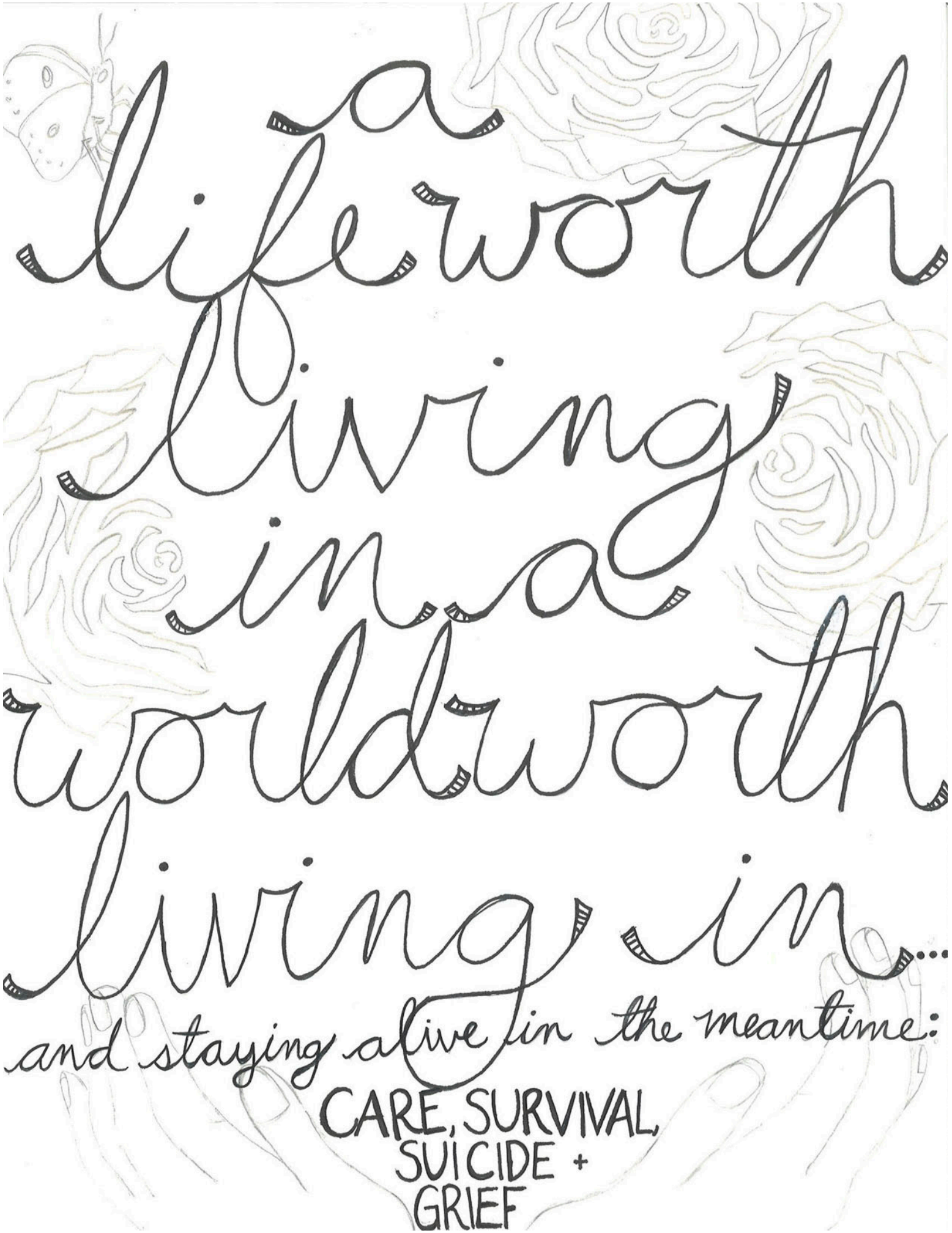

a life worth living in a world worth living in...
and staying alive in the meantime:
CARE, SURVIVAL, SUICIDE + GRIEF

Contents

Welcome

First: this guide explicitly mentions self harm, suicide, mental health struggles + illness, trauma, death, oppression and other topics that may be too painful or overwhelming to read about. Take your time, engage as you can, take breaks. Care for yourself.

Second: If you would like a digital copy, with image descriptions and hyperlinks, please email connect@lizzieanderson.com. Or type in: https://tinyurl.com/bdfz8r3n.

And: this resource is made with love and concern and is limited. It was a very collective experience. All the brilliant and kind eyes, hearts and minds that gave care to this resource...I am floored. A lot of it is culled from memory, experience, and too many resources from the past to cite. I did cite in places that I directly borrowed from in my current research in making this resource.

Please use it however you see fit to care for yourself and the people around you, close or not. I hope this can be a guide in our collective and personal need to be real about suicide, suicidal ideation, and self harm. And, to help us in talking together about the struggles and joys of surviving; the pain and growth found in grief.

It is organized in a way that makes sense for my brain, with the more foundational and longer sections at the end to make room for the flow of the beginning. You can mix and match. Go wherever you need to go at whatever juncture.

A life worth living is what we are striving for, not just not dying. And sometimes, just not dying is all we can hope for until we get there. A world worth living in...sheesh, that's what we're all working for in our relational and organizing work, and there's a lot of necessary work still to come. Thank you for your work, your being.

Support and care for those experiencing suicidality + attempt survivors

If you are someone who is thinking about, intending towards or planning suicide currently, you are not alone. I find myself feeling fear here, for you and for your people. I am holding you in so much tenderness. This can be such a lonely and bleak place; sometimes it's a place of odd hope for relief. You might feel this way for a variety of reasons; maybe a relationship has ended, mental illness runs in your family, you've changed or started a medication, you lost a job, someone you love has died, you are

living with trauma, you live in a world that doesn't accept who you are or doesn't support you. You might feel so much pain that you wish you just weren't alive; wish you would not wake up. Or maybe you're having frequent thoughts about how to go about killing yourself, the logistics.

Regardless of the how or why, that place can be such an internal and private place, and it can feel so challenging or even impossible to imagine ever feeling different, let alone talking to anyone about it. There are so many people who have been in a similar place and have made their way to the other side; to hope, to joy, to wanting to be alive. You may have even been here before and found your way out. I implore you to hold onto the high likelihood that the other side will come, that change is inevitable.

Please, review again and again *Questions To Ask Before Giving Up* (following the *safety plans*). Visit the *general caring and grounding* section and try any of those things. If something works or brings you any relief, keep doing it. Please tell someone, anyone. Call someone, call a professional, call a hotline. On your own or with their help, make a safety plan. Visit the *mental health resources* section to learn more about some professional support options. Go to a safer place. Be around others. Distract yourself. The taboo of suicidal thinking keeps people quiet and in that private place, but connection to others is one of the most powerful antidotes we have to suicidality and depression.

Is there something you can appreciate in the world? Something small? Perhaps soft clothes, sunlight, the sounds of birds, a kind text, a video game, anything. Orient towards that appreciation as much as you can.

This is a quote from an old Icarus Project (now Fireweed Collective, fireweed.org) poster. I couldn't find a more direct source.

> Sometimes wanting to kill yourself just means you don't want to live the life you're living...you can change your life with that power...what the hell -- you were about to lose your whole life...why not instead lose your school, job, pretences, fears, adherence to society's standards, shame. I have found some of my suicidal episodes to be strangely liberating in that way. I wouldn't take back any of what made me who I am today.

If you have attempted suicide, I am feeling so much tenderness towards you. And, the quote above still applies. Please tell someone, anyone about the experience and what you are needing now. Create a safety plan or update your current one. Visit the general caring and grounding section. Visit the *mental health resources* section to learn more

about some local professional support options.

In 2016, with the Icarus Project, Leah Lakshmi Piepzna-Samarasinha and Maryse Mitchell-Brody released some 'femminars,' they are emotional safety planning webinars for femmes of all identities. Here is a link to the first one: https://vimeo.com/199063176. I think much of it could apply to people of many identities. There are many resources at projectlets.org/resources, under I (or someone I know) attempted suicide, including many personal stories from other attempt survivors. The site livethroughthis.org offers portraits and stories from other attempt survivors.

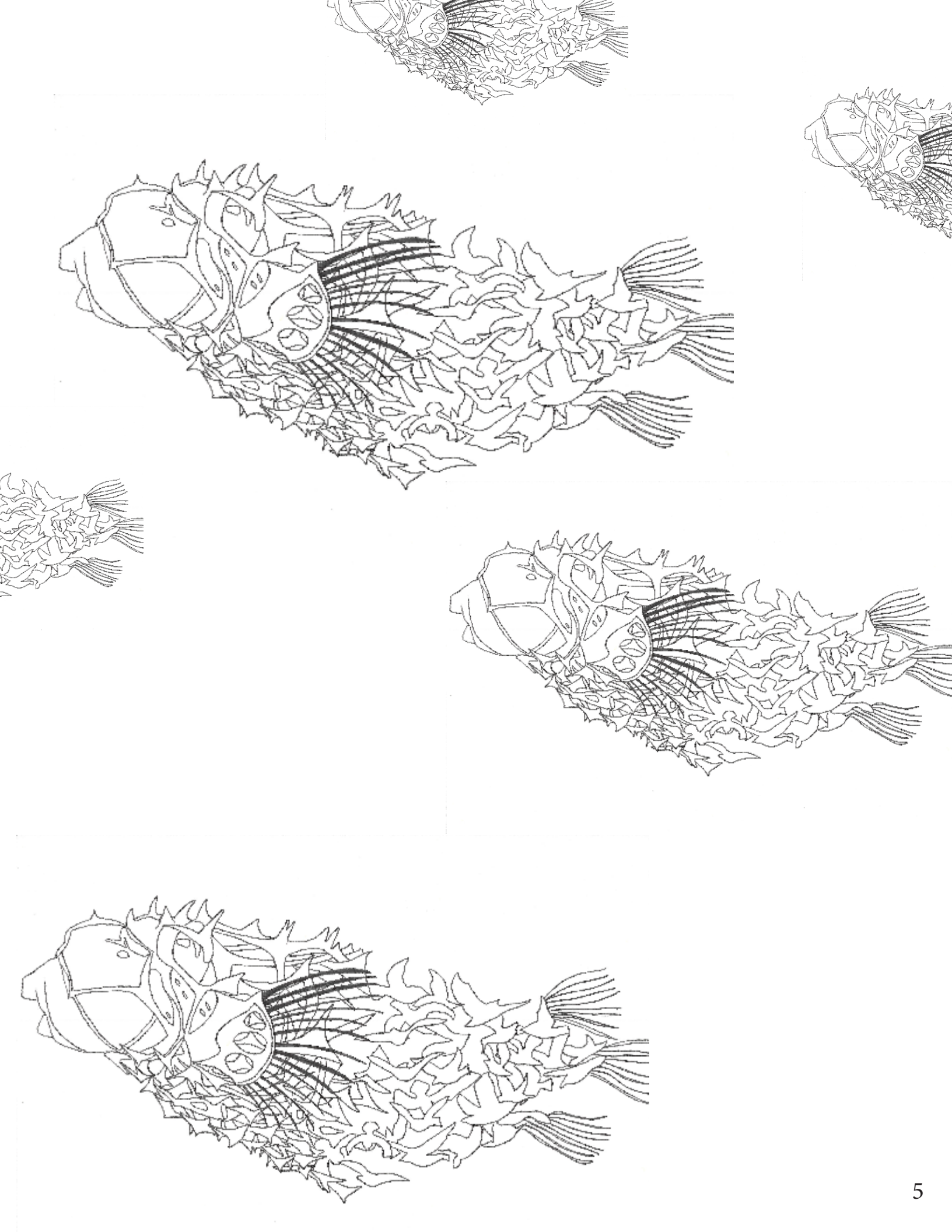
You are not alone.

Safety planning

In my devastation of losing another person to suicide this year, when I first thought about more awareness and prevention of suicide, I thought: everyone should practice safety planning together. So, please, if nothing else, fill out the safety plan. There are several blank copies and you can also make your own copies or write down the answers on a blank piece of paper.

Doing these safety plans together is an effort to encourage more openness in your friend, family and support circles around care, pain, crisis, self-harm, and suicide. Go through the prompts before a crisis so you can use the responses to get the care you need in whatever crisis comes. If you haven't done that and a crisis arises, you can still use the prompts to the best of your ability.

Please safety plan with a friend, your other loved ones, professional care and/or your support team. Or do it alone and share needed details after, if you can. We encourage you to know where your form is, to know where your loved one's form is (have a copy, even), and take pictures on your phone so they are with you digitally. Share with your professional support team, too, if you have one. Please update them frequently as you discover something, anything, new about you and what you may need. Even if you have experienced little to no self-harm impulses or actions or crises, this can still be a useful exercise in learning about your feelings, sensations, needs and to learn how to support yourself and others.



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Name: _____ Date:_____

In order to feel well enough every day I need to…. (Examples include: taking my meds, moving my body, being with loved ones, sleeping __ hours, etc. Try to think of at least 5 things). If you have not done these things today or recently, now is a good time to start.

How do I know a crisis may be developing? Think of warning body sensations, feelings, moods, thoughts, images, situations, behaviors, etc. Try to think of at least 5 signs.

What are internal caring, coping and surviving strategies that I can do alone? Think of thoughts, activities, techniques, memories, etc. that help to either distract from the struggle or generate new feelings or perspective. Think of at least 5 and practice them, or at least walk through the idea of them in your head, as you write them down.

People I can call on, things I can do, places I can go for distraction:

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How will I make my environment safe? (For example: putting objects that I could use to hurt myself in someone else's care; leaving my house, etc.)

What are my protective factors? What keeps me alive? (For example: those dreams I have, my furbaby, my friends, etc. Sometimes these feel inspiring and sometimes they are just obligations.)

Anything else I know is important for me to remember in times of crisis:

Everything Is Awful and I'm Not Okay: questions to ask before giving up

Are you hydrated?
If not, have a glass of water.

Have you eaten in the past three hours?
If not, get some food — something with protein, not just simple carbs. Perhaps some nuts or hummus?

Have you showered in the past day?
If not, take a shower right now.

Have you stretched your legs in the past day?
If not, do so right now. If you don't have the energy for a run or trip to the gym, just walk around the block, then keep walking as long as you please. If the weather's crap, drive to a big box store (e.g. Target) and go on a brisk walk through the aisles you normally skip.

Have you said something nice to someone in the past day?
Do so, whether online or in person. Make it genuine; wait until you see something really wonderful about someone, and tell them about it.

Have you moved your body to music in the past day?
If not, jog for the length of an EDM song at your favorite tempo, or just dance around the room for the length of an upbeat song.

Have you cuddled a living being in the past two days?
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Have you seen a therapist in the past few days?
If not, hang on until your next therapy visit and talk through things then.

Have you changed any of your medications in the past couple of weeks, including skipped doses or a change in generic prescription brand?
That may be screwing with your head. Give things a few days, then talk to your doctor if it doesn't settle down.

If daytime: are you dressed?
If not, put on clean clothes that aren't pajamas. Give yourself permission to wear something special, whether it's a funny t-shirt or a pretty dress.

If nighttime: are you sleepy and fatigued but resisting going to sleep?
Put on pajamas, make yourself cozy in bed with a teddy bear and the sound of falling rain, and close your eyes for fifteen minutes — no electronic screens allowed. If you're still awake after that, you can get up again; no pressure.

Do you feel ineffective?
Pause right now and get something small completed, whether it's responding to an e-mail, loading up the dishwasher, or packing your gym bag for your next trip. Good job!

Do you feel unattractive?
Take a goddamn selfie. Your friends will remind you how great you look, and you'll help fight society's restrictions on what beauty can look like.

Do you feel paralyzed by indecision?
Give yourself ten minutes to sit back and figure out a game plan for the day. If a particular decision or problem is still being a roadblock, simply set it aside for now, and pick something else that seems doable. Right now, the important part is to break through that stasis, even if it means doing something trivial.

Have you over-exerted yourself lately — physically, emotionally, socially, or intellectually?
That can take a toll that lingers for days. Give yourself a break in that area, whether it's physical rest, taking time alone, or relaxing with some silly entertainment.

Have you waited a week?
Sometimes our perception of life is skewed, and we can't even tell that we're not thinking clearly, and there's no obvious external cause. It happens. Keep yourself going for a full week, whatever it takes, and see if you still feel the same way then.

You've made it this far, and you will make it through. **You are stronger than you think.**

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Mental health recovery + healing

When people talk about recovery, they generally think of stopping using drugs or alcohol. There is also mental health (MH) recovery and healing. "Healing involves discomfort, but so does refusing to heal. And, over time, refusing to heal is always more painful," writes Resmaa Menakem in *My Grandmother's Hands* (highly recommended).

Once there was a billboard in my neighborhood by a mental health organization that said something like "1 out of 4 people have mental health." What? Oh, how I fantasized about changing that 1 to a 4; 4 out of 4 people have mental health. We all have mental, emotional health just as we all have physical health. This means we can all relate to our own versions of what it is to feel well, what it is to feel unwell, when we are suffering and need something to change, and what recovery and healing can look and feel like for us. It's ableist and strange to say otherwise. The idea that being healed is a static place, opposite of trauma or disability, or means being 'cured,' is also ableist and strange. There's a big, amazing mad, mentally ill, neurodivergent and disabled (MMIND) community of people all over the world. There's mad pride! Mad justice! Disability justice! Check out projectlets.org/disability-justice.

Leah Lakshmi Piepzna-Samarasinha writes in *Whatever Gets You Through* (also highly recommended):

> There's nothing wrong with wanting less pain, or a different experience of it. There's nothing wrong with wanting to transform generations of passed-down trauma. But what gets more complicated is when those desires bleed into the ableist model of cure. That model and its harsh binary of fixed and successful versus broken and fucked is part of what contributes to suicide and struggle in long-term survivors. I've seen survivors, including myself, struggle with feelings of failure and self-hatred when we're thirty, forty, fifty, sixty, or older and we're still triggered, grieving, and remembering, when we haven't reached that mythic cured place. What keeps me alive and thriving is my work as a disabled survivor. Undoing and picking apart that binary and naming its poison as ableist. Bringing together crip and survivor struggles and knowledge. Mapping a new model of survival that charts where my scars and my still being crazy in adulthood are not signs that I've failed.

In a recent Pittsburgh City Paper essay, Dr. Rachel Kallem Whitman wrote of their version of recovery after a very near suicide attempt:

Since then, I've struggled with my bipolar disorder countless times. Hypomania, mania, psychosis, depression and mixed episodes are part of my existence, but I've kept moving forward. I know I will feel suicidal again, but I feel better prepared to regain my stability. To keep my balance.

What is your version of change, recovery, or healing that honors the realness and okness of struggle and disability? What is your version for today? What is your languaging around all of this? Have you shared this with anyone? Could you? Has any of this changed over time? Are you allowing change? How are you supporting someone else's path even if it is a very different version of what you would do or want for them? What are you a living commitment to; to yourself, to the world? What power do you have with and within?

General caring + grounding techniques

These care and grounding ideas are for everyone, anytime - when and if they work for you. You may need to use these techniques during and after a crisis even more. Whatever distress and/or trauma you experience from going through a crisis, in any role, will need extra care. Here is an interactive, self-care activity you can do again and again: youfeellikeshit.com.

Reminder: what you are feeling and what your body is experiencing now is an understandable reaction to whatever it is you have experienced and have survived/are surviving. Some of those things are responsive and adaptive, and some are more reactive and painful. See a few pages forward for an illustrative graph. None of them are wrong, and yet some changes could support you better.

For care, you can always return to some basics:
What is enough rest and what does it feel like? How much and what kind of food does your body need? What about fluids? What about body movement? Are you taking your vitamins, herbs, medicines as directed? Are you caring for whatever pain or discomfort you are experiencing? Does the environment that you have power over feel safe? What would you need for your environment to feel safe? Are you checking into your emotional landscape, feeling your accessible feelings and caring for whatever is there? What else are your basics?

The following are perhaps a tier above basic, and they may not apply to you if you are in crisis or just feeling shitty. If these questions bring distress, use the other care tactics below to help steady yourself and see if you can ask again from another angle:
What about your relationships to people, other animals, and the world around you: can you allow yourself the possibility of feeling connected, cared for, and caring? Check in on your direction and purpose and remember you are enough, just being here breathing. Do you want to initiate changes to make you feel other kinds of purpose and pride? What about creativity? Are you expressing, generating? And are you prioritizing pleasure? Joy? Passion? Gratitude? Awake and aliveness? What else do you want to be prioritizing? What will you have to say no to in order to do so? What will you have to say yes to?

There are so many ways to care for and fortify yourself when in a more unsteady state. Take a moment: what are your tried and true methods of care? I encourage you to know yours, several options for different settings, and then use them. Then, you can

share them with other people. Here, I am going to focus on care that speaks to our bodily sensations and nervous systems (flip forward for a helpful sensation sheet) and energetic systems that you can do on your own, with some ideas for partner activities at the end. If you want more words to help identify what you are feeling, see the feeling wheel by flipping ahead. The following are in categories that may or may not work for you. Do whatever is best, no use in you being limited by my ideas.

When feeling heightened, anxious, dissociated:

- Breathe - normally; with some extra depth; breathe from your diaphragm/your belly; breathe out with a long 'vroo' or 'voo' sound *; buzz and activate your lips; make big noise as you breathe; alternate nostrils by holding the left and breathe in, hold the right as you breathe out; make your inhale last 5 seconds and your exhale last 7 seconds (or any other times that work for you); sing, hum.
- Multiple senses activity/orientating: Wherever you are, and to your ability, describe 5 things you see, 4 things you touch/feel, 3 things you hear, 2 things you smell and 1 thing you taste (you can even lick your arm). Do it again and again and again as needed. Orient towards pleasure, towards neutrality, towards _____.
- Body scan - starting at your head, move down your body noticing the sensations present. If it's hard to connect to your body, place a hand on or above where you are focusing on your body. Skip places you don't want to focus on. Just observe what is present and don't make cognitive meaning or do and allow yourself to see 'oh, I feel afraid right now, that's why my heart is racing…'
- Clench and release: go through your body and clench a muscle (uni or bilaterally) and then release it as completely as possible, then move to another.
- Butterfly hug (flip forward for a diagram)
- Do a mediation: tarabrach.com/guided-meditations
- Light stream ** - Breathe. Imagine a bright and healing light forming above you, give it a color and a message for you. Imagine it moving over your body, until slowly reaching your feet. As it moves, imagine any other qualities you'd want it to have: textures, tastes, a temperature, etc.

When feeling panicked:

- Breathe, as described above.
- Get a hold of something cold - literally holding an ice cube or walking outside into a crisp day.
- Eat or drink a minty thing.
- Walk, run, dance, move your body however it needs to move. Let the shakiness shake itself out of you, could be all over or isolated shaking or of one small part of you. Stomp. Move your feet or hands, like you're walking or running, even if just in

place.
- Move to someplace you feel safer.

When feeling worn down, depressed, dissociated, grief-stricken:
- Rest!
- Move. Walk, run, dance, move your body however it needs to move.
- Lion breath* - deep inhale and then breathe out with your tongue hanging out as much as possible. Then do the same, now with your eyes as big as possible. Repeat as much or as little as you want.
- Energetic massage* - rub your hand(s) together or on another part of your body, generate heat, move hand(s) to a part of your body that is needing stimulation. Repeat with rubbing hands again and going to the same place or another place.
- Actual massage - Give yourself a gentle or lovingly vigorous massage and/or pat on your body in the places that need it.

When needing a mindful body sensation change:
- Scan your body, notice your body sensations. Then bring in a memory of something else that either feels neutral or better than neutral (like that time I swam in the warm waters of the Gulf with my pal) and then let your body remember that by really feeling it, bringing in the sensations that you had at that time (remember the warm water, the sunshine, the smile on your face) and hold onto those sensations, let them rest in you, breath into them and let them grow into the rest of your body and allow them to alter your previous sensations. This is a small version of the Community Resilience Model.
- If you are experiencing a lot of hard sensations, you can search your body to find anywhere that feels differently. Maybe it's your pinky finger or the bottoms of your feet where you can feel a nice warmth, or even neutrality. Focus there and on that sensation. Either stop there, going back as needed, or work to spread that feeling to other places in your body, with attention and breath.
- Container exercise ** - Picture any container. Imagine opening it and placing whatever you cannot approach or hold well right now. Imagine closing it. Do it as often as you need. Come back to the stuff inside when you're more prepared.

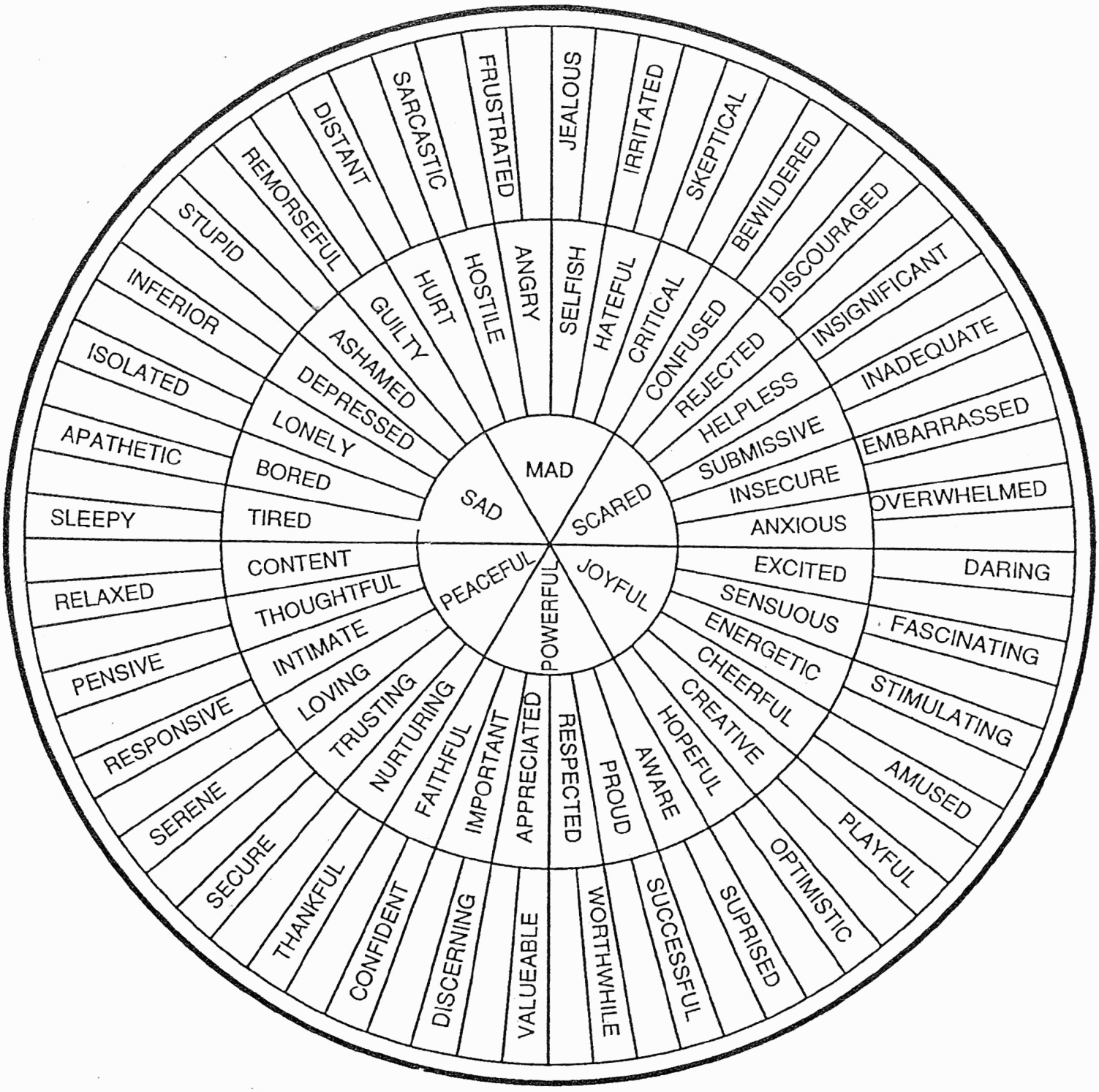
Distract, distract, distract (auto-regulation):
Be with people; watch a movie or tv; listen to music or podcasts; be outside; watch birds, bugs or other animals; play with or pet a cat or dog; draw or do another art activity; ride a bike; go for a walk; buy something you need; follow a recipe and eat the product and/or share it (food can be a sensation awakener if you involve yourself in the smells, tastes, colors, textures).

When needing confidence, support + compassion for self:

- Talk to self in a soothing way - Whatever tone and phrases comfort you. You can imagine you are your best friend and/or someone you really admire, then talk to yourself like you'd talk to them. Love on yourself.
- Circle of figures **- Choose a protective, supportive figure (someone you don't know, someone you do, an animal) and imagine them close by, supporting you, loving on you, telling you exactly what you need to hear. Notice your body as you imagine them here. Bring them wherever you need them. Also, you can expand by adding in other protective figures to be your circle.
- Lovingly send it back - If you find yourself carrying something that isn't yours (someone else's projection or their stress, etc.), you can always give it back. Imagine the person, imagine the thing that isn't yours, encase it in a glowing orb, and send it back to them. Imagine them taking it. Feel the sensations that accompany this release. This can help with your energetic force field that surrounds you.
- Practice a specific loving kindness meditation - many exist online. If nothing else, settle into a comfortable position, expand your breath and choose a loving phrase, image, idea, and really coat yourself with it. Then, send this to everyone you can think of, friends, neighbors, well-known activists, people you feel challenged by, etc.

Things to do with others (co-regulation):
Co-regulate by being together, breathing, moving, laughing together // Talk, share how you are, ask for what you need, listen to how they are and what they need // Practice care techniques together, learn new ones together // Share your commitment to others and the world by giving support, energy and care // Connect with a furry creature // Sing // Dance // Laugh

* From various trainings and all actually originate from other traditions, like yogic breath work and Buddhist practices.
** Modified from EMDRIA training material

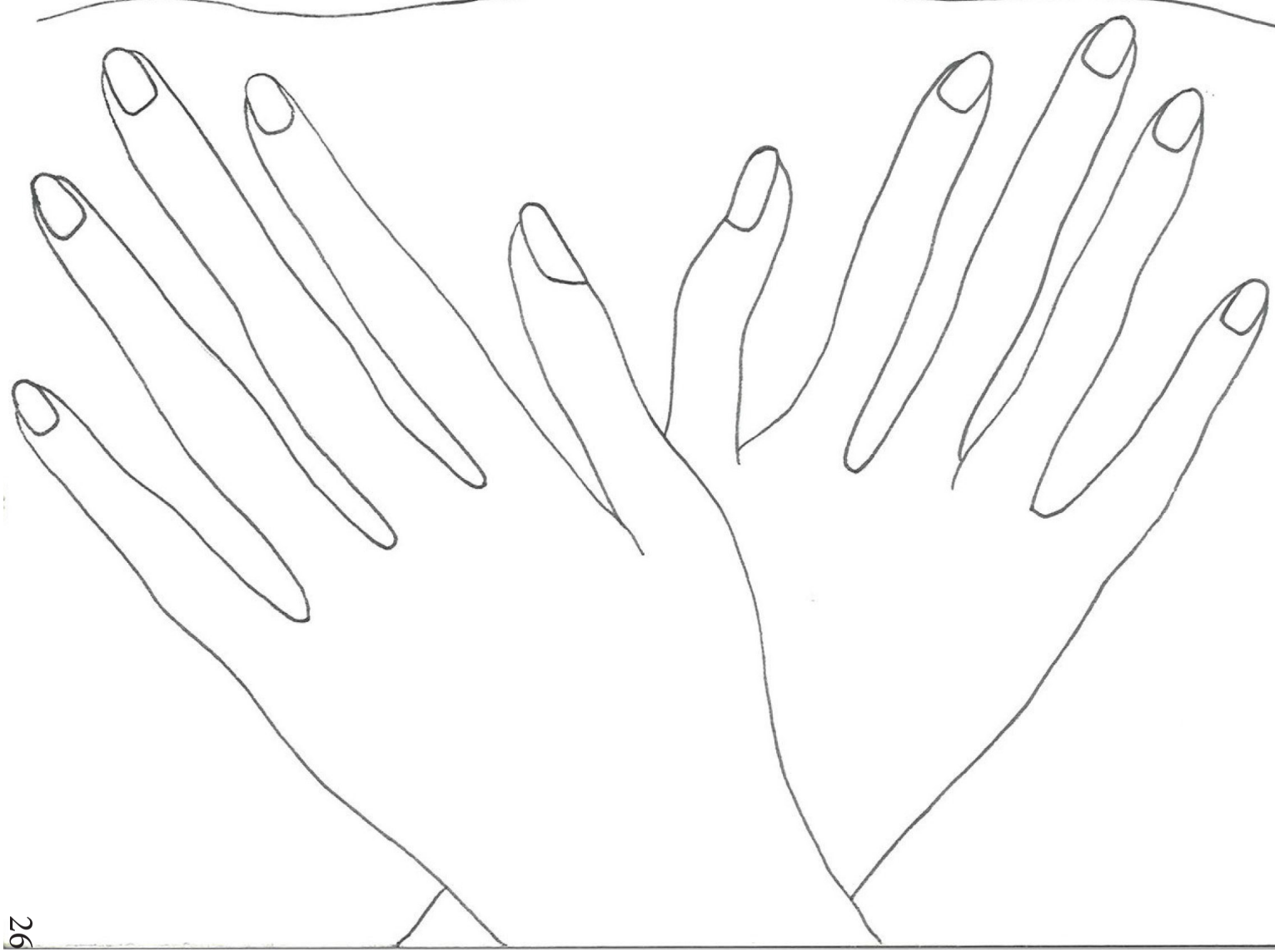


THE FEELING WHEEL

Developed by Dr. Gloria Willcox
P.O. Box 48363
St. Petersburg, FL 33743

Felt Sense: The Language of Sensation

HOW TO butterfly hug



STEPS:

- place one hand across your chest, fingertips rest near opposite collarbone*
- cross the other hand on top
- gently and slowly "flap your wings," alternate tapping each hand
- keep breathing
- repeat as wanted

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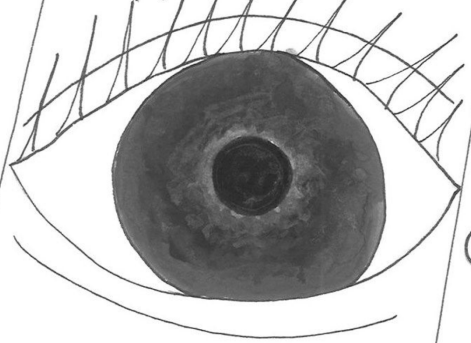
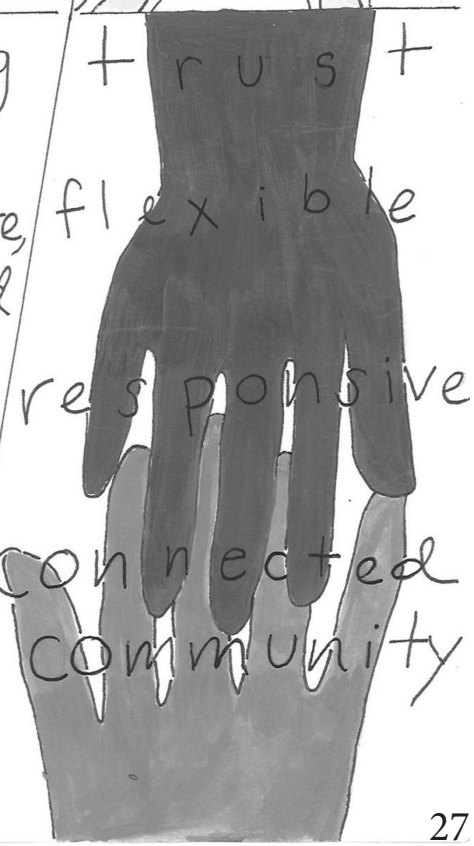
for self regulation and soothing. EMDR inspired. taught by Lumos Transforms

* you can also place hands on upper arms, thighs, etc.

anchoring into resilience*

be the change, make the change

*graphic inspired by Lumos Transforms, it is similar to other nervous system based trauma + resilience models, like the polyvagal theory, with expansion into the relational + world impact- which is necessary.

	FEELING	BODY SENSATIONS	RELATIONSHIPS + WORLD
less connected	low, depressive numb shut down dissociative overwhelm	slow, confused settled into shock  brain releases own opiates (feels "good," but disorienting)	individ-ualism + nation-alism  extreme + costly
	anxious mobilized pressurized rigid dissociative	systems sped up (except digestion)  harder to tune into voices	reactive strained conflict exclusionary 
more connected	settled Spacious ready + steady resilient	knowing calm body aware, not afraid  systems on + steady	+ trust + flexible responsive connected community 

Supporting someone who is suicidal + support teams

In their essay about femmes and suicide in *Care Work*, Leah Lakshimi Piepzna-Samarasinha writes something that can probably apply to every community:

> So many people say, "I had no idea" when someone dies. I think we have to ask ourselves, "Why didn't we"? What is okay to talk about in these places we call queer community? What isn't? It's not enough to say, "Just call." I think we could use suicidal deaths in our communities to interrogate the shit out of how saneism and ableism are diffused throughout queer community. In so many hip queer communities that are not explicitedly disabled, it's not okay to not be okay. We pay lip services, but how many times do you ask someone how they're doing at a party and hear anything besides how great things are going, or feel like you can be honest about how things are really going for you?

How do we support the people we love or just know who are suicidal? It can be similar to how we offer care in other situations. Yet it can have an added, scarier edge to it and it can feel harder to put our care out there, for fear we may make a mistake that could be crucial. And, it's better to try and be explicit in your efforts than to be removed or surreptitious. Check out the *more information on suicide* section if you need a primer.

First, what I am about to write may feel like/are contradictions and I'm asking you to dwell in them: know that you can't "save" the person and what you do is important. Whatever happens, we are not responsible for someone's death; nothing we do or don't do is the cause of someone taking their own life. If you had no idea someone was distressed enough to kill themselves, know that you couldn't have known. We want to build stronger networks of transparency and care so maybe, hopefully that will happen less frequently, and if suicide happens it is not your fault. Yet, stepping in when we notice someone is struggling can be the difference between them sitting alone with suicidal thoughts and urges and maybe acting on them and them feeling connected to people. Your small actions can be so significant.

Always: it's important that you care you for yourself and have support. Please see more in the *supporting someone who is suicidal while supporting yourself* section. Bring in other people and use professional resources (see the *mental health resources* section to learn more about the professional support options that you can call on). Learn to know when the care needed is outside of your scope and to work to support your person alongside their professional support team. Be explicit and real with everyone involved (look at the assessing suicidality subsection under more information about

suicide). If someone is actively suicidal, which means they have the intent to kill themselves and/or have a plan (these lines can be thin), stay with them, within reason. Or if you are unsure what kind of suicidal ideation they are experiencing, also stay with them. This is part of why teams are so crucial; we can't always be there. If it isn't possible for someone to be with the person, consider a hospital or psychiatric institution.

Consider fun things over constant processing and focusing on suicide and depression. Of course, continue to check in regularly and explicitly about their feelings and suicidal ideation. Remember rituals, ceremonies, crystals, astrology, exorcisms, tarot readings, or other insightful tools that help people look at their situation through different lenses. Remember, the person is more than suicide. Sometimes the best thing during depressive or obsessive episodes is distraction or just doing "normal" things. Can the person help you get things done that you need to get done, or can you both support each other's basic needs, like making food together or running errands?

This was graciously shared by a friend:

> I've found that when I'm deeply depressed, being around people while they're doing very routine things, like household chores, makes me feel both less alone and is a reminder of what life is. I might not have the wherewithal to participate at that moment, but just seeing it is enough to make me feel like I can do it again. Also, I find a change in environment very helpful. I'm a bigtime nester/homebody, but sometimes it's a double edged sword. It becomes a place of rumination and stagnation. I find that staying at someone else's house, someone I'm comfortable to be depressed and inactive around, gives me that little bit of stimulation that I need to reconnect with the world. Even just going for a ride in the car is really helpful. I haven't necessarily used these techniques with someone I know is actively feeling suicidal, but this is often my go to strategy when my loved ones are feeling low or stressed and I don't want to leave them alone.

Support teams:
A support team can be a few friends who can talk together and support each other in supporting the person who is feeling suicidal. Often, with suicidality, people feel either like they want to protect their friends from their scary feelings, or they worry that if people know, it will become "gossip" rather than support. However, it is important for people to work together as friends or community to help keep us alive. If you have the opportunity, explicitly ask if you can talk to other supporters or potential supporters. Name the reasons and topics you want to discuss (exploring resources, like helping find a therapist or intensive outpatient program, coordinating hang-outs, brain-

storming ways to better support). Reassure the person that the goal is to provide a wider net of support for them and for you - and make that true.

If you are feeling suicidal, see if you can identify 2-6 friends or acquaintances you trust who you believe could work together to support you. Consider giving them explicit permission to talk with the other members of the team, and/or discuss what boundaries you have around what you would like them to collaborate on.

Contacting your supportee's family of origin depends on the situation. It may be easy and feel natural to include someone's parent or sibling, especially if they have a connected relationship and you have their contact information. Or, it may be really hard to do (you don't know how to get a hold of them), or it's ill-advised because it could cause more damage. This is partially why talking before a crisis is helpful. It provides an opportunity to ask if they could imagine wanting or not wanting that in a crisis. When you haven't done this, and even if you have, be sure to check back in about it as is possible.

If you are feeling the need to share with family (or anyone) without explicit consent of the person you are supporting, ask yourself: what is the purpose of including this person? What do I know about the relationship they have together or the need my person has that tells me that informing this other person/people would be net positive, even if there could be some negative consequences? Would telling them help support me somehow, regardless of the unknown impact on the person I'm supporting? There's no exact 'right' answer here if you don't have explicit consent. And, you can be thoughtful and considerate as you trust yourself to make hard decisions. The point is to remember to share with care and not just to satisfy curiosity.

If a person doesn't have a crisis plan and/or is not able to respond with their needs or wants, which is quite common, you might find yourself having to make decisions for the person that you feel unsure about or feel bad doing (like admitting someone to a hospital). Sometimes, you may feel you need to choose between the person's safety and their autonomy. For instance, if a person is suicidal and not answering their phone, you might decide to go to their house and bang on their door, get a spare key from a neighbor to enter or break in. We can't tell you what's 'right' here; we know it's hard.

Some support team resources:
Mad Maps are a preventative tool developed by the Icarus Project which can be helpful in working as an individual or as a community to strengthen our ability to thrive and prepare for and respond to crises. An example can be found here:

irresistible.org/podcast/35penglish. Dean Spade also shares a mad map structure here: deanspade.net/2020/04/03/mad-maps-for-the-pandemic/.

Another preventative and anti-oppression resource is the video "Starting a Support Team" (vimeo.com/showcase/fireweedcollective), a tool for starting a group that can support each other over time and mobilize during a crisis.

Fireweed Collective knows that a crisis is an opportunity for something new to emerge. They have more on how to support someone during a mental health crisis here: fireweedcollective.org/crisis-toolkit.

Supporting someone who is suicidal while supporting yourself

This section is just about you caring for yourself while being in this challenging and important role. We can't pour from empty cups or light ourselves on fire to warm someone else….however you say it, we can't give care endlessly and without replenishment. Also, your care is important just because it's you.

Some ways to approach your care while in this role:

- Consistently check in with yourself. How are you? How are you really? How are you really, really?
- Are you creating and maintaining your own acts of self-care?
- What and where is your safety plan? Who else knows about it and has a copy? What if you are experiencing an increase in suicidality, who is your support team? What do you need? How can you share that with others?
- What can you do to expand friend and community support for both you and the person/people you're supporting? What can you take off your plate?
- Are you honoring your boundaries and limits? Are you taking breaks? What can you say no to or ask a friend to do for you?
- Can you take time off work or from other responsibilities? Give your energy to what's most necessary in the moment and grant yourself permission to not do it all.
- What is bringing you connection, joy, pleasure? Can you amplify this?

Be gentle with yourself and take solace in knowing that you're doing the best you can for your person and yourself. Even if they are so hurt or confused, other people's actions and choices are their own. We can practice radical acceptance and recognize that there is a difference between control and power. We cannot control other people and systems. We can use our power to be and do in ways we are proud of; to create and generate change; to care and love; and know when to release.

Bystander intervention*

The more you pay attention to people, the more you may see struggle and crisis. If you are witnessing distress in someone you don't know and choose to interject, that is called bystander intervention. You can intervene in many situations, like if someone is hurting their dog or another person. Here I am talking about mental health crisis intervention specifically that does not involve violence towards another being, and the points still could be useful if there is violence. If you go to the *mental health resources* section, you will see many options for bringing in professional support, like with hotlines and from the home or street care subsection. If you cannot access professional support (i.e. you don't have a workable phone on you) or don't want to for reasons of uncertainty or worry about more violence from the 'support' (most seen by cops), there are other tactics to use. In intervening, you are protected under the good samaritan laws which "offer legal protection to people who give reasonable assistance to those who are, or whom they believe to be injured, ill, in peril, or otherwise incapacitated" (wikipedia).

People experiencing a mental health crisis are much more likely to hurt themselves than a stranger, but that is not always true, especially if a weapon is involved. Stay safe and trust your intuition. Know you have options, and use them, including leaving if you feel unsafe. Any emergency medicine person will tell you not to run into a crisis; rather, move quickly and deliberately, always checking your surroundings for threats. Care for yourself and know this has a two-fold effect. First, it cares for you, and second, your grounding will contribute to the grounding of another through co-regulation and our mirror neurons (what allows us to learn from imitation; they are at least partially responsible for our empathy), if nothing else.

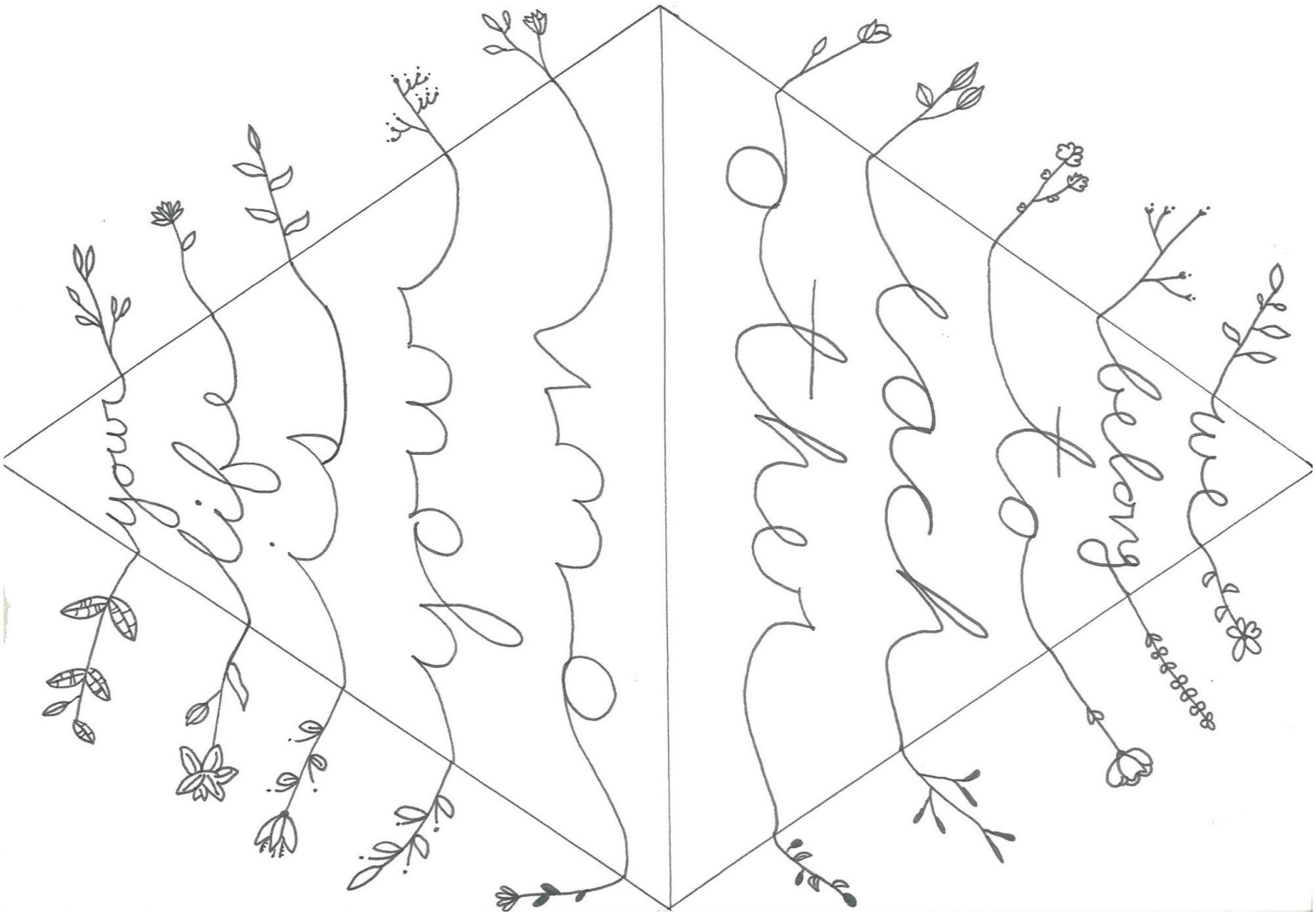
Be aware that a mental health crisis could mean many things and look many ways. It can be hard to distinguish between a mental health or physical health need, intoxication, or a combination of these things. All of these situations may need intervention, regardless. Some signs of a mental health need are: increasing agitation / impulsivity / verbal or physical aggression towards self or others / talking to self / hyperventilating /shaking / uneven walking (ie stumbling) / increased heart-rate / cold or hot flushes / dizziness / decreased ability to process information / visible injuries / dehydration (people moving into the shade or pausing to catch their breath or acting "winded") / crying / muting / inability to answer questions such as "what do you need?"

Now, you can practice de-escalation tactics. The following are very modified from the 10 Domains of De-escalation from the American Association for Emergency

Psychiatry Project:

- Ask for consent and permission throughout your encounter.
- Approach with and maintain body language that is confident and that won't harm others - hands should be visible and open and feet should be open and at an angle so as to not appear confrontational.
- Respect personal space - maintain at least two arm's length of distance; you can get closer or farther depending on the situation. You can either ask and receive consent or just try out different positions and see what works. Do not touch them unless it seems like an obvious need (i.e., they begin to faint).
- Share your suspicions that they are in some level of distress and want to offer support.
- Be concise - keep messages simple; repeat often and as needed.
- Identify wants and feelings - ask what the individual wants or feels they need. listen closely to what they are saying - convey through verbal acknowledgement, body language, and conversation that you understand or ask for clarification.
- Offerings - offer clear and simple choices; do breathing or movement exercises together, this helps with self consciousness; go on a walk with them; make the actions about you: 'it really helps me to breathe this way when I'm stressed so I'm going to do that if you want to join me"; ask if there is anyone you can call, including professional services, or you can go and get for them.
- Agree, or agree to disagree - agree with truth (this world is hard; that person did spit on you; etc.); don't argue against someone's truths you can't validate if they are not causing panic or stress (if they see a lion and that lion is fine where it is, no need to dispute); if the other truths are causing distress, calmly tell them they are safe from that thing (if they are) or even try to get rid of that thing (like chasing a lion away); avoid control battles or getting in the last word about what is happening or what is right or wrong.
- Be direct and set clear limits - "No, you cannot touch me."; "I do have to leave and go to work soon and I want to try and help before I do. What can I do?"; "I am very worried about you and don't think I can help anymore, so I am calling Resolve Crisis Line"; "I think you may be having a stroke. I am going to call 911."
- Care for yourself and others who were also impacted during and afterwards.

*This section is very informed by a de-escalation workshop for protest settings that was co-created by MH practitioners friends and I in the summer of 2020.



Surviving suicide + grief

only in silence the word / only in darkness light / only in dying life
-Ursula K. LeGuin, The Creation of Éa, Earthsea Trilogy

Ring the bells that still can ring
Forget your perfect offering
There is a crack, a crack in everything
That's how the light gets in
- Leonard Cohen

The above wisdom can remind us that life is life because of death and the shattered places within us are sources of power. Sometimes I wish it were as simple for humans as Mira Ptacin writes about much of nature: "I remember to revere the outdoor world. The purity of its reasoning, the beauty of its math and its magic. How it holds no grudges yet favors no one." And, it is not that simple for us. While I have found solace in the idea that some people are not long for this world (and really none of us are very long for this world), the deep ache of that knowledge is haunting, down to my fascia.

Especially because many, many deaths are born of injustice and wrongness: war, genocide, toxicity, despair, poverty, oppression, distraction, neglect, other violences. I think of true, applied justice as both a good life and a good death for all. Instead, after someone dies, there is the death industrial complex to navigate. It shouldn't be this way. (See the orderofthegooddeath.com for more on 'good death').
We all know grief. It's not just the deaths of other beings we grieve. We lose so much through life through relationship endings, job losses, gentrification. We feel solastalgia as we grieve the destruction of the world. As author Maggie Nelson has said, we have "to reckon ... with the fact that everything is not going to be OK, that no one or nothing is coming to save us and that this is both searingly difficult and also fine." Chills.

The following are excerpts from a 2014 blog post written by adrienne maree brown entitled grief is not linear, and it is everywhere. I think they speak so clearly to what many grievers feel:

> i have been reflecting on how falling in love is, among other things, committing to future grief. the more you know someone, love them, share life with them, the more you also carve out the space for future grief...i am holding the babies too close and eating too much trying to just feel this singular truth in a new way. i have moved through grief before, i have reached places of peace and even liberation around it. but now i am like a child again, distraught, incredulous...and i am left with the fact that grief is not linear. i can still tap into the tender wound for each person i have lost...i have personal ancestors, not as many as some, more than i'd want. i feel them learning how to be elsewhere, i feel them still connected to me. i feel them everywhere.

When talking about grief, references to Elisabeth Kübler-Ross' five stages of grief are rampant. As a researcher of near-death, her model was actually about people's own feelings leading up to their own death, their anticipatory grief, not grief over the death of someone else. Nonetheless, it seems as if many people resonate with them after losing someone. The stages are: denial, anger, bargaining, depression, and acceptance. If you do resonate with them, please know that they are not linear; nothing in grief is. You may move from one to the other and back again, we straddle more than one at once, we start over, etc. Another model adds in both an upward turn and reconstruction and working through it as additional stages. For more on this, check out the *Very Bad Therapy* podcast, episode 89.

Regardless, just pay attention to your own 'stages' and just go with that. I really appre-

ciate grief support work because there is ample room for what is 'normal.' Everyone grieves differently! Everyone's timeline varies! What use is it to even have a timeline?! It includes the knowledge that grief is so impacted by whatever overlapping cultures the person exists in. There is a 'complicated grief' concept, which is essentially when what you are experiencing is reaching beyond what is 'just' grief and it is happening for longer than is serving you or your loss. There is even a prolonged grief disorder diagnosis. I mention this not to diagnose anyone, I personally don't use this diagnosis and find it to be steeped in denial of death and grief. In the way that any diagnosis is both folk wisdom and can be useful, I mention it here to say: if you notice your grief is too big to carry for far too long, that is probably a sign that you need more care. Is it pulling on your already existing or dormant depression or anxiety or otherwise? Are you feeling your own suicidality? Can you no longer organize or work in the ways you want nor can you enjoy life? Has this exact thing, or worse, been going on for a long time? This is grief plus. Please seek (more) personal and professional care.

I tend to use 'complicated grief' or 'complex grief' in another way and that is to reference how complicated and complex relationships add other layers to our grief, muddying the waters. It can be confusing and disconcerting. If your parent was abusive and now they are dead, you will have another course of grief than someone who felt very cared for by and close to their parent who just died. If your partner of 8 years just broke up with you after you discovered they were cheating on you and is now dead, your grief will look different than without that rupture. You may feel more angry, more removed or less sadness, or anything else. Either way, comparisons aren't that useful but if you are comparing, which is very common, know that the difference found in grief, sometimes between two siblings, is to be expected. You are not doing it, whatever it is, wrong. Additionally, each new grief can wrap into the old, pulling on past losses and demanding new attention paid to them. This also can complicate any current grief.

Grief from suicide is its own particular experience and can feel differently complex. If you have survived suicide (losing someone to suicide), you are not alone. Death by suicide can be so confusing to make sense of, especially in the wake of the devastation after a suicide. People kill themselves when they have people they love, when they feel loved, when they have plans they are looking forward to, when you saw them yesterday and they seemed fine or happy, and of course, when they've been talking about it for a while or have mentioned the idea once before. The emotional impact on suicide survivors is so immense. When people we love, admire, or just loosely know die by suicide, it can stir up so many feelings. Grief often contains some level of regret and guilt, and with suicide, there is often much more. "If only I…." and "what if…." are very typical

and understandable reactions, having the idea that this was a preventable death that we personally could have prevented. And, anger is common - anger with the person who died, anger with someone who hurt them in the past, anger with the terror of the world. There are often infinite questions and unknowns that may always be unknown. It is indelibly painful. As Judith Butler wrote: "Let's face it. We're undone by each other. And if we're not, we're missing something."

Suicide (for Jude) by Zoë Zelmanovich

We say
"her suffering
is over"

But only she is.

Her suffering lives on
r e d i s t r i b u t e d

If you have survived suicide, please be very caring with yourself and seek the support you need. There are resources in this packet. While I am hoping for more awareness and less suicide and am sharing intervention tools to those ends, when someone you know kills themselves, it is not your fault. Ever. The American Foundation for Suicide Prevention (afsp.org) lists bereavement support groups and postvention care (grief care after a suicide).

Forgiveness can be so meaningful. Here is a mantra, also by Zoë Zelmanovich.

I forgive myself
for being caught up in my own life
for not being present for them at the end of their life
for not knowing what they needed

I forgive their family and friends
for not knowing how to keep them alive
for not sharing everything they knew

I forgive them
for not reaching out
for not getting help

for abandoning me
for not saying goodbye

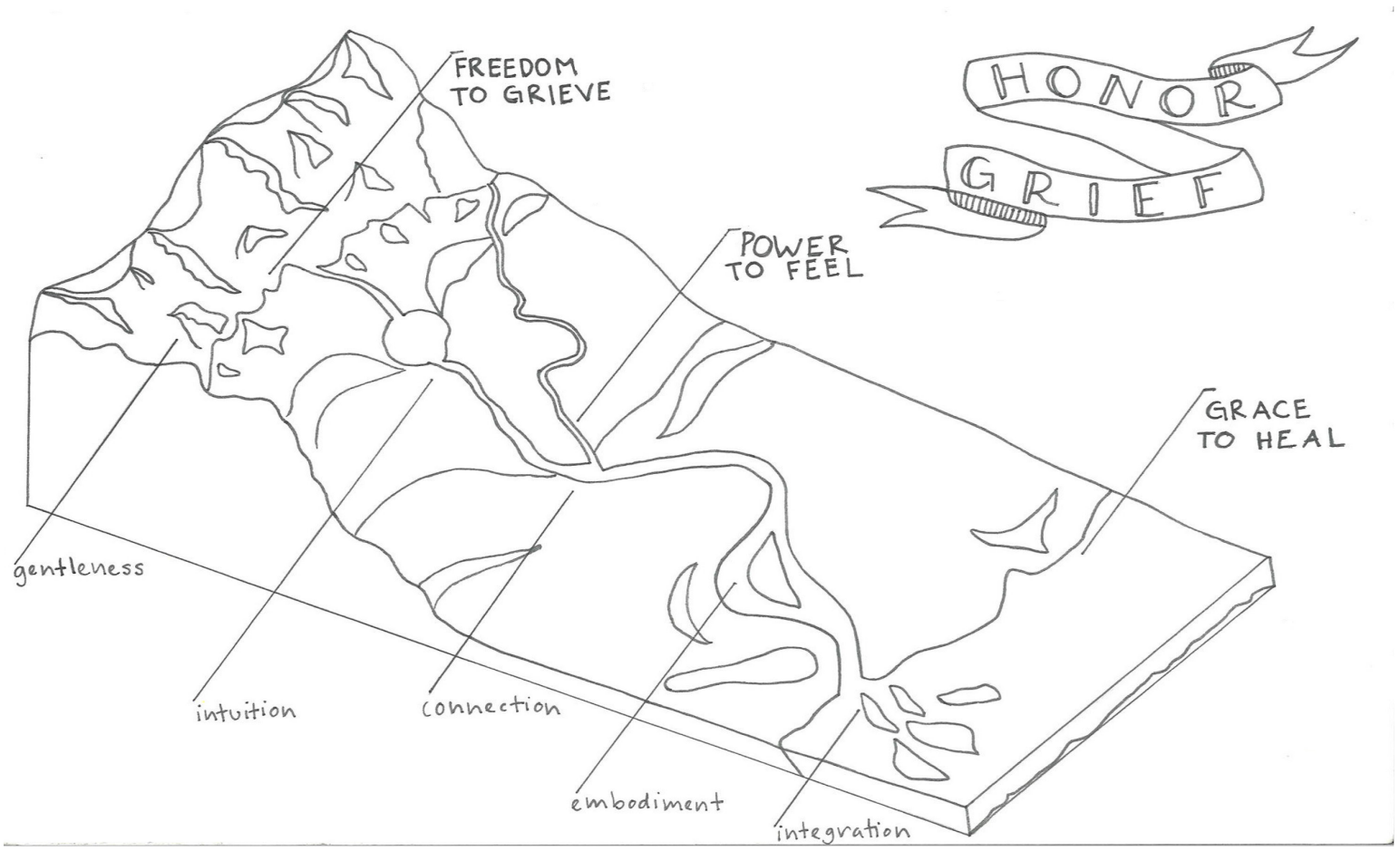
We must honor our grief. As Rabbi Elliot Kukla states: "Without honouring grief, loss remains unreal—we cannot adapt and find new ways of being and doing...Grief is transformative. When we name the immensity of loss, we also claim the depth of our capacity for love."
Honoring grief is whatever it is for you. Some ideas:

- We must grieve and we must do so as ourselves - Somatic trainer Amber McZeal recently shared in a training, "walk your path, not anyone else's." And, we make the path by walking it.
- Stay connected to yourself - Yes you are a griever, you are also a creature who needs sustenance, nourishment, care, breaks, levity, more.
- Stay connected to your person - it is normal (fine) and typical (happens with frequency) to have times where you wonder if you ever even knew the person who died, or feel very disconnected from them and the memories you shared, their voice and mannerisms. You can work to be ok with the connection floating in and out. We have a tendency to just exalt people who are dead but staying connected is to be with all of the person; what we liked and what we struggled with. Remember it all. You can work to maintain this connection, and the relationship, by looking at pictures, talking to them, talking to others about them, sharing stories, making an alter, doing activities you once did together alone or with others, writing about them or to them, and more.
- Stay connected to and grow your connection to others - Grief can be quite internal and isolating. When we can, connecting with others in our grief, whether or not that person knew our person, can support us in our carrying of the grief. Also, practice asking for help and then ask and receive. Generally, your people want to support you; they just don't always know how to do so. And, you may lose the support of very important people along the way, which is more grief. You may find your best support in others who know the intense magnitude of grief, something everyone will know but doesn't always yet know.
- Let grief transform you - In their essay about femmes and suicides from *Care Work*, Leah Lakshmi Piepzna-Samarasinha ends with "my grief about femme suicide is the garden where our futures grow." What can grow from your grief?
- Find integration - While I hesitate to make broad generalizations, I do feel confident in saying that we do not 'get over' loss or grief. We do learn to move with it differently, in all of its different phases, through our lives. Sometimes it feels 'easier' and sometimes, maybe more often than that, it just is. We integrate it and feel it differently with time and other life experiences. It's as if we start with the largest, most

unwieldy suitcase, dragging it through the airport with no help. Then maybe it transitions to a big rolling suitcase, heavy but possible. Then a medium sized backpack that doesn't strain our back too badly. And eventually, a wallet. All of this will shift and change, go back and forth. Or, it feels like none of this. Everyone grieves differently.

- Welcome in and acknowledge healing - Healing, whatever that looks and feels like, is possible. Having this different relationship with grief can be very bittersweet. The sweetness can be an ability to find more freedom from the deluge of pain. The bitterness is that this change can feel representative of the distance we are traveling from our person, from the intensity and importance of their life and their death. Yet, you are always connected. Mark your healing, notice your changes, sit with both the openness and the sadness of this. You can also take breaks from grief. You can let in all the accompanying feelings: the humorous, the bizarre, the confusing, the beautiful, more.

The Artists Grief Deck is a beautiful, useful resource of artful prompt cards for grief. You can see all the cards online and order hard copies here: griefdeck.com.



Supporting someone in grief

Remember that everyone you meet is afraid of something, loves something and has lost something.
- H. Jackson Brown Jr

Everyone knows their own version of loss. While supporting someone who is grieving, reaching into ourselves, seeing our own versions of struggle and sadness and then reaching out with care is often exactly what is needed. A listening ear, a loving gesture, a tangible gift of service (food, laundry, errands, food again). And, what we have experienced and needed is not always what is needed by another. Relating and resonating are different from comparing. Everyone, and every grief, is different. If you are both experiencing grief, how can you rely on each other through the ebbs and flows, even as you may be in different places?

Ask! Listen! Share! If someone cannot tell you how they are right now or what they need, gently try things and adjust as needed, which may be often. Being there, chekking in and being nimble are all necessary. In the section above about grieving, you will see some ideas about what grief can be like and can support grievers by encouraging those feelings and acts. Make a team and offer group support. Most support needed is too much for one person to provide; other talents, perspectives and energies are needed.

Sometimes supporters worry that bringing up the dead will exacerbate or remind someone of their pain. Rest assured your prompting will not remind someone of what they carry around all the time. Generally, people want to be asked about their person, about their grief. And, let them guide you without leaving it behind. It can be a delicate balance. "I've been curious to hear about how you are grieving these days, are you wanting to share? I'm here to listen now or later." Genuine expressions of care, even "wow, I have no words that could hold that pain," are more meaningful than platitudes like "everything happens for a reason."

Grief is a part of us and we are all more than our grief. You can still invite people to things, offer fun and play, and be ready to receive noes but also yeses. If someone is very sad and not taking up the invites, make something more for them. "What is something that would help you feel a part of the group again? Or feel some distraction? Or joy?"

With grief from suicide, there may be more guilt and self blame. While it is not your supportee's fault, they may feel that it is. No need to rush too quickly to defend them, as expressions of guilt are ok. Yet, gently and with care you can find ways to reaffirm: "Yes, you are so sad and wish you could have done more, of course, it is still not your fault. I will hold onto that knowledge until you can hold it for yourself." If you feel as if they could have done something more to support their person, you can tuck that away as there may be a place for that in the future as you strategize as a community on how to care for a suicidal person. There is not a place for that in the immediacy of grief.

Grieving after someone survives suicide may stir up their own suicidal ideation. Pay attention to cues, ask explicitly what they are feeling and work to connect them with needed care. It may also stir up your own suicidal ideation as a supporter. The same applies to you. See safety planning, more information about suicide and mental health resources for guidance. Also, even if it's not suicidality you are experiencing, please ask for the care you need, from yourself and others.

Or, they may not feel much at all. Numbness, distraction and dissociation are all understandable, too. While feeling and expression are a necessary part of grieving, how that looks and how it unfolds is very specific to that person. No need to force anything or judge someone's process. The beauty and ease of it is that you can just meet them where they are. If they are showing concerning behaviors, you can show curiosity, "how do you feel like your grieving process is going?"; make observations, "I've been noticing how removed you've been and are drinking a lot more than usual."; or share worry, "I am concerned since I know you are suffering but you never talk about your grief anymore."

Regardless of how it looks or what appreciation is or is not expressed, you showing up is invaluable.

Some basics on mental health, trauma + healing justice

We have to talk about mental health more broadly and trauma, when talking about suicide. Mental health is our lived emotional and psychological experience, our thoughts, feelings and behaviors. Our mental health is deeply intertwined with our body, our physical health, our spirit, our social connections, and everything we interact with in the whole world, both great and terrible. Mental health issues, struggles or illnesses are many things. They are thinking and behavioral patterns that are often outside of whatever norm of society has been set. They can cause some kind of impairment and/or distress. They can be mild to severe, and oscillate in intensity. They are

quite common experiences. As my sister says: "mental illness is a justifiable reaction to the pain of this world." As Jiddu Krishnamuri has said: "it is no measure of health to be well adjusted to a profoundly sick society."

Trauma is our response to any kind of wounding, our response to anything we were not ready to encounter that has overwhelmed us. Trauma is generational, historical, and individual. Trauma is often related to social and systemic oppressions and violences and is a collective experience. Trauma is a common occurrence. It can happen over and over again. We carry it with us through our lives and it can be so haunting. However we respond (simply referred to as fight, flight, freeze, fawn and flux) to all of this hurt isn't wrong, all of it has helped us survive. It's just that sometimes our reactions are more helpful and adaptive than other times and that depends on the situation. And, when we find safety again, even if it's a small, contained amount, we have the chance to not react in the same ways we did when we were in danger. Instead we can respond from that more steady and adaptive place. This is a form of healing, resilience and resistance. Resmaa Menakem shares: "Trauma is not destiny. It can be healed." And "to heal we must resist and to resist we must heal," is something I read a long time ago from a forgotten source.

How we are taught to deal with trauma is with mental health professionals and the mental health care system. Sometimes this is life saving, great or at least neutral. And Project LETS reminds us that mental health institutions, and many of the players within, are a part of the carceral state (institutions and policies and practices that work to control, punish and oppress). They emphasize that:

> Mental health literacy is not enough. Raising awareness about mental illnesses without also addressing health disparities, cultural differences, inadequacy of mental health care treatments, insurance issues, and professional and clinical stigma is not enough. We must actively work to create accessible resources, reform existing oppressive policies, and understand that clinical and professional help does not work for everybody. We must actively support individuals with mental illness...and not just shout into the void.

Yes. Please. Let us all work towards this. I have peppered this necessary political lens throughout and there are people and resources who will educate you far better than this resource will. I encourage you to do your own extensive research into the gross entanglements of the mental health systems and the carceral state, engage with the violence, uncertainty and intensity of it, and forge new pathways.

Radical mental health organizations challenge this and create other support and beauty, one local example is Inside Our Minds (insideourminds.org). Fireweed Collective (fireweedcollective.org) promotes healing justice, which "is a framework rooted in racial justice, disability justice, and economic justice. Healing Justice provides us with tools we can use to interrupt the systems of oppression that impact our mental health." Millionexperiments.com "explore[s] snapshots of community-based safety strategies that expand our ideas about what keeps us safe," including those for mental health.

More information about suicide

Suicidality or suicidal ideation is the act of thinking about, worrying about, obsessing about and/or planning on ending your life. This all happens on a spectrum. Many people have suicidal ideation and haven't yet identified it as such before. It can be very passive (like passing and idle thoughts) or very active (like intending, planning and enacting). Sometimes this experience is chronic and sometimes it is fleeting. Many people have suicidal ideation for a period of time, and then don't anymore. Support and healing and change and surviving and thriving are all possible. And sometimes, it doesn't happen that way and suicide occurs. Talking about it, being open, listening, asking for care and giving care is all important in whatever healing or shifting away from suicidality may occur.

My experience with OCD, mostly the obsessive part, really latches onto the ways I know other people have harmed themselves and I cannot get the images and thoughts out of my head. It can be consuming and confusing to separate what is theirs and what is mine. There have also been times when I have felt so much despair that I have welcomed a swift, deadly accident, just to have my life over with but not have to act on my own. All of this is on the suicidality spectrum. I have rarely talked about any of it.

A friend graciously shared some of her varied experiences. All of this is also on the suicidality spectrum.

> I would be overcome by a desire for death as a means to escape current overwhelming feelings of fear, loneliness, or loss but not really think up a plan. Other times were related to both stimulant and non-stimulant prescribed ADHD meds. Being without a med for one day felt like the plug had been pulled on joy, motivation, and interest; thoughts of what I needed to do to kill myself came into my mind repeatedly. Another time, I tried Ritalin and had incessant, intrusive thoughts and feelings about suicide: wanting death; feeling like it was a reason

able thing to do; feeling a sense of peace at the thought of death/an end; practical thoughts about how to be thoughtful and care for friends, what do with belongings, when to text someone to get my dog…detailed planning. This experience felt like being taken over by a robot for death (and was told later by my doctor that Ritalin can cause depressive symptoms). All experiences were preceded by social losses or rejections and accompanied by an experience of great loneliness, hopelessness, and doom about the world.

Suicide is a choice. And it can also feel more like an absolute lack of choice. Suicide can be an attempt at solving a really overwhelming problem. Suicide happens often or always under duress, often extreme duress. And, suicide is political. Project LETS, a disability justice organization fighting ableism and saneism, has great, necessary conversation and resources on this exactly (projectlets.org/political-education). We live in a gorgeous and tragic world where most people most of the time do not have what they need to survive, let alone thrive. It is despairing and sometimes too hard to see a way through.

Anyone can feel suicidal or complete suicide (when someone dies by suicide). And here are some factors that may increase the risk:

- A family history of suicide; general substance use, current intoxication; access to firearms or other lethal means (like drugs); a serious or chronic physical or mental illness; history of trauma or abuse; prolonged stress; a recent tragedy or loss (NAMI).
- Mental health conditions/symptoms that increase risk of suicide: depression, substance use disorders and psychosis carry the highest risk. Anxiety, personality disorders, disordered eating, and trauma-related disorders (like PTSD), as well as neurocognitive disorders, also can contribute.
- Self-harm or self injurious behavior. This is anything that you do to harm yourself on purpose - like cutting or burning yourself or increased and dangerous alcohol and drug use. (Some acts of self-harm can also act as harm reduction as they can be calming or deterring from suicide).
- Prior suicide attempts. (Attempt survivors (someone who has survived their own attempted suicide) need lots of care and understanding).
- Some medications, even for mental health treatment, can at least temporarily increase the risk of suicide. Also stopping medications can lead to increased risk. Contact your provider, or at least a friend, if you notice an uptick in these feelings/thoughts while starting a new med and/or going off of one.
- Any identity of person can complete suicide. And, in this country, the highest rates of suicide are among middle aged white cismen; cismale deaths represent 79% of all suicides (I'm assuming the cis part based on the source, afsp.org). The highest

rates generally are among white people, then indigenious people broadly and then people indigenious to what is now Alaska. People with schizophrenia are 4.5 times more likely to complete suicide than people without. LGBTQ teenagers are three times as likely to attempt suicide as their heterosexual peers (Trevor Project). It's hard to find suicide completion statics in relation to sexuality and gender identity. Black youths are two times more likely to die by suicide compared to their white counterparts (Arielle Sheftal). See projectlets.org/race-and-mental-health for race specific mental health resources.

A completed suicide may have signs leading up to it or there may also be little to no signs. And, if they are there, we can start to notice them and intervene. Here are some signs of suicidality:

- Alarming and different behavior; aggressive behavior; withdrawal from friends, family and community; dramatic mood swings; impulsive or reckless behavior; collecting and saving pills or buying a weapon; giving away possessions; tying up loose ends, like organizing personal papers or paying off debts; saying goodbye to friends and family (NAMI).
- Direct and indirect sayings like: I wish I were dead...I just want it to be over…I am going to kill myself...I can't keep doing this…I can't imagine living the rest of my life like this…I want to disappear...I should just kill myself…If I should die, make sure to...If I should die, you know I love you, right...My life is not worth living anymore... You are all going to be sorry when I am no longer here…*
- Sometimes, a sudden increase in happiness or ease, especially after a lot of struggle, can also mean someone is planning suicide. This comes from the resolution that death will come soon and the anticipated relief from suffering.
- Even though signs can be apparent, suicide is still often impulsive and/or happens within a short period of time (5 minutes to 24 hours) after someone begins to really plan and enact. This probably means the person has thought about suicide before and many things have aligned to get to this moment, but the significant action towards suicide is often quick.

*Threatening suicide as a means to have power over or manipulate someone, even if the suicdiality is also a real feeling, is emotional control and abuse. If you are doing this or this is being done to you, the abuse needs to be addressed and stopped alongside caring for whatever actual suicidality is happening.

Assessing suicidality is an important part of being suicide aware and in being able to give extra care as needed. It is, however, important to note that studies on suicide assessment are inconclusive on their actual predictive ability. Even professionals can not

ability to support someone, so it is worth the effort. There are several ways to assess. This following section is adapted from the VA's Suicide Risk Assessment Guide:

Be aware – learn the risk factors and warning signs for suicide, how to respond and where to get help (see *mental health resources*).

When talking about suicidal ideation:

- Be direct – talk openly and matter-of-factly about suicide, what you have observed, and what your concerns are regarding their well-being.
- Be willing to listen – allow expression of feelings, accept the feelings, and be patient.
- Be available – show interest, curiosity, understanding, and support.
- Be non-judgmental – don't debate whether suicide is right or wrong or whether the person's feelings are good or bad.

Questions to ask in assessing suicidality:

- Are you feeling hopeless about the present or future?
- If yes ask: Have you had thoughts about taking your life, wishing you were not alive, wishing you were dead or were never born?
- If yes ask: When did you have these thoughts and do you have a plan to take your life?
- Have you ever had a suicide attempt?
- Have you ever self harmed?

If yes to any, take action:

- Safety plan and or review and update plans as needed.
- Offer hope that alternatives are available – but don't offer reassurances that any one alternative will turn things around in the near future.
- Get support from others, like a friend circle support term (see *supporting someone who is suicidal + support teams*) or get help from those with more experience and expertise (see *mental health resources*). Be actively involved in encouraging the person to see a mental health professional as soon as possible and ensure that an appointment is made.
- Offer to remove, or just remove, means of self-harm such as sharp objects, pills, ropes, firearms, and alcohol or other drugs.

There are also protective factors that prevent against suicide:

- Positive social support and strong bonds
- A connection to spirituality

- Sense of responsibility to family, friends
- Having children in the home or being pregnant/having a pregnant partner
- General life satisfaction
- Reality testing ability - the ability to tell what is real and true
- Positive coping skills and positive problem-solving skills
- Positive therapeutic relationship(s)
- Going back to suicide being political and apart of a larger constellation of experiences, a/the biggest protective factor is a caring and just world that we feel held and a part of...or at least having enough pockets of it in the meantime.

Mental health resources + how they fit together

The mental health care system is really hard to navigate and often disappointing or worse. As a therapist, I can be stunned and angry, or at least annoyed, while trying to access simple care for my people. Sometimes, I am pleasantly surprised. I hope the following can help demystify it all a little bit. This is a brief outline from my professional and personal experience, there is always more to the story and there are often anecdotes that will contradict what I have written here. The resources to follow can be generally helpful for mental health care and are all also listed here because they can each address suicidality. They are mostly Pittsburgh specific because that is where my experience lies. If you are somewhere else, these programs, networks and systems generally exist in some form.

Note: If anyone who is professionally trained thinks that you could kill yourself, they are legally obligated to support you in getting to safety. This does not have to look like being involuntarily committed or being "302'd" (they are the same thing). And, it could. More information on that is below.

What it more often looks like, or could look like, is working with you to coordinate accessing services that can literally meet you where you are or monitor you in a facility. The police may be called in, by anyone, even if you are voluntarily seeking treatment, sometimes just for literal transportation to where more help is. We know this means sometimes you get the help you need and sometimes it leads to a bad experience, jail, violence on top of a crisis or death. "People with untreated mental illness are 16 times more likely to be killed during a police encounter than other civilians approached or stopped by law enforcement," according to a 2015 Treatment Advocacy Center study. When someone contains other identities that are violently oppressed, especially if they are Black, Brown and/or trans, the rate of violence from the police increases.

People experiencing mental health struggles are so overrepresented in prison and jails that those institutions have been called "the new asylums." Police violence and the violence of the carceral system only add more trauma. We all have to weigh the risks of what police and institutional intervention could mean for the people we're caring for, professionally or personally, versus the need for ourselves and our loved ones to get where they may need to go and maybe literally surviving another day. I really hope this is all different some day; we need it to be different. Remember, take a breath and know that where there are alternative choices, you can use them.

The following on involuntary commitment is directly taken from a Public Source article by Juliette Rihl written in 2019:

> Emergency evaluation (aka "a 302"): This is typically the first step of involuntary treatment. When a person is believed to be a danger to themselves or others due to mental illness, they can be taken to a hospital [or the police can be called first to assess on the spot and then taken to the hospital] and evaluated by a physician. A physician or police officer can authorize the medical evaluation without a warrant, or a petitioner — often a person's loved one or a mental health professional — can sign a 302 form petitioning the county mental health administrator to issue a warrant. A 302-related evaluation can last up to 120 hours, after which the person is either released or, if the doctor finds that the person needs extended treatment, a hearing can be held to extend the person's involuntary treatment. Extended involuntary treatment: After an emergency evaluation, if a doctor decides that a person needs to spend more days in the hospital, a 303 hearing is held and a mental health review officer can sign an order issuing extended emergency hospital treatment up to 20 days. If further treatment is still necessary after 20 days, a 304b hearing is held and treatment can be extended for up to 90 additional days. After the additional 90 days, a 305 hearing can be held to extend treatment for up to 180 more days. More information about types of extended involuntary treatment in Allegheny County can be found on the Department of Human Services website.

First lines of care (in no certain order):
Helplines - Put these numbers in your phone under something you can easily remember. These hotlines also support the support people, not just people in crisis. All of these hotlines are free.

- Easy to remember: call 211 from any phone to get connected to the local United Way where they will give you information on almost any resource. 24/7 and in 140 languages.
- Resolve Crisis Line and Center is for Allegheny County residents. They are a 24/7 ho-

tline that can be reached at 888.796.8226.

- Nationally, there is the Suicide & Crisis Lifeline (988lifeline.org), also a 24/7 hotline, you can reach by just dialing or texting 988. For TTY Users: Use your preferred relay service or dial 711 then 988. For Spanish/Ayuda en Español: 988.
- The Crisis Text Line, is available anywhere in the U.S. and Canada: Text HOME to 741741 for 24/7 access to a crisis counselor.
- The National Alliance on Mental Illness (NAMI) HelpLine can be reached Monday through Friday, 10 a.m.–8 p.m., ET at 800.950.6264 or info@nami.org.
- Trans Lifeline, 877.565.8860, is a peer support line "for our trans and questioning peers" and they do not do any non-consensual active rescue, meaning they won't call 911, emergency services, or law enforcement without permission. The other hotlines and the Crisis Text Line will.
- Never Use Alone hotline: 800.484.3731. With some fatal drug poisonings (lethal overdoses) it is unclear whether they are intentional or accidental. Opioid related suicides are increasing, as are opioid related accidental deaths. I felt compelled to include this resource, regardless. Anyone who is using potentially fatal drugs by themselves can call and "you will be asked for your first name, location, and the number you are calling from. An operator will stay on the line with you while you use. If you stop responding after using, the operator will notify emergency services of an 'unresponsive person' at your location." See more in 'useful trainings' at the end of this section to learn about local Naloxone trainings and access.
- And, anyone can always call 911 and have police go to the place where you are or where your person is.

Peer support - This is where someone who has had a similar mental health experience offers you support. These care systems often operate outside of the more professionalized care on purpose. Some local examples are Peer Support & Advocacy Network (peer-support.org) which has a "warm line," which is not a crisis line but offers mental health support "by someone who has been there." 866.661.9276, 9 am until 1 AM daily. Milestone also has a peer-support program, milestonepa.org. Project LETS has peer support, look at projectlets.org/resources under "I need immediate support." You can aslo train to be a peer support person. These programs are free.
Sidenote: there are also peer run crisis alternatives and peer respites, although none are located in the immediate area. See power2u.org/directory-of-peer-respites/ for more.

Therapists/counselors* - Someone who has been trained to talk with you, care for you, assess, diagnose and help you get the care you need, including support accessing additional resources. Therapists have all different styles and see individuals, partnerships

and families. Finding one you "fit" well with is important; working with a therapist you feel trusting of, can be honest with and feel both supported and lovingly challenged by is important. It can be easier to get initial appointments with therapists who work in group practices or at social service agencies. Virtually, you can see therapists anywhere in your state or any therapist who is licensed in your state. There are virtual only therapists with Better Help or Talk Space. There are also mobile therapists (who will come to your home) and school-based therapists - see further on for more on this.

Medication* - General care doctors/primary care practitioners (PCPs), nurse practitioners, and psychiatrists can prescribe mental health medication/psychiatric medication. It's important to trust the person you are working with and if you already have a PCP, maybe try them first as psychiatrists often have long waits. Even if you don't have a PCP, you can often find one quicker than a psychiatrist. If you need/want multiple psychiatric drugs or ones that are beyond antidepressants or antianxiety meds, a psychiatrist may be most helpful. Please know that initially it may be a struggle to find a medication and a dosage that works for you. As mentioned before, some medications can increase your risk of suicide. Take extra good care and notify anyone, including and especially the person who prescribed the medication to you, if you notice any increase in suicidality or other mental health changes for the worse or weirder.
For medical marijuana first register (at padohmmp.custhelp.com/app/login), get a doctor's letter, and pay the $50 annual fee. There is now ketamine assisted psychotherapy (KAP) in Pittsburgh, which is for major depression and suicidal ideation. Check out UPMC Ketamine Services and Pittsburgh Ketamine in Monroeville. There are other non medicine, medical depression treatments. Look into Transcranial Magnetic Stimulation (TMS) and Electroconvulsive Therapy (ECT). Search "UPMC interventional psychiatry."

* For help accessing therapists/counselors and doctors: ask your friends for recommendations, ask your insurance company, check out psychologytoday.com, and check out bewellpgh.org, especially if you are under-resourced, underinsured or uninsured (thank you, Jude). If you're in school, try your school's counseling center Steel Smiling (steelsmilingpgh.org, 412.532.9458) provides mental health funding, referrals and training for Black Pittsburghers. If you have questions about qualifying for health care, either through Medicaid, Medicare or the ACA, call PA Health Access Network's (PHAN) hotline: 877.570.3642.

Crisis centers: If an immediate intervention is needed, but maybe you are unsure if you need a full-on inpatient facility (described more below), here are some options.

- UPMC's Resolve Crisis Center is located at 333 N Braddock Ave, Homewood, Pittsburgh, PA 15208, 888.796.8226. You can just talk to someone in person or they will

offer up to 72 hours of inpatient care.
- Pittsburgh Mercy has walk-in crisis services on the South Side, available 24/7 at 264 South 9th Street, Pittsburgh, PA 15203.
- You can show up at any ER and receive an emergency mental health evaluation. If you and they feel you need to be monitored to stay alive, they will find you a place to be monitored either in the hospital, in a general area or in a psychiatric area of that hospital, or transfer you to another specific psychiatric facility.

Inpatient treatment options:
These exist to hopefully keep people alive and to help with internal and external resources, proper medication, and general support. Inpatient is literally living in the facility, not leaving for breaks or to go home at night, etc. You have access to therapists, group therapy, activities, social workers for very tangible planning and psychiatrists for medication management. In Pittsburgh, we have several and you can show up at any, any time of day or night to be evaluated and then admitted. If these units are a part of a larger hospital and you can't find the psychiatric department, you can always go to the emergency department. If admitted, they often have different units for different needs, like dual diagnosis (MH and substance use), elder care, adolescents, OCD and more. People can stay for a very short time, if they are there voluntarily, or 72 hours to several months if needed. The experiences people have within these programs are variable; sometimes they are really meaningful or necessary to harmful or at least not helpful.

These facilities are not big enough for the need and they will only keep people who they deem are the most in danger, people with the most intent and commitment to harming themselves….there are big flaws in this subjective system, of course. If you do these programs, you will experience Dialectical Behavioral Therapy (DBT). It is a kind of therapy that is used for many things and often used in response to depression and suicidality. DBT was created by Marsha Linehan for suicidality and personality disorder treatment, both she herself experienced. Personality disorder traits can increase the risk of suicidality. DBT is also used within outpatient programs, explored more below.

Wherever you go, it's important to bring all of your medications with you to prevent a delay in taking them. If possible, bring a buddy for support.

Inpatient psychiatric facilities*:
- UPMC's Resolve Crisis Center - 333 N Braddock Ave, Homewood, Pittsburgh, PA 15208. 888.796.8226. They offer up to 72 hours of inpatient care.
- UPMC's Western Psychiatric Hospital or WPIC - 3811 O'Hara St, Oakland,

Pittsburgh, PA 15213. 412.624.1000.
- St. Clair Hospital - 1000 Bower Hill Rd, Mt. Lebanon, Pittsburgh, PA 15243. 412.942.4800.
- AHN's Forbes Behavioral Health - 2570 Haymaker Road, Monroeville, PA 15146. 412.362.8677.
- Staunton Clinic - 701 Broad Street, Sewickley, PA 15143. 412.749.7335
- East End Behavioral Health - 225 Penn Avenue Pittsburgh, PA 15221. Main Hospital: 412.247.2000. Admissions: 412.247.2365. They also have a geropsychiatry unit for our elders.
- Jefferson Behavioral - 565 Coal Valley Road, Jefferson Hills, PA 15025. 412.469.5000.
- For children and adolescents only: Southwood Psychiatric Hospital - 2575 Boyce Plaza Rd, Upper St. Clair, Pittsburgh, PA 15241. 412.257.2290.

*If you have a person who is missing and may be in a facility, or you know is in there but haven't heard from, you can call the facility. They will not be able to confirm or deny if that person is there if your person hasn't signed a written release for you specifically (although sometimes, depending on who you talk to, they may actually tell you regardless…) but you can leave messages for them to call you back. Always leave your phone number. The same goes for any hospital.

Residential programs (longer term, inpatient care) examples below. Reach out to healthcare residential assistant Stephanie Buerkel, stephanie.buerkel@acadiahealthcare.com or 412.738.4122 for tailored options.
- Pittsburgh Mercy offers several specialized residential treatment facilities, including extended, acute care services and long-term structured residences. 877.637.2924.
- The Bradley Center Psychiatric Residential Treatment Facility (PRTF) for people ages 6-18. They tailor the time people stay to meet their needs, it could even be 6 months to a year. Call their Admissions Department at 412.788.8219. Or fill out a form on their website. 35 Devassie Road, McKees Rocks, PA 15136.
- Then there are farm-type places like **Hopewell** in Ohio (440.426.2000) and Spirit of Gheel in Kimberton, PA (610.495.7871). These examples and similarly styled drug/alcohol rehabs, can be private, not covered by insurance and expensive.

Outpatient treatment options:
Whether it is an intensive outpatient (IOP), partial hospitalization (PHP), diversion and acute stabilization (DAS) or day care program, outpatient programs are where you live somewhere else but go to the facility for groups or other consistent treatment during some part of some days or every day. All of the inpatient programs mentioned above (except for maybe the farm-type ones) have some form of these outpatient op-

tions. Since you will also often transition to an outpatient option from inpatient care, a person who works there will help you get into the most useful one for your situation. In fact, outpatient programs can be hard to get into unless you are coming out of inpatient care. If you or your therapist calls and asks for you to be put on a list and they say no, the trick is to physically go to the facility for an evaluation, at any time, even if you do not want or need to stay inpatient and they don't deem that either. You will be given a date for an outpatient interview and then will be put on a list for their programs, if you are admitted. It may take a few weeks for the interview and then a few more weeks for the outpatient program to begin.

- Pittsburgh Mercy also offers some of these outpatient programs - 1.877.637.2924. At their 330 South 9th Street, South Side Pittsburgh, PA 15203 location, they do intakes Monday through Friday from 9 am - 3:30 pm. They also do intakes at 412 East Commons, North Side, Pittsburgh, PA 15212-5310 on Thursdays from 8 am - 10:30 am.
- Wesley Family Services also offers various outpatient care. They have kid and family programs, too. They have many locations surrounding the city. The one in WIlkinsburg is at 221 Penn Avenue, 15221 and that location's direct number is 412.342.2300. The whole agency can be reached at 412.342.2270 or 888.222.4200. And this is their daytime crisis line number: 724.335.6242.
- Teenager outpatient services: Services for Teens at Risk (STAR) Center, located in Oakland. 412-864-3346.

First psychosis episode care: These are outpatient programs for evaluation, treatment, and rehab of people who are showing early symptoms and signs of psychosis (which includes hearing things, seeing things, having paranoid thoughts, etc.) The cause for psychosis could be schizophrenia, major depression, bipolar disorder, or drugs. Psychosis is a risk factor for suicide.

- UPMC has the Services for the Treatment of Early Psychosis (STEP) program, call 412-246-5599.
- Wesley Family services has the ENGAGE program, 412.694.6142, wfspa.org/service/engage/.

Mobile and school-based therapy: Mobile therapy is where the therapist comes to you. Traditionally, mobile therapy is used for people with significant physical and emotional barriers in attending office-based therapy and/or is geared towards meeting families where they are.

- UPMC offers services, call the Mobile Therapy line at 412.383.1575.
- Pittsburgh Mercy has mental health residential services that are "designed to support adults who have a mental illness to maintain their own residence in the community. We offer supports and teach you the skills you need to maximize your in-

- Pittsburgh Mercy (877.637.2924) has mental health residential services that are "designed to support adults who have a mental illness to maintain their own residence in the community. We offer supports and teach you the skills you need to maximize your independence. Some of our programs offer supportive services to you in your home. Others offer around-the-clock support."

School-based programs supplement what the school can offer to support mental and behavioral health needs. Check out Family Links (familylinks.org, 866.583.6003) and Family Resources (familyresources.org, 412-363-1702).

Home or street care:

- Resolve Crisis Services - If you call the hotline, 888.796.8226, hotline workers will talk to you and will send their mobile crisis team to where you are if you need them. If they do not have those people available, they will send the police. Either will transport you to a facility if needed. Resolve also does wellness check ins at your home. They have a specific program for kids and teens, call 412.864.5065 for an intake.
- Bridge to the Mountains (412.699.0462) + Operation Safety Net (412.232.5739) + Allegheny Link/OCS Field Unit (866.730.2368) - provide basic care, supplies and resources/referrals for more care for unhoused people. Maybe not for a current mental health crisis, but yes for support before or after a crisis.
- 911 - The police will come to any home, or anywhere else with an address, and do 'wellness checks' or transport to facilities regardless of who calls (i.e. you could call for your friend in another state).

Housing for people with a mental health diagnosis: The Allegheny County Human Services website explains the general options well; I recommend searching: "Allegheny County housing for persons with a mental health diagnosis." Agencies like Community Human Services (chscorp.org, 412.246.1600) and Pittsburgh Mercy (contact information above) offer some of these options.

Groups:

- Support groups, organizing groups, spiritual groups - Really any support, life and world enhancing groups that support you, and where you can support others, are useful. The more connections we have, the more life giving energy and care we can receive. Many of these options are free.
- Fireweed Collective (fireweedcollective.org/support-groups/) - Offering mental health support groups, including BIPOC specific groups and ones for disabled/chronically ill/neurodivergent folks.
- Dialectical Behavioral Therapy skills groups - As mentioned before, if you do an in/

outpatient program, you will experience DBT. There are also DBT skills groups led by therapists that might meet once a week or so for people to learn skills or keep their skills fresh, outside of an institution setting. A local Pittsburgh option is hihcounseling.com.

- Hearing voices network (hearingvoicesusa.org) - "Represents a partnership between individuals who hear voices or have other extreme or unusual experiences, professionals and allies in the community, all of whom are working together to change the assumptions made about these phenomenon and create supports, learning and healing opportunities for people across the country." They have a chapter in Pittsburgh and all groups are virtual right now.

Drug/alcohol rehab programs: Drug/alcohol use, especially to the point of over or "misuse," and current intoxication contributes to suicide. As Bruce Alexander says, "drug addiction of all kinds arises primarily from the relentlessly increasing dislocation in our society...people are dislocated when their vital needs for individual autonomy and belonging are unmet...the disconnected, fragmented nature of our culture causes addiction, which causes further fragmentation. Most serious addictions are actually an adaptation to dislocation. To some extent addiction is a functional way of dealing with the problem. Of course, what people really need is to be genuinely recognized and accepted and believed in — to have a purpose."

- Harm reduction: Harm reduction is any practice that decreases the negative impact of a behavior, like drug or alcohol use. Find out more at harmreduction.org. Locally, Prevention Point Pittsburgh (pppgh.org) offers many kinds of free harm reductionist care. *Over The Influence*, a book by Patt Denning and Jeannie Little, is a great harm reductionist guide and workbook.
- Rehab facilities: There are also inpatient and outpatient rehab facilities; they do medically monitored withdrawal programs; they monitor medications that support someone not using the current drug but also not being without anything - like replacing suboxone for heroin; they tend to have both adolescent programs and family support programs. Locally, some examples are Gateway Rehab, Pyramid Health, UPMC Mercy, Jade Wellness Center, Greenbriar Treatment Center and Pathway to Care and Recovery. They also often provide support to those giving support.
- There are always Alcoholics Anonymous and Narcotics Anonymous programs, and their partner groups of Al-Anon and Nar-Anon (for those impacted by someone else's relationship to drugs/alcohol). They are a free, abstinence based, nonhierarchical, nondenominational spiritual and prolific support network, with groups everywhere. Often, the success they do have is attributed to what community is built.

Other hotlines and resources: Because you may need other, more pointed care on your

crisis, discovery and healing journey. These are all free:

- Center for Victims Crisis Line (Pittsburgh, centerforvictims.org) to "respond to emergency needs of crime victims and witnesses, answer questions, and provide support." Call 866.644.2882.
- Pittsburgh Action Against Rape Helpline (paar.net) is for people who have experienced sexualized violence, call 1.866.END.RAPE (866.363.7273). Ayuda en Espanol, tambien.
- Postpartum Support Warm-line (National, postpartum.net) is not a crisis line, but a support line for people in the perinatal period, call 800.944.4PPD (800.944.4773). Ayuda en Espanol, tambien. Text in English: 800.944.4773, text en Español: 971.203.7773.
- LGBT National Hotline (glbthotline.org) "provides telephone, online private one-to-one chat and email peer-support, as well as factual information and local resources for cities and towns across the United States." Call 1.888.843.4564.
- Casa San José (Pittsburgh, casasanjose.org) – emergencias migratorias (emergency migrant support) a 412.736.7167 y los otros recursos (other resources) a 412.343.3111.

Payment for all of the above mentioned services, except for those explicitly said to be free or private: If you have commercial insurance (like through your job or the ACA), you will have to pay for these services as dictated in your plan, which could be a lot of money or no money. It is often similar to any other medical service in that there is often copay for the service, or a set amount (like $1000) or maybe you need to meet a deductible first before they'll pay for anything…the private, for profit insurance system we have is not made for caring. If you have Medicaid or Medicare, these services will be free to you. If you have no insurance, you are entitled to emergency physical and mental health care, even if you have to pay for it later. While in a facility, a social worker should assist you in this financial aspect, by getting you signed up for a payment plan, by applying for aid or debt forgiveness or by signing up for insurance. You can also call PHAN (877.570.3642) for help finding health insurance options. Check out pittsburghmutualaid.com to give or receive resources. Steel Smiling (steelsmilingpgh.org, 412.532.9458) provides mental health funding for Black Pittsburghers. I know that I will always donate to any fundraiser that is raising money for your care. Money does not have to be an obstacle here, we'll figure it out. We'd much, much, much prefer you alive than having that extra $25 individually or thousands of dollars collectively.

Useful trainings and resources: These are for anyone, including people who are not trained mental health practitioners.

- Mental Health First Aid (Mentalhealthfirstaid.org) - tools to respond to a MH crisis.

- Intervention and de-escalation - Step Up! (stepupprogram.org) offers MH intervention trainings. Hollaback (ihollaback.org) offers "virtual, interactive harassment prevention & bystander intervention trainings."
- Naloxone (Narcan)- Get trained in using this opioid overdose reversal drug and to carry it with you to save lives, either from accidental or purposeful fatal drug poisonings. Naloxone doesn't hurt anyone to receive, even if not using or overdosing, and it is still important to be trained. It comes in both an intramuscular injection (easy to inject into any large muscle) and nasal spray form. Prevention Point Pittsburgh (pppgh.org) is a great resource for training and for receiving free Naloxone. You can also get Naloxone from the pharmacy, through your insurance.
- Steel Smiling's Beams to Bridges (steelsmilingpgh.org) - A one year "Mental Health Workforce Development Program … equips Black children, youth, and families with the knowledge, skills, and competencies needed to serve as Community Mental Health Workers."
- Inside Our Minds (insideourminds.org/) - "Centering The Voices of People with Lived Experience of Mental Illness and Madness in the Greater Pittsburgh Area." They have many resources on their website.
- Trauma and nervous system work - Community Resilience Model (traumaresourceinstitute.com/crm), Lumos Transforms (lumostransforms.com), generative somatics (generativesomatics.org), Somatic Experiencing (traumahealing.org), and check out the public programs from ciis.edu. Read the Staci K. Haines book, *The Politics of Trauma.*
- Mediation and conflict work - Locally, Just Mediation (justmediationpgh.org) offers training and volunteer opportunities. Kai Cheng Thom has an amazing, free conflict resolution workbook at: https://ariseembodiment.org/free-workbook/

Excerpts from Remy Garland's (formerly Take Care Herbals) Surviving a world that doesn't want you: Herbalism and Suicide

Disclaimer:

This is for practitioners working with folks who are struggling with suicidality. It's also meant for anyone who needs it. This is not meant to treat, claim, or diagnose. This is also not a substitute for seeing health care practitioners. This is not meant as a stand-out alone article where you can do this all unsupervised. Because I care about you and know that the few pages of this article can not fight this battle alone. Tell your therapist you are reading this. Holler at a witch if you have questions. And talk with a trusted health care practitioner before changing your herbal, food and movement routines.

Sleep as medicine:

I often see sleep regulation as a key factor. If folks are not sleeping adequately, sleep herbs can be crucial. I like catnip (Nepeta cataria) in my sleep tinctures for its ability to let down smooth muscles including the gut, a common place tension is held. It is both a sedative and a nervine popularly, and I have seen in my practice specific for those who are absolutely exhausted but their tension patterns betray them at night.

Food as medicine:

Everyone has a deep relationship with their food. We are aiming for food that fuels neurotransmitters. Come up with a few foods that are high in protein and nutrient rich. Herbs that I've seen stand out that are both nutrient rich and nourishing to the nervous system include Oatstraw, Milky Oats, Tulsi, and Lemon Balm. These are great as teas, tinctures, vinegars. Consistent dosing is important. If PTSD is a factor, regulating blood sugar, eating foods low on the glycemic index, and eating three meals a day can have a positive effect on strengthening mood stability. Managing blood sugar can help keep a survivor in the resiliency zone longer, with less frequent and less overall dysregulation. If eating this way and these things are not an option at the time, a multivitamin is a good alternative. I include a B-complex (including folic acid, thiamine and B-6) when anxiety and depression are significant responses to handling stress. Vitamin D is important for folks who feel exhausted and drained from living with serious mental health lows.

Movement as medicine:

Movement is key when stagnation is a factor. Based on your ability to move, get creative with how to get energy flowing again. Hydrotherapy can be a tool if someone is not able to move much but has access to water. Stick your feet in warm water and then cold water, switching back and forth until you can feel the flight instead of the freeze. (End on cold water.) Other ideas include standing in place and punching the air until you can feel your hands, stretching starting with a safe part of the body like wiggling your toes, run as fast as you fucking can, etc.

Herbs as medicine:

- If the life force is hard to tap into, use vital reminders, stimulants and relaxants. Anything that shakes your life into flow and ignites vitality. I have had good results with herbs that are crossovers for the nervous system, circulatory system, mood uplifters, and have the energetic quality of uplifting. For this combination of herbal actions, I like lemon balm (Melissa officinalis), damiana (Turnera diffusa), st. john's wort (Hypericum perforatum/punctatum), ginger (Zingiber officinalis), and rosemary (Rosmarinus officinalis).

- Damiana (Turnera diffusa) is an antidepressant, a nerve tonic and an aphrodisiac due to it's relaxant/stimulant qualities while increasing circulation to the pelvis. I use this herb in my formulas when one is unable to move through their states of tension held in the body. I also add this herb when someone can't seem to access joy from day to day interactions. Tincture dose is one dropper full three times a day.
- Rosemary (Rosmarinus spp) is one of my all time favorite herbs to add into mental health formulas. I like that it is a kitchen witch herb and can often be found already in pantries and yards. Excellent for increasing mental alertness and memory, especially when one has a foggy, lethargic state of depression. Tincture and tea dose is medium to taste. Can eat in food, make an infusion, use the essential oil in steams (not internally), or take in tincture form.
- Black Cohosh (Cimicifuga racemosa) is often taught as specific for gloom/doom despondency and "black cloud" depression. For when depression is of a deep, dark and heavy nature. I like tincture more than tea for this plant medicine. Tincture dose is 1-2 droppers full.
- Lemon Balm (Melissa officinalis). It is the herbal ally that consistently showed up when nothing else seemed to touch my deep sadness. Used often for folks with Seasonal Affective Disorder (SAD) in combination with St. John's wort. An excellent tea for those who experience seasonal lows in the summer. This herb can be taken daily, for a long period of time and is great in tea or tincture. Tincture dose is 2-3 dropper fulls three times a day. In tea, steep 1 tablespoon in an eight ounce glass of water, covered for 15-20 minutes. Sip throughout the day.
- When I think of Milky Oats (Avena sativa) the word "nourishment" comes to mind. It restores the nervous system, indicated both during and after big events in one's life. Specific for people who have "bottomed out" from pushing too hard or for nervous exhaustion. Take tincture over a significant period of time to see best results. Dose is 2-3 dropper fulls 3 times a day in tincture form. Note: If there is a gluten intolerance make sure your source is not cross contaminated (most local herbalists will have a gluten free source). Not for those with celiac disease.
- Rhodiola (Rhodiola rosea) is a wonderful adaptogenic herb and anti-depressant for the right picture. Specific for when there is a pattern of exhaustion, easy to jump out of their resiliency zone, and cognitive function is impaired especially in response to stressors. Tincture dose is 1-3 dropper fulls 3-4 times daily. Start with a smaller dose to see how someone responds to this herb plus their regular caffeine. There is some risk of increased mania or manic state if prone or sensitive to stimulants.
- St. John's Wort (Hypericum perforatum) is a beautiful mood uplifter and a specific antidepressant. It directly works with the nervous system and the liver making it a great and common choice. I think it really lives up to its reputation but is not a blanket for all types of depression and sadness. I like it for a frayed nervous system

that has a normal state of hypervigilance. In cases where someone is not on medication and is definitely not going to go on any medication (including birth control), this can be a powerful ally in seeing someone's survival mode shift. Dosing depends on the situation, seek consultation.

- Mimosa (Albizia julibrissin) bark and flowers remind one how to smile without trying or forcing anything. Calms the spiritual heart while mood uplifting. Combine with Hawthorn and Rose during times of personal, environmental, and societal grief. Caution: Can cause manic episodes in those prone to mania. Do not take if you experience Bipolar Disorder or similar symptoms.
- Ashwagandha (Withania Somnifera) is a staple herb specific for people experiencing signs from enduring and putting hard demands on their physical/emotional selves. Specific for a pattern of arthritic inflammation, anxiety, insomnia, respiratory disorders, and lowered immune response. I add large amounts to formulas for folks who are experiencing burnout from direct care work, organizing/activism work, and can't see life outside of the burnout cycle. Research shows that Ashwagandha when taken at the dosage below can decrease cortisol levels significantly within one month. Dosage: 3 dropperfulls 3-4 times per day. Decoction: 1 Tablespoon of cut and sifted herb per 1 cup boiled water. Cover and simmer on low for 15-20 minutes. Can drink throughout the day or at night. For some, nighttime is better as it can cause sleepiness. Traditionally prepared with milk in Ayurveda. Caution in those with allergies to nightshades.

Flower essences:

- Gentian (Gentiana spp) is one of my favorite flower essences for maintaining momentum. Known most commonly for setbacks. Bach flower indications suggest it restores "faith in the meaning of life."
- Sweet Chestnut (Castanea sativa) essence can also be a powerful addition to formula in addressing hopelessness.
- Witch hazel (Hamamelis) flower essence is a winter blooming flower that holds hope in times of doubt. For belief in how thriving can exist in newness. When the beauty of life is hard to connect to, when everything seems dead, over, or gone.
- Gladiolus (Gladiolus) essence is specific for reciprocity, when it does not come easily or if you have never known belonging.
- Sage (Salvia officinalis) is excellent for finding perspective, for purpose in life and meaning in life events.
- When Trout Lily (Erythronium americanum) is for the ability to make positive shifts, not shying away from the details of the concern, while understanding the nature of it without blame or shame.

I believe in plant medicine as a necessary social justice tool. Plants and herbalists alike have an unremitting rigor to our well being. It is steadfast and it is unrelenting and you deserve no less from those on your health care team. We will stand together with our hands shredded by the rope, the rigor of plants wrapping vines around the pull. Inch the line.

It might be your neurotransmitters. It might be your trauma. It might be survivor mode. It might be long slow strings of rejection. It might be the mainstream world that says we don't belong here. We are living on this earth, in this time, on this depleted and abundant soil together. We can watch each other get older and be surprised at how much you like boiled peanuts. You used to think they were too salty. But now, you suck the juices out like a summer peach. And each moment will blend together like one big harvest season. Reap the work and form a universe where your sadness gets to be a fact and not all you are.

Thank you.

Thank you for doing whatever it is that you are to learn more and to care for yourself and others. And to change everything.

The first version of this resource was made between August and October of 2021.
This is the second version, which was finished in November of 2021.
This was created especially in honor of Jude, Corinne and L and all of their people, all of us.

 The title of "A life worth living in a world worth living in" is a conjoined phrase inspired by Albert Camus, Marsha Linehan and Project LETS. The rest of the title is descriptors.

This project was really a collective effort because together we know a lot. Thank you so much Remy Garland for the herbal wisdom and insight. Thank you so much to Jess Cox, Caitlin Crawford, Uma Kirkwood, Cindy Crabb, Zoë Zelmanovich, Katherine Anderson, Dalia Shevin, and Amy Lewis for all your necessary additions and insight.
Lizzie Anderson, LCSW, wrote and drew the remainder of this resource guide. Except for the little birds, which were drawn by Katherine Anderson. They are reimagined replicas of the birds that graced the body of dear Jude. May she fly free.

Notes, reflections, hopes, dreams...