## An Informational Toolkit for

# FUNERAL DIRECTORS

## PROMOTING SUICIDE AWARENESS

**This toolkit is donated by the**

*TODD WAITE LEGACY FOUNDATION*

**for suicide awareness**

**www.twlf4suicideawareness.com**

**Blessed are those who morn for they will be comforted**

**Matthew 5:4**

# The *TODD WAITE LEGACY FOUNDATION* for suicide awareness

was formed by family members on behalf of the Waite family. The Waite family lost their 19 year old son/brother Todd to suicide in July, 2010. They are now dedicated to spreading awareness about suicide so that others will never have to encounter the pain and loss that they feel.

In 2014 famous actor and comedian Robin Williams along with other celebrities took their own life as a result of a mental illness.

What about the shootings by people with mental illnesses at Sandy Hook Elementary School, Fort Hood, and other places around the world?

It is time to put an end to these tragedies!!

We need to start educating people about mental health, suicide awareness and prevention, and where to turn to for help or comfort in an otherwise confusing time. We have put together some informational toolkits and other literature to point people in the direction of areas for help and information.

**Our mission is to spread suicide and mental health information and awareness to: churches, first responders, foster parents, funeral homes, the media, medical professionals, military veterans, police departments, retirement homes, schools, suicide victims, survivors of suicide, the workplace, and anyone or anyplace else that can benefit from our information.**

Visit our web site at – www.twlf4suicideawareness.com

Our e-mail address is - twlf4suicideawareness@gmail.com

Check out our Facebook page at - www.Facebook.com/twlegacyfoundation

All of our material is free of charge and can be downloaded from our web site.

Please help us to keep spreading the word about suicide awareness. Visit our web site for information on donations. We are a 501 (c) (3) non-profit organization.

# 20 Best Things to Say to Someone Who Is Depressed

**1. "I love you!"**

**2. "I Care"**

**3. "You're not alone in this"**

**4. "I'm not going to leave/abandon you"**

**5. "Do you want a hug?"**

**6. "When all this is over, I'll still be here and so will you."**

**7. "All I want to do is give you a hug and a shoulder to cry on.."**

**8. "Hey, you're not crazy!"**

**9. "May the strength of your past reflect in your future."**

**10. "God does not play dice with the universe." -- A. Einstein**

**11. "A miracle is simply a do-it-yourself project." -- S. Leek**

**12. "We are not primarily on earth to see through one another, but to see one another through"**

**13. "If the human brain were simple enough to understand, we'd be too simple to understand it."**

**14. "You have so many extraordinary gifts -- how can you expect to live an ordinary life**

**15. "I'm sorry you're in so much pain. I am not going to leave you. I am going to take care of myself so you don't need to worry that your pain might hurt me."**

**16. "I listen to you talk about it, and I can't imagine what it's like for you. I just can't imagine how hard it must be."**

**17. "I can't really fully understand what you are feeling, but I can offer my compassion."**

**18. "You are important to me."**

**19. "If you need a friend..... "**

**20. "I'll stick with you no matter what."**

# PROMOTING SUICIDE AWARENESS FOR FUNERAL DIRECTORS

**The purpose of this Suicide Prevention Awareness toolkit is to provide information and educate everyone about the causes, and warning signs of mental illness and suicide.**

**The views and opinions expressed in this toolkit are those of the author who formed this information by researching many of the web sites listed in the back. The information in this toolkit may not reflect the policies of all mental health or suicide organizations.**



**Copies of this toolkit are available on line at**

**www.twlf4suicideawareness.com**

Despite the high death toll of suicidal and mentally ill people, many people have failed to address the problem as a public health concern. Many people view mental illness and suicide purely in terms of its tragic consequences for individuals, not as a problem plaguing society as a whole. Complicating the issue is the stigma attached to suicide and mental health. As a result people with mental illness and possibly contemplating suicide and their families may be reluctant to seek help. Community members may be apprehensive about taking a proactive stance towards the problem.

Suicide and mental health has lagged behind other social problems, such as child abuse and domestic violence, in gaining recognition as an issue that deserves public attention from individuals, organizations, and society. This kind of public attention is essential in order to identify or create the tools and knowledge to prevent suicide, help the mentally ill, and save lives.

Unlike distress signals resulting from physical trauma, such as a heart attack or deadly disease, the pain of people considering suicide may go unrecognized until it is too late. This is why a public health approach to suicide prevention is so important--targeting or identifying at-risk people before they appear in the emergency department of a hospital. Through increasing awareness in the community-at-large, the signs and symptoms of suicide and mental illness can be recognized and addressed.

**More than 90 percent of people who die by suicide have depression and other mental disorders, and/or a substance-abuse disorder.**

***Suicide and mental illness is at the same level as breast cancer was a few years ago. No one dared talk about it and many women died because of the stigma associated with breast cancer. Suicide and mental illness has to be brought to the public attention. People need to be made aware of the symptoms of suicide.***

# IT IS TIME TO GIVE MENTAL HEALTH AND SUICIDE PREVENTION THE ATTENTION IT DESERVES!

# SUICIDE – The Result of a Mental Health Problem

**Much of the information listed on the following 3 pages is from SAMHSA's National Suicide Prevention Lifeline Crisis Centers Conference in Baltimore, MD • July 27, 2011**

**A special thank you to Pamela S. Hyde, J.D. SAMHSA Administrator for providing this information. SAMHSA stands for Substance Abuse and Mental Health Administration. (www.samhsa.gov - 1-877-SAMHSA-7 or 1-877-726-4727)**

**Here are some tough realities of suicide –**

36,000 Americans die by suicide each year
1.1 million (.05 percent) Americans (18 & older) attempted suicide in the past year
2.2 million (1 percent) Americans (18 & older) made a plan in the past year
8.4 million (3.7 percent) Americans (18 & older) had serious thoughts of suicide in the past year
30 percent of deaths by suicide involved alcohol intoxication at or above the legal limit
2005-2009: 55% increase in emergency department visits for drug related suicide attempts by men 21 to 34
2005-2009: 49% increase in emergency department visits for drug related suicide attempts by women 50 or older
Every year some 650,000 persons receive treatment in emergency rooms following suicide attempts
50% of those who die by suicide were afflicted with major depression, and the suicide rate of people with major depression is eight times that of the general population
90% of individuals who die by suicide had a mental disorder
2005 – 2009: More than 1,100 members of the Armed Forces took their own lives; an average of 1 suicide every 36 hours
2010 Army suicide rate (active-duty) soldiers is down slightly (2009 = 162; 2010 = 156)
Number of suicides in the Guard and Reserve up by 55% (2009 = 80; 2010 = 145)
More than half of the National Guard members who died by suicide in 2010 had not deployed
Suicide among veterans accounts for as many as 1 in 5 suicides in the U.S.

**MISSED OPPORTUNITIES = LIVES LOST**

Individuals discharged from an inpatient unit continue to be at risk for suicide

10% of individuals who died by suicide had been discharged from an emergency room within the previous 60 days

8.6% hospitalized for suicidality are predicted to eventually die by suicid**e**

77% of individuals who die by suicide had visited their primary care doctor within the past year

45% had visited their primary care doctor within the month

**THE QUESTION OF SUICIDE WAS SELDOM RAISED!!!!!!!!!**

**3 PRIORITY AREAS FOR CONSIDERATION**

**Issue One:** Too many missed opportunities to save lives in primary care settings

**Issue Two:** Millions of Americans still lack access to evidence-based care and health based professionals that can reduce suicidal behavior

**Issue Three:** Too many discharged from emergency rooms/inpatient units following suicide crisis at significantly elevated risk yet 50% referred to care following discharge do not actually receive outpatient treatment

**DAILY CRISIS OF UNPREVENTED AND UNTREATED Medical/Suicide attempts**

| | |
|---|---|
| Any Mental Illness: | 45.1 million 37.9% receiving treatment |
| Suicide attempts: | 22.5 million 18.3% receiving treatment |
| Diabetes: | 25.8 million 84% receiving treatment |
| Heart Disease: | 81.1 million 74.6% receiving screenings |
| Hypertension: | 74.5 million 70.4% receiving treatment |

**PERCEPTION CHALLENGES**

60% of people who experience mental health problems & 90% of people who experience substance abuse problems and need treatment do not perceive the need for care

Suicides vs. homicides - Suicides outnumber homicides by 3:2

Suicides vs. HIV/AIDS - Twice the number of people die by suicide than who die as a result of complications related to HIV/AIDS

**WHAT AMERICANS KNOW**

Most know *or* are taught:

Basic First Aid and CPR for physical health crisis

Universal sign for choking; facial expressions of physical pain; and basic terminology to recognize blood and other physical symptoms of illness and injury

Basic nutrition and physical health care requirements

Where to go or who to call in an emergency

Most do not know *and* are not taught:

Signs of suicide, addiction or mental illness or what to do about them or how to find help for self or others

Relationship of behavioral health to individual or community health or to health care costs

Relationship of early childhood trauma to adult physical & mental/substance use disorders

**SO, HOW DO WE CREATE A PUBLIC HEALTH APPROACH THAT:**

Engages everyone – general public, elected officials, schools, parents, churches, health professionals, researchers, persons directly affected by mental illness/addiction & their families

Is based on facts, science, common understandings/messages

Is focused on prevention (healthy communities)

Is committed to the health of everyone (social inclusion)

The *TODD WAITE LEGACY FOUNDATION* for suicide awareness is providing information about mental health and suicide prevention to anyone and everyone who comes in contact with people with mental health issues and suicidal tendencies, and the community-at-large to help identify those at risk, reduce stigma, and take other measures to deter and prevent suicides.

## The *TODD WAITE LEGACY FOUNDATION* for suicide awareness

**wants you to know the warning signs of suicide and mental health. They may be listed more than once in this toolkit but they are worth repeating. Everyone needs to learn and know the warning signs You could save a life!!**

### Warning Signs and Symptoms of Suicide

These signs may mean someone is at risk for suicide. Risk is greater if a behavior is new or has increased and if it seems related to a painful event, loss or change.

- Talking about wanting to die or to kill oneself.
- Looking for a way to kill oneself, such as searching online or buying a gun.
- Talking about feeling hopeless or having no reason to live.
- Talking about feeling trapped or in unbearable pain.
- Talking about being a burden to others.
- Increasing the use of alcohol or drugs.
- Acting anxious or agitated; behaving recklessly.
- Sleeping too little or too much.
- Withdrawn or feeling isolated.
- Showing rage or talking about seeking revenge.
- Displaying extreme mood swings.

### Additional Warning Signs of Suicide

- Preoccupation with death.
- Suddenly happier, calmer.
- Loss of interest in things one cares about.
- Visiting or calling people to say goodbye.
- Making arrangements; setting one's affairs in order.
- Giving things away, such as prized possessions.

**Recognize the warning signs of suicide:**

**Here's an Easy-to-Remember Mnemonic:**

**IS PATH WARM?**

**I** Ideation
**S** Substance Abuse

**P** Purposelessness
**A** Anxiety
**T** Trapped
**H** Hopelessness

**W** Withdrawal
**A** Anger
**R** Recklessness
**M** Mood Changes

## Warning Signs and Symptoms of Mental Illness

The following are signs that your loved one may want to speak to a medical or mental health professional.

In adults:

- Confused thinking
- Prolonged depression (sadness or irritability)
- Feelings of extreme highs and lows
- Excessive fears, worries and anxieties
- Social withdrawal
- Dramatic changes in eating or sleeping habits
- Strong feelings of anger
- Delusions or hallucinations
- Growing inability to cope with daily problems and activities
- Suicidal thoughts
- Denial of obvious problems
- Numerous unexplained physical ailments
- Substance abuse

In older children and pre-adolescents:

- Substance abuse
- Inability to cope with problems and daily activities
- Changes in sleeping and/or eating habits
- Excessive complaints of physical ailments
- Defiance of authority, truancy, theft, and/or vandalism
- Intense fear of weight gain
- Prolonged negative mood, or thoughts of death
- Frequent outbursts of anger

In younger children:

- Changes in school performance
- Poor grades despite strong efforts
- Excessive worry or anxiety (i.e. refusing to go to bed or school)
- Hyperactivity
- Persistent nightmares
- Persistent disobedience or aggression
- Frequent temper tantrums
- Recognize the warning signs:

## Facts and Fiction About Suicide:

Perhaps because suicide is rarely talked about openly, there are a lot of misconceptions about issues as to who is at risk, why and under what circumstances, and about how to get help. Knowing the facts is critical to taking action and essential to saving lives.

Fiction: Suicide usually happens with no warning.
Fact: Eight out of ten people who kill themselves give some sort of warning or clue to others, even if it is something subtle.

Fiction: There's always a note left behind when someone commits suicide.
Fact: Actually, in most cases, there is no suicide note.

Fiction: Someone who talks a lot about suicide is just trying to get attention.
Fact: It's just the opposite. More than 70% of people who kill themselves have previously threatened to do so or actually attempted to do so. When someone says they feel this way, take it seriously.

Fiction: People who are suicidal are intent on dying and feel there is no turning back.
Fact: Most people who are suicidal are actually of two minds about it. Part of them wants to die, but part of them doesn't. The main thing they want is to stop their pain.

Fiction: People who attempt suicide once are unlikely to try it again.
Fact: 80% of people who die from suicide have made at least one other attempt already.

Fiction: Someone who survives a suicide attempt is obviously not serious about it.
Fact: Any suicide attempt should be treated as though the person intended to die, and not simply dismissed as an attention-getting device.

Fiction: If you mention suicide to someone who seems depressed, you're just planting the idea in his or her mind
Fact: Discussing it openly can actually help, not hurt.

*I received the call that I did not want to get. I had to pick up the body of a person that had died by suicide. I have thought about what I would do when I was put into this situation of dealing with a death by suicide. Now I have to deal with it. What do I say to the family and friends of the suicide victim? How do I handle the funeral service? This has got to be the hardest funeral service to have. I hope I can handle it.*

## INFORMATION FOR FUNERAL DIRECTORS

The following suggestions are intended to assist funeral directors as they care for family/friends that have lost a loved one due to suicide. Though it isn't possible to answer all questions, it is hoped that these recommendations can help promote healing and help prevent future deaths by suicide.

### Understanding Why

Although many questions are left unanswered when someone takes his or her own life, in retrospect, suicide is rarely entirely unexplainable. Those who end their lives do not act out of moral weakness or a character flaw, as some used to think. They are nearly always suffering from intense psychological pain from which they cannot find relief. In 90 percent of suicides, this pain may be associated with a brain illness, such as depression, schizophrenia, and bipolar disorder, and is often complicated by alcohol or other drug abuse. The illness may have existed for some time or be of relatively recent onset. These people are commonly constrained in their thinking and are unable to make rational choices, the way most are able to do under normal circumstances. There are effective treatments for these brain illnesses, but too often people suffering with this psychological pain are not able to (or choose not to) find access to those treatments. And in some instances, even when treatment is given, it is not enough to prevent the suicide. In a proportion of cases, suicidal acts are responses—sometimes impulsive—to difficult life situations, however temporary those situations may be. Even very close family members and friends may not have had sufficient awareness of the issues to understand the true severity of the crisis. Although some suicidal individuals go to great lengths to hide evidence of their self-destructive plans, most individuals communicate their intent in some way or display signs of suicide risk. However, these signs often pass by without eliciting a response, for a variety of reasons. Sometimes the communications are obtuse, making them difficult to recognize as warning signs. Or, when someone does recognize the signs, he or she may not know how to respond effectively. In other cases, even the most determined responses by loved ones do not prevent a tragic end.

**Suicide is complex.** Historically, it was thought individuals with moral weakness or a character flaw ended their lives. This is far from the truth. One warning sign is that 90% of those who die by suicide experienced a mental illness (depression, schizophrenia, etc.). Also, substance abuse is often a contributing factor. There are effective treatments for mental illness but too often people are not able to or choose not to find treatment. Suicide is the result of an interaction of risk factors, warning signs, and protective factors. Most persons communicate their intent in some way and some go to great lengths to hide their plans. These warning signs often pass by without eliciting a response, for a variety of reasons. The signs could be too obtuse and difficult to recognize or, if the warning signs are recognized by someone, he or she may not know how to respond. Sadly, in some cases, even the most determined response by loved ones does not prevent a suicide.

**Educating the Community**

As a society, we have not informed ourselves well about suicide. Misinformation and inaccurate religious views of suicide create an environment that leaves survivors isolated and embarrassed, even though they may have been powerless to prevent the tragic event. This should be a time for healing, not judging. The individual act cannot be undone. A community will be able to bring healing to its members if it has a better awareness and more accurate understanding of suicide. A better informed community is also better equipped to recognize and respond to signs that someone else they know and love is at risk of taking his or her own life.

**Theological issues**

A suicide within the community will allow people the opportunity to carefully examine his/her views regarding suicide. As a funeral director, the opportunity to bring healing and comfort to survivors by framing informed responses with sensitivity, grace and respect.

**Recommendations for Memorial Services**

Memorial services are important opportunities for increasing awareness and understanding of the issues surrounding suicide and thereby ridding the community of some of its unfounded stigma and prejudice. The ultimate goal of a memorial service is to foster an atmosphere that will help survivors understand, heal, and move forward in as healthy a manner as possible. In preparing for memorial services, it is important to recognize that public communication after a suicide has the potential to either increase or decrease the suicide risk of those receiving the communication.

**Support For and Care of Survivors**

Surviving family members and intimate friends can best be helped by people who accurately understand the special ramifications of a suicide. Only by paying special attention to these factors can community and faith leaders effectively support survivors as they progress on their journeys of grieving and healing.

There are a variety of ways in which the community can support survivors:

- Recognizing the unique challenges in grieving the loss of a loved one from suicide.
- Reaching out to intentionally draw survivors into the fabric of the community's normal activities. Deliberate inclusiveness is an important antidote to the inappropriate stigma that so often accompanies a death due to suicide. The faith community should be an important source of love and grace for the grieving.
- Supporting them with the same gestures of kindness that are extended to others who have deaths in the family (taking in meals, etc.).
- Talking with the survivors about the deceased in the same sensitive way they would about any other person who had recently died. This openness will help the surviving family overcome any embarrassment or shame they may be feeling.
- Encouraging them to seek specialized support in their grieving process, either through support groups for survivors of suicide or by seeking professional grief counseling with a therapist experienced with suicide survivors.

Grieving after a suicide can be distinctly different from other grieving experiences, due to the complexities discussed above. The grief may be marked by extremely intense emotional pain, which, though it may wax and wane, can persist for an extended time. Some survivors may also experience nightmares or flashbacks to the event, both of which are associated with post-traumatic stress.

It is not unusual for well-meaning friends, fellow workers, classmates, etc. to inappropriately criticize those closest to the deceased for the manner or duration of their grieving. It is important to remember that people grieve at their own pace and in their own way.

Sometimes, the difficult life of the deceased has caused such intense conflict and suffering for the loved ones that grief is complicated by a sense of relief.

Whatever the mix, the emotions are usually intense and complex, and require unusual sensitivity and understanding from those in roles of support.

**Help Survivors Deal with Their Guilt**

Survivors are almost invariably left with a sense of unwarranted guilt or an exaggerated sense of responsibility from not being aware of what was going on with their loved one, or not acting in time to prevent the suicidal death. Others may feel unfairly victimized by the act of their family member or friend and by the stigma that society inappropriately places on them. Consequently, it is common for survivors to relive for weeks, months, and even years a continuous litany of "What if . . . ?" "Why did . . . ?," and "Why didn't . . . ?" Rehearsing or rehashing these questions, although a nearly universal experience will not necessarily produce answers that satisfy the longing for understanding and closure. Once again, it is helpful to offer survivors solutions that can be found within their faith traditions. After sufficient time, a better understanding of why suicide occurs may provide the beginning of healing for some survivors.

**Help Survivors Face Their Anger**

Feelings of anger commonly occupy the minds and hearts of those mourning the loss of a loved one to suicide. These feelings may take several forms: anger at others (doctors, therapists, other family members or friends, bosses, the deity, etc.), anger at themselves (because of something done or not done), and/or anger at the deceased (for abandoning the survivor, throwing away all plans for a future, and abrogating responsibilities and obligations). Surviving family and friends should be assured that feeling or expressing their anger is often part of the normal grieving process. Even when their anger is directed toward the deceased, it does not mean they cared for their loved one any less.

**Attack Stigma**

Stigma, embraced by ignorance, can be the greatest hindrance to healing if it is not dealt with directly. Take this opportunity to make as much sense as possible of what could have led to the person's tragic end. One approach is to disclose selected information about the context of the specific suicide, such as a mental illness from which the deceased may have been suffering. (Do not describe the suicidal act itself.) An alternative approach is to discuss the factors commonly associated with suicidal acts (e.g., psychological pain, hopelessness, mental illness, impulsivity) without mentioning the specifics of the person's death. At a minimum, dispel the common myths about moral weakness, character flaws, or bad parenting as causes (except in cases where parental violence or abuse was known to be a contributing factor). Recognition of the role of a brain illness may help community members understand suicide in the same way that they appreciate, for example, heart disease, another common cause of death.

**Use Appropriate Language**

Although common English usage includes the phrases “committed suicide,” “successful suicide,” and “failed attempt,” these should be avoided because of their connotations. For instance, the verb “committed” is usually associated with sins or crimes. Regardless of theological perspective, it is more helpful to understand the phenomenon of suicide as the worst possible outcome of mental health or behavioral health problems as they are manifested in individuals, families, and communities. Along the same lines, a suicide should never be viewed as a success, nor should a non-fatal suicide attempt be seen as a failure. Such phrases as “died by suicide,” “took his life,” “ended her life,” or “attempted suicide” are more accurate and less offensive.

**Prevention imitation and modeling**

Information about resources for treatment and support should be made available to those attending observances. Avoid normalizing the death by suicide that it was a reasonable response to a very distressing life circumstance. Make clear distinction, and even separation, between the positive accomplishments and qualities of the individual and his/her final act. Providing accurate information about mental illness and other risk factors, not glamorizing the act, and encouraging community members about resources available for treatment helps to motivate the community to improve the way it cares for, supports, and understands all its members, even those with the most pressing needs, rather than contribute to the community’s collective guilt.

Public communication after a suicide can potentially affect the suicide risk of those receiving the communication. Some types of communication about the deceased and his or her actions may influence others to imitate or model the suicidal behavior. Consequently, it is important in this context not to glamorize the current state of “peace” the deceased may have found through death. Although some religious perspectives consider the afterlife to be much better than life in the physical realm, particularly when the quality of physical life is diminished by a severe or unremitting mental illness, this contrast should not be overemphasized in a public gathering. If there are others in the audience who are dealing with psychological pain or suicidal thoughts, the lure of finding peace or escape through death may add to the attractiveness of suicide.

**Consider special needs of youth.** If possible hold the funeral service after school hours and not at a school. Youth will associate the school with the funeral. Youth need to be given the choice to attend the funeral or not. In a memorial observance it is helpful to address the young people in attendance very directly since they are most prone to imitate/model the suicide event. Impart a sense of community to the audience and the importance of pulling together. Make suggestions that promote the community to unite for the purpose of caring for one another more effectively. Also, ask the young people to look around and notice the adults on whom they can call on for help in this or other times of crisis, such as teachers, counselors, youth leaders, and coaches. In the course of this discussion, endeavor to normalize the value of seeking professional help for emotional problems in the same way one would seek professional help for physical problems. Focus attention on the hope for a brighter future and the goal of discovering constructive solutions to life's problems. Consider pointing out specific adults who are known to be particularly caring and approachable. Note the desire of these adults to talk and listen to anyone who is feeling down or depressed or having thoughts of death or suicide. Focus attention on the hope of a brighter future and the goal of discovering constructive solutions to life's problems—even when these problems include feelings of depression or other signs of mental or emotional pain. Encourage the youth to reach outside themselves to find resources for living their lives to the fullest and to talk with others when they are having difficulties. Additionally, it is critically important that the young people who are present watch one another for signs of distress and that they never keep thoughts of suicide a secret, whether those thoughts are their own or a friend's. Stress the importance of telling a caring adult if they even think one of their friends may be struggling with these issues.

Schools and faith communities may wish to organize individual classes or small discussion groups with prepared adult leaders in which youth can more comfortably discuss their thoughts and feelings regarding their loss and where questions may be more easily raised and addressed.

**Consider appropriate public memorials.** There have been several cases where dedicating public memorials after a suicide has facilitated the suicidal acts of others, usually youth. Consequently, dedicating memorials in public settings, such as park benches, flag poles, trophy cases, yearbooks, or dances, etc. after the suicide is discouraged. In some situations, however, survivors feel a pressing need for the community to express its grief in a tangible way. Open discussion with proponents about the inherent risks of memorials for youth should help the community find a fitting, yet safe, outlet. These outlets may include personal expressions that can be given to the family to keep privately such as letters, poetry, recollections captured on videotape, or works of art. (It is best to keep such expressions private; while artistic expression is often therapeutic for those experiencing grief, public performances of poems, plays, or songs may contain messages or create a climate that glorifies the method of death and inadvertently increases thoughts of suicide among vulnerable youth.) Alternatively, it is suggested that surviving friends honor the deceased by living their lives with community values, such as compassion, generosity, service, honor, and improving quality of life for all community members. Activity-focused memorials might include organizing a day of community service, sponsoring mental health awareness programs, supporting peer counseling programs, or fund-raising for some of the many worthwhile suicide prevention nonprofit organizations. Purchasing library books that address related topics, such as how young people can cope with loss or how to deal with depression and other emotional problems, is another life-affirming way to remember the deceased.

**Personal care**

As a supporter of survivors, one must pay close attention to their own emotional, psychological and spiritual needs. It is not uncommon for one to experience grief following a suicide, especially if they provided care, counseling, or support to the deceased prior to their death.

# It Is Vital That Funeral Directors Know How To Recognize Suicide Risk and Prevent Suicide.

Here are some steps:

1. **Notice if the person appears quiet and withdrawn**, oversleeps, has crying episodes, has loss of appetite and energy, appears disheveled, the gaze is downward, the voice tone is flat, consistently negative comments, irritability, or says things like, "Life's not worth living," or "I hate my life," etc.

2. Ask: "How would you **rate your mood right now** on a scale of zero to ten with zero meaning life's not worth living and ten meaning life is great?"

3. If the person rates the mood as 5 or under, ask: "Have you had any **thoughts of suicide** or of harming yourself?" *****

4. If the person indicates yes, go to the next step. If the person says, **"I don't know,"** hear this as a "yes" to the question in #3.

5. Ask: "Have you **thought about how you might end your life**?" If the person says yes, the risk is increased.

6. Ask: "**What have you thought about as how you might do it**?" If the means is ineffective or non-lethal, such as cutting wrists, risk is lower. If the means is lethal such as using a gun or jumping from a bridge, etc., risk is higher.

7. Regardless of the means, ask: "**Can we agree together** that if you have thoughts of killing yourself, you will speak to me personally (not my voice mail) before carrying out a plan to harm yourself?"

8. If the person says "no" or "I don't know," to the question in #7, say: "What I am hearing is that you are in a lot of pain right now and thinking of ending your life, so **I am going to take you to get help** right now to help to feel better right away. Will you go? I will make sure you get there safely. Is there a family member or someone I can call to go with you?" Or tell the person you will go with them yourself.

9. Arrange for the person to **be accompanied to a help center**, (a hospital or mental health facility) and **call 911 or 1-800-273-TALK (8255)** to tell emergency staff you are coming.

10. If the person refuses, then ask the person to wait there with someone while you **call police** in another room to report that the person has threatened suicide with lethal means. Ask the police to come and accompany the person to a help center.

***Note: If the person rates the mood as 6 or over (in answer to the question in #3), after feeling consistently depressed, and she/he now reports life is great and she/he is smiling, the risk may be increased because she/he has decided to end their life and have made all arrangements.**

Don't be afraid of being wrong. It is difficult for even experts to understand who is at serious risk of suicide and who is not. Many of the warning signs for suicide could also indicate problems with drug or alcohol abuse, domestic violence, depression, or another mental illness. Young people with these problems need help—and you can help.

# 10 Little Known Facts About Suicide

1. The word “suicide” comes from two Latin roots, *sui* (“of oneself”) and *cidium* (“killing” or “slaying”).

2. It is more likely someone will die from suicide than from homicide. For every two people killed by homicide, three people die of suicide.

3. In America, someone attempts suicide once every minute, and someone completes a suicide once every 17 minutes. Throughout the world, approximately 2,000 people kill themselves each day.

4. Suicide is the 8$^{th}$ leading cause of death in the United States.

5. The spring months of March, April, and May have consistently shown to have the highest suicide rate, 4-6% higher than the average for the rest of the year. Christmas season is actually below average. Some studies suggest greater seasonality in suicides in rural rather than urban areas.

6. Over the last decade, the suicide rate among young children has increased dramatically. In 2002, suicide was the sixth leading cause of death of five- to 14-year olds and the third leading cause of death in preteens. Suicidologists are alarmed that children as young as age two are also increasingly attempting suicide.

7. During 2008, 140 American soldiers committed suicide, breaking all previous suicide records in the military. In the first four months of 2009, 91 soldiers committed suicide. If this rate continues throughout 2009, by the end of the year more than 270 soldiers will have killed themselves, leading some scholars to claim there is a suicide epidemic in the military.

8. Although women attempt suicide about three times more often than men, men complete suicide about three times more often than women.

9. Four out of five people who commit suicide have attempted to kill themselves at least once previously.

10. In America, the most common suicide method for both men and women is firearms, accounting for 60% of all suicides. For women, the next most common method is ingesting solid and liquid poison or pills. The next most common method for men is hanging/strangling/suffocation.

# ***IF YOU ARE THINKING ABOUT SUICIDE READ THIS FIRST!!!!***

If you are feeling suicidal now, please stop long enough to read this. It will only take about five minutes. I do not want to talk you out of your bad feelings. I am not a therapist or other mental health professional - only someone who knows what it is like to be in pain.

I don't know who you are, or why you are reading this page. I only know that for the moment, you're reading it, and that is good. I can assume that you are here because you are troubled and considering ending your life. If it were possible, I would prefer to be there with you at this moment, to sit with you and talk, face to face and heart to heart. But since that is not possible, we will have to make do with this.

I have known a lot of people who have wanted to kill themselves, so I have some small idea of what you might be feeling. I know that you might not be up to reading a long book, so I am going to keep this short. While we are together here for the next five minutes, I have five simple, practical things I would like to share with you. I won't argue with you about whether you should kill yourself. But I assume that if you are thinking about it, you feel pretty bad.

Well, you're still reading, and that's very good. I'd like to ask you to stay with me for the rest of this page. I hope it means that you're at least a *tiny* bit unsure, somewhere deep inside, about whether or not you really will end your life. Often people feel that, even in the deepest darkness of despair. Being unsure about dying is okay and normal. The fact that you are still alive at this minute means you are still a little bit unsure. It means that even while you want to die, at the same time some part of you still wants to live. So let's hang on to that, and keep going for a few more minutes.

Start by considering this statement:

## Suicide is not chosen; it happens when pain exceeds resources for coping with pain.

That's all it's about. You are not a bad person, or crazy, or weak, or flawed, because you feel suicidal. It doesn't even mean that you really *want* to die - it only means that you have more pain than you can cope with right now. If I start piling weights on your shoulders, you will eventually collapse if I add enough weights... no matter how much you want to remain standing. Willpower has nothing to do with it. Of course you would cheer yourself up, if you could.

Don't accept it if someone tells you, "That's not enough to be suicidal about." There are many kinds of pain that may lead to suicide. Whether or not the pain is bearable may differ from person to person. What might be bearable to someone else, may not be bearable to you. The point at which the pain becomes unbearable depends on what kinds of coping resources you have. Individuals vary greatly in their capacity to withstand pain.


When pain exceeds pain-coping resources, suicidal feelings are the result. Suicide is neither wrong nor right; it is not a defect of character; it is morally neutral. It is simply an imbalance of pain versus coping resources.

You can survive suicidal feelings if you do either of two things: (1) find a way to reduce your pain, or (2) find a way to increase your coping resources. Both are possible.

Now I want to tell you five things to think about.

1. You need to hear that people *do* get through this -- even people who feel as badly as you are feeling now. Statistically, there is a very good chance that you are going to live. I hope that this information gives you some sense of hope.

2. Give yourself some distance. Say to yourself, "I will wait 24 hours before I do anything." Or a week. Remember that feelings and actions are two different things - just because you *feel* like killing yourself, doesn't mean that you have to actually *do* it right this minute. Put some distance between your suicidal feelings and suicidal action. Even if it's just 24 hours. You have already done it for 5 minutes, just by reading this page. You can do it for another 5 minutes by continuing to read this page. Keep going, and realize that while you still feel suicidal, you are not, at this moment, acting on it. That is very encouraging to me, and I hope it is to you.

3. People often turn to suicide because they are seeking relief from pain. Remember that relief is a *feeling*. And you have to be *alive* to feel it. You will not feel the relief you so desperately seek, if you are dead.

4. Some people *will* react badly to your suicidal feelings, either because they are frightened, or angry; they may actually increase your pain instead of helping you, despite their intentions, by saying or doing thoughtless things. You have to understand that their bad reactions are about *their* fears, not about you.

But there *are* people out there who can be with you in this horrible time, and will not judge you, or argue with you, or send you to a hospital, or try to talk you out of how badly you feel. They will simply care for you. Find one of them. Now. Use your 24 hours, or your week, and tell someone what's going on with you. It is okay to ask for help. Try:

- Call the National Suicide Prevention Lifeline at 1-800-273-8255 (TTY:1-800-799-4TTY)
- (In Australia, call Lifeline Australia at telephone: 13 11 14
- Teenagers, call Covenant House Nine Line, **1-800-999-9999**
- Look in the front of your phone book for a crisis line
- Call a psychotherapist
- Carefully choose a friend or a minister or rabbi, someone who is likely to listen

But don't give yourself the additional burden of trying to deal with this alone. Just talking about how you got to where you are, releases an awful lot of the pressure, and it might be just the additional coping resource you need to regain your balance.

5 Suicidal feelings are, in and of themselves, traumatic. After they subside, you need to continue caring for yourself. Therapy is a really good idea. So are the various self-help groups available both in your community and on the Internet.

Well, it's been a few minutes and you're still with me. I'm really glad.

Since you have made it this far, you deserve a reward. I think you should reward yourself by giving yourself a gift. The gift you will give yourself is a coping resource. Remember, back up near the top of the page, I said that the idea is to make sure you have more coping resources than you have pain. So let's give you another coping resource, or two, or ten...! until they outnumber your sources of pain.

Now, while this page may have given you some small relief, the best coping resource we can give you is another human being to talk with. If you find someone who wants to listen, and tell them how you are feeling and how you got to this point, you will have increased your coping resources by one. Hopefully the first person you choose won't be the last. There are a lot of people out there who really want to hear from you. It's time to start looking around for one of them.


# Now: I'd like you to call someone.

# Resources & Organizations

**American Association of Suicidology**
**www.suicidology.org 202-237-2280**

**American Foundation for Suicide Prevention**
**www.afsp.org 888-333-2377**

**American Psychiatric Association**
**www.psychiatry.org** 1-888-35-PSYCH or 1-888-35-77924

**Kristin Brooks Hope Center**
**www.hopeline.com 202-669-8500**

**Mental Health America**
**www.mentalhealthamerica.net** 1-800-969-6642

**National Council for Community Behavioral Healthcare**
**www.TheNationalCouncil.org** 1-202-684-7457

**National Youth Violence Prevention Resource Center**
**www.safeyouth.org 301-562-1001**

**Substance Abuse and Mental Health Services Administration (SAMHSA)**
**www.samhsa.gov 877-SAMHSA-7**

**Suicide Awareness Voices of Education**
**www.save.org 888-511-7283**

**Suicide Prevention Action Network USA Inc.**
**www.spanusa.org 202-449-3600**

**Suicide Prevention Resource Center**
**www.sprc.org 877-438-7772**

**The Compassionate Friends**
**www.compassionatefriends.org 877-969-0010**

**The Jed Foundation**
**www.jedfoundation.org 212-647-7544**

**Yellow Ribbon Suicide Prevention Program**
**www.yellowribbon.org 303-429-3530**

*TODD WAITE LEGACY FOUNDATION*  for suicide awareness

**Informational Toolkit Order Form**

| Quantity | Toolkit |
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| | Clergy |
| | College Students |
| | First Responders |
| | Foster Parents |
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| | Mental Health Issues |
| | Military Veterans |
| | Nurses |
| | Primary Care Providers |
| | Senior Living Communities |
| | Survivors of Suicide |
| | Teachers & Youth Leaders |
| | Teenagers and High Schoolers |
| | The Media |
| | The Workplace |

Send toolkits to:

Name_____ Address_____

City _____ State_____ Zip_____

email address_____

Mail order form to: Todd Waite Legacy Foundation, 3857 Canal Ave., Grandville, Mi. 49418
email request to: **twlf4suicideawareness@gmail.com** or fax form to - 616-534-9708
visit our website at **www.twlf4suicideawareness.com** for more **Free** information