safe for them to go before everything becomes an emergency? I want better answers to those questions than we currently have.

I want people to have hope that the person they love will always have somewhere to live, and I don't think our choices should be complete independence on one end and institutional care or homelessness on the other. Some people need affordable housing and very little additional help. Someone else may need help managing medication, transportation, appointments or money. Another person may be capable of living mostly independently but needs a community around them and somebody who notices when they haven't been seen in a few days. Needs change too. Someone may need substantial support during one period of life and much less later.

This is the kind of thing I mean when I say suicide prevention has to become bigger than waiting for someone to say, "I want to die." By then we are already dealing with the end of a very long chain of events.

Maybe suicide prevention was housing six months earlier. Maybe it was substance-use treatment. Maybe it was finding out why someone's physical health suddenly changed. Maybe it was a psychiatrist appointment that didn't take four months to get. Maybe it was somebody helping with an eviction. Maybe it was peer support after a hospital discharge, transportation to treatment, somewhere to go on a terrible Thursday afternoon, or simply a community where somebody noticed you hadn't shown up.

This is also why I built Find Support Today. I got tired of the assumption that telling somebody a resource exists is the same as making that resource accessible. There are around 24,000 resources on that website now, organized so people can search geographically and by the kind of help they're looking for. I didn't create those services. I created a way to find them because I have spent enough time looking for help to know how ridiculous it is to expect somebody who is already overwhelmed to open twenty browser tabs, call twelve dead phone numbers and figure out which program serves which county.

Find Support Today doesn't solve the shortage of services. It can't make a psychiatrist take your insurance. It can't make a bed appear, create supportive housing or shorten a six-month waiting list. But it solves one piece of the problem, and I have come to believe that solving pieces of the problem is actually how a lot of this work gets done.

That is pretty much how I ended up doing most of the things I've done. The support groups showed me one gap. Aaron disappearing showed me another. The drop-in center came from asking why there wasn't somewhere people could simply go. PANS and PANDAS advocacy came from watching families, including my own, run into a completely different wall. The task-force work approached problems through education and policy. Find Support

Today came from the nightmare of finding resources. The Burgeon Project came from another direction. Beyond September is another attempt.

None of them solves suicide.

I don't think one thing will.

Maybe that is the biggest change in how I think about prevention now. I used to think much more in terms of awareness and crisis response because those are the things we tend to call suicide prevention. Now I think prevention is scattered throughout someone's life. Some of it belongs in psychiatry and psychology. Some belongs in medicine. Some belongs in housing policy, substance-use treatment, schools, families, workplaces and communities. Some of it requires enormous systems and millions of dollars, and some of it may literally be six people meeting at the library or a few empty chairs at a pub table.

We should probably stop assuming that because the problem is enormous, every useful response has to be enormous too. At the same time, I don't want to finish this book with the kind of optimism that makes people who are living this roll their eyes. I know what "keep trying" can sound like when you have already tried everything you can think of. I know what it feels like when somebody says, "Have you tried therapy?" and you could hand them a twenty-year history of all the things you've tried. I know there are families who have spent years going from doctor to doctor, program to program, medication to medication, hospitalization to hospitalization and relapse to relapse. So when I say keep trying, I don't mean keep doing the same thing indefinitely and hope it magically works.

I mean don't confuse "we haven't found the answer" with "there is no answer." Those are different statements.

The first therapist can be terrible. The fifth can be exactly what someone needed. A medication can fail. A diagnosis can be incomplete. Something physical can be missed. A person can relapse after treatment and eventually recover. A family can discover a resource they didn't know existed. Circumstances can change. Research changes. Treatments change. People change.

Sometimes the person saying, "I can't do this anymore," may be telling us something very literal. They cannot keep doing this. Living in this house. Being in this amount of pain. Feeling this way. Fighting this addiction. Being this lonely. Living with this financial pressure. Existing inside whatever is happening to their brain or body at that moment.

We have to be curious enough to ask what this is. And sometimes we still won't know.

I wish I could end this book by telling you that if you recognize the warning signs, ask the right questions, find the right treatment, build the right support system and love someone hard enough, everything will be okay. I can't tell you that because my own life disproved it. My brother died and I didn't know. My father-in-law died and we did. Aaron had people who cared about him.

There are people throughout this book whose families fought incredibly hard for them. There are also people who survived periods when they were convinced they wouldn't, people who eventually found treatment that helped, people who found an explanation for what was happening, and people whose lives changed in ways they couldn't imagine while they were in the middle of it.

We don't know the ending while we're living the middle.

Maybe that is where hope actually belongs. Not in promising an ending we cannot guarantee, but in leaving room for one we cannot see yet. That is what I want Beyond September to be about.

September is useful. We talk about suicide. We share statistics. We teach warning signs. People tell their stories. Organizations raise money. Buildings turn purple and teal. For thirty days we collectively remember that suicide is a problem.

Then October comes.

The person who couldn't get an appointment still can't get one. The family trying to find supportive housing is still looking. Someone is still trying to stay sober. Somebody's medication still isn't working. A mother is still researching at midnight. A husband is still sitting in an emergency room. A caregiver is still exhausted. Someone is still grieving. Someone else is sitting alone in a house wondering whether anybody would notice if they disappeared.

That is the part I care about.

What happens after the awareness?

What happens after the hospital?

What happens after the first treatment doesn't work?

What happens after the family is exhausted?

What happens when the crisis is over but the problem that caused it isn't?

What happens the other eleven months of the year?

I don't have one answer. After everything I've written here, I think it would be ridiculous to pretend that I do. What I have are a lot more places where I think we can do better, and a lot more respect for how complicated the whole thing actually is.

We can notice sooner. We can ask better questions. We can listen to the person who is struggling without assuming we already understand why. We can listen to families without treating them as irrelevant. We can look at the body as well as the mind. We can make treatment easier to reach. We can build the middle spaces between weekly therapy and emergency rooms. We can make resources easier to find. We can create housing that doesn't require someone to fail completely before they qualify for help. We can support the people doing the supporting. We can learn from people who have actually lived inside the systems we're trying to improve.

And when something doesn't work, we can ask what else there is.

I started this book because of a phone call I never wanted to receive. I have spent years trying to understand what

happened before that phone rang, and I still don't completely understand it. Maybe I never will.

But somewhere along the way, the question changed.

It isn't only, "Why did this happen?"

It's also, "Where can we intervene?"

Where can we make something easier? Where can we connect two things that aren't connected? Where is someone falling through a gap? What does this family actually need? What changed? What haven't we considered? What exists that nobody can find? What doesn't exist that probably should?

Those are questions we can do something with.

And that, more than a month on the calendar, is what Beyond September means to me.

Chapter 13

Finding a Hand to Hold: Where to Get Support

If you have reached this chapter because you or someone you love needs help right now, you do not have to read the rest of the book first. Start here.

There is also an important distinction between needing someone to talk to and needing emergency intervention. You do not have to be actively suicidal to use many of these services. You can be overwhelmed, frightened, lonely, worried about somebody else, struggling with substance use, or simply having a night when you don't think you should be alone with your thoughts.

If someone is experiencing a life-threatening medical emergency, has made a suicide attempt, has been seriously injured, has overdosed, or there is an immediate danger that cannot safely be managed where you are, call 911 or go to the nearest emergency department.

988 Suicide & Crisis Lifeline Call or text: 988

The 988 Suicide & Crisis Lifeline is available throughout the United States, including U.S. territories and Tribal lands. You can call, text, or use online chat. It is free and confidential.

You do not have to be moments away from attempting suicide to call 988. You can call because you are in emotional distress, worried about someone you love, or unsure what to do next. When you contact 988, a counselor will first ask about your immediate safety. They can listen, help you work through what is happening, and connect you with resources when appropriate.

Family members, friends and caregivers can also contact 988 because they are concerned about somebody else.

Website: 988lifeline.org

Crisis Text Line: Text HOME to 741741

Crisis Text Line provides free, confidential, 24-hour text-based support in the United States. You can reach out about suicidal thoughts, but you can also text because of anxiety, depression, loneliness, stress, self-harm, relationship problems, bullying or simply because you need somebody to talk to.

You will be connected with a trained volunteer Crisis Counselor who will listen and help you work through the immediate situation. This can be particularly useful for someone who does not want to talk out loud, cannot speak privately, or simply finds texting easier than making a phone call.

Website: crisistextline.org

211 Call: 211

This is one I wish more people knew about.

211 is not primarily a suicide crisis line. It is a nationwide information and referral network that helps people find actual local resources, and sometimes the problem contributing to a mental-health crisis is something practical.

You can call 211 for help locating mental-health and substance-use services, but also housing assistance, food, transportation, utility assistance, healthcare resources, caregiver resources and other community services.

Calls are confidential and can be anonymous. Local 211 agencies can also have text, chat and online resource-search options. If part of the reason life has become unbearable is that you don't know where you're going to sleep, can't pay the electric bill, can't get to treatment or don't know where to find affordable care, those are not irrelevant problems. They may be exactly the problems that need attention.

Website: 211.org

SAMHSA National Helpline Call: 1-800-662-HELP (4357) TTY: 1-800-487-4889

SAMHSA's National Helpline is a free, confidential, 24-hour treatment referral and information service for individuals and families dealing with mental-health or substance-use disorders. It is available in English and Spanish. This is particularly useful when the problem is not simply getting through tonight but figuring out where treatment actually exists. The service can provide referrals to treatment facilities, support groups and community organizations.

You can also search for treatment through FindTreatment.gov.

Veterans Crisis Line Call 988, then press 1 Text: 838255

The Veterans Crisis Line provides free, confidential, 24-hour crisis support for Veterans, service members, National Guard and Reserve members, and the people who care about them. You do not have to be enrolled in VA healthcare or receiving VA benefits to use the service. Family members and friends who are concerned about a Veteran can reach out as well.

Website: veteranscrisisline.net

The Trevor Project Call: 1-866-488-7386 Text START to 678678

The Trevor Project provides free, confidential, 24-hour crisis support for LGBTQ+ young people in the United States through phone, text and online chat. You do not have to wait until you are suicidal to contact them. Someone who is overwhelmed, frightened, isolated or simply needs to talk can reach out. Website: thetrevorproject.org/get-help

Trans Lifeline United States: 1-877-565-8860

Trans Lifeline is a peer-support service run by trans people for trans and questioning people. It is specifically designed for someone who wants to talk with another trans or nonbinary person, and you do not have to be in crisis

to call.

Unlike several of the services above, Trans Lifeline is not currently available 24 hours a day, so check its website for current hours. Website: translifeline.org

Warmlines: When You Need Someone to Talk To. Not every difficult night is a crisis. Sometimes you're lonely. Sometimes you're anxious. Sometimes you're overwhelmed by your family, your job, your diagnosis or your life and you just need another human being on the other end of the phone. This is where warmlines can be incredibly useful.

A warmline is different from a crisis hotline. Many are peer-run and staffed by people with their own lived experience with mental-health challenges or recovery. Their purpose is conversation and emotional support before something necessarily becomes a crisis. Hours and eligibility vary. Some serve only residents of a particular state or county, while others accept calls from outside their area.

NAMI maintains a national directory of current warmlines: Website: nami.org/WarmlineDirectory

I would encourage people to find their local warmline before they need it and save the number in their phone. You don't want your first attempt to find somebody to talk to happening during the worst night you've had in six months.

Mobile Crisis Teams: Help That Can Come to You

This may be one of the most underused options in our mental-health system simply because many people don't know it exists. A mobile crisis team is exactly what the name suggests: a behavioral-health crisis team that can respond to a person where they are rather than automatically requiring that person to go to an emergency department.

Depending on the community, the team may come to a home, workplace or another community location. Teams can include mental-health professionals, substance-use professionals, trained paraprofessionals and peer-support workers. Some communities use behavioral-health-only teams, while others use co-responder models involving EMS or law enforcement along with a mental-health professional.

The goal is generally to assess what is happening, determine immediate safety needs, de-escalate the situation when possible, develop a safety plan, connect the person with services and determine what level of care is actually necessary.

That last part is important. Calling a mobile crisis team does not automatically mean someone will be hospitalized. One of the purposes of mobile crisis care is actually to help resolve crises in the community when that can be done safely and avoid unnecessary emergency-department visits, law-enforcement involvement and hospitalization.

However, a mobile crisis team is still responding to a crisis. They will assess safety, including suicide risk. If they determine that someone is in imminent danger and cannot safely remain where they are, hospitalization or emergency transportation may become necessary. Availability is the frustrating part.

Mobile crisis services are not yet available everywhere, and how they operate varies tremendously from one

community to another. Some are available 24 hours a day. Others have limited hours. Some can be dispatched through 988. Some states or counties have their own crisis numbers and dispatch systems.

If you think a mobile crisis team might help, call 988 and ask specifically: “Is there a mobile crisis team available where I live?” You can also call your county or regional mental-health authority and ask how mobile crisis services are accessed locally.

This is another number worth finding before the crisis. If somebody in your family has recurring mental-health or substance-use crises, find out whether your community has mobile crisis services, how they are dispatched, what hours they operate and what happens when you call. Put that information somewhere everyone in the household can find it.

If You Don't Know What Kind of Help You Need

You may not know.

That's okay.

If the immediate problem is suicidal thoughts, emotional crisis or concern about someone else's safety, start with 988.

If you primarily need somebody to talk to, a warmline or Crisis Text Line may be enough.

If you need local practical resources, including housing, food, transportation, financial help or community services, try 211.

If you need mental-health or substance-use treatment, SAMHSA's National Helpline can help you look for it.

If you believe someone is experiencing a behavioral-health crisis but may be able to remain safely in the community with the right intervention, ask 988 about mobile crisis services in your area.

If there is an immediate life-threatening emergency, call 911 or go to the nearest emergency department.

Outside the United States: Crisis numbers are different in other countries.

Find A Helpline maintains a directory of verified helplines in more than 175 countries. You can choose your country and find phone, text and chat services available where you live.

Website: findahelpline.com

Save These Before You Need Them

If there is one practical thing I would like you to do after reading this chapter, it is this: don't wait for a crisis to figure out your crisis system. Put 988 in your phone. Find your local mobile crisis service. Find your local warmline. Find out where the nearest psychiatric emergency service is. Save the number for your county

mental-health center. If someone in your family has a recurring condition, substance-use disorder or history of suicidal thinking, write down the people they trust, their providers, medications, insurance information and the resources you would want at two in the morning.

Because two in the morning is a terrible time to start opening twenty browser tabs. And if the first person you reach cannot provide what you need, ask them the next question: “Who else can I call?”

Chapter 14

When Help Is Refused: Navigating Difficult Decisions

There is a particularly awful situation families sometimes find themselves in that we haven't really talked about yet.

You know someone is in trouble. You have tried talking. You have tried reasoning. You have offered treatment. You may have found the treatment, called the insurance company, figured out how to pay for it, and offered to drive them there yourself.

And they say no. Now what?

I live this one, and because I live it, I probably look at involuntary intervention somewhat differently than someone approaching it only as a legal or ethical question.

I understand the concern about taking away another adult's autonomy. I understand why the legal threshold needs to be high. Giving families, doctors, hospitals, or the government unlimited power to force people into psychiatric or substance-use treatment would create its own enormous set of problems, and history gives us plenty of reasons to be cautious about that.

But I also understand what happens on the other side of that argument because families live there.

Sometimes the person is not standing in front of you saying, "I'm going to kill myself." They aren't threatening to kill anyone else either. If you ask whether they're suicidal, they may very convincingly tell you no.

That doesn't necessarily mean they're okay.

They may be deteriorating right in front of you. They may not be sleeping, eating properly, taking care of themselves, thinking rationally or functioning anything like the person they normally are. Substance use may be completely controlling their decisions. They may be cycling in and out of crisis, refusing treatment, becoming increasingly paranoid, angry, impulsive or disconnected from reality, destroying relationships and creating chaos throughout the household while remaining just functional enough to keep saying, "I'm fine."

And everyone around them knows they aren't.

This is where the phrase "danger to themselves or others" can become incredibly frustrating for families. We use it so often that people can come away believing nothing can be done until somebody is standing on a bridge, holding a weapon or making an explicit threat. That isn't an accurate description of every state's law, and I don't think it is a particularly useful way to think about intervention either.

Depending on the state and the type of intervention, the legal standard may also consider whether someone is gravely disabled, unable to meet basic needs, experiencing serious deterioration, unable to appreciate the need for treatment, or so impaired by mental illness or substance use that their judgment and ability to protect themselves have substantially deteriorated.

The exact words matter because these laws vary enormously from state to state.

But there is something else I want to say here that may be less comfortable for a lot of people. Sometimes sadly, involuntary interventions really may be where you have to start.

Not because it is ideal. Not because forcing someone into treatment guarantees recovery. Not because families should be able to commit another adult every time that person makes a terrible decision. Sometimes you start there because you have already discovered there is nowhere else to start, and the situation just is unsustainable as it is.

You cannot make an adult call the psychiatrist.

You cannot make them tell the psychiatrist the truth.

You cannot make them stop drinking or using drugs.

You cannot make them take medication.

You cannot make them acknowledge that something is wrong.

You cannot make them recognize that their behavior is affecting everyone around them.

And you certainly cannot reason someone into having insight they do not currently have.

Meanwhile, the family can spend months or years living around those consequences.

I think this is something we miss when we discuss involuntary treatment primarily in terms of the trauma it can potentially cause the person being treated. That trauma deserves consideration. So does the possibility that coercive treatment can damage trust or make someone less willing to seek care later. But there can already be trauma happening.

There can be a spouse who hasn't slept properly in six months. Parents terrified every time the phone rings. Children learning to read somebody's mood before they decide whether it is safe to speak. Family members canceling plans because they don't know what condition someone will be in that evening. There can be overdoses, disappearing, police calls, financial destruction, screaming, threats that don't quite meet somebody's definition of imminent danger, driving while impaired, medication refusal, repeated emergency-room visits, and an entire household organizing itself around one person's illness or addiction.

That suffering doesn't become irrelevant simply because the person at the center of the crisis says they don't want treatment. Sometimes the illness itself is part of why they don't want treatment. That isn't lost on me.

There is a difference between an adult making an informed decision that I disagree with and an adult whose illness has substantially interfered with their ability to understand what is happening to them.

Figuring out where one becomes the other is extraordinarily difficult, which is exactly why there should be clinical assessment, legal standards, and judicial oversight rather than leaving the decision entirely to a frightened family.

But I don't think families should be told, basically, what amounts to, "Come back when somebody is about to die." I have a situation with a friend where that was the case, and they almost didn't make it. We should be able to intervene before that.

There is another reason I think we need to take that seriously. People who eventually die by suicide are not necessarily completely disconnected from healthcare before their deaths. In a large U.S. study of 2,674 people who died by suicide, researchers looked at healthcare use before death across eight healthcare systems. About 6.5 percent had been seen in an emergency room or urgent-care setting during the previous seven days. Within thirty days, it was 14.1 percent. Within the previous year, 43.8 percent had been seen in an emergency room or urgent-care setting, and more than 91 percent had some kind of healthcare encounter during that year.

That doesn't mean those emergency-room visits were necessarily for suicidal thoughts, and it certainly doesn't mean every one of those deaths could have been predicted or prevented. In fact, that is part of what makes the numbers interesting to me. People can pass through healthcare for all kinds of reasons while whatever is happening underneath remains unidentified, unresolved or simply impossible to see during that particular visit. The study also only included people enrolled in participating healthcare systems, so it isn't a national percentage that we can apply to every suicide in America.

But it does make me question the idea that our only opportunity to intervene begins when somebody announces that they intend to die. Sometimes people have already been through the doors of our healthcare system. Sometimes families have already been asking for help. Sometimes the person has already been evaluated and sent home. If our standard for taking deterioration seriously is always waiting for the unmistakable emergency, then we are going to miss people whose lives do not present themselves that neatly. And this is where understanding the legal options becomes important.

The Baker Act

Florida's Baker Act is probably one of the best-known examples of an involuntary mental-health law. People use "Baker Act" as though it is a generic national term, but it isn't. It is Florida law, and other states have their own statutes and terminology.

The Baker Act provides a process for involuntary psychiatric examination when specific legal criteria are met. It isn't simply a way for a family member to call a hospital and order someone committed.

Under Florida law, there must be reason to believe the person has a mental illness and, because of that illness, the person has refused voluntary examination or is unable to determine whether an examination is necessary. The law then requires additional circumstances involving serious self-neglect that threatens substantial harm or a substantial likelihood of serious bodily harm to the person or another person in the near future.

That means Florida's standard is more nuanced than the shorthand "suicidal or homicidal."

The first step is an examination, not an automatic long-term commitment. Depending on what clinicians find and what legal criteria continue to be met, the person may be released, agree to voluntary care or enter additional proceedings concerning involuntary treatment.

The Marchman Act

This is Florida's law addressing substance-use impairment and treatment, and for families dealing with serious addiction, it can be extremely important to know that it exists.

The Marchman Act provides mechanisms for involuntary assessment, stabilization, and, under particular circumstances, treatment for someone whose substance use has reached the statutory threshold.

Florida's current criteria are significant because they don't simply say the person must announce that they intend to kill themselves. The law considers whether the person has lost the power of self-control with respect to substance use. It can also consider whether someone's judgment has become so impaired by substance use that they are incapable of appreciating their need for services and making a rational decision about receiving them. Refusing treatment by itself isn't enough, but refusal combined with the degree of impairment required by the statute can be very different.

That is much closer to the reality many families recognize. The person may sincerely believe they don't need treatment. That belief doesn't necessarily mean they're making a fully informed decision.

Depending on the circumstances and legal requirements, Florida's system can involve protective custody, emergency admission, involuntary assessment and stabilization, and court proceedings for additional treatment.

Families can have a role in petitioning the court, although exactly who can petition, what evidence is required, and what happens next depends on the particular procedure being used.

What About Everywhere Else?

If you don't live in Florida, neither “Baker Act” nor “Marchman Act” is particularly useful terminology.

What you need to know is what your state allows.

Every state has some mechanism for involuntary psychiatric intervention, but the legal standards, length of emergency detention, who can initiate it, and what happens afterward differ.

And we can't assume that a “72-hour hold” is a national rule. It isn't.

Substance-use commitment varies even more. A majority of states have some form of involuntary civil commitment specifically addressing substance-use disorders, but the criteria and procedures are far from uniform.

This is one situation where I think families should learn the rules before they need them. If you live with someone who has a history of severe psychiatric episodes, psychosis, mania, serious substance-use disorder, or recurring crises, find out what your state's law actually says.

Search your state government's website for: [State] involuntary mental health commitment and [State] involuntary substance use commitment

Find out whether family members can petition. Find out what evidence is required. Find out where petitions are filed. Find out whether your county has a mobile crisis team. Find out what happens after business hours.

Call 988 and ask what crisis services operate in your area.

Because the middle of a crisis is a terrible time to learn an entire state's civil-commitment system.

Tell Them What Is Actually Happening

This is also important. If you are trying to get someone evaluated, don't reduce six months of deterioration to "he's acting crazy" or "she's drinking too much."

Describe what has actually changed.

How much are they sleeping? Are they eating? Are they bathing? Are they working? Are they taking medication? Are they hallucinating? Have they become paranoid? Are they driving impaired? Have there been overdoses? Are they disappearing? Are they spending money in ways completely outside their normal behavior? Are they capable of managing food, shelter, and basic safety? Have they become increasingly impulsive? What are they saying? What have they done?

Write it down if you need to. A person can look remarkably composed during a fifteen-minute assessment after an entire family has spent three weeks watching them fall apart. The people evaluating them need the actual history.

Involuntary Intervention Still Isn't the Finish Line

This is where I agree with the critics of involuntary treatment. Getting somebody through a door does not mean we have treated them. If someone is hospitalized for seventy-two hours, stabilized enough to no longer meet the legal standard, and sent directly back into exactly the circumstances that contributed to the crisis, what have we actually accomplished beyond getting through those seventy-two hours, except making them angrier and more resentful of us trying to get between them and the treatment they don't want?

Sometimes that is enough. Staying alive for another three days is certainly not insignificant. But then we need the next part.

Treatment. Follow-up. Medication when appropriate. Substance-use care that actually treats substance-use disorder. Housing when housing is the problem. Medical evaluation when something physical may be contributing. Peer support. Transportation. Family education. A psychiatrist who is actually accepting patients. Somewhere to go between the hospital and the next emergency.

If we are going to use the extraordinary power of involuntary treatment, then I think we have an obligation to make the treatment on the other side of that intervention worth reaching.

There are legitimate concerns about coercive treatment. There are legitimate concerns about civil liberties. There are legitimate concerns about people being traumatized by involuntary hospitalization.

And there are also families watching somebody they love deteriorate while being told there is nothing anyone can do because the person hasn't crossed some final, catastrophic line yet. They live in chaos, walking on eggshells, living each day minute by minute, waiting for outbursts and meltdowns. Those realities exist at the same time.

I don't want a system that casually takes people's autonomy away. I also don't want one that respects someone's autonomy so absolutely that everybody has to stand around watching and waiting and tolerating until their illness finally produces enough danger to qualify for intervention.

There has to be something between those two extremes. And until we build enough voluntary treatment, community support, mobile crisis care, substance-use treatment, supportive housing, peer services, and early intervention to fill that enormous middle, families need to know what options already exist when the person they love cannot or will not recognize that they need help.

Sometimes involuntary intervention should be the last resort, but sometimes, after you have lived the reality behind that phrase, you discover it may be the only place you have left to start.

References

Acinas, M. P., Robles, J. I., & Peláez-Fernández, M. Á. (2015). Suicide note and the psychological autopsy: Associated behavioral aspects. *Actas Españolas de Psiquiatría*, 43(3), 69–79. PMID 25999154.

Ahmedani, B. K., Westphal, J., Autio, K., Elsis, F., Peterson, E. L., Beck, A., Waitzfelder, B. E., Rossom, R. C., Owen-Smith, A. A., Lynch, F., Lu, C. Y., Frank, C., Prabhakar, D., Braciszewski, J. M., Miller-Matero, L. R., Yeh, H.-H., Hu, Y., Doshi, R., Waring, S. C., & Simon, G. E. (2019). Variation in patterns of health care before suicide: A population case-control study. *Preventive Medicine*, 127, 105796. doi:10.1016/j.ypmed.2019.105796

British Thyroid Foundation. (2024). Psychological symptoms and thyroid disorders. Cerel, J., Moore, M., Brown, M. M., van de Venne, J., & Brown, S. L. (2015). Who leaves suicide notes? A six-year population-based study. *Suicide and Life-Threatening Behavior*, 45(3), 326–334. doi:10.1111/sltb.12131

Cotter, L., Panchal, N., Claxton, G., & Lo, J. (2026, June 29). Cost and utilization of inpatient mental health and substance use treatment. KFF/Peterson-KFF Health System Tracker.

Florida Legislature. (2026). Florida Statutes § 394.463: Involuntary examination. Florida Mental Health Act.

Florida Legislature. (2026). Florida Statutes § 397.675: Criteria for involuntary admissions. Florida Substance Abuse Services Act.

Florida Legislature. (2026). Florida Statutes § 397.679: Emergency admission; circumstances justifying. Florida Substance Abuse Services Act. Hall, W., & Degenhardt, L. (2008). Cannabis use and the risk of developing a psychotic disorder. *World Psychiatry*, 7(2), 68–71. doi:10.1002/j.2051-5545.2008.tb00158.x

Hawton, K., Appleby, L., Platt, S., & Foster, T. (1998). The psychological autopsy approach to studying suicide: A review of methodological issues. *Journal of Affective Disorders*, 50(2–3), 269–276. doi:10.1016/S0165-0327(98)00033-0

Hjelmeland, H., Dieserud, G., Dyregrov, K., Knizek, B. L., & Leenaars, A. A. (2012). Psychological autopsy studies as diagnostic tools: Are they methodologically flawed? *Death Studies*, 36(7), 605–626. doi:10.1080/07481187.2011.584015

Kendler, K. S., Ohlsson, H., Sundquist, J., Sundquist, K., & Edwards, A. C. (2020). The sources of parent-child transmission of risk for suicide attempt and deaths by suicide in Swedish national samples. *American Journal of Psychiatry*, 177(10), 928–935. doi:10.1176/appi.ajp.2020.20010017

Lewy Body Dementia Association. (2022, April 5). Robin Williams and the impact of Lewy body dementia.

Massachusetts General Court. (2021). Chapter 260 of the Acts of 2020: An Act Promoting a Resilient Health Care System That Puts Patients First. See § 242, PANDAS/PANS Advisory Council.

Massachusetts Medical Society. (n.d.). Cannabis-induced psychosis: Recognition and assessment in a changing landscape. *Vital Signs*. Moncrieff, J., & Horowitz, M. (2022, July 20). Analysis: Depression is probably not caused by a chemical imbalance in the brain—new study.

University College London. Motillon-Toudic, C., Walter, M., Séguin, M., Carrier, J.-D., Berrouguet, S., & Lemey, C. (2022). Social isolation and suicide risk: Literature review and perspectives. *European Psychiatry*, 65(1), e65. doi:10.1192/j.eurpsy.2022.2320

National Alliance on Mental Illness. (n.d.). Suicide warnings on medications.

Petersen, L., Sørensen, T. I. A., Andersen, P. K., Mortensen, P. B., & Hawton, K. (2013). Genetic and familial environmental effects on suicide: An adoption study of siblings. *PLoS ONE*, 8(10), e77973. doi:10.1371/journal.pone.0077973

Petersen, L., Sørensen, T. I. A., Andersen, P. K., Mortensen, P. B., & Hawton, K. (2014). Genetic and familial environmental effects on suicide attempts: A study of Danish adoptees and their biological and adoptive siblings. *Journal of Affective Disorders*, 155, 273–277. PMID 24300827.

Pouliot, L., & De Leo, D. (2006). Critical issues in psychological autopsy studies. *Suicide and Life-Threatening Behavior*, 36(5), 491–510. doi:10.1521/suli.2006.36.5.491

South Carolina General Assembly. (2019). H. 3725, 123rd Session: Advisory Council on Pediatric Acute-Onset Neuropsychiatric Syndrome (PANS) and Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal Infections (PANDAS). The bill passed the South Carolina House and was referred to the Senate Committee on Medical Affairs.

Substance Abuse and Mental Health Services Administration. (2025). National guidelines for a behavioral health coordinated system of crisis care.

Substance Abuse and Mental Health Services Administration. (2025). Model definitions for behavioral health emergency, crisis, and crisis-related services.

von Borczyskowski, A., Hjern, A., Lindblad, F., & Vinnerljung, B. (2006). Suicidal behaviour in national and international adult adoptees: A Swedish cohort study. *Social Psychiatry and Psychiatric Epidemiology*, 41(2), 95–102. doi:10.1007/s00127-005-0974-2

von Borczyskowski, A., Lindblad, F., Vinnerljung, B., Reintjes, R., & Hjern, A. (2011). Familial factors and suicide: An adoption study in a Swedish national cohort. *Psychological Medicine*, 41(4), 749–758. doi:10.1017/S0033291710001315

Resources Mentioned in This Book:

988 Suicide & Crisis Lifeline

Call or text 988 for crisis support in the United States.

211 Community resource navigation for needs including housing, food, utilities, transportation, healthcare, mental-health services, and substance-use services.

Beyond September: Year-round suicide-prevention education, awareness, resources, and action.

Crisis Text Line Text HOME to 741741 in the United States.

Empty Chairs A UK community initiative creating low-pressure opportunities for people experiencing loneliness to sit with and meet other people.

Find A Helpline International directory of verified crisis and emotional-support helplines.

Find Support Today: A resource-navigation website created to make mental-health, substance-use, housing, practical, and other support resources easier to find.

NAMI Warmline Directory Directory of peer-run non-emergency emotional-support lines. Availability and geographic eligibility vary by program.

SAMHSA National Helpline 1-800-662-HELP (4357). Treatment information and referrals for mental-health and substance-use concerns.

The Burgeon Project: A developing community and supportive-housing model for autistic and neurodivergent adults.

The Trevor Project: Crisis and emotional support for LGBTQ+ young people.

Trans Lifeline: Peer support by and for transgender and questioning people. Hours vary.

Veterans Crisis Line Call 988 and press 1 or text 838255.

Legal and Crisis-Care Information

Laws governing involuntary psychiatric examination and involuntary substance-use treatment differ by state. The Baker Act and Marchman Act discussed in this book are Florida laws and should not be assumed to apply elsewhere.

Readers looking for involuntary-intervention options should consult their state's current statutes or official behavioral-health agency. Search for “[state] involuntary mental health commitment” and “[state] involuntary substance use commitment.”

Mobile crisis services also vary by location. SAMHSA describes Mobile Crisis Teams as part of the “someone to respond” component of a coordinated behavioral-health crisis system. People can contact 988 and ask whether a mobile crisis response is available where they live.